Beekay Investments Limited

Greenfields Residential Home

Inspection report

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Date of inspection visit: 03 February 2015
Date of publication: 20/05/2015

Ratings

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

Overall summary

We undertook an unannounced inspection of Greenfields Residential Home on 3 February 2015. The home provides residential care and support for up to 36 older people. At the time of our inspection there were 23 people living in the home.

The service is required to have 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. There was a new manager in post at this service and they were in the process of registering.

There were sufficient staff employed to meet people's needs, and people were supported in a kind and compassionate way which was personal to them.

Staff were aware of people's rights and choices, and provided people with support in a person centred way and respected their privacy and dignity.

Summary of findings

The provider had a robust recruitment process in place, and staff had received a variety of training.

They had a good understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Safeguarding concerns were not always reported in a timely way due to a lack of staff understanding of their responsibilities and reporting processes.

Care plans did not always contain up to date information to enable staff to support people safely and effectively. Activities in the home were limited.

People were involved in making decisions about their care or, where they were unable to, then the staff involved the person's family or representative with any decision making.

People were supported to have a healthy and nutritious diet and to access healthcare professionals when required.

Medicines were administered by staff who had been trained to do so safely, but they did not always receive them at the times they were prescribed.

The new manager had started embedding quality monitoring systems and promoting an improved inclusive culture within the home. People were encouraged to share their views and raise complaints and these were used to drive improvements and achieve a better standard of care.

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?
The service was not always safe

Staff had not always promptly reported to relevant agencies when safeguarding concerns were raised.

Staffing levels were appropriate to meet the needs of people who used the service.

Medicines were not always given in a timely way.

Requires improvement

Is the service effective?
The service was not always effective

Staff had the skills and knowledge to meet people's needs.

Staff were aware of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs).

People were supported to eat and drink enough to maintain good health.

Requires improvement

Is the service caring?
The service was caring

People who used the service had positive relationships with staff and the manager.

People's privacy and dignity were maintained.

Good

Is the service responsive?
The service was not always responsive

People's care plans did not always reflect their changing needs so that care could be provided in a timely manner.

People were provided with regular opportunities to raise any concerns that they may have.

Requires improvement

Is the service well-led?
The service was not always well led

Staff felt well supported and felt the management team were approachable.

The staff demonstrated that there was a positive and open culture which was enabling.

The new manager was in the process of improving the quality monitoring processes so that people received good care.

Requires improvement

Greenfields Residential 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 3 February 2015 and was unannounced. The inspection team consisted of three inspectors and an expert by experience whose area of expertise is caring for older people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service this included information we had received from the local authority and the provider since the last inspection, including notifications of incidents and action plans. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with six people who used the service, the manager of the home, four care staff and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of four people who used the service, reviewed the records for four staff and records relating to the management of the service. We spoke with four family members on the telephone.

Requires improvement

Is the service safe?

Our findings

People who lived at Greenfields were relaxed and happy in the presence of the staff. People said that they felt safe and did not have any worries. One person did however, mention that at times other residents came into their room, which they found distressing. They said that staff would come and assist when they rang the call bell. A visiting health professional said, "I believe people are safe here because the staff know them all so well." We observed staff supporting people to keep them safe by allowing them independence and only intervening when necessary to maintain people's safety. For example, a member of staff sat with people in the lounge and observed them getting up and moving around, but would remind them to use their walking aid or not to attempt walking if they were not able.

We were aware that the provider had failed to report a recent safeguarding incident appropriately. We discussed this with the manager who demonstrated to us that systems had been put in place to ensure that this did not occur in the future. We saw that staff had since received further training on safeguarding and had completed assessments to confirm their understanding and competency in this subject. In addition they had received further advice through the local authority's safeguarding lead who had attended the home and met with staff. Staff had also had further team meetings to discuss their responsibilities in relation to safeguarding people and work towards bringing the required improvements.

Staff demonstrated that they were aware of their responsibilities. They were able to identify behaviours or actions that would raise concerns and the correct reporting processes. One member of staff said, "I would always go to the manager first, but I could also report to social services myself if I thought it necessary." Another member of staff said, "I feel confident with what to do and there is a poster in the office as a reminder." We saw that advice about how to report concerns was displayed and included contact details for the relevant local authority.

Staff were also aware of the provider's whistleblowing policy and how they would report any concerns. They told us that they would be confident to report bad practice if they observed it. One member of staff said, "There is information about whistleblowing to the management and also outside agencies like CQC."

There were sufficient staff on duty to keep people safe. We observed that staff were visible throughout the home and able to assist people quickly when required. Regular agency staff were used if the staffing levels dropped because of sickness or the home's own staff were not able to cover. We spoke with an agency staff member who was working at Greenfields for the first time. They told us that they had been partnered with a regular member of staff so that they could become familiar with the needs of people using the service. Staffing levels were determined according to people's assessed needs and what support they required.

We reviewed the recruitment files and saw that new staff underwent all the necessary pre-employment checks before they started work. These included reference checks, Disclosure and Barring Service (DBS) checks and a full employment history. This enabled the manager to check that staff were suitable and qualified for the role they were being appointed to. The staff records showed that new staff had previous experience of working in health and social care settings and care homes.

The staff had identified when people were at risk and documented this in individual risk assessments. The risk assessments clearly detailed the risk identified and the procedures put in place to minimise this. They included safe movement around the home, risks of falls, and accidents and injuries. These risk assessments were put in place to keep people as safe as possible. The home also recorded and reported on any significant incidents or accidents that occurred within the home. We saw examples of where an incident had occurred and the steps the provider had taken to learn from the incident.

We saw that the home had carried out general assessments which included fire risk assessments, water temperature checks and also environmental assessments which looked at risks from potential power cuts and bad weather. There was an emergency evacuation plan in place, which ensured that in the event of an emergency people using the service were kept safe and could be removed from the service safely, quickly and efficiently.

People were supported to take their medicines by staff that were trained to administer medicines safely. There were suitable arrangements for the safe storage, management and disposal of people's medicines. The home had good relationships with the supplying pharmacy and were currently working with them to reduce the amount of

Requires improvement

Is the service safe?

unused medication that had to be returned at the end of each month. This process had only just been introduced and there were plans for it to be audited regularly. We carried out a check of the medication stock, and the Medication Administration Records [MAR], and found that staff were administering and recording the medication efficiently. We did however observed that the senior care worker responsible for administering medicines did not have protected time to carry out this task. As a result, the 'medicine round' took a long time, because they were called away to deal with other things. This put people at risk of not getting their medicines at the times they are prescribed and there was an increase risk of errors. We spoke with the manager about our concern and they told us that they would look at protecting the time the carer had to administer medication.

Requires improvement

Is the service effective?

Our findings

People received care and support from staff that were knowledgeable about their needs and had received training so that they could undertake their roles effectively. One care worker said, "We get a lot of different training and it comes in different forms." We saw that training was either internet based or face to face. Senior staff in the home were also attending 'train the trainer' courses so they could provide additional training and support to staff. Staff told us that having this additional support whilst training made it "much more relevant". This showed that the provider supported staff to receive training that supported people's care.

All training carried out by staff required a pass mark to be achieved, and where staff did not pass the modules, they were required to repeat the training course. At the end of every course, staff were required to undertake a competency assessment to ensure that they had fully understood the subject and were competent in the subject. Training that had been completed by all staff included medication awareness, infection control, and safeguarding. We saw that some staff had been enrolled on a 12 week dementia training course. The manager told us they were introducing a 'champion' for different areas such as nutrition, dementia and care planning. They said that they wanted to empower staff so that they took responsibility for a specific area and championed other staff to follow best practice. However this remained work in progress and was not in a position to be assessed at this inspection. All staff underwent a formal induction when they started work at the service which included shadowing more experienced staff so that they could become familiar with the home.

The manager had introduced a system so that staff received an annual appraisal and supervision every six weeks from a nominated supervisor. One care worker said, "I know who will be my supervisor, they just need the time to do it." They went on to say that they could approach any of the management team, if they wished to discuss anything prior to their supervision date.

The manager and staff were able to explain their understanding of Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their understanding of peoples changing abilities to provide consent to the care and treatment they received. They gave us explanations and examples on how the MCA and DoLS was used in the home. Staff told us that that they would "assume capacity", which meant that they would always ask people for their consent before providing care because they recognised that the person may sometimes be able to provide consent. We were told by the manager that people's capacity to consent would then be evaluated and assessed regularly. We saw that staff encouraged people to make day to day decisions.

At the time of our inspection there were six people who had a DoLs in place. When we spoke with staff they were able to explain the support that they provided to those people. For people who did not have the capacity to make decisions about their day to day care requirements, their family members and health and social care professionals were involved in assessing their mental capacity to make specific decisions and a written agreement made to provide care in their 'best interest'. The manager told us that if they had any concerns regarding a person's ability to make a decision, they would ensure that appropriate capacity assessments were undertaken. We saw documentation in care plans about peoples' consent for things such as the use of bed rails as these can be considered a form of restraint. Where people were able to consent but unable to sign, staff had recorded this to indicate how they had come to decisions and involved people in their care planning.

Staff told us that they would call a GP if a person was unwell or required an appointment for a review of their treatment. Throughout the day, we saw that a range of health professionals visited people to meet their health needs including community nurses, GPs, phlebotomists and chiropodists. These visits were recorded within people's care notes. A visiting health professional said, "I can rely on the staff here to do what is needed and report accurately." This showed us that the health care needs of people were met.

We observed that staff encouraged and supported people to take fluids, and that snacks such as biscuits and fresh fruit were readily available for people to help themselves. These were particularly provided for those people who had a tendency to wander, and benefited from food they were able to eat whilst walking around. A visitor said, "The food is always good and if people don't eat, it is because they don't feel hungry." We spoke with the cook who demonstrated a good awareness of how to meet people's nutritional needs and people's food preferences. We saw that a four week rolling programme for menu planning was

Requires improvement

Is the service effective?

in place and people had the option of two meal choices. We observed a mealtime and saw that staff supported those people who required a higher level of assistance first, and then those who were independent or required supervision. One person told us, “The food is alright, I get enough, there is a choice of two things.” Another person said, “Breakfast is very good, you can have a cooked one, but I don’t usually. I like the food, there is always a choice.”

We saw that the home used nutritional scoring and worked closely with the local dietician’s service to assist and support people in maintaining a good healthy and balanced dietary routine. Staff documented the fluid intake of those people at risk of not drinking enough and this information was available within their care documents. Staff completed this in real time and completed the form so that a running total was recorded to enable them to identify any shortfalls or people at risk. However, we found that food intake records were not appropriately completed and did not enable effective monitoring of nutritional intake . People were weighed monthly and recorded. Where concerns were identified regarding peoples weight, there were correctly acted upon and referred to the dietician for further advice.

Good

Is the service caring?

Our findings

One person said, “Staff are all very kind” and another said, “They all care for us so well.” We saw good interactions and spoke with staff that knew and understood the people they were providing care to. When we spoke with family members they also confirmed that people were “treated with the utmost respect” and that “everything about the place was good.”

People using the service said that staff treated them with dignity and respect, One person said. “Some staff are better than others.” Another person said. “They are alright.” We observed staff treating people with dignity and respect and being discreet in relation to how they supported people with their personal care needs. Staff assisted people in a kind and respectful manner and had good understanding and knowledge of the needs of the people they supported. They were aware of people’s preferences and interests, as well as their health and support needs, which enabled them to provide personalised care.

People and relatives confirmed that they were involved in making decisions about their care. Two people, when asked if they were involved in decisions about their care or if they had had sight of their care plan, told us they knew they had a care plan and that they were involved in updating it with the care staff.

Staff always spoke with the people in passing and appeared to know them well. They used people’s preferred names when addressing them and did so affectionately. The staff appeared kind and patient with people and gave the right amount of support when needed. One person said, “I don’t think they [staff] have much time, they’re rushed off their feet.” They did however also say that, “They have been very thoughtful to me.” People also commented that they knew the staff that supported them and that any new staff were always introduced to them.

Staff told us that they promoted people’s privacy whilst they undertook personal care by ensuring that the doors were closed during this. Staff also understood the importance of confidentiality.We saw that staff knocked before entering people’s rooms and spoke with people in a soft and caring manner. A visiting relative told us “[family member] is always well looked after, they are clean and dresses well.” Another person whilst talking to us about the staff and if the home was caring said “[family member] is really well looked after, they [staff] are always smiling when I visit.” We observed that people had been supported to dress appropriately to maintain their dignity and received personal care in line with their wishes.

People’s independence was promoted by staff and people told us that they were encouraged to do things for themselves whenever possible. Where people were able to walk unaided, they were encouraged to do so. People were encouraged to eat and drink themselves where they were able to or with minimum support from staff.

We observed and people confirmed that they were offered choice in relation to the time they got up in the morning, what clothes they wanted to wear for the day, whether they participated in social activities or not and the time they went to bed. Staff were seen and heard to offer people choice in relation to where they sat during the day or where they had their meals. People were given a choice of what they wanted to eat at meal time and also when snacks were being served.

People were supported to maintain contact with family and friends and, relatives told us that they were always welcomed and that there were no restrictions on visiting times. We observed people coming and going as they pleased, utilising the garden.

Requires improvement

Is the service responsive?

Our findings

Staff showed a good understanding of the people they provided care for, their needs and how to support them. Staff dealt with behaviour that challenged appropriately by distracting the person with an activity or conversation.

Peoples needs had been assessed and we saw that each person had a care plan in place which provided staff with information on how to best support them. This included the type of hoist and sling to use when moving someone, and the appropriate setting for pressure relieving equipment where people were at risk of pressure ulcers. However, the care plans had not all been reviewed monthly and we found that some information in the care plan was no longer relevant to the person. For example, a person who chose to sit alone because they found it distressing to sit amongst other people did not have this recorded in their care document. Although regular staff were aware of this, there was a risk that agency staff who did not know them well may start to encourage socialisation which they did not want or respond well to. A member of staff said. "We are good at providing care but sometimes the paperwork is not so good." This comment reflected what we saw.

One relatives that we spoke with told us, "The best interests of people are put first so sometimes the paperwork comes second". Another relative spoke to us about the care plans and documentation in the home and they said, "The manager has a bit of a mess to clear up but is getting there." They also said that the manager was responsive because they "only have to mention something and it's sorted".

Relatives told us that they were involved with the care planning of their relatives care and changes were made in response to the person's changing needs. For example we saw that on the day of our inspection, the management had arranged for an extra member of staff to support a person who needed close supervision.

There was a lack of activities at the home and people said they did not have an opportunity to participate in many activities. We did however see that on the afternoon of our inspection, some people were engaged in activities in the main lounge, whilst others were watching old movies in the second lounge, and another person was playing a board game with a member of staff. We spoke with the manager who advised that they had identified that a more structured approach was needed to activities and they were in the process of employing a dedicated activities person for the home, for which we were shown applications for. We also saw that sensory equipment and memory boxes had been purchased to further expand on activities, but that this was still to be set up and used. Staff told us that they looked at people's past history and tried to encourage them to take part in activities that interested them. For example, one person liked to knit and the home had provided them with knitting materials. Relatives we spoke with also said that previously there had not been many activities in the home, but "more activities were now in place."

Although the complaints policy was available in the 'residents information pack' and displayed on the home's notice board, people were not all aware of the provider's complaints procedure. However they said that if they had any concerns they would either speak to a care staff or the manager. The manager showed us the complaints received, but could only account for complaints received since they had been in post. We found that the manager had responded to the complaints in a timely manner and was able to demonstrate how the matter had been investigated and resolved. One relatives that we spoke with said, "If the family were not happy about something we would say so." and "We haven't had a need to complain but I wouldn't hesitate to make a complaint if I needed to." Regular residents meetings had recently been introduced by the manager, which gave people the opportunity to provide feedback and share their views on the service being provided. Records showed that discussions had taken place around the activities and trips people would like the home to arrange.

We saw that people were supported to access the community in order to minimise the risks of isolation and where they were unable to go out, the home arranged for community groups and volunteers to attend the home. We were told that people who were unable to attend the local church services were provided with a pastoral service within the home.

Requires improvement

Is the service well-led?

Our findings

The home had recently recruited a manager, who was in the process of registering with the Care Quality Commission (CQC). The manager was driving improvements to achieve a better standard of care for the people living at the home. For example, we saw that all care plans were in the process of being reviewed and updated to ensure that they correctly reflected the needs of each person. A relative told us, "There has been a big improvement since the management change." The manager was able to demonstrate how they had been working towards embedding an improved culture within the home which was clearly visible during this inspection. The philosophy within the home was to put people first regarding the care and support they were being provided with.

Staff told us that the manager was, "working hard to get things right". They said that the manager was bringing about improvements in the home, including more activities for people. The manager was also encouraging staff to take ownership of certain tasks within the home and developing lead roles for staff. For example, a member of staff was the infection control lead. This was being done to further encourage a high standard of care. Staff were aware of the whistleblowing policy and were encouraged to speak out if there were any areas of concerns regarding care practices in the home. Staff told us that if they had any concerns, they would raise this with the manager.

The manager had recently started to carry out quality checks within the home. These included checks of the premises, care plans and medicines administration records. When the manager identified issues and concerns, these were documented and discussed with staff to promote further learning. The manager told us that action plans were put in place to provide timescales and directives for the required improvements. The manager told us that they were working to make further improvements in the quality of care they provided, and they were working with the provider to drive these improvements forward. For example, when the manager had identified the need for a dedicated activities person, the provider supported this proposal and had allocated funding for the post and the equipment needed to provide meaningful activities for people to be involved in.

The provider was in the process of sending satisfaction questionnaires to people and their relatives to enable them to share their views and experiences, and to provide feedback about the home. We noted that several compliments had been received over the past six months. Relatives provided positive comments about the care being provided and the recent change in management. People said, "There has been a big improvement since the change in management" and that the home is "a site better then it has been" since the change in manager.

We saw that the manager was visible and accessible to people due to the location of her office. They encouraged open and transparent communication within the home and we saw that people using the service freely came into the manager's office and chat with them. The home had also recently introduced 'residents meetings'. We saw from the notes that the manager had discussed improvements with people and also encouraged feedback on what they would like to see in the home, for example future activities and trips out.

The provider had not always informed the CQC of all notifiable incidents within acceptable time frames. However the manager had put systems in place to ensure that notifications were now sent in a more timely manner. Staff had also received additional training and support on how to record and process notifications. This demonstrated how the provider had used this incident to promote learning to further drive improvements.