Granby Holdings Limited

Granby Rose SDU

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 23 October 2014. Granby Rose SFU provides accommodation and nursing care for up to 25 people living with dementia who have residential or nursing care needs. There were 23 people living at the home when we visited.

During the visit we spoke with the 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. We also spoke with fourteen members of staff including, registered nurses, care staff, activities organiser and kitchen staff. We also spoke with staff attending the service to carry out quality assurance checks for the provider's accredited dementia care scheme (PEARL). We also spoke to two visiting professionals.

The home met all the regulations we inspected during our last inspection which was carried out on 23 October 2014.

The service was safe. Staff recruitment procedures meant appropriate checks were carried out to ensure staff were

Summary of findings

suitable to work with vulnerable people. Staff had received training with regard to safeguarding adults and were able to demonstrate they understood the action to take if they suspected abuse. Staff had received training to equip them for their role; this including mandatory health and safety training. We saw staff showed care, compassion and respect for people. The experiential training they received contributed towards this. The service provided meaningful activities and occupation which reflected people's interests and choices. The relationships staff had developed with people helped them be imaginative in the way they engaged people in activities.

The service was well led. Staff people using the service and their relatives and representatives expressed confidence in the manager abilities to provide good quality care. The service was responsive to any comments or complaints they received in making the necessary improvements where shortfalls were identified and there were effective quality assurance systems in place to monitor the service.

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

This service was safe.

There were policies and procedures in place to reduce the risk of people coming to harm.

Staff had received training with regard to safeguarding people and they were able to demonstrate good understanding of the issues and how to report any suspected abuse.

Recruitment practices followed helped reduce the risk of unsuitable people working at this service.

There were sufficient numbers of staff to ensure that people had their needs met in a timely way.

We found the registered provider had systems in place to protect people against risks associated with the management of medicines.

Is the service effective?

Good

The service was effective.

People's needs were assessed and recorded. Information about people's need was detailed and as such assisted staff to provide care in a way which the person preferred.

Staff had completed training to equip them with the skills and knowledge to provide specialist care for people living with dementia.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). The registered provider knew when to gain an independent mental capacity assessment, they were about to refer everyone to the local authority for further assessment to help to protect people's rights.

People's nutritional needs were assessed and those people at risk of weight loss were monitored and referrals to appropriate health professional made. Attention was given to the dining experience and was enhanced by having two sittings in order that staff were available to support people with their meals.

Is the service caring?

Good

The service was caring.

We observed staff treating people with kindness and compassion, staff spoke with people at a pace which appeared comfortable for them. We saw staff kneel so they were able to make eye contact and used physical contact appropriately.

Is the service responsive?

Good

This service was responsive.

People's needs were recorded in a person centred manner and reflected current good practice with regard to providing dementia care.

Staff knew people well and people's needs were reviewed regularly.

Summary of findings

Staff had good knowledge of people's background and social histories and were able to use this to reassure, build relationships and connect with people and engage people in meaningful activities.

Complaints were taken seriously. The service was open to accepting any feedback and make the necessary improvements where shortfalls were identified.

Is the service well-led?

Good

The service was well led.

The manager had specialist knowledge and expertise with regard to providing care to people living with dementia. He was able to demonstrate an understanding of current research, national dementia care strategies and sought continued professional development.

Staff reported a strong leadership and with positive support with the emphasis on good team work and learning evaluating practice.

There were effective quality assurance systems in place and the manager welcomed feedback on the quality of the service so that improvements could be made.

Granby Rose SDU

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 23 October 2014 and was unannounced.

The inspection was carried out by two inspectors, a specialist professional advisor with expertise in dementia care 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 carried out observations of staff interacting with people and included two structured observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was reviewed along with other the information we held about the service and the service provider to assist in the planning of the inspection. We had received no concerns since the previous inspection carried out on 23 October 2014. We contacted the local authority contracting and commissioning teams who report no concerns about the service provided.

During the inspection visit we reviewed four people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings and satisfaction surveys, medication storage and administration. We also spoke to the registered manager and the regional manager; fourteen members of staff including, registered nurses, care staff, activities organiser and kitchen staff. We also spoke to two visiting health professionals; two people who lived at the service and two relatives.

Good

Is the service safe?

Our findings

We asked people who lived at the home if they felt safe living there. One person living at the home said, "Yes I feel safe. I would seek someone in charge if there was any problem." We spoke with another person whose relative required support with moving and transferring. They said they thought their relative's handling was undertaken with sufficient care and safety. They said, "I have observed them being hoisted several times. I have never seen a problem. The staff are mindful of how out of control she must feel and explain what they are doing every time they move her."

We saw the provider had safeguarding and whistle blowing (telling people) policies in place, to provide staff with guidance about protecting people from abuse. The staff we spoke with were aware of the different types of abuse and described how they would respond if abuse was suspected or happening. Staff told us they had received safeguarding training. The training records we looked at confirmed this. This helped to make sure staff were aware of their roles and responsibilities in identifying, reporting and recording abuse. The manager demonstrated openness and transparency with regard to safeguarding and had made safeguarding referrals to the local authority. We saw evidence that the manager worked positively with other agencies to ensure people were kept safe.

The home was purpose built with accommodation situated on the ground floor with level access to an enclosed quadrant garden area. During the day we observed people moving around the home freely and accessing the outdoor space. We saw hand rails to assist people and alcoves around the corridors for people to stop and rest safely. We noted appropriate signage to support people in navigating around the home and recognised use of colour to aid people to identify bathroom areas.

The manager collated information about accidents and incidents and had monitoring systems in place to analysis trends and patterns. We saw in these records evidence that one person had experienced an increase in falls at a specific time of the day. Increasing staff support for that person at that time of day had reduced the number of falls effectively.

We reviewed four people's care plans and saw they contained risk assessments. There was evidence of assessments in place. For example the Abbey Pain Scale and Distressed Reaction Monitoring Form was being used which were appropriate for people living with dementia and lacking capacity to articulate pain and distress.

We spoke with the manager about staffing levels and reviewed actual staff rotas for the previous four weeks. The service was registered for 25 people, with 23 people resident on the day of the visit. We saw from the rota's we looked at that the home's usual staffing compliment included one qualified nurse and four care staff supported by the manager, activities organiser and ancillary staff. Overnight there was one qualified nurse and two care staff. Any vacancies, sickness and holiday leave was covered by bank staff.

Staff were deployed effectively; from our observations and discussions with staff they were clear about their responsibilities and tasks assigned to them at the beginning of the shift. We observed that people were attended to promptly and staff anticipated when people required support. On the day of the inspection the manager and deputy were due to attend training at another location. To cover the management and nursing care of the home an agency nurse was on duty and in charge. We spoke to the agency nurse who confirmed this was the first time she had worked in the home. Discussions took place regarding with the manager about arrangements when the manager and deputy manager were not available and whether the nurse in charge role was the most appropriate person to take on this responsibility, particularly as in this instance that person was working for the first time in the home and was an agency nurse. The manager agreed that another senior member of staff who was familiar with the home and the people living there, would be better placed to undertake this role, leaving the agency nurse to take responsibility for nursing tasks.

We spoke with the manager about recruitment processes. They told us they were supported by a human resources department who processed applications and tracked whether important information had been received and checked to make sure those using the service were not at risk from staff who were unsuitable to work with vulnerable people. The manager told us two references would always be obtained as would a Disclosure and Barring Service check (previously called Criminal Records Bureau (CRB)

Good

Is the service safe?

check) to make sure people employed were suitable to work with vulnerable adults. We looked at three staff recruitment files and saw applications forms, interview records and relevant checks had been completed.

The manager explained new staff complete a 12 week induction which consisted of a combination of e learning, face to face and competency based assessments. Staff were appointed a mentor to provide additional support through the induction process.

We checked the systems for the storage, administration and record keeping with regard to medication. Medication was located in a locked clinical room. Medication was stored in two lockable trolleys secured to the wall and a lockable medication fridge. We also saw a number of other lockable cupboards in the room, a work top and hand wash facilities. The deputy manager explained that medication was supplied in a monitored dosage system with pre-printed medication administration sheets (MAR). Medication boxes were colour coded to indicate whether morning, lunchtime or evening medication and were transferred according to time of day from one trolley to the other. This meant medication taken out into the home was the only medication required for that time of day. We completed a random check of stock against MAR charts and found them to be correct. We noted prescribed Timodin cream located in the trolley and saw the label specified that the cream should be stored under 15C; when we visited the room thermometer measured 20C. We raised this with the deputy manager who said she would ensure the cream was stored in the fridge. We saw controlled drugs were stored in a recommended locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record.

We noted that where people were prescribed PRN (as required) medication information was recorded about the circumstances under which medication could be administered, this included nonverbal clues the person might present if they were unable to, for example, express pain verbally.

We saw one person prescribed Warfarin, the deputy manager reported this person was visited weekly by the phlebotomist and the deputy manager reported a good service with results from bloods taken that morning and returned the same afternoon. The manager however confirmed that they were in discussions to improve this service still further as at present initial readings were fed back over the telephone and he wanted a written report to reduce the likelihood of errors.

Good

Is the service effective?

Our findings

We found the service was effective in meeting people's individual needs. We spoke with the manager about how people were admitted to the home. They told us pre-admission assessments were completed and every effort was made to involve other professionals and relatives in order to gather as much comprehensive information to ensure a placement at the home was appropriate.

We looked at four people's care records and saw each person had a detailed assessment completed, which identified their needs, individual preferences and choices. We could see where the person had been unable to participate towards these and relatives had made a contribution based on their prior knowledge of the person and their history. We spoke with staff about people's records we had looked at and they were able to demonstrate they knew people well and their knowledge reflected what we had seen recorded. For example a member of staff spoke to us about the reactions displayed when a person became distressed and we saw this recorded in their care plan.

We spoke with staff about how they were supported to fulfil their roles. They told us they received a variety of training which included specialist training. The provider operates a quality mark scheme called PEARL, which assesses quality standards in the understanding and delivery of specialist dementia care. The PEARL team were attending the service on the day of the inspection to deliver some training and carry out quality assessments. We spoke to the team and members of staff about the training. They spoke in particular of the 'experiential training' which all members of staff including, ancillary staff undertake. This consistedof spending a day as a person living with dementia and experiencing both good and poor care. Staff reported that this experience had a profound effect on their care practice and one member of staff told us they were 'proud' to have undertaken this. The manager spoke with us about staff meetings and using 'live' events to evaluate and complete lessons learned exercises. They believed this had a positive and changing influence on improving care practice.

Staff told us they received regular supervision, which encouraged staff to consider their care practice and identify areas for development. The records we looked at confirmed this.

We spoke to a relative who told us they felt confident staff knew their relative well and said, "They (staff) know the little things about residents and it's the little things that matter." Our observations during the inspection indicated staff knew people well and their responses to people were personal and individualised. Staff showed good skills at interpreting people's needs and responded in a calm and non- restrictive manner. For example we observed a person becoming distressed; a member of staff fetched a doll for the person to cradle, which helped soothe them and reduce their distress.

People had access to all parts of the building and secure outdoor area. We saw one person regularly go into the garden throughout the day; staff encouraged them to wear a coat as it was chilly outside.

We observed lunchtime which was served in two sittings, this meant there were sufficient staff to provide individual support to people and promote a relaxed social occasion. During lunch we saw people offered a choice of food and those who needed it were supported discreetly. We observed light hearted banter which contributed to a positive meal time experience. There was some use of coloured crockery to aid recognition and independent eating. We saw people were weighed regularly and saw in two care plans where weight loss had triggered nutritional assessments and there had been referrals made to the dietician and speech and language therapists, with specific care plans for staff to follow.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is appropriate and needed. The manager told us all staff had received training with regard to Mental Capacity Act (2005) and deprivation of liberty safeguards. When we spoke with staff they demonstrated a good understanding of the issues with particular regard to day to day care practice. An example was of a person accessing outdoor space; this we observed as this person went out into the garden regularly throughout the day, staff supported this person to wear appropriate clothing to keep them warm and respected their wish to go outside.

The manager told us they had a good working relationship with the local authority DoLs team and had made

Good

Is the service effective?

appropriate applications. At the time of the inspection there were two approved deprivations in place. We saw as part of the care planning process people had their mental capacity assessed. We saw an example of where a best interest decision had been taken to administer essential medication with the remaining medication left for the person to decide whether they took it or not. We saw information recorded in this form demonstrated 'thinking' to show how best interest decisions were arrived at. Our specialist advisor felt this was good practice and demonstrated a skilled level of understanding with regard to people's capacity and choice.

The local area operated a system where each service was linked to a specific general practitioner surgery, (although people living at the home have the choice to remain with their doctor prior to admission), they held a surgery in the home every week and responded to emergency visits if required. We spoke to the doctor as they was holding a surgery on the day of the inspection. They reported a good working relationship and said their experience of the care provided at the service was 'spot on'.

The service was purpose built with bedrooms and small communal areas located around a quad with a secure garden. There was specialist coloured signage to support people in recognition and location, for example pale green doors and signs for bathrooms and toilets. People's bedrooms were personalised and fitted with appropriate moving and handling equipment if needed.

Good

Is the service caring?

Our findings

Some people living at the service with dementia were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff. We observed staff treating people with kindness and compassion, staff spoke with people at a pace which appeared comfortable to them; staff knelt down enabling them to make eye contact and used physical contact appropriately.

We spoke with two relatives who both expressed satisfaction with the care their relatives received.

One person told us, “They’re (staff) lovely.” We saw a member of staff come especially up to this relative and enquire about the resident. The relative told us afterwards “That carer knows everyone. She’s absolutely fab. They know the little things about the residents.” Another relative said, “The staff regularly stop and talk to mum even if there’s no response.”

People’s bedrooms were personalised and for those who chose to, brief personal histories were displayed outside their bedrooms. We had some discussion with the manager about the confidentiality of this information and were reassured that relatives and the individual made the decision about whether to have this information displayed and how much detail was included. Staff told us having this information helped them understand people’s distressed reactions, involved people in activities which have been previously enjoyed and assisted in providing reassurance

We were told people had access to an external advocacy service if required and the service promoted an open door policy for people who live at the service and their relatives. We were told for people at end of life care, the service would engage people and/or their relatives in advanced decision making which covered peoples expressed preferences and choices for their end of life care. The advanced decision making would consider areas such as equipment, specialists’ services (such as palliative care) and refusal of treatment. We did feel the service could engage further in end of life care planning, in terms of having a supportive care register in place where people are identified as being in the last 12 months of life to include preferred place of death and anticipatory prescribed medication. The manager did say that the service works closely with the doctor’s services and the process of regular visits would ensure any deterioration would not go unnoticed.

Good

Is the service responsive?

Our findings

Prior to people being admitted to the service an assessment of their needs was completed to ensure the service could meet their needs. We looked at four people's care plans; we felt the format of the documentation difficult to follow and locate information easily. We were told a review of the format was being carried out and a new more streamline care plan format was being implemented by the corporate provider. However, we saw the content of the care plans provided sufficient information to explain how each person needed to be safely supported by staff. We saw that people's wishes and preferences were clearly recorded, so they were cared for in the way they had chosen. The manager had implemented a daily progress record which we saw was linked to care plans, which demonstrated care plans were being followed. The provider used assessments to support people who lacked capacity and were not able to verbalise for example the Abbey Pain Scale and Cornell assessment for depression. Both assessments identify indicators for pain and depression using the individual's non-verbal physical and facial expression and reactions. This helped staff respond to people's pain and interpret people's mood and emotions when they were unable to verbalise this.

Risk assessments were in place for areas such as moving and handling, falls, nutrition, skin and pressure care and risks to people were minimised and managed appropriately. Risk assessments and management plans were reviewed regularly. This helped staff deliver continuity of care and support and ensured that changing needs were identified and met.

Arrangements were in place to ensure people had access to meaningful activities. The service employed a dedicated activities organiser who took responsibility for coordinating and evaluating activities. There were two events boards located in different parts of the building, both had pictorial prompts. We observed an organised "sing along' in the lounge with two staff and the activity co-ordinator joining in. A large colourful beach ball with names of songs printed on was thrown to the music. Some people actively participated and appeared to enjoy the physical activity. We saw staff sing along enthusiastically and actively engaged with those people less engaged. They did this by carefully approaching at eye level and singing to them gently with appropriate touch and encouragement.

We spoke with the activity coordinator about how they planned activities. We were told they kept an assessment log which was completed after each activity to build a picture of what each person experiences and if there were any signs of enjoyment or not They also told us "Musical movement is very popular and we put things on that the relatives can do too." We were told that activities were not only provided for groups of people but also on an individual basis. For example we were told staff played vintage board games with individuals. We observed during the afternoon the activity co-ordinator playing a game with counters with a person in their room.

We spoke with one person who said, "I like to play the piano – but I feel too shy to play in the music room. There was a small keyboard in the corner of the person's room and they also commented, "I like to play that in my room."

We spoke with a visiting massage therapist whilst they were massaging a person's hands in a communal area. We noted this person's posture seemed relaxed and they were smiling. The therapist said "I have been coming regularly for many years. Granby Rose was the first place to respond to the idea of massage therapy when I started out. This impressed me and I've been coming ever since. I am DRB checked. The manager puts the relatives in touch with me if they are interested."

On the day of the inspection people were informed of a baking session by the activities coordinator who used a pictorial aid to enhance people's understanding. Prior to the session we observed one person was woken to join in; the member of staff explained she was waking them because 'they really enjoy baking and wouldn't want to miss it. ' We observed the activity, which people appeared to enjoy. Afterwards we saw the activities coordinator spend time with another member of staff completing an assessment log to reflect on how well the activity had gone and to record how people had engaged in it.

During our SOFI observation we observed two people in a lounge area. This was a small area with some discreet background music. During the half hour we spent in this area we saw one person sit passively for 15 minutes and the other person was asleep. During this time we saw members of staff come in to check on people and offer reassurance.

The service had policies and procedures with regard to concerns, complaints and compliments. The manager told

Good

Is the service responsive?

us they promoted an open door policy and the location of their office meant they were visible to people, their relatives and visitors. We reviewed a recent complaint and saw that the service's complaints procedure had been followed and responses to the complainant had been made accordingly. The manager also told us that analysis of complaints formed part of quality assurance and lesson's learned for the organisation, as a whole and individually as staff whichever was appropriate.

We spoke with a relative who told us they felt comfortable approaching the management team if needed. They said "Oh yes, If I want to point anything out I generally write a letter and I do get a reply. They do respond to anything I raise and I would persist if necessary though I've never had to complain. I know there are meetings with staff available, but I don't go because it's not convenient for me."

We spoke to another relative about access to health care. They said, "If my wife is unwell the doctor comes very quickly – better than at home." They also told us, "All the residents were changed to the same doctor's practice. I wanted my wife to stay with our usual practice and was given the choice to do so."

The manager told us the service operated a 'resident of the day' to review people's care. This meant that on 1st of the month the person in room one would be reviewed, the 2nd room 2. The review was a 'whole person' review with all staff departments contributing so, for example, housekeeping and kitchen staff were involved and the focus was not just the personal care the person was receiving but their whole experience within the home.

Good

Is the service well-led?

Our findings

This service was well led. The manager was knowledgeable and experienced; from evidence gathered through this inspection we could see they placed much emphasis on person centred care and encouraging people to maintain and increase their independence. The manager told us they did not operate a 'blame culture' and promoted an ethos of openness and learning from feedback to improve people's lives and develop staff skills and expertise.

The manager had specialist knowledge and expertise with regard to providing care to people living with dementia. They were able to demonstrate an understanding of current research; national strategies and a commitment to continued professional development. The service promotes person centred care and training for staff, and used recognised, renowned dementia care models. For example the Dawn Booker VIP assessments. (Values, Individuals perspective and social).

From our discussions and observations with staff we could see the manager's style and expertise was imbedded in staff practice. Staff told us they had confidence in the manager and felt well supported through staff meetings and supervision. They reiterated the open door policy and said they felt the manager was approachable and fair. We were told that where high performance and innovation was identified there were staff awards as a form of recognition.

The service had a range of quality assurance systems in place to help determine the quality of service the service offered. These included monthly visits by a senior manager and we looked at the past three months audits. These had included auditing staffing, the environment, record keeping, training and discussions with the people living there and with staff. The manager told us the provider is in the process of implementing a system to ensure appropriate staffing levels called (CHESS) Care Home Equation for Safe Staffing tool ("CHESS").

People who used the service and their relatives were sent questionnaires annually which were returned anonymously. The results had been analysed and published. We saw the results of the most recent survey which showed that people were satisfied with the service they received.

Staff meetings were held at regular intervals which gave staff the opportunity to share their views and to receive information about the service. Meetings were arranged with different staff groups so that appropriate information could be shared. Minutes of the meetings indicated that staff were able to voice their opinions and share their views.

We saw evidence of working with other professionals, for example the local doctor, in an initiative to reduce the number of admissions to hospital for people living with dementia. Individuals have a 'pink passport' completed which details essential information for instances when people move between providers, for example an emergency admission into hospital.

We reviewed records of accidents and incidents. The manager explained and had shown us evidence that incidents were analysed and action taken to reduce incidents. We saw this for falls and distressed reaction monitoring.

The service had in place emergency contingency plans. There was a fire risk assessment in place for the service and for individuals (Personal emergency evacuation plan).

The manager was able to demonstrate their understanding of their responsibility to notify the commission of specific events and incidents. From a review of our records we saw that notifications had been reported to the Care Quality Commission as required.