

GCH (Alan Morkill House) Limited

Alan Morkill House

Inspection report

88 St Marks Road
London
W10 6BY

Tel: 02089641123
Website: www.goldcarehomes.com






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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 5 and 7 April 2015 and was unannounced on the first day. We last carried out an inspection on 9 November 2015, where we found that the service was in breach of regulations with regards to providing safe levels of staffing. At this inspection we found that the service had made the improvements we required.

Alan Morkill house is a residential service providing accommodation for up to 49 older people and people living with dementia. At the time of our inspection there were 36 people living in the service. The provider had recently closed the dementia unit on the ground floor, meaning that there were now six units across the three upper floors of the building. Each of these units had a dining room and shared kitchen. On the ground floor there was an activities room, lounge and kitchen.

The service had a registered manager, who had registered in February 2015. 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 had been significant improvements in staffing since our last inspection. Staff and people who used the service told us that this had made them feel safer and better supported. The provider had measures in place to manage the risks of people falling or leaving the building in a way which may be unsafe and these were reviewed regularly and in response to accidents.

We saw that the provider used a monitoring system to notify staff when people may have fallen and to allow people who used the service to call for help. Staff responded quickly to calls from this system, however the service did not have measures in place to ensure the system was working effectively, which meant there were times when people were not safe. There was also a large number of vacant rooms in the service, where the provider had not carried out appropriate measures to reduce the risk of legionella from unused taps and showers. The provider has since put measures in place to manage these risks.

The new registered manager had an improvement plan in place for the service. As part of this, staff training was being reviewed and training was arranged when necessary, and a new timetable was in place for staff supervision. However, at the time of our inspection staff training and supervision was still not adequate to ensure that staff were able to carry out their roles effectively.

We saw that people were treated with respect and appeared clean and well-cared for. People had the opportunity to attend activities which were appropriate for people living with dementia and carried out in an inclusive and sensitive manner. Care plans provided detailed information about people's support needs and wishes, these were routinely reviewed every month. People's nutritional needs were assessed monthly and measures were in place where people were at risk of dehydration or malnutrition to manage these risks. We saw that people were able to choose their own meals, and the kitchen had systems in place to ensure

that people received food of their choice which met their nutritional and health needs.

Where people may be deprived of their liberty due to restrictions such as door locks, the provider had carried out its responsibilities to apply to the local authority and demonstrate that these restrictions were proportionate and in the person's best interests. However, staff were not working in line with the Mental Capacity Act 2005 to demonstrate that a person's care plan was in the person's best interests where they did not have capacity to consent to their own care.

We saw a number of compliments about the service, and relatives and people who used the service were positive about the care staff and management. Where people had complained about the service these concerns were addressed quickly and effectively. The registered manager had brought about significant improvements to the service, however it was too early for all of these improvements to be effective or sustained.

We found breaches of regulations concerning the safety of people who use the service and the training of staff. We have made a recommendation regarding the consent of people to their care. You can see what actions we have told the provider to take at the back of the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Despite improvements, the service was not safe in all areas.

Additional staffing had been put in place following our last inspection, meaning that people were now safely supported.

The service maintained a call bell system including sensor mats for people's beds. Calls were responded to quickly by staff. There were not adequate checks that this system was operational.

Checks were carried out of the safety of the building, however there was a risk that people may be exposed to legionella from unused taps and showers. Risks to people who used the service were assessed and reviewed on a monthly basis.

Medicines were safely administered by staff who were subject to observations conducted by the management team of their skills and abilities to do so.

Requires Improvement 

Is the service effective?

The service was not effective in all areas.

Where people may be deprived of their liberty, the service had taken appropriate steps to notify the local authority. However, where people did not have capacity to consent to their care, the service could not demonstrate that it was working in line with people's best interests.

Staff did not have training in several important areas in order to carry out their roles effectively.

Systems were in place to address people's nutritional and health needs.

Requires Improvement 

Is the service caring?

The service was caring.

People and their relatives told us staff were kind and they felt well cared for. We observed respectful and kind interactions from staff who respected people's privacy. People who used the

Good 

service appeared clean and well-dressed.

People benefitted from an activities programme which was regularly discussed and reviewed. This was carried out in a way which involved people and respected their choices.

Care plans detailed people's choices and preferences, and people had been supported to express their wishes for after their deaths. We saw that people had choice over their food.

Is the service responsive?

Good ●

The service was responsive.

People had detailed assessments of their care needs, preferences and wishes. These were reviewed on a monthly basis, and changes were made to care plans in order to reflect these. We saw that these changes were put into practice.

The provider had a policy for dealing with complaints, and these were addressed promptly and outcomes were recorded. People knew how to make a complaint and were comfortable approaching the registered manager.

Is the service well-led?

Requires Improvement ●

Aspects of the service were not well led.

The registered manager was responsive to concerns about the service and had a service improvement plan in place. However, in some areas these improvements were still in progress or we did not have enough evidence to say that they were sustained.

There was an effective system of audits for care records and the management of risks.

The provider had introduced a regular programme of staff supervision, but this was in its early stages. Team meetings were carried out regularly and demonstrated leadership by the registered manager. People told us they were confident bringing concerns to the registered manager.

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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.

The inspection took place on 5 and 7 April 2016 and was unannounced on the first day. On the second day the provider knew that we would be returning. The inspection was carried out by two inspectors on each day, including a pharmacy inspector on the first day.

In carrying out this inspection we reviewed information regarding significant incidents since the previous inspection that the Provider was required to notify us of. We looked at records for the storage and administration of medicines and the records of care relating to four people. We looked at the staff files and supervision records of four staff, rotas and allocation sheets and other information related to the running of the service. We spoke with eight people who used the service, one relative, six care workers, the Registered Manager, Deputy Manager, Area Manager, Activities Co-ordinator and two kitchen staff. We also met with a member of the Provider's quality team.

Is the service safe?

Our findings

At our inspection on 9 November 2015 we found a breach of regulation concerning safe staffing levels. We found that floating support was not being provided as required, meaning that staff working alone in each unit were unable to summon additional staff when people needed it. We found at this inspection that the provider had made the improvements we required. Floating support was in place for the dementia units at all times. In other units there was an allocated worker in the morning, and at other times staff were able to access floating support on other floors. The registered manager undertook daily checks of the rotas to confirm that adequate staffing was in place. The provider had installed cordless telephones on all units which staff were able to carry with them and to use in order to request additional support without leaving the unit. Staff told us "It's better than before and I'm happy about it" and "It has changed since before and has improved, especially when supporting people in the morning."

People told us they felt safe living in the service. One person said, "It's safe, it's pleasant and people look after me." Another person said, "Even though I'm quite independent staff check on me throughout the day." Another person told us that the security system had been improved and entry codes were changed regularly; "I feel much more secure now this is in place." One person had told us that they had felt harassed by a member of staff, but after speaking with management it had stopped.

The service had a Medicare system in place. This provided call bells to people to use in their rooms to call staff or to indicate an emergency. On several occasions we activated these emergency alarms and staff responded in under a minute. Additional equipment such as sensor mats on people's beds were being used with this system when people were at risk from getting up unsafely in the night. We saw that when the alarm was activated, it could only be cancelled by staff going into the person's room. We reviewed the logs of the system and saw that in all cases staff had responded to calls within three minutes. However, we found that the system had not logged any alerts during a three-day period in March 2016, which meant that the system may not have been working correctly. This was noted and repaired only on the third day. The Provider showed us that following our inspection, they had now introduced twice daily checks to ensure that the system was working correctly.

The temperature of water from all outlets was checked on a weekly basis to reduce the risk that people may be scalded by hot water. We also noted that although there was a risk assessment in place for legionella, there was no procedure in place for ensuring that outlets that were not currently in use were being flushed regularly in order to reduce the risk of an outbreak of legionella. This was of concern as an entire unit on the ground floor was disused, and all rooms had a kitchenette which was not in regular use. The provider showed us following the inspection that they had put a procedure in place to manage this risk.

The issues in the two paragraphs above constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us, "I'm trying to get rid of neglect and poor practice." Where information was received suggesting that a person was at risk of abuse, we saw that the provider had followed its legal obligations to report these to the local authority and to the Care Quality Commission (CQC). These incidents

had been investigated by the registered manager, and where appropriate the provider had provided additional training or taken disciplinary action against staff. However, we found that a large number of staff had not undertaken training in safeguarding adults. This meant there was a risk that staff would not fully understand the forms of abuse or their responsibilities if they suspected a person was being abused.

Where people may have been at risk the provider had carried out detailed risk assessments and put in place management plans, for example with regards to people falling. These plans were reviewed on a monthly basis. Where people had fallen, records showed staff had taken appropriate action, including assessing the reasons for the fall and carrying out 72 hour monitoring for the person. One person told us that they had a fall about six months ago. They were supported to get a mobility aid as they wanted to keep their independence. They told us "I feel much safer when I use this walking around here and when I go shopping." The provider had assessed all people who used the service for their risk of developing pressure sores, and we saw that these were being reviewed monthly.

Where people needed support with making transfers, staff had carried out a risk assessment which was also reviewed monthly, and where necessary the management plan stated that two staff were needed to make this transfer. Logs of support showed that people received this support, however in a limited number of cases this was not recorded by staff, which meant we could not be certain that people always received support from two staff when necessary.

Following an incident whereby a person had left the service without support in an unsafe manner, the service had fitted coded locks to the dementia unit and to the front floor. We saw that a CCTV system was in place which covered communal areas on the ground floor, the monitors for this were located at the senior care worker's desk in the reception area, alongside the monitor for the alarm system. This was not permanently staffed, however alarms sounded in all areas of the building, and there was a member of staff at this desk for most of the period of our inspection.

Staff undertook daily checks of the safety of the building, including fire doors, whether trip hazards were in place and cleaning materials were safely locked away. When actions were required, these were recorded and followed up. However, this was not always completed, for example when the registered manager was off work. There were personal emergency evacuation plans in place for everyone who lived in the service, these included essential information such as the support or equipment a person may need to leave the building in an emergency. These were prominently displayed in the registered manager's office, and had been recently reviewed. We saw that fire alarm checks were carried out on a weekly basis. However, not all staff had undertaken fire safety training.

The kitchen had a maximum score of five from the last food safety inspection in January 2015. We saw that food was safely stored in the fridge and freezers, and that these temperatures were checked on a daily basis. Food order forms held by the kitchen were printed with people's special dietary requirements, which were recorded alongside people's food choices.

Staff files showed that people were recruited in line with safer recruitment processes. The provider had copies of proof of identification for staff, and had carried out Disclosure and Barring Service (DBS) checks before they started working in the service. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. References had been obtained for all staff from their previous employers. This meant the service had taken steps to prevent unsuitable staff from working in the service.

All medicines were stored securely and appropriately, including controlled drugs and those requiring cold storage. The medicine administration records we looked at were clear and included photographs for

identification and details of people's known allergies. Medicines had been signed for on administration and codes were used where medicines had been omitted for a reason. All the medicines we checked had been given as prescribed. We saw that the GP was asked to review medicines regularly, particularly for people who refused medicines. Appropriate changes were made and documented.

Staff we spoke with displayed knowledge of the medicines they were giving to people and people's own preferences for taking them. We saw that all staff who administered medicines had had recent competency checks and actions resulting from those checks, for example further training, had been followed up.

Some people were prescribed medicines to be taken 'when required'. Protocols were in place to support staff to give these medicines safely when needed; however for one type of medicine these did not have sufficient detail to guide staff. One person managed their own medicines and this was supported with a risk assessment and care plan that was reviewed monthly. We noted on their risk assessments that one risk, which staff were aware of, was not recorded in relation to safely taking medicines. Staff undertook to review this during the inspection.

Daily controlled drugs checks and monthly medicine audits were carried out on all units. These covered all the aspects of safe medicines management and were followed, where necessary, by actions which we saw were completed.

Is the service effective?

Our findings

People told us that they were supported by staff who knew how to look after them. One person told us "The care workers are good at their jobs, my care worker is very good and does the job very well." The registered manager told us that they were in the process of reviewing all training for staff, and we saw that training was scheduled for dementia awareness. At the time of our inspection a third of staff had undertaken this, despite the service providing care to 11 people with a diagnosis of dementia. Significant numbers of staff had not had training in fire safety, safeguarding adults, infection control, Control of Substances Hazardous to Health and Health and Safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

All staff had undertaken moving and handling training. One care worker told us about a recent training course she had completed on Dementia Awareness. They said, "It was really interesting to understand how people felt but also learn strategies to support people."

A care worker told us that their induction consisted of two full days of observing senior staff carrying out their work, then one week continuing to shadow but also carrying out some tasks with support from staff. They commented, "The support I've had from my colleagues has been really good but I'd have liked to have had more time learning the job."

The provider was not always working in line with The Mental Capacity Act 2005 (MCA). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people may be deprived of their liberty, we saw that the service had regularly reviewed the situation, and made applications to the local authority in line with DoLS.

Where people may not have had capacity to make their own decisions in certain areas of their lives, staff had carried out thorough assessments of the person's capacity. However, when people lacked the capacity to make their own decisions, we saw that staff were routinely asking relatives to sign on behalf of the person, even if the person did not have a Lasting Power of Attorney, rather than following a process to demonstrate that they were working in line with a person's best interests. The provider had a form in place to demonstrate this process, however this was not currently being used.

We observed lunch, and saw that people who needed support with eating received it from staff in a professional and timely manner. We saw that people had choices at mealtimes and plenty of choices of drinks were available. We saw a sample of menu request forms that people were supported to fill out to highlight their preferred choice of meal. Care workers told us that people had choices when it came to

mealtimes and we saw people having the options explained to them. One care worker said "We are able to support people with the help they need during mealtimes. I make sure the food they choose is the food they get."

All people whose files we reviewed had had a Malnutrition Universal Screening Tool (MUST) assessment carried out. These were reviewed monthly. Where people were at risk of dehydration, the service maintained fluid balance charts which were completed daily and reviewed by senior staff, who noted when fluid intake was low and actions were recommended, leading to an improvement. People's weights were checked on a monthly basis, and action taken when a person's weight had fallen, including carrying out regular dietetic reviews. Where people required a soft food diet, this information was recorded in their care plans and reviewed monthly. We saw that this information was printed on food order charts for the kitchen to follow.

People had monthly assessments of their oral health, and when a risk was identified a care plan was put in place, including measures such as increased oral hygiene or giving a person pineapple chunks to chew; these care plans were also reviewed monthly. The provider maintained forms which provided clear information in the event of a hospital admission, including the person's medicines, emergency contact details and a short summary of their care needs.

Where people appeared unwell, there was evidence that staff had sought attention from an appropriate medical professional. Records of people's health appointments were clearly recorded on people's files, with outcomes, and where necessary people's care plans were reviewed as a result. In a small number of cases this information was recorded on the wrong sheets, which meant there was a possibility that important information may be lost.

We recommend that the provider take advice from a reputable source with regards to ensuring care is delivered in line with the Mental Capacity Act.

Is the service caring?

Our findings

People told us that staff were kind and caring and were comfortable talking with them. Comments included "Most of the staff are really kind and helpful, they go out of their way to help" and "The staff are always kind to me, it's like a home from home." A relative said "Staff always make me feel welcome. They are kind and friendly and do a fantastic job."

We observed respectful interactions between staff and people who used the service. For example, during an activity we saw staff stop and fetch a blanket for a person who appeared cold. We saw that staff would hold people's hands and provide reassurance for the person. People were addressed by their preferred names.

There was an activities programme for people, including a quiz, exercises, Tai Chi, ball games, crafts and bingo. We observed two of these sessions, and saw that staff worked to include everybody in the activity. For example, when playing a board game, the activities co-ordinator would move the table in front of a person and explain the activity to the person. At one point a person who used the service arrived with a guitar, and people were offered the choice as to whether to continue with the activity or to listen to a song.

People had a 'residents choice form' in place, this covered areas such as their preferred gender of care worker, hair style and choices of food, and individual choices such as "I prefer to have lots of pillows." Staff had completed a "This is me" document which was provided by the Alzheimers Society for people with dementia. This gave information on who the person is, some of their life history and likes and dislikes. People told us that they got to eat the meals they chose, and we saw records that showed people's dietary choices were recorded on a daily basis and the correct food was delivered by staff. Kitchen staff told us that often people would change their minds when food was brought, and they would do their best to accommodate this, for example by preparing fish and chips and omelettes.

Each person had a care plan in place which described their religious and cultural needs and their preferred activities. These were reviewed monthly, and changes made based on the person's wishes, including their engagement in the activities that they had been offered.

The provider held monthly residents meetings, which were well attended and minutes were recorded. We noted that these mostly related to the choice of activities in the service and were led by the activities co-ordinator. This showed that people's satisfaction with the activities was monitored and the programme adjusted accordingly, however the provider did not take the opportunity to discuss other aspects of the service which may affect residents. The service had recently held a meeting with families and people who used the service which discussed a broader range of subjects, however as this was the first meeting it was too early to say whether this had resulted in positive outcomes for people.

Staff had supported people to express and record their wishes for after their deaths. For example, people had stated the kind of funeral they wanted, who would be informed of their death and what would happen to their possessions. One person held the ashes of a relative, and had recorded that they wished to have these ashes scattered alongside their own.

Everyone we saw appeared clean and well-dressed. We saw that staff respected people's privacy, for example by knocking on doors and announcing their presence before entering.

Is the service responsive?

Our findings

We saw that people had care plans in place for areas of their lives including safety, activities, personal care, sleeping, continence, nutrition and pressure area care. The provider carried out assessments of people's dependency on staff, nutritional risks, and oral health. All of these areas were reviewed monthly by staff, and changes were made to meet people's changing needs. We saw that when additional support had been put in place due to changes in people's needs, logs of care provided showed that this was taking place. Care plans gave a good overview of people's health needs and the input that they had received from healthcare staff in order to meet these.

Whilst detailed, care plans and their associated review documents were long, and essential information was at risk of being overlooked. The provider had recently engaged a quality officer, who was in the process of introducing a new style of care plan. This gave a simple one page summary of a person's needs, life story and preferences. We observed staff meeting with the quality officer in order to compile these, and noted that staff were encouraged to use their knowledge in order to build up a detailed profile of the person. This led to outcomes for the staff member to follow up, for example to investigate how to obtain talking books for a person who liked to read but had lost their eyesight. We observed that where appropriate, members of staff were able to communicate with people using their native language.

The quality officer told us of their plans for the service. For example, in another service they had refurbished an area to provide a café-bar area, and intended to put this in place at the service. The provider also had plans in place to improve the grounds and the general condition of the décor.

One person told us that they had spoken to the registered manager about an issue that they had concerns about. They said "we discussed it last week, and it has been resolved. She is very approachable and I feel comfortable talking to her."

We saw compliments from people and their relatives about the care that they had received. There was a complaints policy in place and prominently displayed in the lobby. People we spoke with were aware of how to make a complaint, and were comfortable speaking with the registered manager, who had a strong presence in the area. A small number of complaints had been made since our last inspection. These were recorded and addressed promptly in line with the provider's policy. The outcome of the complaint was also recorded, including whether the complainant was satisfied with the response.

Is the service well-led?

Our findings

People said they felt comfortable speaking with the manager. One relative told us that the registered manager was very approachable and would feel comfortable bringing up any problems if they did arise.

The registered manager told us, "I am trying to get rid of neglect and poor practice." We saw that she had taken steps to address our concerns raised at the previous inspection and those identified in audits. For example, the registered manager now personally checked and signed off staffing rotas to show that adequate staffing levels were in place. We saw signs that the registered manager had recognised shortfalls in the training given to staff, and had organised significant amounts of training sessions in order to address this, however this process was not yet complete.

Staff did not receive adequate levels of supervision in order to demonstrate good management and leadership. We saw that the registered manager had ensured supervision was carried out for all staff in October 2015 and February 2016, and had put a timetable in place for two-monthly supervision for all staff. However, it was too early to see that this programme was being followed and that this improvement had been sustained.

We saw that a programme of staff meetings had been introduced for the year and was being followed. This included meetings for all staff, heads of care and night staff. Team meetings were being held monthly this year, and discussed issues such as health and safety, infection control and improving communication and recording.

The provider had put a programme of audits in place. People's care plans and risk assessments were checked to make sure that all necessary documents had been updated and were in place. Where something was required to be done there was an action plan recorded within the document highlighting when it needed to be completed by. We saw evidence that these actions had been carried out. For example, one care plan audit highlighted that a person's infection control risk assessment needed to be updated and when we checked we saw that this was in place. We saw that the registered manager completed a weekly report with regards to admissions, staffing, health and safety and risk issues, and that points raised by this had been addressed and followed up by the management team. We also saw that our concerns under the key questions "Is it safe?" were addressed promptly by the registered manager, and that systems were quickly put in place in order to manage these risks.

A service improvement plan was in place and reviewed regularly. This reviewed concerns raised by internal audits, including a pharmacy audit, Healthwatch and the local authority. We could see that actions were identified in response to concerns and that these were followed up as required.

The changes to the service had brought about a considerable improvement in morale, particularly with regards to the improvements in staffing levels. Some staff expressed concerns that this would not be sustained as the service began to take in new admissions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not being carried out in a way which ensured the safety of people who used the service. Regulation 12(1)(2)(e)(h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)