London Residential Healthcare Limited

London Residential Health Care Limited - Brook House Nursing Home

Inspection report

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Date of inspection visit:
22 March 2016

Date of publication:
15 April 2016

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 22 March 2016. At our previous inspection on 22 July 2014 the service was meeting the regulations inspected.

Brook House provides accommodation, nursing and personal care to up to 32 older people, some of whom are living with dementia. At the time of our inspection 32 people were using the service.

The service had a registered manager in post. 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. The registered manager was also the registered manager for another of the provider's services. Whilst the registered manager was at their other service the head of care and other senior members of staff undertook the day to day management of the service.

People received the support they required from staff to have their health and social care needs met. Staff were knowledgeable about the people they supported. This included their preferences, routines and their support needs. Staff provided people with the support they required in line with their care plans. Staff regularly discussed people's needs to identify if the level of support they required changed, and care plans were updated accordingly.

Staff were knowledgeable about signs and symptoms that a person's health may be deteriorating and liaised with healthcare professionals as required to meet those needs. Staff were aware of the support people required with their nutritional needs and in regards to risks to their safety. Risk management plans were developed and we observed people being supported in line with these plans to maintain their health and safety. People received their medicines as prescribed and safe medicines management processes were followed.

Staff ensured people were engaged and a range of activities were provided at the service. This included implementation of programmes to keep older people active and providing people with dementia with sensory stimulation.

Staff had built caring and friendly relationships with people. People were aware of who the staff were and we observed people and staff engaging in friendly conversations. There were sufficient staff to meet people's needs, and staffing levels were flexible to provide people with the support they required. People told us there were always staff around and if they needed any assistance a staff member came to support them promptly. We observed staff spending time with people in communal areas as well as engaging with people in their rooms.

People were involved in decisions about their care and staff offered people choices about daily activities.

Staff were aware of who had the capacity to make decisions and supported people in line with the Mental Capacity Act 2005. Where appropriate, staff liaised with people's relatives and involved them in discussions about people's care needs. People were supported to make decisions about end of life care and how they would like to be supported during that time.

Staff received the training their required to ensure they had the knowledge and skills to undertake their role. Systems were in place to ensure staff remained up to date with the training considered mandatory for their role. Staff were supported by their line manager and received regular supervision and annual appraisals.

The registered manager and the management team monitored the quality of service delivery. A range of weekly and monthly audits were undertaken, and information was gathered about key aspects of service delivery. Where it was identified that improvements were required these were undertaken promptly.

There were open and honest conversations amongst the staff about service delivery. Staff were invited to express their views and opinions, and these were used when looking at service improvements. People and their relatives were also encouraged to express their views about the service and where they had made suggestions for improvements these had been implemented.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were supported to have their medicines as prescribed and records were maintained of all medicines administered.

There were sufficient staff to meet people's needs. Staffing levels were flexible to provide people with the level of support they required.

Staff were knowledgeable about the risks to people's safety and supported them to manage those risks. Staff were aware of their responsibilities to safeguard people from harm.

Is the service effective?

Good

The service was effective. Staff received the training and support they required to undertake their role. Staff were supported with career progression and to obtain additional skills.

Staff were aware of and adhered to the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff supported people with their health and nutritional needs. Staff liaised with other healthcare professionals to obtain specialist advice about how to support people's needs.

Is the service caring?

Good

The service was caring. Friendly and caring relationships were built between staff and people using the service. Staff involved people in day to day decisions and decisions about their care.

Staff respected people's privacy and dignity, and supported them to practice their faith.

People and their family were involved in end of life care arrangements and staff supported people in line with their preferences.

Is the service responsive?

Good

The service was responsive. Staff provided people with the level

of support they required to have their health and social care needs met.

Staff engaged people in activities and reduced the risk of people becoming socially isolated. A range of activities were provided, including supporting people to stay active and provide sensory stimulation.

A complaints process was in place. People and their relatives felt comfortable speaking with staff if they had any concerns or complaints.

Is the service well-led?

Good

The service was well-led. There was open and honest conversations amongst the staff team and staff felt their views and opinions on service delivery were listened to.

Processes were in place to review the quality of the service, and prompt action was taken when it was identified that improvements were required.

The registered manager adhered to the requirements of their registration with the Care Quality Commission.

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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.

This inspection took place on 22 March 2016 and was unannounced. The inspection was undertaken by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the 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.

During the inspection we spoke with eight people, six relatives, and five staff. We reviewed five people's care records and five staff records. We looked at medicines management processes and records relating to the management of the service. We undertook general observations throughout the day and used the short observation framework for inspection (SOFI) during lunchtime in the main lounge. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

One person told us, "The staff are nice here. Very kind and speak to us nicely. This makes me feel safe." Another person said they were able to take their asthma inhaler but the staff looked after their other medicines for them. They told us, "I used to do it and I'd forget if I'd taken them. This way it's safe and I like it."

Medicines were stored securely and at a suitable temperature. Medicines stock checks were completed weekly and the stock we reviewed was as expected. People received their medicines as prescribed and all medicines administered were recorded on a medicines administration record (MAR). The MARs we checked were completed correctly. Some people were prescribed controlled drugs. These were stored securely and administered as prescribed. Some people were also prescribed medicines to be taken 'when required' (PRN). There were protocols in place to instruct staff when these medicines should be given and there were processes in place to record when and why these medicines were given. Staff provided people with pain relief when they needed it. One person said, "Painkillers are given when I need to have them." Staff arranged for people to have medicines reviews and one person told us the staff had supported them to see their GP to have their diabetes medicines reviewed. The pharmacy that supported the service had undertaken an audit of medicines management processes at the service. At our inspection we saw that prompt action had been taken to address the areas identified as requiring improvement from their audit. Staff undertook monthly medicines audits to ensure the service adhered to good practice and safe medicines management.

Staff were aware of their responsibilities to safeguard people from harm. They were aware of the signs of possible abuse and reported any concerns they had to their manager. There were whistleblowing procedures in place and staff felt able to use them if necessary. Any changes in people's behaviour or marks on their skin were recorded and discussed during staff handovers, so that all staff were aware and could monitor any concerns to protect the person from avoidable harm.

Staffing levels were appropriate to meet people's needs. People told us they felt there were enough staff at the service. One person said, "If I want something, they [the staff] come to me." Another person told us, "There's always someone around." We observed there were staff around to support people and respond to their needs. We observed call bells being answered promptly and when staff needed additional support from their colleagues this was provided. Staffing levels were adjusted as people's needs changed, this included providing one to one support from people that required it and at times in the day they needed the additional support.

Safe recruitment practices were followed to ensure appropriate staff were employed at the service. We saw that potential staff were asked to complete applications and attend an interview so their knowledge, skills and values could be assessed. The recruitment team undertook checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK and obtaining references from previous employers and/or character references.

People's care records clearly identified risks to people's safety and the management plans in place for staff

to support people to minimise those risks. We observed staff supporting people in line with their management plan. For example, one person who was assessed as at high risk from falls was supported by two staff and the support of a transfer belt. Bed rail assessments were undertaken to support people at risk of falling from bed at night. Appropriate consent procedures were undertaken in regards to the restrictions in place. Preventative measures were taken to support people at risk of developing pressure ulcers and moisture lesions. Records showed that people were supported to reposition when in bed to reduce pressure points. Staff were instructed to ensure people's continence care was maintained and people were supported with their personal care appropriately to reduce the risk of moisture lesions. Barrier creams were applied to further protect people with dry or fragile skin. Staff told us if they had any concerns regarding a person's health or safety they would either discuss this with the nurse on duty or if they had urgent concerns they would use the call bell. They were confident that staff attended to call bell alarms promptly and we observed this on the day of our inspection. One person told us, "I use a call bell at night and it doesn't take long to answer it."

Support plans were used to monitor people's behaviour for those that displayed behaviour that challenged staff, and for people who displayed verbal or physical aggression towards staff and other people using the service. Information was included in people's support plans about triggers of this behaviour and how staff should support the person during and after they displayed aggressive behaviour to maintain the person's safety and the safety of others. A behaviour monitoring chart was completed recording all displays of aggressive behaviour and what actions the staff took to address the behaviour. This information was discussed with the community mental health team to establish whether any additional treatment or medicines would help support the person.

We observed staff responding promptly to incidents. Staff reassured the person involved in the incident and checked the person for injury and pain before supporting them to move after a fall. Records were completed of all incidents that occurred and the action taken to support the person at the time, as well as additional action taken to prevent further incidents. The registered manager reviewed all incidents that occurred to identify any trends or patterns, including the time and location that they occurred.

Good

Is the service effective?

Our findings

New staff were supported to complete the Care Certificate. This is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Staff who required it were also supported to complete English literacy and numeracy classes. One staff member told us they felt able to ask their colleagues for support if they were unable to understand any words or phrases. This enabled them to improve their English and how they communicated with people and family members. We spoke with one staff member who had recently completed their probation period. They felt well supported by their colleagues and felt they had received the training and information they required to undertake their role.

Systems were in place to ensure staff stayed up to date with the training the provider considered mandatory for their role. The staff records we viewed showed that staff had completed mandatory training on safeguarding adults, moving and handling, the Mental Capacity Act and Deprivation of Liberty Safeguards, fire safety, food hygiene and health and safety. Some staff also received additional training on medicines management, skin integrity, catheterisation, venepuncture and syringe drivers. Additional training was also provided by the dietician to ensure staff were aware of how to support people who required a percutaneous endoscopic gastrostomy (PEG) feeding tube. One staff member told us the training they received "prepares you for all incidents."

The manager organised for some staff to attend train the trainer courses in key topics so they could provide additional training to staff at the service. This included training on infection control, safeguarding adults and moving and handling. This provided a flexible approach to ensure staff received the training they required in a timely manner.

Staff competency and performance was reviewed through supervision sessions and appraisals. These processes also identified whether staff needed any additional support from their manager and what support they required with career progression.

The Mental Capacity Act 2005 (MCA) 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff adhered to the Mental Capacity Act 2005. They were aware of whether people had the capacity to make decisions and what decisions they

were able to make. People were encouraged and supported to make decisions where able. Mental capacity assessments were undertaken to establish whether people were able to make a decision. If people did not have the capacity to make decisions 'best interests' meetings were held to make decisions on people's behalf. Where people had allocated individuals with lasting power of attorney, these nominated individuals were involved in care decisions.

The manager had identified that some people required their liberty to be deprived in order to keep them safe and free from harm. The manager had applied to the local authority for authorisation to deprive people of their liberty and maintained records about the restrictions in place and when DoLS were due to be reviewed.

People were supported with their nutritional needs. There was a choice of meals provided and people told us if they did not like what was on the menu they could request alternatives. The people we spoke with told us the food tasted good and there was plenty of food available. One person said, "The food is delicious."

Staff liaised with dieticians if they had concerns about a person's nutritional intake. Staff regularly weighed people and if they had concerns a person was losing weight they liaised with healthcare professionals appropriately. People who required it were supplied with supplements and fortified meals. Where people had difficulty swallowing staff worked with speech and language therapists to ensure people were supported to eat safely. Staff were aware of what thickness people required their fluids to be and whether they required a pureed diet, to reduce the risk of them choking. Where people were unable to orally eat staff worked with dieticians to ensure they supported people safely with their percutaneous endoscopic gastrostomy (PEG) feeding tube. The PEG feeding tube enabled food to enter directly into the person's stomach.

We observed staff spending time with people when they were feeling unwell and regularly checking whether their symptoms had increased or whether they were beginning to feel better. Staff liaised with people's GP and other healthcare professionals as required to ensure people's health needs were maintained. One person's relative told us staff were quick to get medical assistance for their family member when they required it. A GP visited the service weekly to review people's health needs and staff were able to ask the GP to attend outside of scheduled visits if they had concerns about a person's health. The care workers we spoke with were knowledgeable in recognising signs and symptoms that a person's health was deteriorating. They liaised with the nursing staff if they had concerns about a person's health so that additional medical support could be obtained.

Good

Is the service caring?

Our findings

One person told us, "I'm very lucky" to be at the service and we observed them laughing and joking with the staff. One person's relative said the staff were, "very, very attentive" and they were "friendly and very caring." Another person said they got on well with all the staff and they had got to know each of them.

Staff had built caring and positive relationships with people. We observed staff speaking to people politely and regularly checking on them if they were feeling unwell. We saw staff laughing and joking with people, and supporting people to be involved in activities of daily living. For example, one person liked to help the staff to serve hot drinks for people. One person's relative told us, "The staff are very kind and very helpful. Mum is very happy here." They also said that staff took the time to reassure their family member if they became upset or tearful.

Staff respected people's privacy and dignity. People told us staff always announced themselves and asked for permission before entering their rooms. Personal care was provided in the privacy of people's room and staff were quick to support people with their continence needs. People were supported to change their clothes if they became dirty during the day. We observed people looking clean and well presented, and their relatives told us people were always supported to dress in line with their preferences.

People were informed and involved in decisions. We observed staff offering people choices and respecting people's decisions. People's care records also instructed staff to discuss with people what support they were providing and how they wanted to be supported. For example, discussing with them before supporting them with transferring what equipment they were going to use and how this would support the person.

People's care records included information for staff about how people's diagnosis of dementia limited their ability to be involved in decisions and how staff could support people to be involved. This included ensuring staff used appropriate communication which people understood. For example, using short sentences and maintaining eye contact.

For the majority of the time we observed staff communicating appropriately with people and in a manner they understood. However, we saw that in a previous observation check undertaken by the registered manager at mealtimes it was identified that not all people were informed that it was lunchtime. We observed this also occurred on the day of our inspection which meant some people were disorientated and confused about what time of day it was and what was happening. We discussed this with the head of care who stated this was something they were working on and would address with all staff.

People's relatives were involved in discussions about people's care. This included involving them in care reviews and end of life arrangements. Staff asked people for their preferences in regards to their end of life care and documented their wishes in their care records. This included conversations with people, and their relatives, about their decision as to whether to be resuscitated and whether they wanted to be hospitalised for additional treatment and in what circumstances. Staff liaised with people's GP and the palliative care team if people's health deteriorated and had arranged for palliative care medicines to be stored at the

service in preparation for when people required palliative care.

Staff supported people to practice their faith and in line with their culture preferences. Staff accompanied people to church and celebrations were held at the service to acknowledge religious festivals.

Good

Is the service responsive?

Our findings

One person's relative said their family member was "well looked after." Another relative told us, "It's brilliant here…care is very good."

Care plans were developed in regards to people's support needs. Care plans were updated regularly and in regards to any changes in people's health and support needs. Staff new to their role told us in addition to reading people's care plans they were also provided with 'quick reference sheets' which provided them with the core information they needed to know about people in order to provide a personalised service.

Staff were knowledgeable about people's needs and the level of support people required. The care workers we spoke with told us if they were unsure about the care and support people required, or if they noticed a change in a person's health, that they would always speak with the nurse on duty. This enabled them to update their knowledge and skills, and ensure they provided the personalised care people required. Staff were able to describe the risks to people's safety and how this impacted on the level of care people required. Staff told us they had sufficient time to provide people with the care they required, whilst encouraging them to undertake tasks independently and at a pace they dictated. Staff were able to describe people's daily routines and their preferences as to how they were supported and cared for.

We saw that when people developed pressure ulcers, wound management charts were developed. Dressings were changed in line with guidance from the tissue viability nurse and staff regularly monitored the wound. We saw from people's wound management charts that for those with pressure ulcers that these were healing.

People at the service were kept stimulated and engaged. One person told us, "There's lots of activity. I like bingo and a lot of the games." During our inspection the activities coordinator was running an OOMPH session. The OOMPH programme helps to maintain the health and quality of life of older people through exercise and activity classes. We observed this session on the day and people were smiling and joining in the activity. We also observed one of the people using the service helping the activities coordinator to run the session and encouraging other people and visitors to join in. During the afternoon we also observed a session being undertaken using the Namaste Programme. The Namaste programme is designed to improve the quality of life for people with advanced dementia. It enables staff to spend time with people stimulating all their senses. Staff and relatives told us the Namaste programme enabled everyone to be involved in the activity and get some enjoyment as it did not rely on people verbally communicating or being physically active.

Staff ensured that people were not socially isolated. We spoke to some relatives who said their family member preferred to spend most of their time in their bedrooms, but that staff regularly checked on them and engaged them in conversations. They said staff always informed them about the activities taking place and provided them with one to one activities, if they did not wish to take part in the group activities. The service used the 'resident of the day' initiative to ensure people received the care and support they required, and also to provide people with additional attention during their allocated day.

People, and relatives, told us they felt able to raise a complaint if they had any concerns. The people we spoke with felt they had not needed to make a complaint and felt able to discuss any concerns or worries they had with staff. A complaints process was in place to ensure all complaints were investigated and dealt with appropriately. Staff told us they would support people if they wanted to make a complaint and ensure this was reported to the registered manager so it could be dealt with.

Good

Is the service well-led?

Our findings

One person said in regards to the registered manager, "She's lovely that one." One person's relative told us that if they needed to speak to the registered manager they would make themselves available. People told us they knew who the registered manager was and one person said, "We see her all the time."

People and their relatives were invited to feedback about the service and make suggestions. The relatives we spoke with told us they found these meetings useful and the meetings also enabled staff to update people and their relatives on any service developments. The relatives we spoke with felt informed and involved in the service. One relative said, "Staff always ask me about the service."

Staff felt well supported by their colleagues and the management team. One staff member said, "I'm happy with my manager." They also told us they was good joint working and that they were, "happy to support their colleagues." Staff said there were open and honest conversations amongst the staff team. Staff felt able to express their opinions and that their views were listened to. They felt the registered manager was approachable and that staff at all levels of management were involved in service development.

Staff meetings were held to discuss the support and care provided to people and to discuss any changes in their needs. This ensured all staff were informed about people's current needs, for example, if there were concerns someone was losing weight or there had been an increase in people displaying behaviour that challenged. We saw that the registered manager also used the staff meetings to acknowledge and recognise individual staff members who had performed well.

Within the staff team individuals were nominated as 'champions' to lead on key aspects of service delivery. This included leading on safeguarding, infection control, and nutrition. The 'champions' were delegated the task of ensuring the staff team adhered to policies, procedures and good practice guidance.

A weekly clinical review was held to review each person's needs. This reviewed the needs of all new admissions, and those presenting as at high risk in regards to malnutrition, pressure ulcers, falls and those displaying behaviour that challenged staff. The support provided to these people was reviewed to ensure it was appropriate and to identify if any additional support or referrals to other healthcare professionals was required.

Processes were in place to review the quality of service provision. This included a range of weekly and monthly audits to review medicines management, infection control processes, catering arrangements and to review the quality of care records. Information was also collected to review people's needs and ensure they reviewed the support they required. This included reviewing incidents such as falls and the number and development of infections and wounds.

Where audits and monitoring information identified that improvements were required to service delivery we saw that the necessary action was taken promptly. For example, a medicines audit had been undertaken by the pharmacist and action had been taken to address their concerns.

The managing director regularly reviewed the quality of service delivery. This included reviewing staff's adherence to the service's policies and procedures, and speaking with staff, people and their relatives to get their feedback about the service.

The registered manager was aware of their registration responsibilities with the Care Quality Commission and submitted statutory notifications about key events that occurred at the service as required.

The registered manager was also the registered manager at another service. When they were not at the service the management team undertook the day to day management of the service, and the registered manager was available on the phone. The two services were located close together and the staff from the two services offered support to each other.