London Residential Healthcare Limited

Chestnut House Nursing Home

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

Summary of findings

Overall summary

Chestnut House Nursing Home was last inspected on 24 October 2016. At that inspection the home was found not to be meeting all requirements in the areas inspected. We found that improvements were required with regards to people's risk assessments and in the way management ensured the quality of care people received.. At this inspection we found that improvements had been made.

Chestnut House is a purpose built care home accommodating older people. The home is registered to provide accommodation for 85 people who require nursing or personal care. At the time of the inspection there were 78 people living at the home. It comprises of two main areas; people with nursing care needs are resident on the ground floor; people with enduring mental health needs live on the two upper floors. The second floor is allocated for the care of females only.

There was a registered manager in place who had been in post for a number of years. 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 home had safe systems in place to protect people from the risks they faced. People's individual care records evidenced that risks were recorded and action had been taken in accordance with the providers policies to minimise these risks.

Medicines were managed in accordance with best practice guidance. Medicines were stored, administered and recorded safely. People were supported to access external health professionals, when required, to maintain their health and wellbeing.

We observed that staff had developed an empathetic approach to the people they supported. We saw that people appeared comfortable in the company of staff. Staff knew people well and were able to tell us about the people they supported including their history, family, likes and dislikes. This demonstrated staff knew people well and listened to their preferences.
People were offered a varied choice of meals, where staff were concerned that people may be at risk of dehydration or malnutrition the provider had systems in place to address these risks.

People told us and we observed that people were supported by sufficient numbers of staff who had a clear knowledge and understanding of their individual support needs. People living at Chestnut House told us they were happy with the care and support provided. These comments were supported by the relatives we spoke with.

People were supported by staff who had received training with regards to their needs. Staff told us they were supported by the provider to train in areas that they wished to.

People's social and emotional needs were met by a group of staff employed to provide activities and social stimulation. People told us there was plenty to do if you wished too. The home also enjoyed the support of volunteers and members of the wider community who supported fund raising and the provision of activities.

Some people who lived at the home were able to make decisions about what care or treatment they received. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the Mental Capacity Act (MCA) when making decisions for people in their best interests.

The service was responsive to people's individual needs. Care and support was personalised to each person which ensured they were able to make choices about their day to day lives.

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

There were systems to make sure people were protected from abuse and avoidable harm.

There were enough staff to keep people safe.

People received their medicines when they needed them from staff who were competent to do so.

Is the service effective?

Good

The service was effective. Where people lacked the mental capacity to consent to aspects of their care or treatment the provider acted in accordance with current legislation

Staff had the skills and knowledge to effectively support people.

People had access to appropriate healthcare professionals to make sure they received the care and treatment they needed

Is the service caring?

Good

The service was caring. Staff demonstrated a caring approach to their work. People were respected as individuals. People were treated in a kind and friendly manner.

Staff were aware of people's daily routines and supported them in the way that they wished.

People made individual choices about how they spent their time with the guidance of staff.

Is the service responsive?

Good

The service was responsive. People's care and support was responsive to their needs.

A varied program of l activities was in place to support people with their social and emotional needs..

People knew how to make a complaint and said they would be comfortable to do so.

Is the service well-led?

Good

The service was well led. Staff were supported to do a good job.

There were quality assurance audits to ensure that the support delivered by staff met the expectations of the people they supported.

People, relatives and staff spoke positively about the management of the home and felt they were approachable. People felt included in the way the home was run.

Chestnut House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 19, 20 and 21April 2017 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about and feedback from relatives. At the time of the inspection a Provider Information Record (PIR) had not been requested. 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. We were able to gather this information during our inspection.

Some people who lived in the home were not able to fully express themselves due to their dementia and other health care needs. We therefore spent time observing the care and support practices in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

In order to gain further information about the service we spoke with six people living at the home and two visiting relatives. We spoke with eight members of staff and members of the provider's management team.

We looked around the home and observed care practices throughout the inspection. We looked at eight people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments and quality monitoring records.

Before the inspection we spoke with representatives of the local authority's contract monitoring team who had experience of the service.

Good

Is the service safe?

Our findings

At our last inspection we found that the way the provider was managing risk needed to be improved. At this inspection we found that improvements had been made. The risks that people faced was being managed. We looked at the people's care records that evidenced that the provider had a system in place to ensure the safety of those people who needed supervision, due to a risk of harm. We looked at individual monitoring records that recorded that staff had checked the safety of identified people every half an hour. Staff told us that this level of observation had helped to ensure risks relating to issues such as isolation, anxiety or falling were minimised.

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We looked at the staffing rotas for the home which informed there were sufficient staff on duty to support people with the physical care needs. Two people told us they felt there were enough staff one person said "There always seem to be someone around to help if I need it, I seldom do but I watch others and they get lots of help so I feel reassured that there will be some to help me if needed". We spoke with visiting relatives that also confirmed that they considered there were enough staff. In addition to the care and clinical care staff there was a group of activity staff to directly support people with their social and emotional needs.

People's medicines were stored and recorded safely. The staff responsible for administering medicines had been suitably trained. We observed people receiving their medicines safely and saw staff carry out safety checks, including staying with people while they took their medicines. The medicines were stored in a lockable area and were well organised. The provider had a system to audit medicines received and dispensed in the home. We looked at the most recent audit that identified any concerns. We looked at the Medicines administration record (MAR) and controlled medicines book and noted that an error had recently taken place. The management were away of this error and had taken action to address this and were in the process of writing a report on this.

Risks of abuse to people were minimised because there was a safe recruitment procedure for new staff. Staff members described the appropriate checks that were undertaken before they started working. These included satisfactory Disclosure and Barring Service (DBS) criminal record checks and written references. The (DBS) helps employers make safer recruitment decisions and prevent unsuitable staff from working with people. These checks had been completed and recorded.

The service protected people from the risk of abuse through appropriate policies, procedures and staff training. The staff we spoke with told us they had received safeguarding vulnerable adults training. They were able to tell us about different forms of abuse, how to recognise the signs of abuse and who to report concerns too. The staff told us about the provider's whistle blowing policy and could identify who they would raise concerns with.

In addition, we saw evidence that the manager had notified and worked with the local authority safeguarding team when safeguarding concerns had been identified. We observed the staff interactions with people living at the home and found them to be positive and empathetic. We spoke with a visiting relative who told us "I come in every day, the staff treat people with kindness and compassion, I have never

seen or heard anything that would cause me any concern."

Good

Is the service effective?

Our findings

The principals of the Mental Capacity Act 2005 (MCA) were imbedded in the care practices of the service. The staff we spoke with were aware of the need to assess people's capacity to make specific decisions. Where appropriate the provider had involved family and professional representatives to ensure decisions made were in people's best interests.

People's individual care records contained assessments of their capacity to make certain decisions and where necessary, for example the use of some equipment, a best interest decision had been made. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). There was evidence in peoples care records that the registered manager had liaised with appropriate professionals and made applications for people who required this level of support to keep them safe.

Staff were aware of the need to support people to make their own decisions and be included in the design of their own support plans. Staff told us about some of the choices that are encouraged even when the individual may struggle to make choices such as what to wear and what to eat. One staff told us "even though a person may be assessed as not having capacity we still need to include them in decisions".

People were supported by staff who had undergone an induction program which gave them the basic skills to care for people effectively. In addition to completing induction training, new staff had opportunities to shadow more experienced staff. This enabled them to get to know people and how they liked to be cared for. Staff confirmed they had completed an induction program linked to the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training to staff who are new to care work.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs and choices. Training was completed by E learning modules, external and internal training sessions. Training needs were also supported via distance learning and vocational training. We saw that records contained training certificates that confirmed the training staff had undertaken and that these included safeguarding of vulnerable adults, manual handling, infection control and the Mental Capacity Act 2005 (MCA). Staff were positive about training opportunities, and told us they had opportunities to develop skills in supporting people specific needs such as Dementia care.

The people we spoke with who could tell us about how they experienced care told us they were offered a choice of food and the food on offer was good. One person told us "food here is good, always plenty and lots of variety". Another person told us "there is plenty of choice and snacks when you want them". A relative told us that they come in regularly and have a meal with their loved one they told us "very good quality food, always hot with plenty of flavour"

We carried out a SOFI during the dinner period in one area of the home. We observed that there were sufficient staff deployed in the area to ensure people got the support they needed at a time they wanted. We observed that where required people were supported by staff who were patient and encouraged individuals to eat at their own pace. We observed that people were encouraged to stay and eat their meals but were not restricted to leave if they choose. We noted that when they had left a staff member was available to encourage them back with gentle reassurance. This meant they finished their meal.

The provider had systems in place to monitor individuals who may have been at risk of dehydration or malnutrition. When these risks or concerns had been observed, the staff started monitoring and recording food and fluid intake of the person concerned. These individual records together with increasing the monitoring of people's weight and general wellbeing were used to decide on whether to involve other health care professionals and who may be best placed to support the individual and staff such as Speech and language therapist or dietician.

People had access to health and social care professionals when required. Staff were proactive in ensuring emerging needs were acknowledged and acted upon. Care records showed that people were seen by health care professionals in response to changing needs and management of existing conditions. One health professional told us, "The home is good at communicating with us which helps us deal with emerging health care concerns without any undue delay." The registered manager had worked alongside the homes GP to develop a specific tool to monitor and identify individuals nutritional needs due to weight loss

Good

Is the service caring?

Our findings

People were well cared for. We spoke with people living at the home one told us about how the staff met their needs and how they had made new friends since taking up residence Another person told us " The girls (staff) don't rush me, I take my time and they patiently wait, they let me do what I can. One visiting relatives told us about how they considered their relatives were well cared for and how staff ensured their (relative) needs were met saying "I am here most days, I have never seen staff ignore a request for help, I have seen them calming people when they are distressed – hats off to them I am not sure I could be so caring and patient".

Those people who could tell us how they experienced care told us about how staff gained their views about their care needs, mainly by sitting and talking with them. A visiting relative told us " I feel involved in my wife's care, the staff always phone if they have concerns over their wellbeing or an incident has happened. Every once in a while I met with the staff formally and we talk about their plan of care, I can give my point of view and I advocate for my wife, I am always listened too".

Staff respected people's privacy. People could spend time in the privacy of their own room if they wanted to. The staff we spoke with told us about the people who were at risk of social exclusion and talked about those who they need to encourage to leave their rooms. We noted that most bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people feel at home. We observed that staff knocked on doors and waited for a response before entering. We noted staff did not discuss others in communal areas and always looked for confidential areas to discuss people's needs. Staff addressed people using their preferred name and they were discreet when offering people assistance with personal care needs.

The service promoted people's independence. People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. Where needed, people had access to walking frames and wheelchairs. People were seen to move freely around the home. A lift was available to assist people access all areas of the home. The accommodation and grounds were maintained to a good standard and provided a pleasant living environment.

The home was awarded accreditation with the Gold Standards Framework in Care Homes and achieved a beacon status. This is a nationally recognised award which recognises the high quality of care provided for people at the end of their life.

Good

Is the service responsive?

Our findings

People had their needs assessed prior to moving into the home to ensure they could be met. An initial assessment of need established whether it was safe for people to receive a service and for staff to carry out the care and support required. If an individual decided to take up residence a plan of care was developed within the first week of them moving in. We looked at one person's initial assessment of need who had just moved to the home. This assessment identified a risk related to their behaviour. However the person had moved into the home without having a recorded plan in place to reduce this risk.

We spoke with the registered manager and the provider's operations manager about our concerns over this. It was explained that the company policy was that all initial risk assessments are completed within the first 24-72 hours to ensure the safety of the individual. Care plans to support needs are then developed over the initial week in order to provide support for peoples needs. When requires staff utilise tools to monitor behaviours, and develop positive support to meet this need.

We discussed the merits and pitfalls of this approach. The operations manager agreed to bring this issue to the attention of the provider and review the policy of delaying risk assessments, understanding our concerns that known and potential risk's may not be effectively managed during this period.

Systems were in place to review care being provided. Staff demonstrated an awareness of people's changing needs. Care plans were reviewed and updated to ensure they reflected people's current needs.

Staff told us about how people chose to spend their time and what activities they enjoyed. We spoke with two of the activities coordinators. They told us about events that had taken place and how they encouraged the local community into the home for fetes, coffee mornings and special events. We were also made aware of initiatives such as the "wishing well". This was a 'well' for cardboard coins with wish's written on them to be deposited into. The provider then endeavoured to meet these individuals wishes. An example of this was one person went to see a local football team play, as they had done so many times before entering the care home.

Activity staff told us they had enough time to provide social stimulation for people on an individual basis as well as groups of individuals. People we spoke with told us about trips out and craft activities. One person made us aware of the small golf course in the outside area, another talked about eating outside when the weather was warmer. We also noted that groups were being supported with arts activities by an external group of volunteers.

People knew how to make a complaint if they wished to. One person told us that, "Staff sort out the problems, I trust them". The provider had a complaints procedure which informed people what they needed to do to make a complaint and the time scales for the complaint to be rectified. We looked at the records relating to dissatisfaction about issues at the home. These records demonstrated that the management had addressed issues in line with their procedure.

Good

Is the service well-led?

Our findings

At the last inspection we were concerned that the auditing of the standards of care people received at the home and the way records were kept needed to be improved. At this inspection we found that improvements had been made.

There were systems in place to monitor the care support given to people living at the home. The auditing system for medicines was effective. We looked at the last medicines audit that was carried out on 20 April 2017. Whilst the audit did not identify any areas the auditing tool we had sight of did not record a check on controlled drugs at the home, however when we spoke with the management team about this we were reassured that this had been carried out and the recording was on a separate sheet.

We looked at people's care records which evidenced that the system in place to ensure people's care and support needs were delivered in a consistent and appropriate way. The system was largely effective at ensure good quality standards with only two anomalies where there was contradictions in the recorded information were observed. When discussing these with staff it was clear that it was a minor anomaly in the recording and that staff were acting in a safe and appropriate manner.

There was a management structure in place at the home consisting of a registered manager, deputy manager and senior clinical staff and carers. The registered manager was supported by a operations manager who was available to support the registered manager with operational issues and to provide clinical supervision.

Staff told us that they felt valued and their opinions and suggestions to improve the service were listened to. Staff confirmed that they continue to have staff meetings where they could bring up issues, records observed supported their comments. Staff told us that they felt supported and considered the management team approachable.

The registered manager told us they also supported student nursing placements at the home, the deputy manager being approved to cover the supervision and support of student nurses. The registered manager told us that " this encourages our RNs (mentors) to keep up to date with Nursing practice, as they are been given the responsibility of supporting the students, but also it is a two way partnership as our RNs can also learn new things from the student nurses as well."

The head of care told us that they continue to hold weekly review meetings held with clinical staff on duty to discuss any new concerns including areas such as the use of bed rails and if people had broken areas of skin. There was also a 10 at 10 meeting which the registered manager, head of care and clinical staff used to discuss any new clinical concerns with people living at the home. This meant that the provider had systems in place to address issues on a daily basis.

People could identify who the registered manager was, people who didn't use words were relaxed in their company if this was the case. The relatives we spoke with confirmed that all staff were approachable and

that they felt they could speak with members of the management team if they had to.

There was evidence of regular meetings taking place between the people who used the service, their relatives and other professionals involved in their care. Relatives confirmed that the management held meetings with relatives to discuss issues that affect the home where they could bring forward any concerns and suggestions for improvements. One relative told us "I been too a few meetings, it's good to hear what the owners are doing and what changes are being considered, I do feel that I am consulted".