London Residential Healthcare Limited

Hamilton Nursing Home

Inspection report

24 Langley Avenue
Surbiton
Surrey
KT6 6QW

Tel: 02083999666
Website: www.lrh-homes.com

Date of inspection visit:
08 December 2015

Date of publication:
07 January 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

This inspection took place on 8 December 2015 and was unannounced. At our previous inspection on 8 January 2014 the service was meeting the regulations inspection.

Hamilton Nursing Home provides nursing care and support to up to 28 older people, some of whom have dementia. At the time of our inspection 26 people were using the service.

The service had a registered manager in place. 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.

People were provided with care and support that was tailored to their needs. Staff assessed people's personal care and nursing needs, and developed care plans about how those needs should be met. Staff were knowledgeable about people's needs and supported them in line with their care plans.

Staff were aware of people's likes, interests and routines. Staff liaised with people's relatives to obtain information about their life story including previous occupations and significant events. This information was used to help staff to provide personalised care.

A wide range of activities were provided at the service, so that all people could take part in activities. This included using the Namaste programme which stimulated people's senses, and did not rely on people being able to communicate verbally or be physically active.

Staff were aware of people's communication needs, and communicated with people in a way people understood. This included the use of hand gestures and body language. Staff offered people choice about their day to day care and respected their decisions.

Staff were aware of the principles of the Mental Capacity Act (MCA) 2005. Staff arranged for MCA assessments to be undertaken to establish if people had the capacity to consent to care decisions. 'Best interests' meetings were held for people that did not have the capacity to consent. The registered manager had organised for people to be assessed as to whether they required a Deprivation of Liberty Safeguard (DoLS) to keep them safe. For those that had a DoLS in place, staff adhered to the conditions stipulated. DoLS is a way of making sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Staff were aware of the risks to people's safety, and supported them to manage those risks. This included risks associated with developing pressure ulcers, falling and malnutrition. Staff supported people with their nutritional needs, and liaised with other healthcare professionals to support people with their healthcare needs. There were safe medicines management processes in place and staff ensured people received their

medicines as prescribed.

Staff were aware of their duties in regards to safeguarding people and reporting concerns, incidents and accidents. Incidents were reviewed and action was taken to minimise the risk to people and to keep people safe and free from harm.

There were sufficient staff to meet people's needs. There were robust induction, training and supervision programmes in place to ensure staff had the knowledge and skills to meet people's needs.

The management team undertook regular checks on the quality of care provided, and attended meetings to discuss the care provided to people. Where it was identified that improvements were required, the registered manager ensured these were implemented.

There was open and transparent communication amongst the staff team, and with people's relatives. There were mechanisms in place to obtain feedback from people and their relatives about the care their received. Staff were encouraged to express their opinions about the service and to suggest ways of improving the care delivered.

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

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. Suitable staff were employed and there were sufficient numbers of staff to meet people's needs.

Staff undertook assessments to identify the risks to people's health and management plans were in place to protect people from harm. Staff were aware of the reporting procedures to follow if they had concerns a person was being harmed.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective. There were robust induction and training requirements in place to ensure staff had the knowledge and skills to meet people's needs. Staff were supported by their colleagues and manager to develop their knowledge and provide care that met people's needs.

Staff adhered to the principles of the Mental Capacity Act 2005. People's decisions were respected and best interests meetings were held for people who did not have the capacity to consent to their care.

Staff supported people to access healthcare services and followed advice from specialist healthcare professionals. Staff supported people with their nutritional and hydration needs.

Is the service caring?

Good

The service was caring. Staff were aware of people's communication needs. We observed staff speaking to people politely and in a friendly manner. They were of people's level of understanding and used short sentences and gestures appropriately to help people to understand what was being said.

People were involved in decisions about their day to day care. Staff had liaised with people and their relatives to obtain information about their likes, routines and preferences, so this information could be used to provide an individually tailored

service.

People's privacy was respected and their dignity maintained.

Staff supported people to discuss and plan for their end of life care. This was clearly documented in their care records so they could be supported in line with their wishes.

Is the service responsive?

Good

The service was responsive. Staff assessed people's personal care and nursing needs, and developed care plans outlining how these needs were to be met. Staff were knowledgeable of people's needs and supported people in line with their care plans.

Staff supported people to have their social and recreational needs met. A range of activities were provided including the Namaste and OOMPH programmes.

There were processes in place to investigate and respond to complaints. Relative told us any concerns raised were dealt with promptly.

Is the service well-led?

Good

The service was well-led. There was open and transparent communication at the service, and the registered manager welcomed people, relatives and staff to feed back about the service. Staff felt supported and there was flexible teamwork.

Audits were in process to check the quality of care provided to people. A range of meetings were also held to review the quality of care delivery and to ensure any action required to improve service delivery was implemented.

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

Hamilton 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 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 8 December 2015 and was unannounced. The inspection was undertaken by one 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 the inspection we reviewed the information we held about the service including statutory notifications received. We reviewed information contained 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 seven staff, including the registered manager, four people and five relatives. The people we spoke with were unable to engage in full conversations but were able to indicate one word answers or gestures in response to our questions. We reviewed three people's care records, four staff records, medicines management processes and records relating to the management of the home. We undertook general observations and used the Short Observational Framework for Inspections (SOFI) during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we spoke with a representative from the local authority.

Good

Is the service safe?

Our findings

One person's relative told us, "Safety is very good." Another person's relative said they were thankful now that they could go on holiday because they knew their family member was in "safe hands".

Suitable staff were employed. Recruitment checks were undertaken to ensure staff had the relevant knowledge, qualifications and qualities to support people. Checks were undertaken as part of recruitment to ensure fit and proper persons were employed, including obtaining references from previous employers, checking their eligibility to work in the UK, and completing criminal records checks.

There were sufficient staff to meet people's needs. The registered manager used a ratio of one staff member to five people as a basis to calculate staffing needs and then increased staffing numbers according to the needs of the people using the service. Some people had needed more support in the morning with their breakfast. The registered manager ensured additional staff were available during this time. When the registered manager was concerned about a person's dependency needs they liaised with other health and social care professionals to assess whether the person would benefit from one to one support from staff.

The service used some agency staff. However, these staff were familiar with the service and the people using the service. The same agency staff were used to provide consistency in care delivery. The numbers of staff employed were sufficient to provide cover for annual leave, staff sickness and to enable staff to complete training courses.

Staff were aware of the risks to people's safety, and were aware of the procedures to follow if they had concerns a person was being harmed. Body maps were completed if staff noticed bruising and this was monitored to establish why bruising may have occurred. Staff discussed any changes in people's behaviour and any concerns that these were due to a person being harmed with the clinical lead, registered manager or a senior member of staff from the provider. The staff team liaised with the local authority's safeguarding team if they had concerns about a person's safety. The registered manager told us they had a good working relationship with the safeguarding team and often contacted them for advice and guidance to improve their practice and ensure people were kept safe. The staff member with the lead role for safeguarding was available to support staff who had safeguarding concerns or were involved in safeguarding investigations. Serious incidents were reviewed by the provider's clinical director so they were able to identify if there were any safeguarding concerns that needed reviewing.

Staff assessed the risks to people's safety and regularly reviewed these as people's health and behaviour changed. We saw that people were assessed as to whether they were at risk of malnutrition, falling and developing pressure ulcers. Preventative measures were put in place to minimise the risks to people, including pressure relieving mattresses, air cushions and use of mobility aids. Sensor mats were used for people at risk of falls so that staff knew when people got out of bed and were able to support them appropriately. Some people were assessed as requiring bed rails to stop them from falling out of bed. Appropriate consent procedures had been followed to ensure the bed rails were in a person's best interests.

If staff were concerned about a person's health they called the nurse on duty, a person's GP or called the emergency services depending on the severity of the concerns. We saw that when people fell if there were signs of injury or a possible head injury that the person was supported to go to hospital to be checked.

All incidents that occurred were recorded and reviewed by the registered manager or clinical lead to ensure that appropriate action was taken to support the person at the time of the incident and to implement preventative measures. The registered manager undertook monthly analysis of all incidents to review the type, time and location of the incident to identify any trends and underlying reasons why the incident occurred.

Safe medicines management processes were followed. Medicines were stored securely. We saw that people received their medicines as prescribed. Medicines administration records (MAR) were completed correctly so there were accurate records of the amount of medicines given. This included recording if people refused their medicines so that if this continued staff could discuss this with the person's GP. Some people refused their medicines regularly and it had been assessed that the person did not have capacity in regards to their medicines. Therefore it had been agreed that it would be in the person's 'best interests' to receive their medicines covertly. There were clear records about what medicines were to be given covertly and how these were to be administered. We saw that protocols were in place for 'when required' medicines so staff knew when to give people their additional medicines and at what dose. Daily stock checks were kept to ensure all medicines were accounted for and that people received their medicines as prescribed.

A safe environment was provided. The staff liaised with the local fire brigade to ensure the service adhered to fire safety procedures. Building work was being undertaken at the service. The registered manager had invited the local fire brigade to come and visit the service to review the fire exits and evacuation routes because they had to be changed due to the building work. Each person had a personal fire evacuation plan and there was regular testing of fire alarms and evacuation procedures.

Good

Is the service effective?

Our findings

Staff were knowledgeable about people needs and had the knowledge and skills to meet those needs. One person's relative said, "They're on the ball with their training."

An induction process was in place which enabled staff to become familiar with the provider's policies, the service's procedures and to get to know people. New staff shadowed more experienced staff until they were assessed as being competent to support people unsupervised. A staff member who had recently joined the service told us they felt well supported and the other staff were helping them to become familiar with the people using the service.

Staff received the training required to enable them to provide quality care. New staff were being supported to complete the Care Certificate. The Care Certificate is a national recognised tool that gives staff the introductory knowledge and skills to support people with their personal care needs. The provider had a mandatory training programme which staff were required to complete. The provider's system enabled staff to monitor what training they had completed and when they were required to attend a refresher course. We saw that staff had completed their training and had been reminded which courses they were due to refresh. The service's clinical lead was a manual handling trainer and the provider's clinical director was a safeguarding trainer so they were able to provide these trainings regularly to staff. Staff had completed training including fire safety, manual handling, first aid, health and safety, the Mental Capacity Act 2005, safeguarding adults and food hygiene. We saw that nursing staff had also completed relevant clinical training relevant to people's nursing needs.

Staff told us they were supported by their colleagues and the manager if they needed advice or guidance about how to support people. One staff member told us, "They teach me…They help if I don't understand." They felt comfortable approaching their colleagues and asking questions to help them develop their skills and knowledge of how to support people, for example, understanding pressure ulcers and the preventative measures that should be implemented.

The manager reviewed people's skills and addressed any concerns during supervision sessions. We saw that supervision and appraisal processes reviewed staff's performance, whether staff were working towards set goals, and what additional support they required to achieve those goals.

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 were aware of the principles of the Act and ensured that when people were able to make decisions that their decisions were respected. We saw that MCA assessments were undertaken to establish if a person had the capacity to make certain decisions about their care. When people did not have the capacity to make a decision best interests meetings were held. Information was included in people's records if a lasting power of attorney had been allocated and staff ensured they were involved in decisions about the person's care. The registered manager had arranged for people to be assessed as to whether they required a DoLS where appropriate. For those that did require a DoLS staff adhered to the conditions stipulated.

Staff worked with other health care professionals to ensure people's health needs were met. We were informed that the nurse was concerned about one person's diabetes management and had arranged for this person to be reviewed by the diabetic nurse. The nurse told us if they noticed any changes in people's behaviour they arranged for a healthcare review. For example, they organised for one person to be reviewed by a consultant psychiatrist due to changes in their behaviour, and another person to be reviewed by their GP as they had concerns that a recent medicines change had negative side effects. People's relatives told us healthcare professionals such as GPs, physiotherapists and podiatrists came to visit the service.

Speech and language therapists and dieticians were involved in assessing people's nutritional needs and advising staff about how to support people to have their nutritional needs met. Staff were knowledgeable about who required specific diets, the reason why and what to do if they were concerned about a person's nutritional intake.

People were supported with their nutritional and hydration needs. People were able to access food and drink throughout the day, and we saw people regularly being offered drinks. We observed at mealtimes that people had food that they enjoyed eating and there was a choice of food provided. We observed that one person did not want to eat what was first offered. They were unable to verbally communicate with staff what they did want. Staff used their knowledge of the person to offer foods which they knew the person enjoyed eating until they found something the person wanted. Some people preferred to eat small, frequent meals and this was respected.

Good

Is the service caring?

Our findings

One person's relative told us, "The staff are very friendly and attentive."

We observed interactions between staff and people. Staff were aware of people's communication needs and supported people to understand what time it was and what was happening, for example, staff kept reminding people it was time for lunch. Staff supported people at a pace dictated by the person, and we observed staff speaking to people politely and in a friendly manner. At lunchtime we observed a couple of times where staff referred to a person as 'she' or 'he' rather than using their name. We spoke with the registered manager about this and they told us they would address this with all staff to ensure that people were always referred to by their preferred name.

Information was included in people's care records about their life story including information about their family, previous occupations, where they lived and their lifetime experiences. People's relatives told us staff asked them about their family members and obtained lots of information about their life and what they were interested in. Also included in people's care records was a one page summary of 'my life now' which outlined what the person's life was like now and what they liked, disliked, what upset them and how they wished to be supported. When staff were describing people we saw that this matched with what was included in people's care records. This enabled staff to provide people with individually tailored support.

Staff were aware of people's communication needs and we saw staff using a range of communication methods with people. This included engaging some people in full conversations, using short sentences and using hand gestures to ensure people understood what staff were saying. Some people's first language was not English and staff had learnt some basic phrases in the person's language to help communicate with these individuals. Staff whose first language was not English were offered English courses to help communication with people. We observed staff speaking loudly and clearly so people could hear what was being said.

People were involved in their day to day decisions and as much as possible people were involved in decisions about their care. For example, we saw in one person's records that sometimes they got agitated at night and when this occurred the person preferred to go to sleep in their day clothes. People were offered choices throughout the day including what they wanted to do, what activities they wished to participate in and where they wanted to spend their time. The majority of people spent their time in either of the communal lounges, however, some people preferred to spend time in the privacy of their bedroom.

We observed staff knocking on people's doors and asking for permission before entering. People's bedrooms were identified with a sign on their room with their name and pictures of things that were of interest to them or represented their previous occupation. We also saw that some people had memory boxes next to their rooms filled with reminiscence objects. This helped people living with dementia to identify and locate their room. One person's relative told us, staff "do give them respect."

People were supported to practise their faith and undertake tasks important to their culture. Staff told us

they celebrated many religious festivals and it gave them and people the opportunity to learn about different cultures. For example, they had recently celebrated Diwali and they were in the process of learning about the Christian nativity in preparation for their Christmas celebrations.

End of life wishes had been discussed with people. We saw that when people wished to engage in this conversation their decisions and wishes were documented in their care records so they could be supported appropriately at the time. For example, some people wanted to go to hospital for additional treatment, whereas other people preferred to stay at the service. Some people did not wish to be resuscitated and 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were completed by the GP in discussion with the person and their families.

Good

Is the service responsive?

Our findings

A person's relative told us in regards to whether staff met their family member's support needs, "If anyone can, they can here." They also said, "Staff continually review [the person's] care."

Staff were knowledgeable about people's care and support needs, and this reflected what was included in people's care records. Staff assessed people's needs and developed care plans outlining how those needs were to be met. Care plans were developed with input from the person and their family to ensure they were specific to the person and in line with their wishes and preferences. Care plans were specific to people's needs and included information about the support people required with nutrition, personal care, continence support, maintaining their dignity and meeting their social and recreational needs. Care plans were also developed about specific needs for example in relation to diabetes management. Care plans were regularly reviewed to ensure they reflected people's current needs.

Staff were able to describe what caused people to become anxious and how they reassured a person. For example, when one person was anxious staff held the person's hand and engaged them in conversations about their family which helped them to relax and be comforted. We observed staff reassuring people were they became frustrated.

'Grab sheets' were available for new staff and for agency staff which provided them with a clear and concise overview of people's support needs and the risks to their safety. This enabled all staff to have easy access to key information about people.

The staff used the 'resident of the day' initiative to review the care and support provided to people, and to ensure people were given that extra attention when it was their turn to be resident of the day. This included ensuring people's favourite meals were available, and people were engaged in activities of interest. For example, staff played darts with one person, another person was supported to play cards in a small group. Also included in the 'resident of the day' initiative was a thorough review of their care records to ensure they were up to date and reflected the person's needs.

The staff provided people with a range of activities and stimulation. A representative from the local authority told us every day they visited they observed activities taking place. The service had introduced 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 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. We observed a Namaste session taking part on the day and people were happy and enjoying the interaction with staff. We observed one person asked for an additional head massage because they were enjoying it.

The staff were also undertaking an activity called OOMPH with people. 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.

Events were held at the service that were of interest to people. Many of the people that used the service had either owned dogs or their relatives had dogs. The staff held an event where people's families were invited to bring their dogs to the service as well as the visiting 'Pets as therapy (PAT)' dog. A dog show was held that was judged by a local vet. Another event was held where a local farm visited the service. We saw pictures of the events held which showed people smiling and engaging in the activities.

A process was in place to hear any concerns or complaints people or their relatives had. All complaints were reviewed and addressed by the registered manager, to ensure appropriate action was taken to address any concerns raised. A representative from the local authority told us the feedback they received from people's relatives was positive and they were "delighted" with the service. One person's relative told us any concerns they had were quickly dealt with.

Good

Is the service well-led?

Our findings

The registered manager encouraged staff, people and their relatives to express their views and opinions about service delivery. A suggestion box was available for people to use, and an email address had been set up for relatives to propose any questions or suggestions they had. The registered manager had an 'open door' policy and was available when people, relatives or staff wished to speak with them. Relatives meetings were held to give relatives the opportunity to discuss the service and input to service delivery.

A satisfaction survey was sent to relatives to complete every six months to obtain their feedback about the service. We saw the findings from the survey completed in August 2015. 87% of relatives expressed that either a very good or excellent service was provided. Some of the comments provided included, "There is always a nice friendly atmosphere at the home," "Staff are very friendly and helpful," and "Staff are ready to answer any question."

Staff were invited to express their opinions during staff meetings. Staff were able to request for items to be added to the agenda and were involved in discussions had. We saw the minutes from the latest staff meetings which showed that these meetings were also used to remind staff of the importance of accurate record keeping, a reminder about maintaining people's dignity and about correct manual handling procedures for each person.

The registered manager was 'hands on' and took part in the support provided to people. They attended handovers so that they were kept well informed and involved in the service. This enabled them to be aware of changes in people's needs and to quickly identify and address any further support people required.

Staff said they were well supported by the registered manager. One staff member told us the manager was "always available" and they had a good relationship with them. The staff we spoke with felt the team worked well together and that communication was key to that. They said there was open and transparent conversations and dissemination of information from all staff and at all management levels. One staff member told us the registered manager was "friendly and approachable" and that they felt they could "share any issues with her". A representative from the local authority said the staff they spoke with were well supported by their manager and they felt there was good support within the staff team.

Within the staff team there was a clinical lead and leads for different aspects of care delivery, including an infection control lead, dementia lead, dignity lead and safeguarding lead. The lead staff were there to support the rest of the team, review the quality of care in regards to their role and to review staff's adherence to the provider's policies and procedures. We spoke with the lead for infection control who told us they addressed any concerns they observed with the staff member involved and escalated their concerns as necessary to the registered manager and clinical lead so they could be discussed during supervision. We observed the clinical lead role modelling and discreetly informing staff when the support they were providing could be amended or improved. This enabled a continuing focus on quality improvement.

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.

'10 at 10' meetings were held regularly with attendance from as many staff as possible at that time. These sessions enabled staff to give a quick overview of anything that needed addressing that day, for example, a change in meal choice. They were also used to distribute information to staff. Staff had been using these meetings to discuss the 'policy of the week'. One of the provider's policies were chosen each week and the key information was discussed and disseminated so that all staff were reminded about what was included in the policy.

Staff with lead roles and the registered manager undertook audits on the quality of the service, including infection control audits, care records audits, medicines management audits and mealtimes checks. These were reviewed either weekly or monthly to ensure good quality care was provided. We saw that areas requiring improvement were identified and the registered manager followed them up to ensure they were completed.

The clinical director undertook unannounced spot checks on the quality of the service. We reviewed the findings from the previous inspection in June 2015 which identified that some improvements were required in regards to completion of incident records and completeness of care records. We observed that these improvements had been made for the records we reviewed.

'Meet the MD' meetings were held so that relatives could arrange to meet directly with the managing director and to feedback about the service. We saw that whilst the MD was at the service they also reviewed the quality of care and spot checked areas of service delivery.

The registered manager was aware of their responsibilities in regards to their registration with the Care Quality Commission, and they submitted notifications of significant events as required.