Black Swan International Limited

Chiswick House

Inspection report

3 Christchurch Road
Norwich
Norfolk
NR2 2AD

Tel: 01603507111
Website: www.blackswan.co.uk

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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

We inspected Chiswick House on 24 February 2016. This was an unannounced inspection. Chiswick House is registered to provide accommodation and personal care for 26 older people, some living with dementia.

There were 20 people living in the home when we inspected.

There was 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.

Staff understood what protecting people from harm or abuse was, and had received relevant training. Staff understood their roles and responsibilities in keeping people safe and actions were taken when they were concerned about people's safety. Individual care plans had risk assessments to ensure the safety of people using the service. The provider had effective processes in place to minimise risk.

Robust recruitment processes were in place to ensure that staff employed in the service were suitable for the role. People were safely supported with medicines administration by trained staff. Staff were confident in reporting incidents and accidents should they occur. The service had robust quality assurance systems to drive continual improvement in the service.

Staff understood the importance of gaining people's consent to the care they were providing to enable people to be cared for in the way they wished. Two people had applications in for the lawful deprivation of their liberty (Deprivation of Liberty Safeguards (DoLS)) and staff were able to explain how they promoted choice where people had variable capacity. The home complied with the requirements of the Mental Capacity Act 2005 (MCA).

People were supported to access healthcare wherever necessary and in a timely manner, with prompt action taken in response to changes to a person's health needs. People's nutritional and hydration needs were well met by the service, in line with recommendations such as speech and language therapy.

Staff had good knowledge about the people they cared for and understood how to meet their needs. People planned their care with staff and relatives, and activities were carried out in line with people's preferences.

Staff were kind and compassionate. They consistently demonstrated humour and warmth in meaningful interactions with people. Feedback from people and their relatives about the care they received was complimentary. Staff respected people's privacy and dignity.

Staff were well motivated and spoke positively about their job and understood the importance of providing a high standard of care to the people living in the home. There was an inclusive culture including good

teamwork within the service. Staff felt supported in their roles.

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 by a sufficient number of competent, qualified staff.

There were systems in place to protect people from harm.

Risk assessments were in place for individuals and their environment and these were followed to minimise avoidable harm.

Is the service effective?

Good

The service was effective.
The service was effective.

Staff sought consent, and people were supported to make their own choices.

People had timely access to healthcare services and staff followed advice given from healthcare professionals.

People's nutritional and hydration needs were well met.

Is the service caring?

Good

The service was caring.

People living at the home, visitors and health professionals felt that staff were kind and caring.

Care plans contained detailed information about people's needs.

Is the service responsive?

Good

The service was responsive.

People were able to access a wide variety of activities and the service was responsive to specific requests.

Individual preferences were taken into account consistently.

Complaints and issues raised were acted upon in a timely manner.

Is the service well-led?

Good

The service was well-led.

Effective quality assurance processes were in place which helped drive improvement.

The culture of the staff in the home reflected the values outlined by the provider of 'Independence, choice and individuality', as stated on their website.

Chiswick House

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 24 February 2016 and was unannounced. It was carried out by two inspectors.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the company is required to send us by law.

During this inspection, we spoke with five people who lived at the home, four visitors to the home and five members of staff. We spoke with one healthcare professional who visited the service, a visiting activities facilitator, the registered manager and the area manager. The director of the company was present on the day of the inspection.

We observed how care was delivered throughout the day. We reviewed care records and risk assessments for four people who lived at the home and checked five medicines administration records with associated audits. We looked at staff training records, policies and risk assessments and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

One person told us, "Oh yes, I feel safe here." Staff understood how to protect people from harm. This was due to receiving formal induction, training and supervision. Staff were able to tell us that they had training in safeguarding and were able to tell us what types of abuse there were. They told us what kind of behaviours they would look out for. The manager of the home had referred concerns to the appropriate safeguarding authorities where necessary. Staff told us they felt comfortable to raise concerns to the manager or provider if they felt they needed to, and how they would report any incidents relating to poor practice or abuse. This was supported by appropriate safeguarding and whistleblowing policies and indicated that the provider had processes in place to promote people's safety.

We identified concerns for the way one person was being assisted to move in their wheelchair without footplates. Staff told us this was the person's preference whilst within the home. We found that the person was assessed as being able to make decisions about their care. However, the person told us they could not remember being consulted, and said "They don't always ask about footplates but I don't mind. I expect they will put them down when they take me back to my room." This could present a risk for injury.

Care plans contained assessments of risks for individuals covering issues such as manual handling, health conditions, tissue viability and individual fire risk assessments. People's risk of developing pressure ulcers was assessed, regularly reviewed and preventative measures were taken by staff. Staff told us that one person had recently developed a reddened area and that they had reported this promptly. An appointment had been made for the district nurse to visit the following day and re-assess the person's risk so that appropriate equipment could be provided. Where recommended, pressure relieving equipment such as repose cushions had been provided. This meant that systems were in place to minimise the risk of people developing pressure ulcers.

We observed people being assisted to mobilise safely in line with care plans, both with stand aids and frames. Staff managed this whilst promoting independence by prompting people to remember frames and mobilise as safely as possible. We spoke with a person who had been supplied with a pendant alarm so she could walk outside independently. Another person had fallen several times recently due to wanting to mobilise with her frame, and the occupational therapist was due to review her mobility. This meant that people were able to take risks where it maintained their autonomy and independence. The service took steps to effectively manage both environmental and individual risks.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. The last fire service inspection was in October 2015 and the provider had taken action to address their recommendations. We found that the kitchen fire door was not closing properly and presented a risk that a fire in that area would not be contained. The regional manager said they would take appropriate action regarding this as well as reviewing the way fire doors were tested.

Lifting equipment was serviced as required and environmental maintenance and risk assessments were in place. Accidents and incidents were reported and acted upon appropriately and in a timely manner and

staff told us how they reported them. Maintenance records relating to health and safety of the building and outside were monitored by the maintenance person who works full-time.

We had a concern over some medicines being used daily which had been prescribed only for 'as needed'. The registered manager took prompt action to arrange for a review of the regular use of these medicines with the relevant GP. We noticed that one inhaler was out of date and should have been replaced, which the senior carer took action to replace.

We saw in the care plans that people had been given the choice of self-medicating and had chosen for staff to support them with medication. One person told us they were happy with the way staff handled their medicines and that they were offered pain relief when they needed it. We observed staff offering additional pain relief to someone who was in pain during the afternoon. Care staff applied creams and lotions and completed appropriate records and body charts to confirm they had been applied and where they had been used.

Medicines records were audited regularly to ensure that people had received treatment as the prescriber intended. Seniors carried out in-house medication audits and staff had reported and recorded any errors which the manager acted upon appropriately. We noted that the provider completed further checks and when they identified concerns, prompt action was taken to address them. Medicines were sometimes given within a communal area, but staff were observed to be discreet when administering and discussing them with people.

Medicines were stored, managed and administered safely and double checked where necessary by staff who were trained to do so. The medicines administration records (MAR) folder contained photographs to aid staff in identifying people when administering medicines. We checked a random sample of three medicines that were not in blister packs. We found that the balances remaining corresponded to the amount received and signed as given on the MAR chart.

One person waiting for assistance from staff told us, "Sometimes they are a bit of a while coming and I have to wait, but generally they are quite good." Visitors to the home said that they had not had any concerns about staffing levels and the availability of staff to provide support when needed. During our visit, call bells were responded to promptly and we observed that there were staff around in communal areas most of the time. The manager used a dependency tool to determine staffing levels. However the manager reported that staff recognised and reported when people's dependency levels changed and more staff were needed. The staff rota reflected how many staff the manager had deemed necessary. Staff told us they had enough time available to meet people's needs safely. Staff told us that when they occasionally have had agency staff come in, they have consistently had the same staff return to the home.

The provider's recruitment policies and induction processes were robust, and so contributed to promoting people's safety. Appropriate checks were made before staff were recruited, such as criminal record checks and references. The manager told us that volunteers went through the same checks as permanent staff. This showed that a rigorous approach had been taken to maintain a high standard of care and that only people deemed suitable, in line with the provider's guidance were working at the service.

Good

Is the service effective?

Our findings

People told us that they had no concerns about the competence of the staff. A visiting healthcare professional said that staff were aware of people's capacity to consent to receiving treatment. During the inspection we observed consent being sought when staff were using equipment with people.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes are called 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.

DoLs applications were made appropriately in line with the Mental Capacity Act. This was for two people living at the home who had variable capacity including lowered insight into their own safety should they be free to leave the home alone. We found that there was further information available for staff to refer to about mental capacity and consent, which gave examples of how people may consent to care verbally or non-verbally, giving 'implied' consent. This corresponded with what staff told us and what we saw. We found that the service was acting in line with legislation regarding the Mental Capacity Act. It was documented in people's care plans what sort of decisions they could make for themselves and what they may need further support with. Staff acknowledged the importance of making best interests decisions where people had fluctuating capacity, recognising the importance of involving relatives if appropriate.

Staff told us they had supervisions and appraisals in place in order to discuss progress, concerns and any further training. We spoke with two members of staff about their induction, which they reported included shadowing more experienced staff, training and supervisions. Records confirmed this. New staff were subject to a probationary period, over which their competencies were reviewed, and staff had an interview at the end of the probationary period. This meant that the provider had systems in place to ensure staff were supported to work in the way that was expected of them.

The mandatory training for care staff deemed necessary by the provider included manual handling, infection control, food hygiene, safeguarding, dementia, first aid and fire safety. . A staff member told us, "I always wear apron and gloves during personal care", and reflected that this corresponded to their infection control training. The deputy manager on shift had been a trainee deputy for some time before they were appointed; learning the role from an experienced member of staff so they knew what was expected of them. Senior staff completed training in care of medicines, and staff were carrying out qualifications such as the Care Certificate, or they had completed an NVQ in care.

There was a daily allocation sheet to ensure that all people were looked after by particular staff members on shift. Fluid charts were used and allocated staff encouraged people to drink enough. Staff told us, "It works better like that, so you don't think someone else is doing it, and there is more interaction that way. If you just ask, she won't drink, but if you just have a chat about her family and have a cup of tea with her then she'll drink one too." Jugs of cold drinks were refreshed regularly, and people had drinks in their rooms. Alcoholic drinks were available for people and hot and cold drinks were readily accessible in the lounge throughout the day. We observed people being given choices of food and drink throughout the day. We saw that a selection of snacks and drinks was available in all communal areas throughout the day, including fresh fruit and crisps. The service met people's hydration needs well.

We saw that people were regularly reassessed for their nutritional needs. The home had been awarded five stars for food hygiene. People stated that there was a good selection of desserts, which we observed during the inspection. One person acknowledged that it would be nice to have more diabetic desserts. People living at the home, visitors and staff told us that the food was of a good standard at the home. One person living at the home told us, "The mains are good. The homemade soup is very nice, and there's always a platter of fresh fruit, strawberries, raspberries, and buns, cakes and yoghurts." Another said, "the food is very good – there's always two or three nice things to choose from." A selection of cakes, biscuits and chocolate bars was available during tea times. Two visitors to the home told us that the food always appetising. They said, "The food is always lovely. We have eaten here with [friend]." We observed that people were well supported to eat and drink at lunch time, and encouraged and prompted appropriately by staff. One staff member said, "If she doesn't like it, she'll let you know and the cook will make her something else".

Where people had difficulties swallowing, the advice given by a speech and language therapist was incorporated into their care plan. We saw that softer diets were documented in care plans and we observed that advice was followed. Care staff gave us information about one person eating a soft diet as their preference rather than because of swallowing difficulties. This was confirmed within their care plan. The cook was able to tell us about people's preferences and dietary needs. People's weight was monitored and recorded in care plans so that action could be taken if needed to refer to a dietician.

Access to healthcare was well documented. People received visits from district nurses, GPs and chiropodists when this was needed. We saw that staff made a prompt referral to the GP as a resident was unwell. The district nurse visited regularly to review pressure areas. Staff told us that handovers were used between day and night shifts to inform staff of any changes in people's health needs. A visiting healthcare professional confirmed that, if they identified during their treatment that someone needed to see the doctor, staff arranged it promptly, always the same day. This meant that people were supported to access healthcare promptly when needed.

During our inspection there was building work outside which had been planned for an additional extension. The design and decoration of the service was pleasant to people. A visitor had commented in feedback questionnaire "I think the home is lovely with all the new things done to it." Many of the rooms now have en suite toilets and have been recently redecorated. A resident told us, "I'm as happy as I can be not in my own home, and it makes such a difference that it's decorated cleanly." The environment was clean and light, and the manager had responded to people's requests for more lights in the lounge. People had chosen the way in which they wanted the dining room to be set up with a long table, which was laid to create a pleasant environment for people. Visitors, staff and people living at the home commented on how much they liked the conservatory.

Good

Is the service caring?

Our findings

A person living at the home said, "This is a reasonably happy place. People are very well looked after." During the inspection we saw meaningful, fun, caring interactions with staff and residents. This included examples of people joking with staff. A visitor assured us that "Staff are polite, kind and courteous. Staff are very caring." We observed good rapports and jokes between staff and people at the home. A resident told us, "They treat me with respect and even affection." Another visitor said, "They'll do anything for you."

Another person said, "They don't bat an eyelid if anything embarrassing happens. So often when you come into a care home, you lose your dignity, but it's how the staff react to you." Staff were able to tell us how they supported people's privacy and dignity. One staff member said in relation to personal care, "We always cover people and leave them alone when they want, and just be there if they need you." People told us they felt their privacy was respected, although we observed that some staff did not wait for an answer after knocking to enter someone's room. We observed, and it was confirmed in care plans we looked at, that people could stay in their room when and if they chose to.

Some visitors told us that staff communicated with them well, and engaged openly with them. One staff member said, "if you take time to interact with [name] on the spot, she will communicate." We concluded that people's dignity and privacy were well promoted and preserved, and that people's opportunities for interaction were increased because staff communicated with them effectively. We observed that when staff were carrying out work with someone, such as supporting them to eat or drink or mobilise, they spoke kindly and engaged in appropriate banter, humour and physical reassuring touch.

A staff member told us, "I treat people how I'd like to be treated when I'm old." Staff were able to give examples of how they communicated effectively, "at meal times she can choose more if you write it down for her, or use spelling cards, plus it's good interaction and fun. Sometimes we also spell her family's names". The staff member taking mid-morning drinks around checked people's meal choices for lunch time. Staff told us they talked about people's lives and families a lot with them. This meant that choice was promoted and staff took into account individual circumstances to enable opportunities for meaningful interaction. Staff adapted their communication according to the needs of the people they were caring for, and knew about their personal lives.

Staff were able to tell us how they encouraged choice and that they, "get down to eye level and ask and point to things." They added that they always asked if people would like talcum powder or perfume during personal care, and what they would like to wear, and this was reflected in their care plan. Another staff member gave an example of how they promoted daily choice for people with variable capacity by going through their wardrobe with them. A visiting healthcare professional told us that staff took into account people's comfort when they needed treatment. They told us how staff would assist the person to receive treatment on their bed, in their wheelchair or an armchair. They told us that staff took into account how the person felt at the time and what they want.

The care plans we looked at focussed on the needs of each individual. They documented different aspects of each person's preferences and needs, and details about their history and family. This was reflected by people we spoke with in that people were involved in planning their care. People told us that their views and preferences were taken into account in the way their care was carried out, for example if and when they needed supervision to have a shower. People or their relative had signed their care plans where appropriate, and had contributed largely to their own care planning process. The service had a continence champion who was able to review people's continence needs individually and suggest any relevant changes to people's care and equipment. As documented in care plans, this helped to preserve people's dignity and maintain independence. People were offered personal care or assistance with eating discreetly which contributed to their dignity.

Independence was encouraged by staff; we observed staff prompting someone to stand up and waiting for them to be able to do so independently, pushing up from the chair and leaning forward with prompting. We saw that staff always explained to people what they were doing. This meant that staff knew how to facilitate people's independence by providing appropriate levels of support.

Staff and people living at the home told us that visitors came when they liked, and that people could come and go with their families as they pleased. Families and friends had been welcomed to stay for lunch including on Christmas Day. This meant that people's family time and personal relationships were well respected within the home.

Good

Is the service responsive?

Our findings

Visitors to the home told us, "The activities are usually very good." They described one music session people had enjoyed and felt it was, "…very professional. "Activities were in place to encourage people's interests, including arts and crafts, regular exercises classes, newspaper reading, reminiscence, singing and flower arranging. Some of these reflected people's hobbies and life histories as documented. We observed that the activities facilitator, who was doing flower arranging with a lot of people, took an arrangement down to the room of someone who felt poorly that day and was unable to join in. These aspects of the day showed us that people were included as much as possible and treated with equality, and that external staff and volunteers visiting had a consistent approach to caring for each individual.

The service had had some problems carrying out activities recently due to a vacancy for an activities coordinator and some visiting activities being cancelled due to sickness. This was fed back by people and the provider has been acting upon these concerns appropriately. One resident said, "They always make sure everyone can join in, and people in wheelchairs have the same opportunities as the rest of us." During the inspection we observed two people being supported by staff to play a game together, and staff told us that they tried to engage in activities during the afternoons such as board games.

Staff told us that people could choose whether or not to have a male/female carer. We saw that a male member of staff had been asked to attend to a resident who had requested this. Staff were able to give examples of people's individual preferences which correlated with information in people's care plans. Individual care needs had been assessed prior to their admission to the home. This included specific requirements, for example equipment needed or special requirements and preferences, in order for the home to effectively meet their needs. The reviews of people's care included people's families where appropriate. A visiting health professional told us that staff were aware of how people might express their unwillingness to receive treatment but would offer explanation and encouragement if it was needed.

Care plans covered details of finances, life history, wellbeing, going out, hobbies and interests as well as the personal health and care needs of each individual. Staff were able to tell us how they met each individual's needs consistent with their plans. A member of staff told us, "if you interact with them, you really get to know people." Care plans that we looked at included people's views and religious beliefs. The service maintained some links with the local community having visits from the church for Holy Communion, as well as volunteers and people visiting for activities. Staff we spoke with told us that although they read and updated the care plans when needed, they use daily verbal handovers to inform each other of any changes and updates in people's needs. Staff told us that they did not feel the need to use the care plans regularly because they were familiar with the people living at the home.

A visitor to the service described it as "…flexible". They told us they had asked to bring a dog in to visit and that people had enjoyed the opportunity to interact with the animal. One person had their own cat which they had brought with them. Another person spent time with the home's pet cat and both visitors and staff felt this benefitted the person's well-being. The service was responsive to individual requests. A member of

staff told us about people's preferences for times of getting up and going to bed and these were reflected in care plans. A resident had her meal bought to her room as she had decided to stay in bed for the day due to feeling poorly. We concluded that the staff were responsive to people's individual wishes and needs and they were flexible in their approach.

We observed that people felt comfortable to express themselves – a person living at the home had written a poem for the visiting activities facilitator which she read to the other residents during flower arranging. Staff told us that they had film evenings at weekends based on people's wishes. Complaints were responded to and acted upon appropriately by the manager and staff. One complaint was dealt with by organising a family meeting to discuss the issue further. People visiting the home told us that they would feel confident to make a complaint should the need arise.

Good

Is the service well-led?

Our findings

One staff member told us, "It's not like coming to work – it's so welcoming here and like a big family." Another said, "it's rewarding." Staff reported that they worked well as a team and this was reflected by other people. We observed during the inspection good morale and team work of the staff. We observed that the home had a strong core staff team and was able to use their own staff a lot of the time when they needed extra support due to absence, or they shared staff between other homes owned by the provider.

We saw that clinical governance and audits were in place and processes for this had recently been improved, and care plans we looked at were reviewed monthly. Any changes in people's needs and progress were documented in a review record sheet. Staff meeting minutes showed that this process had been improved by the manager asking for more detail about changes in people over the time being reviewed. Staff used an allocation sheet when they were on shift so that they knew their responsibilities and what they would be accountable for.

A person living at the home and two visitors commented that the manager was not as visible around the home as the previous manager, but we acknowledged that the manager had only been registered in post since mid-January. However, people felt able to approach the manager should any issues arise. During our inspection we found that menus displayed in different areas of the home were conflicting, with two in the reception hall showing different information which could lead to confusion. We found that the activity programme displayed and available to people contained conflicting information about dates of events which hadn't been noticed, but the registered manager corrected these promptly.

We noted that the provider's development plan for 2016 had been drawn up after their annual general meeting in September 2015. This was the month after the 'residents' survey' had been completed. The plan contained a statement that, "Items as highlighted on residents' questionnaire to be fully addressed by the end of the development plan." This meant that people's views on the service had directly influenced the material within the plan with a view to making improvements that people suggested.

Responses to people's views about the service were openly displayed on the board in the reception hallway. The management team promoted an open culture, which focussed on the needs of individuals. Staff and other people were encouraged and empowered to express their views. People had opportunities to make complaints during meetings and feedback questionnaires, and contacts for the providers were available. We saw that complaints and feedback were used to inform and improve the service.

Records showed that 'residents' meetings' took place on a quarterly basis, involving a member of regional staff from the provider. Records showed that people were consulted about staffing arrangements, meals and activities. We also noted that the meetings reassured people about access to members of the senior management team if they had issues they felt they needed to raise outside the home. The man We saw that complaints and feedback were used to inform and improve the service. ager and/or the provider was contactable for all staff 24 hours a day, and their phone numbers were on the board in the office. The manager told us that the provider is supportive and if equipment is needed, it's there the next day.

We observed that the home has a strong core staff team and is able to use their own staff a lot of the time when they need extra support due to absence, or they share staff between other homes owned by the provider. Staff told us that when they occasionally have had agency staff come in, they tended to be the same people that come back.