Havering Care Homes Ltd

# Upminster Nursing Home

## Inspection report

Clay Tye Road
Upminster
Essex
RM14 3PL

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

About the service
Upminster Nursing Home is a residential home providing personal and nursing care for up to 37 people. The service is provided in one purpose-built building. Bedrooms are on four floors and are accessible by a passenger lift. Communal lounges and a dining area are on the ground floor, but each bedroom has a hand wash basin and a toilet. At the time of our inspection 31 people were living at the service.

People's experience of using this service and what we found
People felt safe in the service. There were systems in place to assess and manage risks to people. Staff understood adult safeguarding procedures, which meant any potential or real incidents of abuse were appropriately reported.

There were enough staff to meet people's needs. Staff recruitment processes were robust ensuring staff were safe to work with people and had the necessary skills to provide care. Staff were provided with ongoing support, training, supervision and annual appraisals.

Medicines were managed safely. This meant people received their medicines as prescribed by their doctors. The service was clean and there were systems in place to manage the risk of infections. Records of accidents and incidents were kept and, where appropriate, lessons were learnt to improve the service.

People's care plans were detailed with information on their needs and how they wanted to be supported. An electronic device staff used to record and update people's care was useful in helping the service keep and monitor people's care records. Staff were kind and caring.

People and relatives felt the food was good. The service ensured people had access to healthcare professionals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were given privacy when they wished it but were also enabled to move around freely and independently in a safe way.

Quality assurance checks were carried out to help ensure people lived in a service that was safe. The registered manager sought feedback from people, relatives and staff and this was used to help improve the service. Complaints were managed appropriately .Staff worked with other agencies to help improve the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published on 15 May 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

## 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.

Details are in our safe findings below.

**Is the service effective?**

Good

The service was effective.

Details are in our effective findings below.

**Is the service caring?**

Good

The service was caring.

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Details are in our caring findings below.

**Is the service responsive?**

Good

The service was responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Good

The service was well-led.

Details are in our well-led findings below.

# Upminster Nursing Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of an inspector, inspection manager 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.

Service and service type
Upminster Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from the local authority who commissioned the home's services. Due to technical problems, the provider did not send us the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We observed how staff provided care and communicated with people. We spoke with six people who used

the service and six relatives. We spoke with four care staff, an activities' co-ordinator, a housekeeper, a cook, maintenance person, a manager, the registered manager and the managing director. We reviewed a range of records. These discussions helped us understand how the service was being run and what it was like to work there.

We reviewed a range of records. These included five people's care records and records relating to staff recruitment, training and supervision. We also looked at information relating to the management of the service, including the provider's policies and procedures, people's medicine administration records (MARs) and quality assurance records.

After the inspection
We continued to seek clarification from the provider to validate the evidence found during the inspection. We looked at training data, quality improvement information and fire safety information.

Good

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people were safely managed. Each person had a risk assessment which detailed areas of risks such as mobility, communication and nutrition, and how these could be managed. Staff had good knowledge of risks to people and how to mitigate them.

● The registered manager had undertaken health and safety checks and ensured the facilities and equipment were safe. Records and certificates confirmed a fire risk assessment was completed and regular safety checks were done on areas such as fire alarms, emergency lights, call bells, and gas boiler safety. This showed people lived in an environment where safety was monitored.

● The service had fire emergency procedures in place. People had personal emergency evacuation plans (PEEPs) which provided guidance to staff and the emergency services regarding the level of support that people would require to evacuate from the home.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. The provider had a safeguarding policy in place and staff had received training on safeguarding. Staff knew how and where to report if they became aware of an incident of abuse. One member of staff told us, "I will report [safeguarding incident] to my manager. If I feel nothing is being done about it, I will report it to social services or the CQC." This meant staff knew how to deal with safeguarding incidents.

Staffing and recruitment

● The service had enough staff. People told us they had no problems with staffing levels. One person said, "Staff always came promptly [to assist me when I needed support]." A relative said, "Yes, I do feel [there are enough staff]."

● However, we observed that during peak hours such as breakfast and lunch times, not everyone was getting prompt support when they needed. We discussed this with the registered manager, who advised us that the staffing level was based on the needs of people using the service. They said they would review staff deployment at mealtimes to ensure there were enough staff to meet people's needs.

● The provider followed safer staff recruitment practices. Staff underwent pre-employment checks, which included checks on their evidence of personal identification, employment histories, qualifications, criminal records, and references to confirm they were of good character.

Using medicines safely

● People received their medicines safely. Staff responsible for administering medicines received training in medicines management which included an assessment of their competency.

● Medicine administration record sheets (MARs) were in place. These showed people had received their

medicines as prescribed. Staff had guidance to help them identify when it would be appropriate for them to administer PRN medicines, also known as medicines prescribed to be administered 'as required'.

● Medicines, including controlled drugs were securely stored and were only accessible by named staff responsible for medicines administration. Staff made regular checks on the medicines storage areas to ensure medicines were kept within a safe temperature range, so that they were effective when taken.

● The registered manager audited medicines on a regular basis. This ensured that any gaps in the administration and records of medicines were identified and addressed.

Preventing and controlling infection

● People lived in a clean environment. One person said, "Beyond doubt [the home is clean]. The vacuum cleaner comes out three to four times a day." A relative told us, "I think they keep the service clean."

● People were protected from the risk of infections. Staff received training in infection control and were aware of the provider's infection control procedures. They had access to personal protective equipment (PPE) such as disposable gloves and aprons and we observed them using these when supporting people.

● There were systems in place for handling, transporting and washing laundry items at appropriate temperatures. These reduced the risk of cross infection.

Learning lessons when things go wrong

● Staff knew how to report and record the details of any accidents or incidents which occurred at the service. The registered manager maintained an accident and incident log which contained information about how it had occurred, and the action staff had taken as a result. The registered manager and managing director also carried out regular accident and incident audits to look for trends and identify any learning.

Good

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were assessed before they moved into the home in order to ensure their needs could be effectively met. A healthcare professional wrote, "The [registered manager] has been very involved in the pre-admission assessment process to ensure the service has all the information to deliver the necessary care for the residents." Care files confirmed pre-admission assessments had been completed before people started using the service. This enabled staff to know people's needs.
- The service received referrals from professionals and, where appropriate, people and relatives were able to discuss any preferences they had in the way people received support. The assessments considered areas such as people's likes, dislikes, mobility, communication, skin integrity, hearing and diet.

Staff support: induction, training, skills and experience

- Staff had the necessary skills to meet people's needs. One person said, "Oh, [staff] do know what they are doing." A relative us, "[Staff] seem to know how to care for people."
- Staff received an induction when they started work at the service. This included time spent shadowing more experienced staff to gain an understanding of the support people required. It also included being aware of the service's policies, procedures and practices in relation to health and safety. Where new staff had no previous experience of working in a care setting, they were required to complete the Care Certificate. The Care Certificate is the benchmark that has been set for the induction of new care workers.
- Staff completed training in various areas relevant to their roles. One staff member told us, "I had online and class-based training. It is helpful." Certificates and the provider's training matrix confirmed staff had completed training in areas related to their roles.
- Staff received regular supervision and an annual appraisal. One member of staff told us, "Yes, I had supervision and annual appraisal with my manager. It is useful because we can discuss how I am carrying out my work and what training I need to attend."

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain a balanced diet. One person told us, "The food is good. I can choose what I want." A relative said, "The food looks absolutely delicious. If [person] doesn't like anything, they just change it. [Person] has put on weight [since person came here]."
- People's dietary needs had been assessed and care plans contained guidance on any support they needed to eat and drink. Staff had sought advice from healthcare professionals where they had identified potential risks around eating and drinking.
- The cook was aware of key information relating to people's dietary needs. They knew people who required specialised diets because of medical or cultural needs and told us they prepared meals accordingly.

● People were able to eat together in the dining room or alone in their rooms, if they chose. We noted some people had to wait a bit longer than others for their meals to be served. We discussed this with the registered manager and were advised that this would be addressed so that no one had to wait longer than other people for their meals to be served.

Adapting service, design, decoration to meet people's needs
● The home was purpose built and designed to meet people's needs. All the floors were accessible with a passenger lift.
● Communal areas and bedroom were well decorated. New carpets had been fitted to some areas and people were comfortable in armchairs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff supported people to have access to a range of healthcare services when needed. One person said, "A doctor comes regularly on Wednesday. An optician and a chiropodist come once every three months." A relative told us, "Yes, the doctor does rounds and looks at everyone."
● Staff monitored people's health and reported any changes in their condition to the registered manager or a member of the nursing team. Staff told us and records confirmed people had been referred to healthcare professionals where their conditions had changed, for example, where they had lost weight.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
● Staff were aware of the need to seek people's consent when offering them support. One person told us, "[Staff] always ask if they can help me." We saw that staff asked people's consent, for example, to take their medicine.
● Staff demonstrated an understanding of the MCA and how it applied to their roles. For example, one member of staff stated that where people lacked capacity to make decisions for themselves, they would discuss the issue with the person's relatives, so the decision could be made in their best interests.
● People's care plans included records of mental capacity assessments and best interest decisions. Records showed that DoLS authorisations had either been granted or were being processed for some people.

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were caring and kind. One person said, "Yes, [staff] are caring." A relative told us, "Staff are caring. [Person] is settled in here. I have no concerns [about how staff treated person]".
- Staff engaged with people in a friendly manner. They communicated with people when providing care, for example, when supporting people with meals. This showed they were friendly and caring.
- Staff promoted equality and respected diversity. One staff member told us, "Everyone has the right to receive care that meet their needs. We do not discriminate people because of their differences such as age, disability, culture, religion, gender or sexuality."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives were encouraged to express their views and make decisions about the support people received. We observed staff involving people in decisions during our inspection. Staff asked people and waited for them to make decisions about their care. For example, they asked people about their meals, drinks, where they wanted to sit and what activities they wanted to take part in.
- A relative told us, and care records confirmed, people and their relatives were involved in making decisions about their care. We saw people's communication needs were included in their assessments and care plans.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and their privacy was respected. One person said, "Yes, staff treat me with respect." Another person told us, "Staff always knock on the door. They respect my privacy." Staff discussed in their meetings the importance of ensuring people's privacy was respected and treating them with dignity, for example, by addressing them with their preferred names.
- A member of staff told us they always knocked on the doors before entering bedrooms. Another member of staff stated that they shut the doors and curtains when supporting people with personal care to ensure privacy.
- Care files were securely stored to maintain confidentiality and protection of people's personal information.
- People were supported to maximise their independence. One person told us staff promoted their independence by encouraging them to do as much as possible by themselves. We observed staff sat by people and encouraged to eat their meals independently.

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans were personalised and detailed the support people required in a range of areas, including communication, personal life, sleeping, medicine, finance, support with mobility, eating and drinking. They also included people's likes, dislikes and how they wanted to be supported. They also included information about people's life histories.

● Staff had a good knowledge of people's care plans. They knew people's preferences of support. The electronic handheld device, which was available to care staff, enabled them to have easy access to care plans and record how they provided care. This was useful to staff to review, update, know people's care plans and respond to their needs.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs had been assessed and their care plans included guidance for staff on how to communicate with them effectively.

● The registered manager confirmed they could provide information to people in formats suitable to meet their needs, where required. These included using suitable fonts and pictures to help effective communication.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People enjoyed different activities at the service. One person said, "We have a lovely [activities co-ordinator] who does the recreations, seated exercises. [Activities coordinator] tries to arrange some things with us." Another person told us that they enjoyed the jigsaw puzzles they did and the day trips they had.

● The registered manager organised various events such as barbecues and Christmas parties, which people and relatives attended. A faith group visited and held services for people who wished to practise their religion.

● People were able to have visitors when they wished. During the inspection we saw relatives visiting people. We noted visitors were able to visit people when they wished.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure, which described what people could expect if they

made a complaint.
● People and relatives knew how to complain and expressed confidence that any issues they raised would be addressed. One person said, "Yes, I do know how to complain. I go to the manager." A relative said, "Yes, I know what to do if I have a concern. I had made a complaint and it was resolved."
● The registered manager kept records of any complaints received, including any investigations and responses.

End of life care and support
● The service provided end of life care. End of life care plans were in place where people were happy to discuss with staff. For example, one person's care plan included information about who they would like to have contacted if they passed away, including contact details for their preferred place of worship. Some people also had 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms in place where this issue had been discussed with them or their relatives and, where appropriate, their GP.
● Staff had good knowledge of how to organise end of life care by working with relevant healthcare professionals such as GPs and the local hospice to ensure people's end of life needs were met.

Good

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- People, relatives and professionals gave positive feedback about the registered manager and the high-quality care and support the service provided. A relative said, "[The manager] is on the floor [visible] and I like [them]. I have [the registered manager's] number. A healthcare professional wrote, "The Manager always appears very professional with the best interests of the residents at heart."
- There was open and transparent culture at the service. Relatives told us the registered manager was open to them. We noted the service produced newsletters to keep people and relatives updated with news and information. For example, the latest newsletter contained information about changes in management and introduced the new manager.
- The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with people's care and treatment.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities and the requirements of the Health and Social Care Act 2008. They were aware of the types of events that they were required to notify CQC about and had ensured the service had submitted notifications accordingly when required. They also knew to display the current CQC rating for the home which was displayed in a communal area within the service and on the provider's website.
- The registered manager had sent CQC a notification advising a new manager had been employed to replace the registered manager, who was due to leave their post. One person told us that they liked the current registered manager and were disappointed they were leaving their role. The new manager would have a six week induction to familiarise themselves with the service. This ensured the continuity of the service.
- Staff were clear about their responsibilities in the service. They demonstrated a good understanding of the provider's procedures and worked in line with regulatory requirements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives' feedback were sought. One person said, "[We complete] questionnaires every three months." A relative told us, "We have relatives' meetings."
● Feedback from surveys and compliments was positive about the service. Comments included, "Words are not enough to express our gratitude and thanks to you all", and "Thank you for the love and care you showed to [people]".
● Staff told us the registered manager involved them in the service. Minutes of the staff showed staff discussed the policies and practices of the service.

Continuous learning and improving care
● Staff had training opportunities to develop their knowledge. The registered manager kept training records and encouraged staff to develop their skills and refresh their knowledge.
● The registered manager used online resources from websites such the CQC and The National Institute for Health and Care Excellence (NICE). This helped the service to be up to date with current care related policies, procedures and practices.
● There were systems in place to monitor the quality and safety of the service. The registered manager carried out regular auditing of aspects of the service including care plans, medicines, health and safety and staff training. These enabled the registered manager to identify and address areas that required improvement.

Working in partnership with others
● The registered manager worked in partnership with other agencies, including local authority commissioners and the local clinical commissioning group (CCG).
● Local authority staff carried out quality assurance checks at the service and were welcome to visit when they wished. The last quality assurance check, which was carried out in May 2018, identified no concerns about the quality of the service. A summary of the report stated, "Throughout the visit, staff were observed to offer appropriate encouragement and engagement with residents. Residents were observed to be treated with kindness in a respectful manner."
● The managing director and the registered manager attended various social and healthcare meetings, conferences and workshops. These helped them to be up-to-date with current care practices and meet other professionals.