Care Quality Commission

Care Uk Community Partnerships Ltd

Highbury New Park

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

Highbury New Park is a care home owned by Care UK Community Partnerships Limited providing residential and nursing care service to 53 men and women from the local community. The majority of people using the service suffer with dementia.

This inspection took place on 3 February 2015 and was unannounced. At our last inspection in January 2014 the service was meeting the regulations we looked at.

At the time of our inspection a registered manager was employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The staff of the service had access to the organisational policy and procedure for protection of vulnerable adults from abuse. They also had the contact details of the London Borough of Islington which is the authority in which the service is located and only this authority places people at the service. The members of staff we spoke with said that they had training about protecting vulnerable adults from abuse, which we verified on

Summary of findings

training records and most were able to describe the action they would take if a concern arose. However, we found that two care assistant staff did not appear to recall if they had received training about this.

We saw other risks assessments concerning falls and risks associated with epilepsy. The instructions for staff were detailed and clear. However, in one example a care plan said a person should be up and in their chair in the mornings but put to bed in the afternoons. It also said they should be turned regularly. The carer we spoke with about this demonstrated no apparent knowledge of this. Risks were identified and reviewed, and acted upon, however, there was a lack of consistent awareness among the staff team about how to respond to all potential risks.

Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home twice each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively and we saw that staff supported people to make and attend medical appointments, for example at hospital.

Everyone we spoke with who either uses the service, and relatives, praised staff for their caring attitudes. The care plans we looked showed that considerable emphasis was given to how staff could ascertain each person's wishes despite their dementia and to maximise opportunities for people to make choices that they were able to make. For example, we saw information in one person's care plan informing staff about how the person might be more able to make decision at some times of the day rather than others, to allow time for the person to respond and to observe their physical reactions. We noted in another person's care plan file that staff were to respect a person's right not to join in with certain activities that they did not enjoy.

Staff said two people who chose to remain in their rooms on the 1st floor were reluctant to mix with the all-female group in the lounge. In one instance it wasn't possible to ascertain whether this meant the person was isolated although they did spend much of the day in their own room. However, a care worker was heard asking a person who did not think there were many activities if they would like to go to a special film showing at a nearby cinema the following week. This member of staff was also seen talking with people about outings once the weather improved.

One concern about communication was raised. During the morning a group of students arrived and were dispersed throughout the facility. The assistant manager who brought them into the different floors said only that they would be doing work experience for two weeks. It was left to a carer to show them around and introduce them to people. This carer later said she was trying to find out what they could do and how much responsibility they could be given as staff had not been told anything about them.

However, we did see that there was usually clear communication between the staff team and the managers of the service. People's views were respected as was evident from conversations that we had with staff and that we observed. We saw that staff were involved in decisions and kept updated of changes in the service and were able to feedback their views and opinions through daily staff handover meeting.

The service complied with the provider's requirement to carry out regular audits of all aspects of the service. The provider carried out regular reviews of the service and sought people's feedback on how well the service operated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe. Although people's safety and any risks to that were identified and reviewed there was a lack of consistency among the staff team about how to respond to all potential risks.

Requires improvement

Is the service effective?
The service was effective. Staff received regular training, supervision and appraisal to ensure they had the skills and knowledge to meet the needs of people using the service. There was clear knowledge about how to assess and monitor people's capacity to make decisions about their own care and support.

Good

Is the service caring?
The service was caring. Throughout the day of our inspection, staff were observed talking with people in calm and friendly tones. They demonstrated a good knowledge of people's characters and personalities and conversations were about far more than just care tasks. We saw that when staff were providing assistance this was always explained, for example when moving somebody or assisting them with eating and drinking.

Good

Is the service responsive?
The service was responsive. We found that most people chose to be actively engaged in daily activities and staff communicated with people regularly and not only about care tasks.

Good

Is the service well-led?
The service was well led. The provider had a system for monitoring the quality of care. Surveys were carried out centrally by the service provider, the most recent in December 2014. This had not yet been published but from other comments made by people using the service, relatives and staff we found that people were usually satisfied with the service and the way that it operated.

Good

Highbury New Park

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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Tuesday 3 February 2015. The inspection team comprised of three inspectors and an expert by experience that had specialist knowledge of caring for a relative who suffered from dementia and used care services.

Before the inspection we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During our inspection we also spoke with five people using the service, seven relatives who were visiting, nine members of staff, the registered manager, deputy manager and the area manager for the provider.

As part of this inspection we reviewed ten people's care plans. We looked at the induction, training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring, audit information, maintenance, safety and fire records.

Requires improvement

Is the service safe?

Our findings

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse. They also had the contact details of the London Borough of Islington which is the authority in which the service is located and only this authority places people at the service. The members of staff we spoke with said that they had training about protecting vulnerable adults from abuse and most were able to describe the action they would take if a concern arose. However, we found that two care assistant staff did not appear to recall if they had received training about this.

It was the policy of the service provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. When we looked at staff training records we found that this was happening. Our review of staff training records confirmed that staff training did occur.

At the time of this inspection there were no safeguarding concerns. We found that where concerns had previously arisen that these were responded to properly.

A relative told us "there's a big difference between the day and night staff." He felt there was a consistency to the former while at night, "you never know who's who." This person thought that staff were caring but it is important that the provider examine the theme of staffing in more detail. Another person told us that whenever they use the call bell in their room to alert staff that they needed assistance that "Oh yes, they come when I press it."

Staff had a wide variety of opinions about whether there were enough staff at different times of day to care for people. Our review of the staff roster and deployment of staff found there were enough staff on duty and the provider operated safe recruitment practices including verification of nurses qualifications. During the inspection we saw staff were able to give people individual attention and reassurance, although the views of staff about this matter could be usefully further explored by the provider.

During our observations around the home during the day it was unclear whether there was a consistent policy on staff being present in the lounges. During the afternoon in the 2nd floor lounge, a carer promised to get a person some juice as soon as another carer came back into the room. She said this was because "I can't leave you on your own." Shortly afterwards when another, more junior carer was the sole member of staff in the same lounge, they left the room unattended having just handed a very frail person a hot cup of tea. People were not left alone for long but the incident raised questions about whether staff understood the home's guidance that a member of staff should always be present in the lounge and if so, whether it's communicated effectively and followed by all members of staff. We raised this with the manager who said that staff would be reminded of the homes written guidance about a member of staff always present in communal areas, including lounges when people were present.

Where people were identified as at risk of pressure sores we saw that detailed and clear information was provided to staff to minimise this risk. Actions included provision of air mattresses and instructions concerning the monitoring of these, regular recording of a person's weight, their need for fluids and a balanced diet, checks required on skin integrity and the application of barrier cream. We did note however that this was a standard list of actions for each person assessed with this risk. We checked the recording of weight for people and the records of checks kept on those beds which required the air pressure ratio to weight to be monitored and found that the correct air pressure was being used. People would be at risk if this was not done correctly of not being supported properly in bed which would increase the risk of people developing pressure sore injuries. This showed that staff had good instructions about how to minimise the risk of pressure sores and carried out the routine checks required.

We noted that one person was said to be at risk due to their behaviour and made allegations against staff. We checked the records of when an allegation had been made and saw that it had been dealt with appropriately. The care plans did advocate the use of a behavioural chart for this person but did not provide any information as to how the likelihood of verbal abusive and expressions of frustration could be managed by staff.

We saw other risks assessments concerning falls and risks associated with epilepsy. The instructions for staff were detailed and clear. However, in one example a care plan said a person should be up and in their chair in the mornings but go to bed in the afternoons. It also said they should be turned regularly. The carer we spoke with about

Requires improvement

Is the service safe?

was not aware of this. They told us the person spent the whole day in their chair and only went to bed at night where, "(the person) can turn themselves, we don't need to turn them."

Risks were identified, reviewed and acted upon, however, there was a lack of consistency among the staff team about how to respond to all potential risks.

This is in breach of Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we checked the communal areas of the service which were all clean and well maintained. We spoke with the maintenance manager who showed us records of health and safety checks of the building. Appropriate certificates and records were in place for gas, electrical and fire systems. We saw that hoists and slings used to support people with transfers were regularly checked and these checks were up to date to support people's safety. The provider had emergency contingency plans for the service to implement should the need arise.

We saw that people were supported with their medicines and these were stored safely. On the day of our visit we observed medication being administered after lunch on all three floors. We saw staff talked with people about their medicines and they had been given information about what their medicines were for. Records showed people's need for support to manage their medicines was assessed and reviewed as their needs changed.

We looked at twenty people's medicines administration record charts (MAR) and saw that staff had fully completed these. The records showed that people had received all their medicines as prescribed at the correct times of day. We saw that staff were trained in supporting people with their medicine and there were guidelines in place for staff to ensure that people received these appropriately. Records showed staff had followed this guidance and the service also had their medicines management audited by the service. Nurses administered medicines on two of the floors which provided nursing care and trained senior care workers administered these on the residential care floor, unless there was the need for controlled medicines which were only permitted to be administered by qualified nursing staff.

Good

Is the service effective?

Our findings

We looked at records which showed that staff received regular training, supervision and appraisal to ensure they had the skills and knowledge to meet the needs of people using the service. Staff attended regular training which included health and safety, infection control, safeguarding adults, moving and handling and fire safety.

Most of the nine staff we spoke with told us they had effective training. This included more specialised training about caring for people with dementia. When we looked at staff training records we could not verify when this training had occurred. The manager was unable to verify this with us during our inspection.

They also told us they received supervision every two months. When we looked at staff supervision records we found this was usually happening consistently for all staff. Most staff we spoke with found this time helpful and supportive of them in their work and had a good understanding of the aim of supervision.

Evidence of the home obtaining people's signed consent to their care and treatment was variable, in part due to the fact that many care records were held on computer. However, consultation with people and their relatives was consistent in the annual reviews which were carried out with the home and local authority.

Senior staff understood their responsibilities under the Mental Capacity Act 2005. Senior staff were also aware of the Deprivation of Liberty Safeguards. Most of the staff we spoke were able to tell us what this meant in terms of their day to day care and support for people. However, when we looked at staff training records we could not verify when this training had occurred and this could not be verified during our inspection.

Most of the care plans records we looked at had the correct forms in place recording decisions about resuscitation choices. We noted that the forms were updated regularly in that the GP who had signed the forms every 6 months but we also noted that in some cases it was not clear who else had been involved in the decision other than the GP. This contrasted with agreements we saw in people's files about giving medicines covertly where necessary which had been signed by the GP, the manager and the person's next of kin.

Where Deprivation of Liberty Safeguards decisions (DoLS) had been made the computer records indicated where a DoLS authorisation had been obtained to restrict a person's liberty or where this had been applied for. We were, however, unable to verify from these computer records if notification had been made to CQC.

There was some inconsistency observed in policy or application of policy on serving food. The main server on the first floor wore plastic gloves throughout the meal service. The one on the second floor did not. People mostly spoke positively about the food. People told us It's not bad, you have a choice", "It's very good" and simply "yes," when asked if they liked the food. We observed people having lunch where drinks were available and repeatedly offered at lunchtime. A carer was observed on the 2nd floor approaching each person to discuss the next day's menu. They demonstrated great patience and understanding as they tried to seek people's choices even from those with very little ability to communicate. We saw that care staff told people about the meal on their plates when their food was placed in front of them. One person said they did not want soup, as they did not like it. A carer with a good understanding of this person's character and eating habits suggested to the person that they leave the bowl in front of them for a few minutes while they continued serving others. The person did not object and started to eat the soup almost immediately and even asked for more.

We found that nutritionist advice was available from the local health care services when required and the service had sought this advice when assessments and advice were thought by care staff to be needed.

It took time to serve everyone at lunch time and some had to wait for about 20 minutes while others were assisted. However, nobody was rushed and staff noticed when people were not eating and encouraged them to do so or offered something else. The home operates a policy of protected mealtimes which is designed to ensure that care staff focus on providing assistance to people at meal times rather than engaging in other work unless urgent care matters arise. However, there were no menus on display in the dining rooms or indeed anywhere in the facility including in the plastic holders marked "menus" by the ground floor lifts.

We saw that there was no water or juice in the lounges though people were offered drinks regularly and in the case

Good

Is the service effective?

of one person, who was suffering a bad cold, were repeatedly encouraged to drink fluids. Tea and coffee were also offered although one person complained of having to wait and of having a dry throat as a result.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home twice each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively and we saw that staff supported people to make and attend medical appointments, for example at hospital.

We saw that people's conditions were reviewed each month. For example this included a dependency score, and risks of pressure sores, height, weight, BMI (Body mass index), and mental health. This helped the service to monitor people's health and wellbeing in order to quickly respond to any health concerns that emerged.

Good

Is the service caring?

Our findings

We spoke with members of the care staff team about how they sought the views and wishes of people who used the service. All of the staff we spoke with described the people they cared for in a respectful and considerate manner. They described how they made a point of asking people about their preferences and explained what they were doing when carrying out care tasks.

Almost everyone we spoke with who either uses the service, and relatives, praised staff for their caring attitudes. For example, "They (the carers) work so hard, they really do. There isn't one I don't like, they're lovely, they don't tell you what to do." Another person told us "they're very good." We saw one person giving a carer a hug after they were served tea and said, "you're my favourite" and then added, "you're all my favourites!"

One person who was more independent than many people living at the home was less happy about staff being around saying "They treat me like a child," and "I don't need checking up on." This person also said they regularly went out to the shop which, on inquiring with staff, was not the case. We asked staff about this and they told us they acknowledged that their offers of assistance had to be made discreetly.

We looked at care files which showed that emphasis was given to how staff could ascertain each person's wishes despite their dementia and to maximise opportunities for people to make decisions that they were able to make. For example, we saw information in one person's care plan informing staff about how the person might be more able to make a decision at some times of the day rather than others, to allow time for the person to respond and to observe their physical reactions. We noted in another person's care file that staff were to respect a person's right not to join in with certain activities that they did not enjoy.

Throughout the day of our inspection, we observed staff talking with people in calm and friendly tones. They demonstrated a good knowledge of characters and personalities and conversations were about far more than just care tasks. We saw that when staff were providing assistance this was always explained, for example when moving somebody or assisting them with eating and drinking.

We observed one carer in particular spending much of their time talking with people individually. They said that they made a point of speaking with everybody first thing in the morning just to say hello. We then saw them sitting for a while chatting with almost everyone sitting in the lounge on the floor on which they worked, engaging warmly even with people who had very limited ability to communicate verbally.

We saw during the day that one person complained repeatedly of being too hot. Each time they said this they were helped out of the lounge by staff to go to their room to remove a sweater or change their top. On another occasion a carer discreetly straightened a person's clothing that had become dishevelled. Nobody's personal care or support needs were spoken about in front of other people and personal care tasks were handled discreetly and in a manner that ensured they were treated respectfully and their dignity was upheld.

Good

Is the service responsive?

Our findings

Relatives and friends of people using the service were seen visiting during the day of our inspection. A relative told us they visited most days and often sat with their relative during lunch and fetched things they asked for from the kitchen. Another relative told us that while the staff washed their relative's clothes, another relative also came regularly to sort them into matching outfits the person liked to wear. These choices were always respected by staff and thgis person told us they thought their relative was always very well dressed.

Staff told us that one of the people who used the service liked a cigarette after lunch. We saw a member of staff, clearly knowing this, ask them after lunch if they would like to go to the smoking room, which they then did.

Another relative told us they had mentioned to staff an aspect of their relatives care that they felt needed attending to. They said that initially nothing was done to address this but, "when we had the annual review we brought it up and it's been much better since then."

A care worker said that residents meetings were held which we also confirmed by talking with people using the service and visiting relatives. This member of staff told us that although sometimes difficult to conduct, due to the limited comprehension and communication difficulties for some people, the meetings usually resulted in some good questions or suggestions. During the day we saw this carer discussing the latest meeting, which had been held the day before our visit, with someone who had not been able to attend. They told us they wanted to share what others had said and to hear the views of the person they were speaking with and explain what the service would do to respond to what people had said. We spoke with the manager about this and they were able to confirm what action was taken as the result of meetings with people using the service as well as with relatives.

Throughout the day, efforts were observed to provide stimulation and some level of activity for most people. On the 1st floor this consisted mostly of one-to-one conversations with the activities coordinator. Paper and colour pencils were provided for the people who wanted to colour in pictures of birds and flowers. Newspapers were provided for others, we saw one person being assisted with their knitting. On the 2nd and 3rd floors there were carers with designated responsibility for activities. These included doing maths problems and word games which carers said were very popular. Another group were shown old photographs and asked questions about them aimed at stimulating memories.

On the 1st floor two people remained in their room for most of the day. Staff said they were reluctant to mix with the all-female group in the lounge. One of these people was described by a carer as "shy", as their verbal abilities had been limited due to a medical condition. Another person told us "It's alright but the trouble is, you don't get out, the place I was in before, they took you out sometimes. I suppose here there's too many of us." However, later in the day a care worker was heard asking this person if they would like to go to a special film showing at a nearby cinema the following week. This member of staff was also seen talking with people about outings once the weather improved.

People's individual care plans included information about cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided. However we found that this information was not readily accessible other than on the computer database mostly used to hold care plans, which many junior staff did not make regular use of.

We asked people about whether they knew how to complain and if they felt confident that they would be listened to. People felt confident they could complain although most said they had never felt the need to. We looked at the complaints that the home had received in 2014 and found that a total of ten had been made. These were all recorded as verbal complaints that had been resolved quickly with no other formal investigation required. The provider had a clear complaints and comments system, which was reviewed by the provider's organisational complaints team.

Good

Is the service well-led?

Our findings

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff felt comfortable to approach the manager and senior staff. Several of the staff we spoke with had worked at the home for a number of years. One, who had worked there for 21 years said, "I love it." Another member of staff told us "if I don't know what to do, the manager is always there for me", whilst someone else said "whenever I have a problem, I go to the manager."

One concern about communication was raised. During the morning a group of students arrived and were dispersed throughout the facility. The assistant manager who brought them into the different floors said only that they would be doing work experience for two weeks. It was left to a carer to show them around and introduce them to people. This carer later said she was trying to find out what they could do and how much responsibility they could be given as staff had not been told anything about them. She said, "communication sometimes isn't very good."

However, we did see that there was usually clear communication between the staff team and the managers of the service. People's views were respected as was evident from conversations that we had with staff and that we observed. Staff told us that there were regular team meetings, which we confirmed, where staff had the opportunity to discuss care at the home and other topics. We saw that staff were involved in decisions and kept updated of changes in the service and were able to feedback their views and opinions through daily staff handover meeting.

The provider had a system for monitoring the quality of care. The home was required to submit regular monitoring reports to the provider about the day to day operation of the service. Surveys were carried out centrally by the service provider, the most recent in December 2014. This had not yet been published but from other comments made by people using the service, relatives and staff we found that people were usually satisfied with the service and the way that it operated. The provider had an organisational governance procedure which was designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified, We found that the service developed plans to address the matters raised and took action to implement changes and improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although risks were identified and reviewed there was a lack of consistency among the staff team about how to respond to all potential risks.