GCH (North London) Ltd

Burrows House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 17 and 18 May 2017 and was unannounced. This was the first inspection of the service as the provider GCH (Burrows House) Ltd applied to cancel its registration. This application has been granted and a new provider, GCH (North London) Ltd has been registered to provide the regulated activities 'Accommodation for persons who require nursing or personal care'.

Burrows House is registered to provide accommodation and care for up to 54 elderly people including people living with dementia. At the time of our inspection there were 53 people living at the home.

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

During our inspection we found that improvements were needed as prescribed medicines were not stored securely. We found that Medicine Administration Records (MAR) for topical creams were either not signed or not completed as soon as the medicines were administered. We found that although there were quality assurance systems in place to monitor the quality of the service, the issues we found at inspection had not been identified during these audits.

People using the service said they felt safe and cared for. The home had robust safeguarding adult's procedures in place and staff understood how to safeguard the people they supported. Risks to people using the service were assessed and risk assessments and care plans provided clear information and guidance for staff. There were enough staff deployed to meet people's needs and the provider carried out appropriate recruitment checks before staff started work.

Staff were received appropriate training and regular supervision. Staff asked people for their consent before they provided care, and they demonstrated a clear understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People received food and drink suitable to their needs and had access to healthcare when they needed it.

People and relatives said staff looked after them in a way which was kind, caring and respectful. Staff knew how to protect people's privacy and dignity. Staff encouraged people to be as independent as possible, when carrying out activities and tasks.

People and their relatives were involved in their care planning. Care plans were reflective of people's individual care needs and preferences and were reviewed on a regular basis.

People's cultural needs and religious beliefs were recorded to ensure that staff took account of these areas when offering support.

People and their relatives knew about the complaints procedure and said they believed their complaints would be investigated and action taken if necessary.

People and their relatives spoke positively about the management and leadership of the service. The provider sought people's views about how the care and support people received and how it could be improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

An aspect of the service was not safe.

Prescribed creams were not stored securely in people's bedrooms.

Medicine Administration Records (MAR) for topical creams were either not signed or not completed as soon as the medicines were applied. The medicines room was not secure as the code number was displayed by the door.

There were appropriate safeguarding adults procedures in place and staff had a clear understanding of these.

Risk assessments were undertaken and care plans were in place to manage these risks.

There were enough staff deployed to meet people's needs. Appropriate recruitment checks took place before staff started work.

Is the service effective?

Good

The service was effective.

Staff were supported with regular and appropriate training and supervision.

Staff asked people for their consent before they provided care, and they demonstrated a clear understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People received food and drink suitable to their needs.

People had access to healthcare when they needed it.

Is the service caring?

Good

The service was caring.

People and relatives said staff looked after people in a way which

was kind, caring and considerate.

Staff knew how to protect people's privacy and dignity. Staff encouraged people to be as independent as possible.

Staff delivered care and support with kindness and consideration.

Is the service responsive?

Good

The service was responsive.

People's cultural needs and religious beliefs were recorded to ensure that staff took account of these areas when offering support.

People and their relatives knew about the complaints procedure and said they believed their complaints would be investigated and action taken if necessary.

Is the service well-led?

Requires Improvement

An aspect of the service was not well-led.

There were systems in place to monitor the quality of the service but these were not entirely effective as issues we found at this inspection had not been identified by the provider.

People and their relatives spoke positively about the management and leadership of the service.

The provider sought people's views about how the care and support people received could be improved.

Burrows 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 17 and 18 May 2017 and was unannounced. The inspection team consisted of one adult social care inspector one pharmacy inspector, an observer and an expert by experience on the first day of the inspection and one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also asked the local authority commissioning the service for their views of the service.

We spoke with six people who used the service, four relatives, four members of staff, the registered manager, the deputy manager and the regional manager. We reviewed records, including the care records of the six people who used the service, five staff members' recruitment files and training records. We also looked at records relating to the management of the service such quality audits, accident and incident records and policies and procedures. We spent time observing the care and support delivered to people and the interactions between staff and people using 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.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said, "I do feel safe." Another person said, "I'm as safe as can be…" A relative told us, "[My relative] is safe here; it's very reassuring as we worried when they were on their own."

On the first day of the inspection, we saw that prescribed topical creams were not stored securely in people's bedrooms. There were no risk assessments in place to show that the risks of this had been considered. We asked a member of staff about this and they confirmed that risk assessments had not been carried out. This meant risks to the health and safety of people using the service were not assessed and creams were not stored in a way that minimised risk of harm to people's health.
MAR charts for topical creams were either not signed or not completed as soon as the medicines were applied. We saw that there were occasions when people were administered more than the prescribed frequency of cream. For example, one person had been prescribed a cream to be applied daily, however between the 13 and 17 May 2016, there was one occasion when the person had the cream applied three times in one day and one occasion where the MAR chart had not been completed to document that they had received the prescribed medicine. We saw a second person had been prescribed a cream that needed to be applied twice daily. We found that between 02 May and 05 May 2017, the person had only had the cream applied once a day and between 12 and 17 May 2017, on one occasion the person had been administered the cream three times in one day and the MAR chart had not been signed on two occasions. This meant that we could not be sure that people received topical medicines as prescribed. We also saw the code number allowing access to the clinical room was displayed next to the keypad. There was a risk that unauthorised persons could gain access to the room and therefore medicines were not safely stored.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these issues to the registered manger's attention who immediately removed the code to the clinical room that was displayed. The registered manager told us that the reason MAR charts for topical creams were not immediately completed after application because they were kept centrally and not in people's bedrooms meaning that staff administered all topical medicines and then collectively completed the MAR charts. The registered manager told us and showed us that they had already identified this was not best practice and were in the process of putting individual topical cream MAR charts in people's bedrooms for people who required them. During the inspection the registered manager put risk assessments in place for people who required topical creams in their bedrooms. However, we did not see all the completed risk assessments for each and every person who had prescribed topical creams in their bedrooms during the inspection. We will follow up on these areas at our next inspection of the service to ensure improvements have been made.

We saw that covert medicines were administered appropriately and in line with health professionals' guidance and best practice. Controlled drugs (CDs) were stored in the clinical room in an appropriate CD cabinet. We saw that stock levels for CDs were checked daily by two senior carers. The quantity of CDs in

stock matched the quantity recorded in the CD register. MAR charts for oral medicines were up to date and signed.

Safeguarding policies and procedures were in place and staff were able to demonstrate they types of abuse that could occur and what action to take to protect people should they have any concerns. The registered manager told us that all staff had received training on safeguarding adults. Training records we saw confirmed this. Staff told us they were aware of the organisation's whistleblowing policy and would not hesitate to use it if they needed to.

We found risk assessments were carried out in relation to nutrition, falls, moving and handling, mobility and skin integrity. This meant that risks to people could be identified and the relevant guidance was available for staff on how to support people to reduce the likelihood of any harm to people was available. We found that staff had followed the service's procedure and guidance on monitoring people's nutrition and hydration to ensure their individual needs were met. Food and fluid intake charts were implemented and completed when necessary.

We saw through staff rotas and observations that there were sufficient numbers of staff deployed to meet people's needs. One person told us, "There are staff everywhere and they are all lovely." A relative said, "There always seems to be enough staff and you see the managers' muck in."
The home had a recruitment policy in place and there were safe recruitment practices were carried out. Appropriate recruitment checks were conducted before staff started work for the service. We looked at five staff files and saw they each contained a completed application form which included details of their employment history and qualifications. Each file also contained evidence confirming references had been sought, proof of identity reviewed and criminal record checks undertaken for each staff member and checks were also carried out to ensure staff members were entitled to work in the UK.
There were arrangements in place to deal with foreseeable emergencies. Staff told us and training records confirmed that they completed training in first aid and fire safety training. We saw that the home had a system in place to record all incidents and accidents for people using the service. This included the detail of the incidents or accident, i.e. what happened, what action was taken, For example one person using the service had had a fall, we saw that an ambulance had been called to evaluate the person and their care plan and risk assessment was updated.

Good

Is the service effective?

Our findings

People and their relatives told us that staff were knowledgeable and competent. One person said, "Staff are very good at what they do." Another person said, "Staff are very knowledgeable." A relative told us, "I feel happy that [my relative] is in safe hands."

Staff training records confirmed that all staff had completed an induction and mandatory training which included safeguarding, first aid, fire and hygiene, mental capacity and dementia awareness. One member of staff told us, "We get a lot of training, I benefit from it". Staff were regularly supported in their roles through supervisions and appraisals. Supervision sessions gave staff the opportunity to discuss topics including progression in their role and any training needs. This meant that any shortfalls in knowledge or training could be picked up promptly and addressed so that people continued to receive appropriate standards of care. One member of staff told us, "I do get a lot of supervisions; it's good to be able to talk to the manager to see how I am doing."

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements of DoLS and had submitted applications to a 'Supervisory Body' to request the authority to legally deprive people of their liberty when it was in their best interests. We saw that applications under DoLS had been authorised and that the provider was complying with the conditions applied under the authorisation. We saw capacity assessments were completed to assess if people did not have the capacity to make specific decisions such as not being able to leave the home and the use of bedrails. Staff had received training in relation to the MCA and understood the principles. Staff told us that they always sought people's consent before providing care. One staff member said, "I always seek consent; I ask people if they want me to help them and explain what I am doing."

We observed how people were being supported and cared for at lunchtime. We saw that menus were displayed on dining room tables. There was a choice of meals and if people did not want the options on offer they could choose an alternative. Staff encouraged people to eat independently, but were on hand to assist people who required support. People who remained in their rooms were served their meals in a timely manner. We also saw that people had access to snack boxes during the day which included finger food that people could pick up and eat easily at any time. We saw that throughout the day people were offered tea, coffee, juice and water. This meant people had enough to eat and were kept hydrated throughout the day. One person told us, "The food is very good and you do get a choice. You choose on the day before lunch

they come round but if you don't fancy it they will make you something else like an omelette, salad or baked potato." Another person said, "The food is very nice, lots of hearty grub." A relative said, "[Staff] helps [my relative] to eat and they are lovely, very patient and encouraging."

People had access to a range of healthcare professionals when needed, this included GPs, district nurses, speech and language therapists and physiotherapists. One person told us, "I go to the hospital sometimes and [staff] remind me when I need to go and sort it all out." Another person said, "I've seen the dentist and got new glasses." We saw daily progress notes were maintained to record the care and support being delivered to people.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were caring, kind and considerate. One person said, "[Staff] are lovely. They give me a hug if I feel sad or frustrated." Another person said, "[Staff] are very caring." A relative told us, "[Staff] are very good at making [my relative] feel looked after."

People were well presented and looked comfortable. Staff spoke to people in a kind and respectful manner. The atmosphere in communal areas throughout the home was calm and friendly and we saw staff took their time and gave people encouragement whilst supporting them. Staff showed people patience and understanding and helped them if they were disorientated. We observed staff using distraction techniques effectively to reduce people becoming anxious, for example through the offer of a cup of tea, a walk or a chat. People were supported to go at their own pace and not rushed.

Staff demonstrated that they knew people as individuals. On staff member told us, "One person likes choosing the clothes they are going to wear. I show them different outfits in the morning and they choose". We saw that staff protected people's privacy and dignity. Staff knocked on people's doors and obtained permission before entering rooms. Staff explained to people about what they would be doing when they supported them. One person said, "[Staff] respect that I like time to myself and they all knock on my door." A relative told us, "[Staff] are very respectful with [my relative] and explain things they need to do to help [them]."

Staff told us and we saw that they promoted people's independence by encouraging them to carry out aspects of their personal care such choosing their clothes and eating and drinking. One person we spoke to told us. "I can help myself in the lounge kitchen."

People's relatives were encouraged to visit with them at the home. During our inspection we saw relatives came to visit family members and we observed them being warmly welcomed by staff. Relatives told us staff kept them informed and updated about their family member's health and wellbeing. One relative said, "[Staff] were welcoming to me today and cared about us having family time."

People and relatives told us they were involved in care planning and were kept aware of any changes in care needs. People's individual needs were identified and respected. Care plans contained people's life history and preferences about their care. One relative told us, "We are always told what is going on and staff contact us if they need to."

People were provided with information about the home in the form of a service user guide which included the complaints procedure. This guide outlined the standard of care to expect and the services and facilities provided at the home.

Staff showed an understanding of equality and diversity. Care records for every person who used the service included details about their ethnicity, preferred faith, culture and spiritual needs. For example, in-house church services were held at the home for people who wanted to attend.

Good

Is the service responsive?

Our findings

People and their relatives told us that staff knew them well and were responsive to their needs. One person said, "[Staff] know me well. I tell them and they listen". Another person said, "[Staff] know how I like things because they ask questions". A relative told us, "[Staff] do know [my relative] well; they know they can't walk far and always help. Another relative said, "I always know what going on with [my relative's] care, staff will call you and tell you things when you arrive for a visit".

Activities boards were placed throughout the home which informed people what activities were taking place on a weekly basis. These included music, hand massage, quizzes, chair exercises, board games and external entertainment. However, we saw that activities on offer to people using the service were limited and there were no meaningful activities designed for people living with dementia. One person told us, "I do my own thing. There isn't much going on." Another person said "I would like to go outside more." A third person said, "I get a bit bored so more activities please". A relative said, "I think they could do a bit more. There are a few things going on but I think more one to one with [my relative] would be good. I never see [staff] sitting with [my relative] and doing anything. [My relative] used to bake and they would like to do that, to keep them occupied."

We brought this to the attention of the registered manager who told us that the home had two activities co-ordinators, however, one had just left and the other was on long term leave, but due to return in the near future. The home was also in the process of recruiting another activities co-ordinator. The registered manager said that until the new activities co-ordinator had been recruited, care staff would carry out activities on a daily basis and thereafter, the home would concentrate on providing more activities for people living with dementia, such as a sensory room. We will check this at our next inspection.

People's rooms were personalised and reflective of their personalities. For example one person's bedroom was decorated in a bright colour with floral curtains. There were personal effects including ornaments, photographs and decorative wall items. This person told us that they loved bright colours and many of the pieces of artwork hanging on the wall had been produced by them.

People's health, care and support needs had been assessed before they moved into the home and care files were reviewed on a regular basis. People's care plans provided clear guidance for staff on how to support them in areas of their daily lives including personal care, communication, nutrition and mobility. Care files included people's ethnicity, religion, life histories, and the name they preferred to be called.

People and their relatives knew how to make a complaint and were confident that the management team would address and resolve any concern they had. The service had an effective complaints handling process in place. We saw that the service had investigated and resolved complaints received within timeframes set in the provider's complaints policy. One person said, "I would go straight to a manager, they get things sorted quickly if you ever complain". Another person said, "I tell them and they get things done. I would tell the manager if it didn't". A relative told us, "The registered manager is good at getting things done".

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered manager. One person said, "The registered manager is very nice and kind." Another person said, "The registered manager pops in and says hello and sits for a catch-up". A relative told us, "I can talk to the registered manager and she does get things done".

There were processes in place to monitor the quality of the service however improvements were needed as these were not always effective. We saw regular audits were carried out at the service to identify any shortfalls, however, improvements were needed because the provider had not identified the issues we found during our inspection. For example, we saw that the regional manager internal compliance visit in March 2017 did not identify that prescribed creams were not securely stored in peoples' bedrooms or that there were gaps in people's MAR charts.

We brought these concerns to the attention of the registered manager who told us that they would carry out medicines audits that specifically covered the issues we found at this inspection.

We also saw that the provider had carried out regular audits to monitor the service that were effective, these included the health and safety, call bells, consent forms and fire safety. We looked at the latest, April 2017 audits for the home and found no issues had been highlighted.

The home had a registered manager who had been in place for some time and was supported in running the service by a deputy manager. Staff described a culture where they felt able to speak out freely if they were worried about quality or safety. Staff told us they enjoyed working at the home and spoke positively about the registered manager and the leadership being receptive to staff input. Staff said that the registered manager was supportive and they operated an open door policy. One staff member said, "I love my job." Another staff member said, "The registered manager is good, the leadership is great."

We saw regular staff meetings took place and were minuted. These meetings were used to help share learning and best practice so staff understood what was expected of them at all levels. Items of discussion included, activities, meals and residents. One staff member told us, "Staff meetings are good, we can discuss any issues and get feedback".

Regular resident and relatives meetings were held to provide people with an opportunity to air their views about the service. Items discussed included people's rooms, activities and menus. Minutes of these meetings showed they were well attended and their suggestions had been actioned. For example, one person said that they had a small appetite and found that normal plates of food were too large for them. We saw that action had been taken and a small plate was provided for the person to eat their meals from.

The provider carried out an annual survey to seek people's views about the service. We saw the results of the survey for 2016 and that overall the responses were positive. Action had been taken to drive improvements where required. For example, people had said that cleaning of the home was not satisfactory. We saw action had been taken in that there had been a staffing review of the domestic team and good infection control

measures had been reinforced to the staff team and we saw these had been followed.