Camden and Islington NHS Foundation Trust

Stacey Street Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Stacey Street provides nursing care to older adults with dementia and long term mental health difficulties.

At our previous inspection of this service on 2 and 9 July 2015, the provider was in breach of Regulations 10 (treating people with dignity and respect) and 14 (choice of meals) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was limited choice of meals and people were not always being treated with dignity or respect in the way some staff spoke with them. The provider sent us an action plan after the inspection detailing how they would address the breach. At this inspection we found that progress had been made, far greater choice and options were available at mealtimes and staff engaged with people in a respectful and dignified way. The provider was no longer in breach of these regulations.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 4 July 2016.

At the time of our inspection a registered manager was employed by the NHS Trust. 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.

There were 18 people in residence at the time of our visit. We received a small number of comments from people using the service as some people were not able to speak with us about their experience of the service, due to their healthcare needs. For this reason we used general observation as people were engaging positively and very regularly with staff in activities of different kinds, or sometimes choosing to be alone in their rooms, watching television or reading. We did not think it suitable to use (SOFI) on this occasion, although did do so at our previous inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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. Records showed that the service was applying these safeguards appropriately and making the necessary applications for assessments when these were required.

People were supported in ways that were most appropriate to their needs and known wishes. On the day of the inspection we found sufficient numbers of staff were available to meet people's needs. The staff rota showed that suitable levels of staffing were also provided at other times of the day.

We found that people's health care needs were assessed, and care was planned and delivered in a consistent way. People using the service had endured long term mental health conditions and care plans showed that the information and guidance provided to staff was clear. Any risks associated with people's

care needs were assessed and plans were in place to minimise the risk as far as possible to help keep people safe.

Staff had the knowledge and skills they needed to support people. They received training to enable them to understand people's needs in ways that were safe and protected people.

We found that the choice offered to people at meal times had greatly improved and their involvement in deciding what should be contained in the menu and at each meal was offered and their choices were respected.

From our observations of interactions between staff and people using the service we found that people felt safe at the service. No concerns about people's safety had been raised since our previous inspection and we found no evidence to suggest that people were anything but kept safe.

Social and daily activities provided had improved significantly and people were provided with a varied and interesting range of activities.

People were able to complain or raise concerns if they needed to. The provider regularly reviewed the performance of the service to ensure that standards were maintained and improvements were made and more was being done to actively seek views from people using the service.

At this inspection we found that the provider was no longer in breach of regulations 10 (treating people with dignity and respect) and 14 (choice of meals). The service was meeting all of the regulations we looked at during this inspection and no further breaches of regulations were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People said they felt safe and we found there were enough staff on duty to care for them.

Staff were trained and knew how to take action in response to any concern that may arise about possible abuse.

Risks to people were identified and acted upon and the service took action to keep people safe from the risk of infection.

Is the service effective?

Good

The service was effective. Staff received regular training, supervision and appraisals to ensure they had the skills and knowledge to meet the needs of people using the service.

During our visit we talked with staff about their understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff demonstrated that they had the necessary knowledge and awareness of both of these areas and took necessary action to assess people's capacity to make decisions and provide informed consent.

Mealtimes showed that people were given the opportunity to make choices or decide on what foods were offered on the menu.

Is the service caring?

Good

The service was caring. Our observations of interactions between staff and the people they were caring for were polite, warm and showed regard for what people needed and how to respond to those needs.

People who were able to speak with us felt that they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care plans were updated at regular intervals and were audited to ensure information remained accurate and reflected each person's current support needs.

The opportunity for people to engage in activities was much improved and provided a wide range of options.

People who were able to speak with us felt able to raise any concerns or issues about the service.

Is the service well-led?

Good

The service was well led. The service had a registered manager and many of the staff team had worked at the service for a number of years.

The provider had a system for monitoring the quality of care. The home was required to submit reports to the provider about the day to day operation of the service who then conducted reviews of the way the service operated.

Surveys were carried out centrally by the service provider and people's views were sought regularly at the home.

Stacey Street Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 4 July 2016. The inspection team comprised of two inspectors and an expert by experience that had specialist knowledge of services for older people with mental health difficulties.

Prior to this inspection, we had asked the provider to complete a Provider Information Return (PIR) which was returned in May 2016. 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. Before the inspection, we looked at notifications that we had received and communications with other professionals, such as the local authority safeguarding and commissioning teams and the local specialist NHS trust nursing team. We contacted a total of ten visiting professionals to request feedback but did not receive any replies. We also contacted health watch and were told they had no information about the home.

We received 12 comment cards that had been left at the home for CQC before this inspection. All but one of these were from the friends or relatives of a person who had celebrated their birthday. All were referring to the birthday party the person had celebrated at the home and none of these comments raised any concerns, including the comment card left by another visitor.

During our inspection we spoke with four people using the service, a relative, six staff of varying roles and experience and the assistant manager as the registered manager was away at the time of our visit.

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

Good

Is the service safe?

Our findings

When we spoke with people about how safe they felt in the home we were told, "Yes I feel safe here because the staff here look after us well," "Yes I feel safe as I'm in a wheelchair and at home I fell over but not here" and about feeling safe at a night someone told us "Yes I'm safe I'm not afraid of anything or anybody day or night."

The service had access to the NHS Trust's organisational policy and procedure for protection of adults from abuse. They also had the contact details of the local authority, London Borough of Islington, who placed people with the service. As children sometimes visited the service there was also training and guidance for staff in child protection.

The members of staff we spoke with said they had training about protecting people from abuse, which training records confirmed. Staff were able to describe the action they would take if a concern arose. Staff had readily accessible information on noticeboards in each staff office about safeguarding and what to do if a concern arose.

It was the policy of the service provider, to ensure that staff had initial training in keeping people safe from abuse which was then followed up with periodic refresher training. We found that this happened. A new safeguarding lead had recently been appointed by the trust and we were told that this person had informed the home that a renewed programme of training was also being arranged within the next few weeks. At the time of this inspection there were no safeguarding concerns and none had arisen since our previous inspection.

All staff, apart from one, told us there were enough staff on duty. Two support workers and a trained nurse were present on each floor during the day and a nurse and a support worker on each floor at night. The staff rota showed this level was consistently maintained and often more staff were available, especially where people needed support to attend appointments and participate in activities outside the home. During this inspection we noted that staff were able to give people individual attention and to provide support and the level of staff availability was suitable to meet the needs of the people currently using the service.

Two new staff had been employed at the home since our previous inspection. Records showed that safe recruitment procedures had been followed to ensure that staff were not employed unless they were suitable and safe to work with people. For example, relevant pre-employment checks had been carried out which included references from previous employers, a disclosure and barring service check (DBS) and verification of qualifications.

Records showed risks to people had been assessed when they first came to the service, and we saw this for the two people who were admitted since our previous inspection. Up to date guidelines were in place for staff to follow. These covered areas such as keeping people safe and the signs to be aware of which may indicate a person's mental health may be deteriorating. 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. Staff had clear instructions about how to minimise the risk of pressure sores and carried out the routine checks required.

We saw other risks assessments, for example, about the risk of falls or using the alarm call system. The instructions for staff about minimising risks were clearly outlined in these assessments.

People were supported with their medicines and these were stored safely. On the day of our visit we observed medicines being administered after lunch. Only the registered nursing staff were permitted to administer medicines and we observed the nurse talking with people about their medicines and what these were for. The nurse focused on each person individually and medicines records showed people's need for support to manage their medicines was assessed and reviewed. We saw that medicines were kept in a locked cabinet in each person's own bedroom, were administered in private and people's verbal consent was requested before these were given.

The home was clean and tidy. Domestic staff were employed and staff we spoke with said they did not believe there were any issues about the standard of cleanliness and infection control, and we found none during our inspection. An infection control and auditing procedure was in place and safety checks, for example of the fire alarm system, electrical and gas safety checks were all undertaken.

Good

Is the service effective?

Our findings

Staff received regular training, supervision and appraisals to ensure they had the skills and knowledge to meet the needs of people using the service. Staff attended regular training which included six mandatory courses: fire safety, manual handling, infection control, equality and diversity, Information governance, CPR and first aid. Over the next month, following our inspection, in house training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was planned as well as a meeting with the trust's new safeguarding manager to set up dates for in house training for staff. When staff had not completed mandatory training within the set frequency, for example each year, this was flagged up on the training database for the manager to follow up.

The staff we spoke with told us about the range of training they had, including topics such as safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards. All nursing staff were either RGN (Registered General Nurse) or RMN (Registered Mental Nurse) qualified.

We spoke with one of the two staff who had been recruited since our previous inspection. This person told us about their induction with the trust and at the home itself as well as shadowing more experienced staff as a part of their introduction to the service. The believed it had been suitable and they had completed their RMN training a few weeks prior to starting to work at the home.

All of the staff we spoke with told us they felt supported by the provider in relation to their training and development. They also told us they received supervision, averaging monthly, which staff supervision records confirmed. These sessions gave staff the chance to review their progress and to identify areas for development, any required training and concerns they had in relation to the people they supported. Monthly team meetings took place and the records of the most recent six months meetings showed that necessary areas were being discussed about client care, day to day running of the home and updates on practices and policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Consent to care and treatment was obtained. Many of the people using the service were unable to provide informed consent for themselves but in those cases their next of kin or allocated health or social care

professional did so. A local advocacy service was used particularly when MCA or DoLS considerations were being reviewed and specifically where people had no relative or friend that could advocate on their behalf.

Staff understood their responsibilities under the Mental Capacity Act 2005. People were supported to make their own decisions about their care. If people were unable to make a decision because of a lack of capacity this was undertaken within their 'best interests' by other professionals involved in their care. Staff were aware of the Deprivation of Liberty Safeguards and records showed that we verified that this system was being used appropriately and new applications were made and updated as required.

We asked people about the food and someone said, "The food not so good it's not first class but its edible hospital food the menu doesn't change very much just like a hospital and at night I can get a coffee or tea but I have my own food, my favourite food is steak and chips or lamp chops but not always get it. I like cod fish cakes and I buy them myself and the chef cooks them for me along with fish fingers." Another person told us, "The food is good and I'm not a fussy about food and I eat at supper and then I don't eat at night" and a relative said, "Yes the food here seems good and (relative) likes what they get but I'm really not sure about at night I will have to ask about that as well." We asked staff about food availability at night and were told that snack food was always available if requested in the kitchen on each floor or they could obtain this from the main kitchen.

People were supported to have enough to eat and drink. At our previous inspection in July 2015 we found that personal choices of food at mealtimes was generally absent and menus were not written out in advance of meals being served. At this inspection we found that everyone during lunchtime was given a visual choice of foods whether they had chosen that particular dish or not. We found this gave people the opportunity to change their mind and was an example of a more person centred approach than we had previously seen. There was a lot of interaction with people and the dining tables were set out in advance. The mealtime was a more sociable and engaging event than we had previously observed at our July 2015 inspection. Staff were actively engaging with people during lunchtime whether they needed assistance to eat or not.

People were supported to use general community healthcare services when they required. Each person had access to a GP, everyone being registered with a nearby health centre, dentist and opticians as well as other specialist medical advice as necessary. We saw that staff supported people to make and attend their appointments and these were placed in the home's diary. Care plan records showed that the service was able to take action and to encourage and support healthy living as well as to respond to emerging healthcare needs.

Good

Is the service caring?

Our findings

People all knew the staff by name who also knew them by name. At our previous inspection in July 2015 we had observed instances where a small number of staff had not been engaging with people and in two cases had used inappropriate language when speaking with people. That was not the case at this inspection. During our visit we saw staff were very engaging with people and did so in a light hearted, unhurried and respectful way.

The garden was laid out well with a gazebo and patio chairs and tables. Ten people were outside in the garden participating in a gardening activity. The atmosphere demonstrated that people were enjoying themselves and staff were readily engaging with people. Staff were seen to encourage people's independence as they participated as well as this being not merely an activity but a sociable event.

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 people in caring and compassionate terms and knew the people they cared for. Staff told us, "Staff here are committed and caring people. They are flexible and hardworking" and "Staff are focussed on providing high quality care based on what we have. We joke with people."

People's histories were known by staff, as too were people's preferences about how they wished to be cared for. We found this in conversations we had with staff and by observing how they approached and interacted with people. Care plans described people's cultural heritage as well as whether or not people chose to adhere to a religious faith. They described, and we observed, how they asked people about their preferences and explained what they were doing when providing care and support.

Throughout the day of our inspection, staff were seen talking with people in a calm and friendly manner. They demonstrated a good knowledge of people's characters and personalities. When staff were providing assistance this was explained to the person they were helping and their agreement for staff to support them was obtained before proceeding.

The provider had a clear and detailed policy for acknowledging and respecting people's unique heritage and individuality, including working with lesbian, gay, bisexual and transgendered people. Staff we spoke with were clear about the expectation that they treat people with respect and dignity. Comments we received from people using the service and relatives showed that people felt that they were treated with dignity and their view of the staff team was that they were genuinely respectful towards people.

People told us, "Yes they (staff) do respect my dignity when they wash me they always have the door closed and they always knock before they come in to my room" and "No there are no restrictions on when my family and friends from the church come in my family come in about once a week and the same with my church friends." We were also told, "Yes they do encourage my independence and I'm a very independent person."

Advanced interests decisions were included in care plans where people had made their wishes known. These decisions included who they would like to be contacted in the event of sudden serious ill health or death.

Good

Is the service responsive?

Our findings

People who were able to give us their views said, "No never made a complaint here and if I wanted to make a complaint I would speak to the manager" and "I like the gardening and the painting and drawing."

The care plans we looked at covered personal, physical, social and emotional support needs. Care plans were updated at regular intervals and were audited regularly to ensure that information remained accurate and reflected each person's current support needs. Since our previous inspection the provider had established an electronic database for people's records within the home. This was readily accessible and easy to use in order to obtain updated information when we looked at three care plans on this system. The electronic system was designed to enable not only the home, but other clinicians working with people in the NHS trust, to readily communicate and update care and support needs.

Where more than one mental health care professional was involved in a person's care the staff ensured the information was coordinated and the person received the support they required. Each person had access, as and when required, to the professionals involved in supporting their mental health. People's care records included information on signs and symptoms that a person's mental health may be deteriorating and how people were to be supported to ensure they got the care and treatment they required.

Where people displayed distressed or physically challenging behaviour records showed that this was monitored and responses were implemented. Discussion took place and levels of these types of incidents, although not frequent, were considered among the staff team and by the provider. Care programme approach (CPA) reviews took place as and when required. CPA is a care planning process specifically designed to monitor and respond to people. Care plans described what staff should look for and how to respond to any instances of these types of behaviour although it was also reported to us that such instances were infrequent.

At our previous inspection we found that there was little to show that activities were being considered or offered. At that time one of the staff team had just been appointed to a part time role of activity co-ordinator. This role has now been made full time and the range and variety of activities was much improved and far more stimulating. We spoke with the activity coordinator who told, and showed us, the programme that they had developed.

There was a list of planned activities that were on a timetable with descriptions and pictures of activities. The timetable did use the words Monday, Tuesday etc. so as not to confuse people. The coordinator told us they changed any activity when people wanted and they met people daily and assessed within the group who wanted to do activities that day. There were a wide range of activities. There were 20 activities listed on the timetable, with more than this available. There was flexibility to other activities for people as well if they didn't want to do the originally planned activity, for example pet therapy, pampering, crafts, baking and games like bingo.

A local library visited the home to lend and refresh the choice of books and films, including audiobook.

Children from local nursery schools come to the home for what is known as "Generation engagement." The children are aged between 2 and 4 years old and the activity co coordinator said that people "love it." The children visit for an hour and colour and paint with people. Some people read for the children and vice versa. The coordinator told us that people who don't usually talk much do talk with the children and really enjoy it. The coordinator told us of the measures that are put into place to ensure that the children and people using the service are safe during these interactions.

We asked people about whether or not they knew how to complain and if they felt confident that they would be listened to. One person gave us their view and said, "No never made a complaint here and if I wanted to make a complaint I would speak to the manager."

We looked at the provider's complaints record and found that none had been made since our previous inspection and none had been received from anyone by CQC.

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. A new person had been registered as the manager since the previous inspection and this this person also managed other services, CQC accepted that there was suitable support in place when this person was registered in August 2015 and at this inspection we found this continued to be the case. Clinical governance, specialist advice about dementia care, pharmacist advice and visits by representatives of the provider took place regularly. This helped the service to maintain appropriate standards of care.

Staff told us they felt able to approach any member of the management team and that they believed things had improved significantly in the last year.

There was clear communication between the staff team and the managers of the service. Staff were regularly communicating with each other and talking about people's care and support needs. There were regular team meetings with the opportunity to discuss specific topics and the day to day operation of the home. Minutes of these meetings showed that the subjects discussed were relevant to the operation of the home.

We saw that staff were involved in decisions and were kept updated of changes in the service. They were able to feedback their views and opinions. Staff were positive about the training opportunities available and felt that the topics that training offered were those that they needed to do their work.

The provider had a system for monitoring the quality of care. The home was required to submit reports to the provider about the day to day operation of the service. The provider sought to learn from areas for improvement that were identified and took action to address these areas. Surveys were carried out centrally by the service provider across the trust and the results were published for the NHS trust as a whole. We have, however, suggested that it might be helpful to look at results for the home being outlined in more detail.

At our previous inspection we recommended that the provider carry out a survey of people using the service to seek their views in as meaningful a way, so that people are able to communicate their opinions. Although most people living at the home would find completing written surveys difficult the provider had looked at other ways of seeking feedback. An advocate visited the home regularly as a part of this process and regular service user and relative meetings had been established.