Golden Manor Healthcare (Ealing) Limited

Charlton Grange Care Home

Inspection report

Charlton Lane
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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

Charlton Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Charlton Grange accommodates a maximum of 62 older people in one adapted building. There were 24 people living at the home at the time of our inspection, all of whom were accommodated on the ground floor. The home is owned and operated by Golden Manor Healthcare (Ealing) Limited. This is the provider's only registered care home.

This inspection took place on 12 December 2018 and was unannounced.

At our last inspection on 1 and 8 March 2018 we identified two areas in which the provider needed to improve. There were few opportunities for people to take part in meaningful activities. The service had been without a registered manager for 12 months and no application to register a manager had been submitted to CQC. A registered manager is a person who has registered with CQC 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 and associated Regulations about how the service is run.

Following this inspection, the provider sent us an action plan setting out how they would make improvements in order to meet the relevant legal requirements.

At this inspection we found the provider had taken action to address these requirements. The availability of activities had increased, which had improved people's experience of living at the home. The provider planned to further improve activities with the recruitment of a directly-employed activities co-ordinator. The manager had submitted an application for registration with CQC although, since our visit, the manager has left their post and the Operations Director has applied for CQC registration.

People told us they felt safe at the home and when staff provided their care. However, some servicing of equipment, such as the lift, was out-of-date. Following the inspection, the provider provided evidence that appointments for servicing had been booked.

We found that medicines were managed safely overall, although we identified an issue with one person's topical medication. The provider addressed this issue during our inspection.

The manager and Operations Director had improved the home's quality monitoring systems, although these had not been effective in identifying the shortfalls we found during our inspection, such as out-of-date safety certification.

The manager and Operations Manager had made a number of changes designed to benefit people who

lived at the home, such as changes to staffing shift patterns and expectations in terms of staff perfomance and practice. The feedback we received from people and their relatives indicated that these changes had led to improvements. However, it was clear that the changes had affected the morale of some staff.

There were enough staff available to meet people's needs without delay. However, the home was heavily reliant on agencies to provide nursing staff at the time of our inspection. The manager told us of the provider's plans to address this issue, which included the appointment of a clinical lead to improve the support available to permanently-employed nurses.

The provider followed safe recruitment processes. Staff understood their responsibilities in keeping people safe and knew how to report concerns. The manager had notified relevant agencies when concerns about people's care had been raised and worked co-operatively with other professionals to investigate these. Risks to people were assessed and managed appropriately. The home was clean and hygienic and staff maintained appropriate standards of infection control.

People's needs were assessed to ensure staff could provide the care they required. Care plans were personalised and reflected people's individual needs. People's wishes and preferences about their end-of-life care were sought and recorded.

People's care was provided in line with the Mental Capacity Act (2005). Staff treated people with dignity and respect. They supported people to be independent where this was important to them. People enjoyed the food provided and any specialist dietary needs were met. Staff monitored people's health and people were supported to access healthcare treatment when they needed it.

Complaints were managed and responded to appropriately. People knew how to complain and the provider's complaints procedure was readily available. The manager and Operations Director had improved communication with people and their relatives. Several relatives told us that the residents and relatives' meetings which had been introduced were useful. They said the meetings had enabled them to hear about developments in the home and to raise any concerns they had.

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

The service was not always safe.

Some health and safety certification was out-of-date at the time of our inspection.

Medicines were managed safely overall.

There were sufficient staff deployed to meet people's needs.

Risks to people had been assessed and steps taken to minimise these.

Staff were recruited safely.

Staff understood their responsibilities in keeping people safe from abuse.

Staff maintained appropriate standards of infection control.

There were plans in place to ensure people would continue to receive care in the event of an emergency.

Is the service effective?

Good

The service was effective.

Staff had access to the training they needed to carry out their roles.

People's care was provided in accordance with the Mental Capacity Act 2005.

People's needs were assessed before they moved into the home to ensure staff could provide their care.

People enjoyed the food provided and were satisfied with the choice of meals.

Staff kept people's healthcare needs under review and supported them to access treatment if they needed it.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People had positive relationships with the staff who supported them.

Staff treated people with dignity and respect.

Staff supported people in a way that promoted their independence.

Is the service responsive?

Good

The service was responsive to people's needs.

People had opportunities to take part in meaningful activities.

People's care plans were personalised and provided guidance for staff about how to meet their needs.

People's wishes about their end-of-life care were recorded.

Complaints were managed and investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although the management and oversight of the home had improved, some issues had not been identified through the provider's quality monitoring systems.

The manager and Operations Director had made changes to benefit people as a result of management monitoring.

The manager and Operations Director had improved communication with people and their relatives.

The manager worked co-operatively with other agencies when required and had notified relevant agencies of any significant events.

Charlton Grange Care 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 was 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 12 December 2018 and was unannounced. The inspection was carried out by two inspectors and an inspection manager. We brought this inspection forward because we had received information of concern about standards of care at the home, some of which was sent to us anonymously.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We also considered information shared with us by the local authority about their monitoring of the service. We had not asked the provider to return a Provider Information Return (PIR) as we had brought this inspection forward. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight people who lived at the service and five relatives. We observed the care people received and the interactions they had with staff. We spoke with eight staff, including the manager, care and nursing staff and the provider's Operations Director. We reviewed care records of four people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We checked four staff recruitment files and records relating to staff support and training. We also looked at records related to quality monitoring, including the provider's audits of different aspects of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home and when staff provided their care. One person said, "I feel safe. I can call [staff] if I feel ill or if I lose my balance." Another person told us, "I came here because I kept falling and wasn't safe at home. I have fallen here but there are people to help me." A third person said, "The staff help me use my walker when I go to the lounge." Relatives told us their family members were safe living at the home. One relative told us, "I certainly feel better now that [family member] is here. She was falling a lot at home and that has not happened here."

Some of the health and safety certification we checked was out-of-date, including servicing for a lift and a boiler, which meant the provider could not demonstrate that the home was adequately safe at the time of our inspection. Following the inspection, the provider sent us evidence that they had scheduled visits by engineers to service the lift and the boiler.

We recommend that the provider establish and maintain systems to ensure that safety checks and servicing are carried out in line with relevant guidance and legislation.

Overall, people's medicines were managed safely, although we identified that one person was having topical medication applied once a day when their prescription stated this should happen twice a day. The manager addressed this issue during our inspection.

The provider carried out monthly medication audits, which recorded that medicines were managed safely overall. The home's dispensing pharmacist also carried out periodic audits of the home's medicines management, the latest of which, in November 2018, had identified no concerns. Medicines were stored in an appropriate, secure environment. Individual medicines administration records included information staff needed to know about how people took their medicines or any allergies they had. There were protocols in place for medicines prescribed on an 'as required' basis.

One person chose to manage their own medicines and a risk assessment had been carried out to support them to do this safely. One person received their medicines covertly, that is without their knowledge or consent. Appropriate procedures had been followed to assess the person's capacity to consent and to ensure that this decision had been taken in their best interests.

There were enough staff on each shift to provide people's care. At the time of our inspection all the people living in the home were accommodated on the ground floor. This enabled staff to ensure they were available when people needed them. The manager told us staff shift patterns had been changed to ensure that permanent staff were available at weekends. The manager said this was beneficial for people as they were supported by staff who were familiar to them and who understood their needs well.

Staff were recruited safely. The provider carried out pre-employment checks before staff began work, which included obtaining a Disclosure and Barring Service (DBS) Certificate. DBS checks help providers make decisions about applicants' suitability for employment in health and social care services.

Staff had attended safeguarding training and knew how to report any concerns they had. They were able to tell us about the types of abuse people may experience and what action they would take if they suspected abuse. One member of staff told us, "I would report anything to the manager straightaway and I would know how to escalate it if I had to." The manager had notified CQC of safeguarding appropriately and worked with the local authority to investigate and respond to these.

Risks to people had been assessed and action taken to minimise these. Assessments had been carried out to identify if people were at risk of falling, developing pressure ulcers or failing to maintain adequate nutrition of hydration. Where risks had been identified, care plans had been put in place to minimise the likelihood of them occurring. Where appropriate, equipment had been obtained to reduce the risk people faced. For example, staff had obtained pressure-relieving equipment for people at risk of developing pressure ulcers. Food and fluid recording charts had been implemented for people at risk of failing to maintain adequate nutrition or hydration. When incidents did occur, there was evidence of learning from these events. Accidents and incidents were recorded by staff and reviewed by the manager to identify any actions needed to address risks.

People told us staff kept the communal areas of the home clean and cleaned their bedrooms regularly. One person said of their bedroom, "They do it night and morning. They keep it tidy." Another person told us, "My room is always clean; the lady that cleans it is very good." We saw that cleaning staff were on duty during our inspection and that the home was clean and hygienic. Staff attended training in infection prevention and control and the provider audited standards of infection control regularly.

The provider had developed a business continuity plan to ensure people's care would not be interrupted in the event of an emergency. Staff maintained appropriate standards of fire safety. There was a fire risk assessment in place and the testing and servicing of fire equipment was up-to-date. Each person had a personal emergency evacuation plan (PEEP), which outlined the support they would need should an emergency occur.

Good

Is the service effective?

Our findings

The consistency of care people received was affected by the regular use of agency staff. The rota showed that the home was particularly reliant on agency nurses at the time of our inspection. The manager explained that they minimised the impact of this on people's care by requesting agency nurses who were able to work at the home regularly. The manager told us the provider was trying to recruit permanent nursing staff but that this was proving difficult. The manager said a clinical lead had recently been appointed to provide support to nursing staff and it was hoped that this would improve the recruitment and retention of registered nurses.

Staff had access to the training they needed to carry out their roles. The provider's training record demonstrated that staff had access to training including health and safety, fire safety, food hygiene, dementia care and equality and diversity. The staff we spoke with told us they had access to the training they needed to provide people's care. They said they had received an induction to the home when they began work, which included shadowing to understand people's needs and how they preferred their care to be provided. Staff had opportunities to discuss their performance through management supervision.

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

We found that people's care was provided in accordance with the MCA. People told us that staff sought their consent before providing their care and respected their choices about how their support was provided. Staff had attended training in the MCA and respected people's rights to make decisions about their day-to-day lives. Where necessary, assessments had been carried out to establish whether people possessed the mental capacity to make specific decisions. If the assessment determined that people lacked capacity, appropriate procedures had been followed to ensure decisions were made in their best interests. Where people were subject to restrictions for their own safety, such as not being able to leave the home unaccompanied, applications for DoLS authorisations had been submitted to the local authority.

People told us they usually enjoyed the food provided at the home. They said they had a choice of meals each day and that staff knew their likes and dislikes. One person said of the food provided, "On the whole it's pretty good. There is a choice and I can usually find something I like." Another person told us, "The food is good, although I don't have much of an appetite. We get cakes and biscuits offered every day." A relative

said, "The food comes in pre-prepared I think but Dad really loves it."

The home's meals were supplied by a specialist supplier of pre-prepared frozen foods. In addition to the standard range of meal options, the supplier also provided meals suitable for people with specific dietary needs, such as dysphagia. People's nutritional needs had been assessed and any dietary requirements, such as texture-modified diets, were recorded. Some of the concerns raised with CQC before the inspection related to staff preparing food without appropriate training. There were vacancies in the home's catering team at the time of inspection and, as a result, care staff were sometimes required to prepare meals. However, because meals were pre-prepared, care staff were not required to prepare specialist diets or to attend further training in addition to the food hygiene training they had received.

People's needs were assessed before they moved into the home to ensure staff could provide the care they required. Assessments recorded people's medical histories and considered people's needs in areas including moving and handling, skin integrity, health and continence. People's health was monitored and they were able to access healthcare services when they needed them. A GP visited the home each week and assessed people identified by staff as unwell. People's care plans addressed their healthcare needs and included professional guidance where relevant. For example, wound care plans outlined the care people needed and included specific guidance from a tissue viability nurse.

People lived in an environment which was suitable for their needs. The refurbishment that had begun at the time of our last inspection had continued and much of the home had been recently redecorated. People and relatives told us the continuing improvements to the home's appearance made it a more appealing place to live. They said the provider had sought people's opinions when planning colour schemes. One relative told us, "The décor has improved quite a bit. It looks a lot smarter now." Another relative said, "People were able to choose what colour they wanted, which I thought was nice." The provider had also implemented measures designed to improve the environment for people living with dementia. Signage had been installed and different areas of the home painted in contrasting colours to enable people to orientate themselves within the home.

Good

Is the service caring?

Our findings

People told us that the staff who supported them were kind and caring. They said they enjoyed the company of most staff. One person told us, "The majority of staff are very kind and friendly, some of them come in and have a good chat with me." Another person said of staff, "Some of them are really lovely, really kind." A third person told us, "Staff are very nice. Whatever you ask, they'll do for you."

Relatives said staff were caring towards their family members. They told us their family members had developed good relationships with staff. One relative described staff as "Great" and another relative said of their family member, "She loves most of them [staff]." A third relative told us, "[Family member] loves it here. They organised a birthday party for her." Relatives said care staff knew their family members well and understood their preferences, such how they liked to spend their time and what they liked to eat.

People told us the home was comfortable and its atmosphere friendly. One person said of the home, "I think it's very comfortable and it has a pleasant atmosphere." Relatives told us they could visit their family members whenever they wished and said they were made welcome by staff when they visited.

We observed that staff engaged with people in a caring way during our inspection. Staff were attentive to people's needs and responded quickly if they required support. For example, we saw one member of staff bring a person their post and ask the person if they would like it read to them as they found reading difficult. We observed the manager responding to a person who had become distressed. The manager was quick to comfort the person and used appropriate language and touch to calm and reassure them.

People told us that staff treated them with respect and maintained their dignity when providing their care. They said they could have privacy when they wanted this and that staff respected their wishes if they chose to spend time alone. We observed that staff communicated effectively with people whilst providing their care, for example when supporting people to transfer using equipment.

People and their relatives told us they were able to be involved in planning their care. They said their views were considered and taken into account when care plans were being developed. Relatives told us they were able to attend reviews if they wished and said staff kept them up-to-date about any changes to their family member's needs or well-being.

People said staff supported them to be independent where this was important to them. They told us staff encouraged them to manage aspects of their own care but provided support where it was needed. One person said, "They do encourage me to do things for myself but I prefer them to do it because I struggle to cope with it."

Good

Is the service responsive?

Our findings

At our last inspection we found people did not have enough opportunities to take part in activities that met their needs. Some people told us they were often bored as there was not enough to do.

At this inspection we found that activities provision had improved and the provider had plans in place to further increase the availability of activities. A self-employed activities provider visited the home on several days each week and the manager told us a directly-employed, part-time activities co-ordinator had recently been recruited, which would increase activities provision. Whilst these developments were encouraging, it is important that the provider sustains improvements in this area, particularly in the event of more people being admitted to the home.

A number of the activities focused on physical and mental well-being, which relatives told us had benefited their family members. One relative said of their family member, "He really enjoys the activities, especially the exercises. It's benefited his well-being and his mobility." Another relative told us, "There are more activities now. They encourage [family member] to join in, otherwise she would just sit in her room. It's nice to see. She has made a friend since she started coming down."

Participation in activities was more actively promoted and an activities programme was displayed, which included Music for Health, Massage and Reflexology, Tai Chi and Mindfulness and Chair Exercises. The activities that took place during our inspection were well attended and clearly enjoyed by those who took part. The activities co-ordinator told us they encouraged people to participate in activities but also spent time with people who spent the majority of their time in their bedrooms. This was confirmed by two relatives, who told us the activities co-ordinator spent time with their family member in their bedroom to ensure they were not excluded from activities and engagement.

The care plans we checked were personalised and reflected people's individual needs across a range of areas, including health, mobility, communication and skin care. Where care plans identified that people needed equipment to meet their needs, such as pressure-relieving mattresses or hoists and slings to help them mobilise, this was in place. Any guidance from healthcare professionals about people's care was incorporated into their care plans. People's wishes and preferences about their end-of-life care were recorded. The home was not providing any end-of-life care at the time of our inspection but we saw that any advance decisions about care and treatment had been recorded in people's care plans.

People and their relatives knew how to complain and told us they would feel confident to speak up if they had concerns. One person said, "If I wasn't happy, I would certainly speak up." A relative told us they had previously complained and had been satisfied with the way in which their complaint was managed and responded to. Relatives said the manager had improved the response to any concerns they had about the care their family members received. One relative told us, "I did have a bit of a problem with the care a while ago. I went to the manager and she sorted it out really quickly". Another relative said, "I have no complaints but if I did, I would speak to the manager. She is always around, I see her every day."

The provider had a written complaints procedure, which was displayed in the home. The procedure detailed how complaints would be managed and included details of agencies people could contact if they wished to escalate their complaint. The home's complaints log demonstrated that any complaints received had been investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we made a requirement that the provider appoint and register a suitable person to manage the service. At the time of this inspection, the manager's application for registration with CQC was being processed. However, since our visit, the manager has left their post and the Operations Director has applied for CQC registration.

The manager and Operations Director told us that, since their arrival in post, they had taken the action they deemed necessary to improve standards at the home. They advised that some of the staff working at the home when they arrived had been disciplined, including some dismissals, for poor practice in their work. The manager and Operations Director explained that shift patterns had been changed to benefit the people who lived at the home.

The feedback we received from people and their relatives indicated that the changes made by the manager and Operations Director had led to improvements, such as more activities and better communication of information. However, it was clear that these changes had affected the morale of some remaining staff. Some of the staff we spoke with said they felt positive about the actions the new management team were taking to improve standards at the home. Other staff told us their morale was low. Two staff said they were aware that shift patterns were changing and told us they would have liked more notice and/or a consultation period.

We saw evidence that the manager and Operations Director had improved quality monitoring systems, including checks to monitor the quality of care people received. Areas such as medicines and infection control were audited regularly and the Operations Director had carried out an unannounced spot check at night. Although the manager and Operations Director had improved quality monitoring, the shortfalls we found at this inspection had not been identified or addressed by the provider. For example, out-of-date certification for equipment had not been identified through health and safety audits.

We recommend that the provider improve quality monitoring systems to ensure that any shortfalls are identified and addressed.

People and their relatives told us the manager and Operations Director had improved communication with them. They said several residents and relatives' meetings had been held, which enabled them to hear the provider's plans for the home and to ask questions. One relative told us, "We have had three meetings since the new managers started and it is much better. We raised the subject of staff taking a while to answer call bells. It was good to hear about the things they were doing." Another relative said, "The relatives' meetings have been very useful. They email us the minutes." A third relative told us, "It is much better now for communication than it was before."

The manager and Operations Director were aware of their responsibilities in terms of informing CQC when notifiable events occurred and had submitted statutory notifications as required. The manager and Operations Director had worked co-operatively with other agencies, such as CQC and the local authority, to

investigate any concerns raised about the quality of care.