M D Homes

Eastbury Nursing Home

Inspection report

12 Eastbury Road
Northwood
Middlesex
HA6 3AL

Tel: 01923823816
Website: www.mdhomes.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 January 2016 and was unannounced.

The last inspection of the service took place on 7 September 2013 when we found that there were no breaches of Regulation.

Eastbury Nursing Home is a care home with nursing for up to 20 people who have mental health needs. Some people also had additional physical needs or learning disabilities. At the time of our inspection 18 people were living at the home. Their needs included support with brain injury, physical and learning disabilities, dementia and other mental health needs as well as nursing care needs. The home was managed and run by MD Homes, a private organisation who ran five nursing homes in North West London.

The last registered manager left the service in 2015. A new manager was appointed in August 2015 and has been managing Eastbury Nursing Home and another of the provider's care homes since this time. The manager had applied to be registered with the Care Quality Commission and this application was being processed at the time of the inspection. 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 and associated Regulations about how the service is run.

Most people were happy with the service and some of the things they said were, ''The service is very comfortable and very friendly'' and ''It is very good here.''

People told us the staff were kind and caring and they had good relationships with them. However, we saw that some of the staff supported people by focussing on the task they were performing rather than people's individual needs and preferences.

People's social and emotional needs were not always met and they did not always feel involved in planning their own care.

There were procedures designed to safeguard people from abuse and the provider followed these. Information about the procedures was available for people who lived at the home and staff.

The risks to people's safety and well-being had been assessed.

The environment was safe and clean.

People received their medicines in a safe way.

The provider's recruitment procedures made sure the staff were suitable to work at the service.

The staff had the skills, training and support they needed to care for people.

People had consented to their care and treatment where they were able. Where people lacked the capacity to consent, the provider had taken appropriate action to provide care in their best interests in accordance with the legal requirements of the Mental Capacity Act 2005.

People's nutritional needs were met and they had a choice of freshly prepared and nutritious meals.

People were given the support they needed to stay healthy.

There were clear and detailed care plans which described the action the staff needed to take to support people.

There was an appropriate complaints procedure and people knew how to make a complaint.

People felt that the service was well managed and they were able to contribute their views.

There were systems to audit and monitor the quality of the service and these included evidence that changes had been made to help develop and improve the service for people living there and the staff.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There were procedures designed to safeguard people from abuse and the provider followed these. Information about the procedures was available for people who lived at the home and staff.

The risks to people's safety and well-being had been assessed.

The environment was safe and clean.

People received their medicines in a safe way.

The provider's recruitment procedures made sure the staff were suitable to work at the service.

Is the service effective?

Good

The service was effective.

The staff had the skills, training and support they needed to care for people.

People had consented to their care and treatment where they were able. Where people lacked the capacity to consent, the provider had taken appropriate action to provide care in their best interests in accordance with the legal requirements of the Mental Capacity Act 2005.

People's nutritional needs were met and they had a choice of freshly prepared and nutritious meals.

People were given the support they needed to stay healthy.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff were kind and caring and they had good relationships with them. However, we saw that some of the staff supported people by focussing on the task they were performing

rather than people's individual needs and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's social and emotional needs were not always met and they did not always feel involved in planning their own care.

There were clear and detailed care plans which described the action the staff needed to take to support people.

There was an appropriate complaints procedure and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

People felt that the service was well managed and they were able to contribute their views.

There were systems to audit and monitor the quality of the service and these included evidence that changes had been made to help develop and improve the service for people living there and the staff.

Eastbury 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 checked 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 12 January 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of using services for people who had mental health needs.

Before the inspection visit we looked at all the information we had about the service. This included notifications of significant events and the last inspection report. We asked the provider to complete 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.

During the inspection visit we spoke with four people who lived at the service and two visiting relatives. Some people were not able to tell us about their experiences so we observed how people were being cared for and supported. We spoke with the staff on duty and this included the manager, deputy manager, chef, care assistants and the organisation's operations director who was visiting the service. We also looked at care records for six people, records of staff recruitment, support and training and the provider's other records used for managing the service. We inspected the environment and we looked at how medicines were managed.

After the inspection we spoke with one relative of people who lived at the service and two social care professionals who supported the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. They told us the staff kept them safe and looked after them.

There was a procedure for safeguarding adults and this was shared with all the staff. The staff had received training in safeguarding adults and identifying abuse. They were able to tell us about this and what they would do if they were concerned about someone's safety and wellbeing. Some of the staff did not know they could contact the local safeguarding authority directly with concerns. The manager told us that this would be discussed with the staff team following our inspection to make sure everyone was familiar with the procedure. Information about abuse, harassment and safeguarding was displayed on notice boards around the home, telling people what action they should take if they felt at risk.

Shortly before our inspection there had been an incident where someone had been placed at risk. The manager was able to tell us what action the staff had taken and how they were supporting the individual to prevent further risks. The person had been involved in making decision about how they should be supported following the incident and had agreed to the action the staff had taken. The manager had notified the police, local safeguarding authority and the Care Quality Commission about the incident. They were working with the local authority to make sure the person was suitably protected.

Some people managed their own money and financial affairs. There were procedures to make sure people who required some support or guidance received the right level of this. One person told us, ''they help me look after my money.'' For example, the provider held small amounts of cash for some people so they could use this for daily expenditures. There were records of the money held, all financial transactions and copies of receipts for all transactions. Where possible people had been involved in recording this and had signed records. For people who were not able to do this two members of staff had to sign all records. The deputy manager audited these on a regular basis.

We saw that staff took action to keep people safe and manage risks throughout the inspection. For example, they used the correct equipment to help people move safely around the home. They ensured the environment was hazard free, moving furniture and objects that could present a risk to people who were visually impaired or using a wheelchair. When they supported people to move, they made sure they were comfortable and safe before they left them, for example adjusting cushions, making sure everything they needed was in reach.

The environment was generally well maintained and clean. One person told us, ''my room is always clean and spotless.'' There were a few repairs that needed attention, including a leaking roof and a broken bath. However, the manager showed us evidence that these had been reported and action to make the necessary repairs had been planned. The flooring in two of the shower rooms required replacement and work on this had started on the day of our inspection visit. The staff undertook daily checks on the environment to make sure it was clean and safe. These checks were recorded. There was a record of the provider's checks and external organisation checks on equipment, such as electrical appliances, fire safety equipment and hoist. These were up to date and showed where action had been taken to repair faults. The staff and people living

at the home took part on regular fire drills and these were recorded.

Where people were exposed to individual risks we saw that these had been assessed and there was information for staff on how to reduce the risks and likelihood of harm. For example, care files contained a summary of risks which included the risks of using equipment, self-harm and neglect, smoking, leaving the home unescorted and falls. The assessed risks varied for each person and reflected their own needs. There was a summary of action staff should take and the support the person needed to stay safe. Care plans included more detailed information about individual risks and supporting people to manage the risks themselves where possible. The nursing staff had also undertaken assessments of risks relating to people's health and conditions, these included the risks of developing pressure sores and nutritional risks. Where people had been identified at risk there was a clear plan for the staff which included consultation with other professionals and making regular checks on people's conditions. We saw evidence of checks by staff and that action had been taken when people's needs had changed. Risk assessments were reviewed and updated monthly.

People received their medicines in a safe way. One person told us, ''the staff help me with my medicines and the medicines help me.'' Medicines, including controlled medicines, were stored securely and appropriately. There were procedures for the administration of these, included covert (without the person's knowledge) and self-administration. The medicines for some people were administered covertly. We saw evidence that an appropriate assessment of this had been made and the reasons for this method of administration had been recorded. There was a signed agreement from the person's GP, pharmacist and next of kin, which included evidence of best interest discussions about this.

Records of medicine administration were accurate and up to date. They included information about if and why people did not take their medicines as prescribed. There were daily audits of medicine stocks and these were recorded. The manager also undertook an audit of medicine records and storage each month.

The staff responsible for administering medicines were trained and had their competency assessed before they started administering medicines. We observed the staff administering medicines. They did this appropriately and safely, explaining what they were doing to the person and asking their permission before they administered the medicines.

The provider's recruitment procedures made sure the staff were suitable to work at the service. The staff told us they had been interviewed and a number of checks had been made before they started work at the service. We saw evidence of staff recruitment for four members of staff. The provider had obtained criminal record checks, references, checks on the staff member's identity and eligibility to work in the United Kingdom. We noted that some of the reference checks appeared to be personal ones rather than references from previous employers. The local authority had identified this during a recent quality monitoring audit of the service. This had led to an investigation by the provider. We saw that they had gathered further evidence that the references were from previous employers (although this information was not in the staff recruitment files). The provider had also agreed to make more thorough checks and gather evidence of previous employment for future recruitment. The manager told us that recruitment took place centrally by the provider's head office and that they were not involved in selecting staff. They told us they hoped to have more involvement in the recruitment of staff in the future.

Good

Is the service effective?

Our findings

People told us they thought the staff were appropriately skilled at caring for them. Some of the things people told us were, ''the staff work very hard without breaks'' and ''the staff are doing their jobs.''

Staff received the training and support they needed to carry out their work effectively. The staff told us they had an induction when they started working at the home and had received training in a variety of different areas. They were able to tell us about the training they had received and how this had helped them in their roles. The training included moving people safely, safeguarding adults, health and safety, food hygiene, dementia awareness and infection control. There was a record of the training the staff had undertaken, and we saw that this was updated as necessary. The deputy manager told us that clinical training was provided for nursing staff and they were supported and encouraged to arrange their own additional training.

The staff told us they felt supported. They said there were good systems for formal and informal support. These included regular team and individual meetings with the manager and annual appraisals of their work. These were recorded and showed that staff discussed their own work practice and development. There were good systems of communication for the staff, including daily handover meetings, notice boards and communication books. The staff told us they felt the manager and deputy manager were approachable and supportive and they were able to discuss their work and concerns they had.

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 saw that the staff had assessed people's mental capacity and these assessments were recorded and updated. There was evidence that decisions had been made in people's best interest where they lacked capacity and these decisions involved people who were important in the person's life, such as their next of kin and relevant professionals. Where people had a representative with lasting power of attorney, this had been recorded and there was evidence that they should be responsible for specific decisions about the person's care. The manager had made applications for authorisations where people had been restricted or deprived of their liberty. For example, some people were restricted from leaving the home without an escort because they were considered at risk if they did not have an escort. There was evidence this had been assessed, including observations of people's individual abilities and road sense. Where a decision had been made to restrict someone this had been authorised by the appropriate authority and there were clear records in place regarding this.

Some people were able to consent to their own care and treatment. There was evidence they had signed their care plans and risk assessments. There was also additional signed consent for other areas of care and treatment, such as consent to the use of bedrails, using the person's photograph and administration of medicines. People told us they were asked to consent to staff care and support. We observed this, with staff offering people choices, respecting their decisions and listening to what the person wanted. For example, one person indicated that they did not want staff support to move their wheelchair but would rather move themselves on this occasion. Not everyone was aware of the contents of their care plans, and although they had signed these, they had not been involved in reviews and they had last seen their plans over two years ago. There were some records which were entitled ''general consent'' and did not specify what the person was consenting to. The manager agreed to review these documents to make sure people had a clear explanation of the consent they were giving. They told us that they would ensure everyone who was able to had the opportunity to review and consent to updated care plans.

Most people enjoyed the food they were given. One person did not like the food and told us, ''the food is terrible, I cannot remember the last time I had a good meal here.'' However, other people's comments included, ''the food is beautiful'', ''they try to make it different for everyone'', ''there is a lot of good variety of food'' and ''the food is good, if it is cold I tell them, sometimes there is not enough variety but there are good portion sizes.''

People's nutritional needs were being identified and met. They were assessed each month. Changes in these needs were recorded and acted upon. People were weighed regularly. There was evidence that dietitians and other professionals were involved where people were considered at nutritional risk. Guidance from the professionals was included in people's care plans or risk assessments. Where people were at risk of choking, there were guideline about food and fluid consistency and we saw the staff following these.

People were able to have hot and cold drinks throughout the day and we saw the staff responding to people's requests for drinks and for fruit. The chef told us that they met with people regularly to ask them about their food preferences and needs. We saw evidence that menus were discussed at meetings and the chef spent time in the main communal rooms talking to people and observing what they ate and enjoyed. People were able to choose from the menu options in the morning before lunch. There was a choice of two main dishes at each mealtime and the chef told us alternatives could be prepared if these were requested or if someone did not like the main choices. The staff confirmed this telling us, ''if someone wants something that is not on the menu, the chef makes it for them.'' Food was freshly prepared each day. On the day of our visit we saw meals were individually prepared and portion sizes reflected people's choices and appetites.

The chef had information on people's allergies, dietary needs and food preferences. They had a good knowledge of individual people. The kitchen was clean and well maintained, and there was evidence of checks on food storage and serving temperatures. The service had received a five star rating from the environmental health officer in September 2015.

People's healthcare needs were being identified and met. They had been recorded in their care plans. The provider employed nursing staff 24 hours a day. Nursing care needs were assessed, monitored and met by these staff. Each person had an assigned nurse key worker who ensured their needs had been identified. There was information on how to manage pressure areas for people who were at risk. This included checking equipment was working correctly and repositioning people when needed. People had a range of different physical and mental health needs, including some complex medical conditions. There was clear information about these and the support they required from the staff. One person told us, ''they help me with my (health condition), and make sure I have regular check-ups.'' People told us they were supported to see their doctor and other healthcare professionals as needed. There was evidence of regular appointments

with different professionals and their advice had been incorporated into care plans.

Requires Improvement

Is the service caring?

Our findings

People living at the home and their representatives told us the staff were kind and caring. Some of the things they said were, ''the staff are very good with us, they are like my family'', ''I can talk to staff, they are there when I need them, like family'', ''the staff are supportive'', (from a relative) ''I am allowed to visit and spend time here at any time of the day or night'', ''we are like a big family here supporting each other'', ''I feel safe leaving (my relative) here – I did not know such a caring place existed'' and ''the place is like an extended family.''

The atmosphere at the home was relaxed and friendly. People living there had a good rapport with the staff and each other. People were able to spend time where they wanted. We saw some positive interactions where staff spoke with people in a kind and friendly way.

However, we also witnessed a number of interactions where the staff appeared to be focussed on the task they were performing rather than the person they were caring for. They did not always treat people with dignity or respect. For example, at one point a person became unsettled and indicated they were distressed. The staff in the room told the person they would be having their lunch soon and guided them to a seat. The person waited for over 20 minutes for their lunch, watching other people being served during this time. They repeatedly stood up and moved around but the staff guided them back to a seat without any reassurance.

In another incident someone started coughing and spluttering whilst they ate. The staff members nearby were attending to other tasks and did not approach the person to ask about their wellbeing or make sure they were safe. One person was positioned in a chair so that many members of staff constantly stood or bent with their backs to the person whilst they used equipment in front of them.

The staff who supported people to move into the lounge and dining room did not always speak with people apart from about the task they were performing. For example, the staff supported one person into a chair using a hoist. They told the person what was happening with the hoist but did not reassure the person and the only conversation was about the actual task. They then adjusted the person's cushions and items around the person, and walked away without talking to them. The staff supporting people with drinks and food did not hold conversations with them. One person asked the staff for a glass of water, when the staff brought this the person continued to ask for water. Instead of exploring whether the person wanted something else. They just told them, ''this is water'' and ignored the person's further requests, this exchange was not friendly and did not alleviate the person's distress. The staff placed plastic aprons on some people without asking their permission before lunch.

In one incident, a person started telling a member of staff about something which had happened in their life which was significant and upsetting. The staff member told the person to ''talk about something nice instead.'' The service is for people who have mental health needs and may have had traumatic or upsetting events in their lives before they moved to the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014

The manager had provided staff with information about dignity in care. This included staff training and meetings and a notice board of information to support staff to understand about dignity and respect.

People told us their privacy was respected. They said they were able to celebrate their culture and religion. We observed the staff calling people by their preferred names and knocking on bedroom doors before entering. During our inspection healthcare interventions, such as a blood glucose test, were carried out in private. Although one person told us that this was not always the case.

Requires Improvement

Is the service responsive?

Our findings

Not everyone could remember being involved in planning their care. Some people had signed agreement to their care plans but they had not been involved in reviews and making changes to care plans since, some of which dated back to 2013.

People told us there were not always a lot of activities or planned things to do. People were not offered therapeutic support with regards to their mental health needs and the care workers had not had specialist training in this area. Some of the things people told us were, ''I do not have a say in what goes on here'', ''my relative would like to go out more'', ''the activities the staff do with my relative are not the activities (they) like'', ''they could improve activities, like therapies and exercise'', ''people would benefit from more one to one staff time'', ''we need more activities, more days out, games , arts and music'', ''no one is allowed in the kitchen to make cakes and this would be a nice activity to do'', ''I would like to go out more, they do not take me out much'' and ''I do not have friends here and no one to talk to.''

We observed that during the morning of our visit one member of staff was assigned to supporting people with activities. They supported a small group with activities but people did not appear enthusiastic or particularly content with these activities. The staff member supporting people did not engage with them, for example we noted that they were watching a television whilst playing a ball game with one person and were looking around the room at other things whilst they were holding a newspaper for another person to read. Their interactions with people were limited and the activities they supported were limited to one small area of the home. Other people in the communal areas were either not engaged in any activity or were talking with each other or smoking. A number of people sat in chairs without anything to do and not talking to others.

There was an activities notice board, although this did not accurately reflect the activities that took place on the day of the visit. Recorded information for people about things they could do and social activities was limited to this board which was inaccurate.

After lunch some of the staff supported small groups of people with board games and nail painting, and people appeared to enjoy this.

People told us they were not involved in planning their own care and they did not feel they had opportunities to suggest things that they could do.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they enjoyed going out on trips. Some of the things they said were, ''someone helps me when I go out shopping'' and ''they help me with shopping.'' People told us, ''I enjoy listening to music and having a chat'' and ''I do craft activities with the staff.'' Most of the people living at the home told us they had friends there. They said, ''I have made a few friends here'' and ''my friends and family come to see me.''

The staff had assessed people's needs when they moved to the service and these needs were recorded in individual care plans. The care plans described people's needs and the action the staff needed to take to meet these. Care plans were reviewed each month and updated when people's needs changed. There was evidence that information from other health care professionals had been included in people's care plans. Where people had specific physical healthcare needs which required monitoring this had been recorded and there was evidence the staff carried this out.

There was an appropriate complaints procedure and this was displayed. People told us, ''if I had a complaint, I would tell the manager or put it in writing'' and ''if I needed to make a complaint I would know what I need to do.'' There had not been any complaints at the service in the past year. However, the manager had a record which could be used for recording and analysing complaints.

Good

Is the service well-led?

Our findings

People told us they felt the manager and deputy manager were approachable and available when they needed them. The operations director for the provider visited the home regularly and people said they had a good relationship with this person. We observed people asking the managers and senior staff questions and they received an appropriate response and support.

The staff told us they thought the service was well led and they were supported at work. They said there was good team work and they communicated clearly with each other. They told us they were well informed and had regular meetings. Some of the things the staff told us were, "everything we do we let each other know about it, the communication is good" and "senior management is very supportive, they are always involved. The service manager leads daily handover meetings and also gives short lectures on best professional practice i.e. how we could recognise what people like or dislike and how they feel."

The registered manager left in 2015. A new manager was recruited in August 2015. This person had applied to be registered with the Care Quality Commission (CQC) and the application was being processed at the time of the inspection. The manager was a nurse and had worked in various settings and in a managerial role before they started work at MD Homes. They also worked as a professional nurse advisor for CQC attending inspections of other services. The manager told us this helped them to keep updated with changes in legislation and good practice. They had been employed to manage two of the provider's services and split their time evenly between them. The manager told us they had introduced some changes to the service. These included providing staff with more information about person centred care and dignity. The deputy manager supported the manager and had worked at the home for many years. They knew the people who lived there and the systems and processes well.

The manager and deputy manager undertook regular audits and checks at the service, on the environment, medicines, paperwork and staff practices. These were recorded along with actions taken to improve the service. The provider's senior managers also conducted regular audits which included feedback from people who used the service and their representatives. The London Borough of Hillingdon quality team had audited the service in 2015. The manager had completed an action plan following this audit which had shown how recommendations made by the local authority had been acted upon.

Accidents, incidents and other events were recorded and the manager analysed these to identify any themes to make sure future incidents could be avoided.

There were regular staff meetings and meetings for people who used the service and their representatives. Minutes of these showed that people were well informed and had the opportunity to raise any concerns they had. The manager told us about the action they had taken following the last meeting of relatives in response to some concerns they had raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with respect and dignity. Regulation 10(1)