Excelcare Management Limited

Peter Shore Court

Inspection Report

Beaumont Square
London
E1 4NA
Tel: 020 7790 2660
Website: www.excelcareholdings.com

Date of inspection visit: 11/04/2014
Date of publication: 27/08/2014

Contents

Summary of findings

Overall summary

Peter Shore House is situated on a garden square near to Stepney Green tube station. It provides care home accommodation (without nursing) for up to 41 people, the majority of whom live with dementia. Most people who use the service come from the local area and represent its diversity. The premises are spacious, with plenty of room to meet people's mobility needs and a choice of lounges.

We found that people who used the service were treated as individuals and staff members were very caring. The three relatives we spoke with praised the care provided. There was a calm and relaxed atmosphere on the day of our inspection and we observed that the majority of people were content, with staff seeking to engage them in the life of the home or daily self-care tasks whenever possible. The provider had worked hard to expand the range of activities on offer; we saw an excellent example of a group activity run by an external organisation which managed to engage a wide range of people. We saw that the provider had plans to continue to deliver a good variety of activities.

In most areas we saw evidence of good reporting and recording by staff and monitoring by managers, but a less developed process for analysis and feedback to the staff team. This meant that opportunities for learning from past events were missed.

The provider carried out regular audits to monitor the standard of care provided. There were systems in place to ensure medication was safely administered, although some aspects of recording could be improved. Food and fluid intake monitoring needed to be more consistent.

We judged that, although some staff needed more help to embed the required skills and knowledge about the Mental Capacity Act into their day to day practice, the provider was meeting the basic requirements of the Deprivation of Liberty Safeguards. People's human rights in this area were, therefore, recognised, respected and promoted.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We saw that there were sufficient staff on duty to meet people's current needs. Staff had access to advice and support outside office hours if required. Medicines were administered using safe systems, but some aspects of recording needed improvement. Staff reliably reported incidents and accidents.

Staff were aware of the need to give people as many choices and as much freedom as possible in their day to day lives. The service was meeting the requirements of the Deprivation of Liberty Safeguards, therefore people's rights in this area were protected.

Are services effective?

People's needs had been assessed before they moved in to try to ensure that appropriate support would be available. Most staff had completed most of the mandatory training required by the provider.

Sufficient space and appropriate equipment was available within the home to ensure people could be cared for safely and comfortably. People's nutrition and hydration needs had been assessed.

Are services caring?

We observed good practice by staff, who adapted their style of communication to suit the person and/or the topic of conversation. We noted that people were not expected to sit still all day and, when required, were supported in their walks around the building. Privacy and dignity were maintained at all times during our visit.

The relatives we spoke with told us that staff were very caring and it did not make a difference who was on shift. We saw that people were routinely offered simple choices and there was evidence that people were treated as individuals. Care plans and risk assessments gave staff an immediate picture of the person and their needs.

Are services responsive to people's needs?

The range of activities had been increased within the home and the provider was working to sustain this change.

Relatives told us staff were responsive to people's emotional needs. They also said that when they had any concerns these had been quickly resolved before escalating into complaints.

The provider worked to meet individuals' needs, including those around end of life care. People were given the opportunity to air their views at residents' meetings.

Summary of findings

Are services well-led?

The registered manager was accessible on site and senior managers visited the home regularly to monitor the quality of the service, however, we found that their audits did not always pick up on all of the issues. Team meetings, supervision and appraisal were taking place at the intervals required by the provider. Managers needed to ensure learning from past events was routinely passed on to staff.

Staff described the management team as supportive. An emergency plan for the premises was in place and regular fire safety checks had been carried out.

Summary of findings

What people who use the service and those that matter to them say

We discussed the care provided with eight people who used the service. One person said, “they are nice people here, very kind.” Another told us, “on the whole they [the staff] are all very good”; and a third person said, “it’s all good here.” We observed that those who were unable to speak with us were relaxed and content and were attended to regularly by staff with whom they seemed comfortable.

One person who was relatively new to the home told us that they needed more help to get to know people and one other person said they could not go out as much as they wanted to, otherwise all the comments we heard from people who used the service were positive.

The three relatives we spoke with were unanimous in their praise, with one relative summing it up by saying, ”nothing is too much trouble, you can’t fault it. It’s just lovely here. Whatever you ask, [the staff] do it.” A relative told us, ”when [my relative] was living alone we had to make sure [they were] alright….We don’t have to worry about anything now [they are] here.” Another said, ”we looked at lots of places and this was just so much better; streets ahead.” One described the care as ‘brilliant’ and told us that this was always the case, saying, “it doesn’t matter who’s on [shift].”

Peter Shore Court

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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection team was made up of three people - a lead inspector, a specialist advisor who was a qualified pharmacist with a specialism in dementia care and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

The team spoke with six staff members, three managers and three relatives who were visiting on the day of the inspection. We also spoke with many of the people who lived in the home, eight were able to give their views and we observed the others in the communal areas of the home to try to gauge how they felt about their surroundings and the people who lived with them or supported them. We reviewed four people's care files, three staff supervision records and looked at medication records, fluid and food intake monitoring forms, many of the home's policies and procedures, as well as reviewing the premises. We also viewed the home's computerised records and audit system. Some of our observations took place at lunchtime and some during a group activity session which was facilitated by an external organisation.

When the home had been inspected in November 2013 it had been found to be meeting all the regulations, but a lack of availability of activities had been noted and some people were not helped to engage with their surroundings as much as they could have been. On inspection in May 2013 the home was also found to be meeting all the regulations.

On this occasion we did not speak to any external stakeholders prior to our visit due to the timing of the inspection and we did not receive the Provider Information Return in advance due to technical issues.

Are services safe?

Our findings

A relative told us, "when [my relative] was living alone we had to make sure [they were] alright….we don't have to worry about anything now [they are] here."

We observed that there were sufficient staff members on each floor to meet people's needs. Staff were kept very busy, but we did not see anyone waiting more than a few minutes to be attended to. When we checked the staff rotas we saw that these staffing levels had been maintained, with occasional staff absence covered by other staff members working additional hours or by the provider's bank staff. We noted that staff could seek advice and support outside office hours, using the provider's manager on-call service.

There were appropriate risk assessments and plans for identifying and managing risks in the four care files we reviewed. We saw that, when needed, charts were in place to help staff to understand people's behaviour. The conclusions had been used to inform the care plans.

Many of the people living in the home were independently mobile, some with the help of walking aids. We noted that one person, who was prone to falling, had previously had input from the local Falls Prevention Service, and their falls risk assessment was regularly reviewed and updated by the home.

Staff we spoke with were aware that they had to use the least restrictive option to assure people's safety and we found that there were appropriate policies and procedures in place to guide staff about making applications for Deprivation of Liberty Safeguards, which had been used appropriately in the past. However, some staff we spoke with were unclear about the application of the Mental Capacity Act 2005 in relation to their day to day work. For example, one staff member described a person as lacking capacity to make decisions, whilst a different staff member told us the same person did have capacity. The managers we spoke with understood their responsibilities under the Act. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted in this area.

We reviewed the accident and incident log for the home and saw it contained reports about unwitnessed falls and, on occasion, an unwitnessed skin tear. Therefore the home demonstrated that staff recorded incidents.

During our inspection we saw that appropriate policies and procedures were in place and occasional formal safeguarding alerts had been made to the local authority. We also noted that when a person was involved in an accident or incident, their social worker or the local Social Services' First Response Team was notified.

A review of medicines rooms on both floors found them to be tidy and well ordered. Environmental monitoring charts were in place and temperatures were within the recommended range.

The drug trolleys were locked and immobilised when unattended. We saw they were clean and tidy and stocked with the medicine people currently required. All medicines were in date and labelled correctly. Returned medicine was separated and there was an auditable trail in relation to a medicine which was no longer required and was returned to the pharmacy. We noted that everyone had regular medicine reviews with their GP and the home also had an auditable trail of prescription items ordered. The controlled drug cupboard was locked and the balance of drugs in stock matched that recorded in the register.

A review of the previous month's medicines administration records (MAR charts) found them to be tidy and accurate. Although we found that people were receiving their medicine as prescribed, the provider may find it useful to note that some staff were not using the correct codes on the MAR charts; nor were staff always recording when required medicine, such as pain relief, was being offered but not required.

Are services effective?

(for example, treatment is effective)

Our findings

A relative told us, "we looked at lots of places and this was just so much better; streets ahead."

We checked the staff training records and saw that most staff members were up-to-date with most mandatory training courses, many of which were offered as e-learning. However, whilst more senior staff were well informed, three staff members we spoke with were unable to satisfactorily explain what was meant by the diagnosis 'dementia' and its impact upon people, other than to tell us that it caused memory loss. The registered manager told us that they had just completed a 'train the trainer' course so that they could personally provide further training on dementia.

We saw that the provider had safe recruitment policies in place and there was evidence that they monitored when visa renewals for overseas staff were required.

Prior to people moving in, senior staff carried out a pre-admission assessment and gathered information from other professionals. This included an assessment of the level of care required and whether their needs could be met.

When we looked at four care files, we saw that people's nutrition and hydration needs had been assessed. Those needing input from a dietician had been referred. We were assured that the kitchen staff had been alerted to the dietician's recommendations and we saw some information on the kitchen wall which confirmed this in relation to several people. However, we saw that monitoring of food and drink intake was poor for the three people we looked at with needs in this area. Staff were not always completing the forms to the standard required.

We observed that the home was using 'doll therapy' in a considered way to give people a purpose. We noted that the dolls were of high quality, clean and beautifully dressed; one had a European appearance, the other was an African-Caribbean; this represented the diversity of the people who lived in the home. We saw that the two people who were looking after them took real pleasure from the task. Staff had used information gathered about one person's life history when considering whether looking after a doll would be beneficial for them. We also saw that hats, accessories and other props were placed around the home and used to promote activity. Staff told us that they collected these from charity shops when off duty.

We observed that the home was well equipped, for example, pressure care mattresses and a mobile hoist were there for those who needed them. One person told us that their 'grabber' had broken and not been replaced. One person, who used an electric wheelchair, was able to move around the building independently without encountering any obstacles.

There was clear signage in place around the home to help people to recognise where they were, but some signs and notice boards were too high for everyone to be able to read them easily. We saw that some people had tiny display cabinets attached to their bedroom doors. All but one was empty, but we were told that the intention was to fill them with objects that were meaningful to the occupant of the room. This would further help people to identify their bedrooms and feel positive about entering them.

People were all accommodated in large bedrooms with en-suite facilities. There was enough space in the bedrooms to support people who needed physical assistance and room for sitting and visitors. The en-suite facilities were tight for some people with mobility needs. Communal bathrooms were also available for those people who required a bath rather than a shower. There were a number of large lounges, smaller lounges, offices and an activity/meeting room throughout the home. This allowed people a choice about where they wanted to be. It also ensured that staff could hold meetings without encroaching into the space for people who lived in the home.

Call bells were available in each person's bedroom, during our visit staff made regular checks on those people who were unable to use them.

Are services caring?

Our findings

People we spoke with were happy with their care. One person told us, “on the whole they [the staff] are all very good”; and another person said, “it’s all good here.” One relative, described the care as “brilliant” and told us that this was always the case, saying “it doesn’t matter who’s on [shift].” One person who lived in the home said, “they are nice people here, very kind.”

When we looked at four care files they gave us an immediate picture of the person, their background and their current needs. This helped staff get to know people and we saw that they had used this personalised information to understand the behaviour of, at least, one person in order to settle them. In another case a relative told us, ”before [they came here, my relative] was not eating – just waiting to die really. Now [they have] gone up from eight to ten stone. They take the time to get to know what you like and what you don’t like.” We observed that people were routinely offered simple choices, such as a choice between orange juice, blackcurrant or water to drink. We saw the cook consulting with some people about the day’s menu choices.

There was a reference file containing information about supporting people who were lesbian, gay, bisexual or transgender. The registered manager told us that they wanted to be able to support people of all sexual orientations, but older people were not always forthcoming about this area of their life.

We saw staff treating people with dignity and respect. Staff varied their communication style according to the needs of the person and the confidentiality of the conversation. For example, staff moved close to people to hear what they were saying or to speak quietly to them. Although people had a choice about where to take their meals we noted that an effort had been made in one dining area to seat people together who could interact with each other. We saw that this allowed them to communicate with each other and not just with staff.

Staff ensured people’s dignity was maintained as personal care tasks were carried out behind closed doors. We also noted that staff did not constantly encourage people to sit down; they were prepared to accompany them on their walks around the building or, for those who did not need a supporting arm, to let them make their own way. A relative told us, ”nothing is too much trouble, you can’t fault it. It’s just lovely here. Whatever you ask, [the staff] do it.”

The layout of the building ensured that people were able to have as much or as little privacy as they needed. However, one person indicated to us that they needed more help to get to know other people in the home before they felt comfortable coming out of their room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We saw that people had access to a range of activities. The provider had responded to a previous inspection report which identified the need to improve in this area and they had worked hard to increase the variety on offer. The inspection visit coincided with a regular singing, exercise and quiz session run by an external organisation. We observed that they held the full attention of twelve out of fifteen people for at least 40 minutes and repeatedly engaged everyone present on a one to one basis during the main activity.

To sustain the improvement the home had to ensure its staff members were trained and given time to carry out activities. There was some evidence that they were starting to do this, for example, through a hand massage and nail care programme.

One of the care plans we looked at indicated that it was the person's wish to go to bed between 11pm and 1am and that they should be supported to do this. There were plenty of other examples of people being treated as individuals. We noted that many of the rooms had been personalised. We saw that one person had a clean, but cluttered bedroom. This reflected this person's wishes; they told us, "I want all my clothes on my chair." We saw that people had the opportunity to discuss the environment of the home, alongside other issues, during monthly 'Residents Meetings'. Information about advocacy services was displayed on a notice board.

The provider responded to people's need to be escorted to hospital appointments, the local shop and similar, but they did not have sufficient resources to accompany one person out as often as they wished. The provider was addressing this issue with the placing authority.

A relative told us that they felt staff were usually very sensitive to everyone's emotional needs when discussing difficult topics and that staff picked up when they were particularly sad about their parent's deterioration. They also said that on the few occasions they had needed to bring something to the attention of the shift leader or registered manager the matter had been dealt with promptly and politely. Other relatives said the same about the response they received.

Staff had attended palliative care training in order to provide end of life care for people who wished to remain in the home. We saw how one former resident's life had been celebrated in a group session for their friends within the home. Nursing support was provided by other agencies, in the same way it would be if the person was dying in their own home.

Are services well-led?

Our findings

When we spoke with the registered manager they described a positive culture within the home and the staff and relatives we spoke with confirmed this. There were policies and procedures in place for staff and others to raise concerns and the manager had an 'open door' policy.

We noted the involvement of the registered manager and other senior staff in best practice forums. For example, they were planning to attend a conference on dementia research the day following our inspection visit.

Senior staff led by example during our visit and promoted involvement, compassion, dignity, respect, equality and independence. One relative told us that all staff members had a similar approach. There was a very low level of formal complaints made to the home, discussions with relatives indicated that concerns were dealt with before they reached that level.

The home's action plans were 'live' documents which were stored in their database and checked by head office. If the registered manager did not update them by the due date they had to account for this. Development managers visited the home regularly to check on progress with action plans and to carry out audits. We looked at the on-line records and saw confirmation of this. However, we found little evidence of continuous feedback to the staff team to help them to learn from the home's strengths and shortcomings. This meant that staff did not always receive the benefit of all the reporting and recording they were carrying out and, as a result, people living in the home did not immediately benefit either, as practice could not improve in the absence of learning.

Monthly audits were carried out on many aspects of the home. Whilst these were, for the most part, very useful and appropriately identified risks, there was evidence that some issues were being overlooked as they did not feature in an audit. The quality of recording on food and fluid charts was an example of this. We reviewed the monthly medicines audits.The provider may wish to note that an independent pharmacy audit in January 2014 documented Medicines Administration Record chart recording errors which were not picked up by the internal audit system.

We heard from senior management how they discussed the home at a weekly meeting. They reviewed the information on the home's database where safeguarding alerts, complaints, audits and other monitoring information was logged. This meant that there was regular scrutiny of the home's performance by the wider organisation. We saw how the registered manager regularly updated the information and was prompted electronically if matters were not progressed.

The registered manager had some flexibility to bring in extra staff as and when required, so long as they remained within budget. For example, to escort someone to an appointment or to assist with a group activity. The service used its own bank staff for this or its usual staff worked additional hours. Agency staff were not used, this was confirmed by staff members we spoke with.

Staff members described management as 'supportive' to us. The provider had a clear management structure in place and staff we spoke with knew who they had to report to on any shift. We noted that the registered manager did not always work office hours, there was evidence of weekend attendance and overlap with the night shift. The registered manager showed us a weekend audit tool that they used and they told us that they saw the night staff regularly so they could carry out supervision. We saw that regular well-attended team meetings were held.

The home's business continuity plan addressed foreseeable events. The home benefited from the nearby location of another of the provider's homes. This meant that, in the event of an evacuation, there was somewhere warm to go which people could access immediately. The provider's maintenance team and the part-time handyperson on-site ensured a quick response to most requests for repairs and maintenance. The home also had contact details for provider approved electricians and plumbers for out-of-hours emergencies. We inspected the home's fire log and saw that the appropriate checks were being carried out.