

Sanctuary Care Limited

# Garside House Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

About the service: Garside House Nursing Home is a care home that provides accommodation and respite care for up to 40 people on three separate floors, caring respectively for people with general nursing needs, dementia and palliative care needs. At the time of our inspection there were 33 people living at the home.

People's experience of using this service:

- People using the service told us they felt safe and trusted the staff caring for them.
- People's needs were assessed before care and treatment was delivered. Risk assessments and guidance were in place and staff were aware of how risks to people's health and well-being could be minimised.
- Systems were in place to safeguard people from the risk of possible abuse.
- Following a recent safeguarding incident involving the disposal of controlled drugs, medicines policies and procedures had been revisited and staff training refreshed.
- Staff demonstrated some understanding of consent and capacity issues in relation to mental health legislation.
- People were supported to eat and drink enough but meals were not always prepared and served in an appetising way.
- Staff completed an induction period that included shadowing more experienced members of staff before working with people on their own. However, some core staff training had not been refreshed and delivery was currently behind schedule.
- The service was working in partnership with other agencies and healthcare providers. People were supported to access healthcare services as required.

Rating at last inspection: At the last inspection the service was rated Good (12 April 2017). At this inspection the overall rating had deteriorated to Requires Improvement.

Why we inspected: This was a planned inspection based on the previous rating.

We made one recommendation about staff records.

Follow up: We will continue to monitor intelligence we receive about this service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

Details are in our Safe findings below.

Good 

### Is the service effective?

Not all aspects of the service were effective.

Details are in our Effective findings below.

Requires Improvement 

### Is the service caring?

Not all aspects of the service were effective.

Details are in our Caring findings below.

Requires Improvement 

### Is the service responsive?

Not all aspects of the service were effective.

Details are in our Responsive findings below.

Requires Improvement 

### Is the service well-led?

Not all aspects of the service were well-led.

Details are in our Well-led findings below.

Requires Improvement 

# Garside House Nursing Home

## **Detailed findings**

### Background to this inspection

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

Inspection team: This consisted of three adult social care inspectors, a specialist advisor 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.

Service and service type: Garside House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home provides accommodation and respite care for up to 40 people on three separate floors, caring respectively for people with general nursing needs, dementia and palliative care needs. At the time of our inspection there were 33 people living at the home.

The manager had applied to become the registered manager for the service. This means that once they are registered they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection took place on 29 January 2019. The inspection was unannounced.

What we did:

- Before inspection: We looked at information we held about the service, such as notifications of serious incidents that the provider was required to tell us about.

- We discussed the provider and service with local authority quality assurance managers to get their views about how the service was performing.
- We reviewed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.
- We used this information to plan our inspection.

During the inspection:

- We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.
- We spoke with seven people using the service and one relative.
- We spoke with six members of staff which included kitchen staff, care and activities staff and registered nurses. We also spoke with the service manager, a regional quality manager and two healthcare professionals based on site.
- We looked at 12 sets of care records, five staff recruitment and personnel records, a range of policies and procedures and other information relating to the management of the service.

# Is the service safe?

## Our findings

Safe – this means people were protected from abuse and avoidable harm.

Good: We found that people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We asked people if they felt safe and whether they trusted the staff caring for them. People told us, "I don't have much but I feel safe", "I'm safer than I would be in my flat", "When my [relative] gave me a radio, [they] were given a form to fill out so they know what possessions I have" and "I really do [feel safe], this is my home."
- Staff completed safeguarding training and understood their responsibilities in relation to protecting people from harm and/or abuse.
- The provider had a safeguarding log in place which included information about what action had been taken to investigate and deal with any concerns.

Assessing risk, safety monitoring and management

- Risk assessments in relation to people's nutrition and hydration, personal care support needs, level of mobility and risk of falls were completed and reviewed on a regular basis.
- Arrangements were in place to manage known risks by ensuring staff had access to appropriate training and guidance in relation to skin integrity, moving and re-positioning and the use of specialist equipment. Hoists and slings were regularly checked and serviced in line with relevant regulations to ensure they were safe to use.
- A call bell system was in operation throughout the service. People told us, "I have a call bell", "It takes [staff] about five minutes to answer" and "I have a watch because sometimes I can't reach my button" and "Yes, [the call bell] does work."
- Fire safety was considered by the provider. Fire doors were kept closed and emergency exits were well sign posted and clear of obstacles. Fire equipment and fire alarms were regularly tested and personal evacuation plans provided staff and the emergency services with important information about people using the service.

Staffing and recruitment

- At the time of the inspection, there were enough members of staff to support people using the service. However, staff were not always available to spend time with people on an individual basis and a high proportion of people remained alone in their rooms. People's comments included, "Staff work very hard, there could be a few more" and "Sometimes they are short [of staff]." Staff told us they were sometimes stretched particularly during meal times and when delivering personal care requiring two members of staff.
- Staff were recruited following an application and interview process. Criminal record and identity checks were completed. However, we noted some inconsistencies in the information sought by the provider in

relation to references, some of which were unsigned, undated and unverified by headed paper or company stamps.

We recommend that action is taken to ensure that documentation related to all recruitment checks is fully completed and verified.

#### Using medicines safely

- People were receiving the appropriate support to take their medicines as prescribed.
- Medicines were stored appropriately in lockable cupboards and trolleys.
- Medicines administration records (MARs) were completed clearly and legibly with no evident errors or omissions. Two signatures were entered when controlled drugs (CDs) were administered. CDs were counted at every shift by two nurses and stock levels audited on a weekly basis by the deputy manager.
- During our inspection we observed medicines being administered appropriately and in line with the provider's policy and procedures.

#### Preventing and controlling infection

- We observed staff reminding each other to follow correct infection control policies when carrying out tasks.
- Staff had access to personal protective equipment (PPE), such as disposable gloves and aprons and used these when supporting people with personal care or when preparing food.
- Handwashing facilities were available in communal areas although hand gel dispensers near entry and exit points were not always being replenished.
- The premises were clean and tidy and free from malodours.

#### Learning lessons when things go wrong

- The manager kept records of any accidents and incidents that had occurred. These were analysed to identify any themes or trends in order to reduce the risk of repeat incidents.
- A recent medicines error resulting in a safeguarding investigation had prompted a re-evaluation of medicines policies and procedures and staff re-training in the management and safe disposal of CDs.

# Is the service effective?

## Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills, and experience

- The registered provider's training programme included an induction for all new staff, based on the Care Certificate. The Care Certificate is a set of standards that care and support staff adhere to in their daily working life. New staff shadowed more experienced members of staff until they were competent to work alone.
- 80% of staff had completed dementia awareness training. However, some core training that required refreshing was behind schedule. For example, training rates were particularly low in relation to basic life support, fire safety and safeguarding.
- Staff performance was reviewed via a comprehensive supervision and appraisal framework. Staff were positive about the support they received from senior members of staff and the manager. A member of staff told us, "[Supervision] reminds me to continue to do my job with a smile."

Supporting people to eat and drink enough with choice in a balanced diet

- A resident's satisfaction survey completed in November 2018 indicated that over 90% of 13 respondents were happy with the food provided. Daily menus included meat and vegetarian options.
- However, staff were not always promoting choice during meal times and meals were not always prepared and served with thought and consideration. People told us, "The things I used to get, I don't get anymore", "[The food] could be better", "It's not very good, there's only one type of food, I can't have meat and there aren't enough vegetables, I have to go without" and "I'd like more choice."
- Some people had been assessed as having swallowing difficulties and recommendations were in place for various different textured diets (for example; food needing to be cut into small pieces, thick and thin pureed meals and fork-mashable meals). However, despite these specific recommendations, we noted that only one type of pureed meal was being served to people at lunchtime and no attempt had been made to make these meals look attractive or appetising.
- Food and fluid intake was recorded when there was a clinical requirement to do so. However, recording charts we looked at were not always fully completed. This was not being identified through quality monitoring processes.

Adapting service, design, decoration to meet people's needs

- The service was wheelchair accessible and lifts were available to all floors. However, communal areas lacked signage, colour and any distinct decorative features which may have contributed to a homelier

environment and enabled those living with declining cognitive ability to better negotiate their home.

- Communal bathrooms were not conducive to rest and relaxation and there was little evidence that they were in regular use. One person suggested that the design of bathrooms could be improved stating: ...."maybe the bath tub, we can't use them alone." Records showed very few bath temperatures were being recorded and where this information was available some entries dated back to 2017.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to or at the time of their admission to the service and care and support was considered in line with good practice guidance.
- Assessment information was used to create a set of care plans that outlined the care, support and treatment people required.
- People's care needs were reviewed on a regular basis to ensure the service was continuing to provide appropriate care and support. However, reviews were formulaic and did not always support a person-centred approach to care provision.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- We found people's capacity to consent was considered and recorded in their care plan.
- Where people lacked capacity to make decisions about their care, best interests decisions, involving people's relatives, senior staff and health and social care representatives, were applied.
- Where people were deprived of their liberty the provider the manager had submitted DoLS applications where needed and approvals were monitored to ensure any conditions on authorisations were being met.

Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare services including GPs, opticians, dietitians, physiotherapists, podiatrists and other specialist clinicians.
- People told us, "The doctor comes twice a week" and "Yes, the hairdresser, chiropodist and a dentist come" and "My nails get done and my hair was done before Christmas. The optician has been twice." Despite visits from a community dentist, we saw little documented evidence to demonstrate that where required, people were being supported with their daily oral care.
- The manager and staff team demonstrated a good understanding of pressure wound management. Each person using the service underwent a risk assessment for the management of good skin care. Wound

management files contained detailed care plans and we saw that these were regularly reviewed.

- The incidence of pressure wounds acquired within the service was notably low. A healthcare professional on site during our inspection told us, "[Staff] are very good at wound care. Some people are admitted with ungradeable pressure ulcers and have gone home with a package of care." Another healthcare professional told us, "[Person's name] came in with a Grade 4 ulcer, [it's] now Grade 2, [staff] provide proper care."

Staff working with other agencies to provide consistent, effective, timely care

- Staff attended regular multi-disciplinary team meetings to discuss people's health status and consulted healthcare professionals when they felt people's health was deteriorating.
- Visits by healthcare professionals were documented in people's care records and provided details of assessments, action plans and recommended treatment.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

- People told us that they were happy living at the service. Comments included, "[Staff] give their best and they're so lovely", "I love [the staff] genuinely", "People go out of their way for you" and "[Staff] are always polite, I can honestly say that I've never had any problem with them."
- Despite the above comments, people's diversity was not always being considered. One person's care plan stated that they were responsive to music. There was no music playing in their room when we visited. Another person told us they would like to be offered more Caribbean food at meal times. A third person told us that they wanted to see a priest but that no-one had asked them about this.
- Throughout the home various Christian motifs were on display. However, not all people using the service were Christian. Staff told us they were unsure how one person of Muslim faith wished to express their faith from day to day and we saw no information in relation to their end of life wishes in their care records.

Respecting and promoting people's privacy, dignity and independence

- People told us, "[Staff] respect my privacy" and "There's so much mutual respect, you don't feel bad when you have to ask for help."
- Despite the above comments, on three occasions we observed staff entering people's rooms without first seeking permission, announcing themselves or exchanging any words.

Ensuring people are well treated and supported

- People spoke positively about the staff caring for them. Comments included, "[Staff] work very hard" and "[Staff] go beyond the call of duty."
- Despite the comments above, some people were at risk of social isolation. One person told us "No-one comes to sit with me in my room to do something." Another person told us they were bored.
- Interaction between staff and people using the service was polite but limited. One person's care record stated that they would like staff to read to them, chat and listen but there was very little evidence to demonstrate that this was a regular event in their life.

Supporting people to express their views and be involved in making decisions about their care

- People we spoke with told us they felt involved in their care. Comments included, "I have seen my care plan and it's quite okay", "Yes, I interact with staff and I feel quite comfortable to ask questions regarding my

condition", "I give input" and "Someone did bring me a form which mapped out my care plan."

- People using the service were invited to complete an annual satisfaction survey. People who were not able to complete the survey independently were supported to do so by staff. The manager was aware that responses elicited in this manner may not always represent an honest account of people's views of care delivery within the service.

## Is the service responsive?

### Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People were not consistently receiving care that considered and responded to their physical, psychological, emotional and spiritual needs.

#### Personalised care

- People's healthcare needs were assessed before moving into the service by referring health and social care professionals. Initial assessments were used to design a package of care for people and included an overview of people's health conditions, risk assessment and planning along with details of the care to be provided.
- Information on how best to meet people's individual preferences was not always being identified. Personal information in the way of people's life stories was not always sufficiently detailed to provide staff with a good knowledge of the people they were caring for.
- The service employed activity co-ordinators. The manager was aware that people may be at risk of social isolation and had made staff aware that people should be supported to leave their rooms and access communal areas. However, during our inspection, we saw that most people had very little to do and remained alone in their rooms. In communal lounges, people were seated around a television. Staff were seen writing notes in one corner and other members of staff did not approach people to talk to them or check how they were and/or whether they needed anything. Activities were not available at weekends.
- The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Care records noted whether people wore glasses or were visually impaired. A sign in the reception area informed people that information was available in alternative formats upon request.

#### End of life care and support

- The provider worked in collaboration with a local hospice and multi-disciplinary team meetings were held fortnightly to discuss people's care and treatment.
- People's care records included some clinical information in relation to end of life preferences. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed (where appropriate). The purpose of a DNACPR decision is to provide immediate guidance to those present on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.
- However, care records lacked specific details as to how staff could meet people's spiritual, emotional and psychological needs. We saw little evidence that people were being supported to live the final years of their lives according to their personal preferences and wishes and with any sense of comfort or fulfilment.

#### Improving care quality in response to complaints or concerns

- People had access to the complaints procedure. People and their relatives told us they were confident if

they had any complaints the manager would address them appropriately.

- Where complaints had been made, they were responded to in line with the provider's policies.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires improvement: The management team were not always ensuring that a person centred approach to care delivery was consistent and effective.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider's vision of 'keeping kindness at the heart' of the care provided was not always evident on the day of our inspection and the implementation of consistently effective and caring practice had not yet been embedded throughout the service.
- The provider had an improvement plan in place. However, not all of the shortfalls we highlighted during the inspection process were being identified and addressed appropriately and expediently.
- The manager told us about areas of service delivery she wished to develop. This included the delivery of personalised end of life care and the re-implementation of the Gold Standards Framework (GSF). GSF is an evidence based approach to optimising care for people approaching the end of their lives.
- It is a legal requirement that the overall rating from our last inspection is displayed within the service and on the provider's website. We found the provider was meeting the legislation, this meant people, relatives and visitors were kept informed of the rating we had given.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- The service manager had applied to the Care Quality Commission (CQC) to become the registered manager. 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 2008 and associated Regulations about how the service is run.
- The manager was clear about the need to notify CQC of incidents affecting the health, safety and welfare of people using the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others

- Effective communication between the manager and staff team ensured staff felt valued and appreciated. A staff member told us, "The manager is doing well, she listens, she advises."
- Staff attended regular team meetings to discuss their roles and responsibilities, people's welfare and any new initiatives planned by the provider. Dignity, compassion and respect were topics featuring regularly on meeting agendas.

- The service involved people and their relatives and staff in discussions about the care and treatment provided.
- The service worked with the local authority and the local clinical commissioning group (CCG), health care services and community groups such as churches and schools in order to promote people's health and well-being.

#### Continuous learning and improving care

- A member of staff told us, "The manager is willing to get out onto the floor to speak to the residents and facilitate anything. As a manager she is incredibly supportive and always positive about new ideas and ways to improve."
- Regular audits and quality monitoring was taking place. Findings were recorded and included the actions taken to improve service delivery.
- The manager undertook a monthly analysis of incidents to identify trends. Incidents and accidents were recorded and investigated appropriately.
- Policies, procedures and best practice guidelines were available and accessible to staff to support them in their roles.
- Supervision and appraisal sessions provided staff with clear performance and training objectives although some training was behind schedule.