Care Quality Commission

Gateway Housing Association Limited

Pat Shaw House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 25 and 27 August 2015. The first day was unannounced. Last time we inspected this service in December 2014 we found breaches of three regulations relating to repairs and maintenance, medicines management, assessment and care planning. During this visit, we found significant improvements had been made in relation to repairs and maintenance, notably the unreliable lift had been replaced and there were robust arrangements for carrying out health and safety checks and a prompt response to repairs. Medicines were now managed safely, although some minor issues were noted which staff quickly rectified. Sufficient progress had been made with assessment and care planning to ensure the service was no longer in breach of the regulations, but more work was needed in this area.

Pat Shaw House is a care home without nursing which provides accommodation for up to 38 mainly older people across three floors. People who develop nursing needs have them met by the local community nursing teams. Some people who use the service have long-standing mental health needs. The service does not admit people who are living with dementia, but it

Summary of findings

continues to care for them if they develop the condition once they have moved in. Most people live in the service on a long term basis, but at the time of the inspection there were three people staying for a short break/ respite care and there were three vacancies.

The 32 individual bedrooms have en-suite bathrooms and their own kitchenette facilities, although the hot plates are disconnected. There are six larger self-contained flats, with fuller kitchen facilities.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found staff were caring and related well to people who used the service. They helped people to maintain their independence and they were very accepting of their lifestyle choices. Staff had access to appropriate training and received regular supervision from their line managers. Two staff had received extra training in end of life care to ensure the service could offer people appropriate care and support when this need arose.

The environment smelled clean and fresh. The provider carried out checks to ensure they only recruited people who were suitable for the post. Recently appointed care workers all had appropriate qualifications for their role.

Whilst progress had been made in relation to the quality of the service, inconsistencies remained and this is why most areas still require improvement. Information within care plans varied from good to patchy. Appropriate policies were in place within the service, but staff did not always have up-to-date procedures or forms to guide them. The provider's audits did not identify all issues, so small things combined together to have an impact on the quality of care provided. Together, these factors amount to a breach of a regulation of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe in all areas. Whilst we had no major concerns about safety, several small improvements were needed.

The provider was keeping staffing levels under review to ensure people's needs could be met, but the tool they were using to do this did not address people's mental health needs.

People were receiving medicines as prescribed. If an error occurred it was quickly rectified with advice from the GP or pharmacist. Creams and lotions should have been stored in a room where the temperature was monitored.

Staff knew how to identify signs of abuse and how to report it. The unreliable lift had been replaced and people who used the service were no longer smoking in their bedrooms. Night staff had not participated in a recent fire drill.

Is the service effective?

Requires improvement

The service was not effective in relation to eating and drinking. People's dietary needs were not always met.

Appropriate steps had been taken to support people who could no longer make decisions for themselves. Others had the freedom to come and go without restriction.

Staff praised the training they received; they also had monthly supervision sessions with their line manager.

Is the service caring?

Good

The service was caring. Staff spoke to people in a polite and respectful way.

They were very accepting of people's lifestyle choices and we saw most of them could adapt their approach to meet the communication preferences of each individual.

Staff understood why some people displayed behaviour which challenged the service and we found some of them were very skilled at supporting people who were distressed.

Two members of staff had completed Gold Standard Framework end of life care training, so they knew about best practice in this area.

Is the service responsive?

Requires improvement

The service was not responsive in all areas.

Group activities were available most days, but we saw they were subject to interruption. Some people who preferred to stay in their bedrooms needed more time with staff to get their social and emotional needs met.

Summary of findings

The provider had a suitable complaints system and people knew how to use it.

Is the service well-led?

Requires improvement

The service was not well-led in all areas. Policies were well developed, but procedures, audit and other tools needed further work. Whilst assessments and care plans and a system of evaluation and review were in place, the content was not always of a sufficiently high standard.

There were clear lines of accountability within the service and all levels of management were committed to driving up the standard of care.

Regular meetings took place with people who used the service and their relatives, as well as staff meetings. Relevant information and lessons learned were shared.

Pat Shaw House

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 27 August 2015 and the first day of the inspection was unannounced. We arrived at 6.30am on day one; the night staff were on duty.

Two inspectors carried out this inspection. One was present for one day of the inspection, the other was there for both days.

Before the inspection took place we reviewed the information we held on the service. We looked at information supplied by the local authority and the 'enter and view' report prepared by Healthwatch – Tower Hamlets.

We spoke with nine people who used the service, one relative and one healthcare professional who were visiting the service and nine members of staff, including the registered manager. We looked at ten medicines administration records across two floors, we read six care files and three staff recruitment files as well as a range of records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

One person who used the service told us they were pleased they could no longer smoke in their bedroom, "I used to smoke 35 [cigarettes] a day, now I have cut down to eight or ten." We found some people were not feeling as safe as they had before, due to the arrival of a person whose behaviours challenged the service. However, we saw the provider had worked hard with local authority and healthcare colleagues to reduce the impact on others by day two of our inspection. People who used the service were much less disgruntled when we asked them their views for a second time.

Staff were able to explain how they were alert to potential signs of abuse. A team leader described how they would gather information and discuss the matter with the registered manager before making a referral to the local safeguarding team. We saw there had been no safeguarding referrals since our last inspection, but we did not identify any incidents which had been missed, so we had no concerns about this.

There were procedures in place for staff to follow if they had concerns about the care provided.

Information about accidents and incidents was recorded and entered into the provider's database where any trends were analysed. We saw evidence of body maps being routinely used to record any injuries or potential pressure areas.

A fire risk assessment was in place and there was evidence of all routine health and safety checks taking place at the required intervals, including those involving gas, electricity and fire equipment. All the staff we spoke with were able to describe the fire evacuation procedure, but a written fire evacuation procedure was only available in draft form. Fire drills had taken place regularly, although we noted they were always timed for mid-morning. It is good practice to vary the timing of fire drills to ensure, for example, there is a satisfactory response at night as well as during the day. The provider had a business continuity plan in place.

Some risk assessments for individuals required more work. When we looked at the care plan for one person who used a wheelchair without a lap belt or footrests there was no reference to this personal preference by someone who had capacity to make this decision, nor did the associated risk assessment or the subsequent audit pick up on this. There was no evidence the person knew the risks of using their wheelchair this way.

A team leader was able to provide us with a good example of how the service responded when a person with some health issues insisted on going out unescorted. For a period, with the person's consent, staff followed the person at a distance on their trips out in order to assess the risks. The information they gathered was shared with the local authority and a risk management plan was put in place which maintained the person's freedom, but also identified a threshold which would trigger staff intervention.

A new lift had been installed to replace the unreliable one and a stair-lift had been installed as a back up. Smoking was no longer permitted within people's bedrooms. Smokers had been provided with an outside shelter for this purpose with light and heating.

The provider had embarked on a programme of works to improve the environment, such as new extractor fans and boilers. Cosmetic work to communal areas, such as painting and decorating, was due to start now the lift installation was complete. Meanwhile bedrooms were being refurbished as they became vacant. This included improvements to lighting to assist those with visual impairments. The provider was researching the best call bell products with a view to replacing the existing system.

The service smelled fresh and clean. The main kitchen and en-suite shower rooms had recently been deep cleaned. There was a daily cleaning schedule in place and we noted the domestic staff had a good rapport with people who used the service. Personal protective equipment, in the form of disposable gloves and aprons, and liquid soap and hand gel were available to help prevent the spread of infection. We saw staff members using them regularly.

We looked at the recruitment files for recently appointed staff and saw the provider had successfully recruited staff who already had qualifications in health and social care. There was a safer recruitment policy in place and evidence it had been followed.

The provider collected information on dependency levels on a regular basis and used them to check they had

Requires improvement

Is the service safe?

enough staff hours within the service. However, the tool used focused more on the needs of those requiring care on account of their physical health than those with fluctuating mental health conditions.

We found there were sufficient staff to meet people's needs at the time of the inspection, but staff could have spent more time supporting people if some aspects of their work were better organised, for example, handover meetings, key holding arrangements and the location of frequently used items. We also noted how an early morning food delivery impacted on the night staff's provision of care to people on the ground floor. Moving the administrator's office nearer to the front door had reduced the amount of time care staff had to spend answering the front door bell during the day, which was beneficial to people who used the service.

Absence was covered by staff members working additional hours or by a small pool of bank staff. The provider was in the process of looking at ways to expand bank staff, which will be beneficial as we heard it had been a struggle to cover some shifts during the summer holiday period.

Although we found one error which staff quickly rectified, medicines were otherwise obtained, administered, stored and disposed of correctly. All care staff had received medicines training, but only team leaders carried out medicines administration. Staff competency was tested before they administered them alone. There was a written agreement with a local pharmacy which dispensed medicines for people within the home. Staff could access advice and support around medicines management from the pharmacy.

The temperature of rooms where creams and lotions were stored needed to be checked routinely as many of the labels showed they should not be stored above 25 degrees Celsius. We were assured this would be implemented. The registered manager carried out a regular audit of medicines administration. We found the issues identified had been addressed, with the exception of obtaining up-to-date photographs of some people; these were helpful if new staff were administering medicines.

We recommend the provider seeks advice and guidance from a reputable source to keep their staffing levels under review, as some people within the service have fluctuating mental health needs.

Requires improvement

Is the service effective?

Our findings

One person said, "I don't feel caged up here like I did [where I lived before]." Another said, "I can come and go as I want as long as I tell staff in case the fire alarm goes off."

There was a choice of food, snacks and drinks available. Menus for each meal were posted on each dining table. We saw people being asked their meal preferences for the next day. The care worker did not have information about people's nutritional needs to hand to guide people towards appropriate choices. Someone with diabetes took advantage of the care worker's ignorance of their condition and made some unwise choices. We saw people's wishes were accommodated even if they changed their minds at the last minute.

On the first day of inspection oxtail was on the menu. Although well cooked, this was a very bony dish and, unless removed from the bone, difficult for many of the people to eat. Two people complained and staff removed it from the bone or offered them an alternative.

Some people who used the service brought food from outside and a microwave was available to heat it up. Although there were set mealtimes, we saw evidence of food being kept aside for those who wanted to eat later.

The provider informed us that a comprehensive survey of people's food and drinks preferences was carried out in June 2015 and was used for the development of new menus that offer a choice at each meal time.

Mealtime menus were displayed on the dining tables. People's dietary needs were displayed in the kitchen, for example cultural preferences, soft diet, any allergies and specific diets to meet the needs of people with a medical condition and/ or prescribed medicines that impacted upon their diet.

New staff completed mandatory training before they started to support people who used the service. One care worker described how, at first, they were allocated a "buddy" on each shift "to show me the ropes", even though they were already an experienced care worker. This demonstrated the provider had a robust induction programme.

Staff described the mandatory and other training courses arranged by the provider as "excellent". We saw records which showed staff members were up to date with mandatory training and refreshers. We heard about a course on dementia some staff members were about to commence which included some practical sessions looking at how learning could be applied within the service. Previously we had reported staff needed more help to apply theory to practice, so this was a useful development.

In order to ensure there were always appropriately trained staff available, the provider trained staff to carry out certain tasks, even when this was not a regular part of their role, for example, fire marshal training was incorporated into everyone's fire safety training. Normally this was the team leader's responsibility, but if they were out of the building, other trained staff were available who could step up into the role.

The provider required all staff to receive a monthly supervision session. Records showed this was being achieved. Appraisal forms had just been circulated to all staff members so they could think about their strengths and needs before their first appraisal under this provider.

We had evidence the registered manager took steps to seek out the latest best practice guidance as she had, on occasion, rung CQC for signposting towards it. The housekeeper had also obtained recently published information on infection prevention and control.

We looked at records in relation to the Mental Capacity Act 2005 and found the provider made applications for Deprivation of Liberty Safeguards (DoLS) whenever they thought a person lacked capacity to make their own decisions and there was a risk of unlawful restriction. Nine DoLS applications had been approved, some with conditions. It was impossible for us to assess if the conditions were being met in many cases as the wording used by the supervisory body was vague, for example, "If possible, try to take [the person] out more."

Although staff had a broad understanding of the Mental Capacity Act 2005, there was still some work to be done to ensure all staff knew who could sign what for whom. However, all staff were very conscious of the need to balance people's safety and freedom; they kept restrictions to people's liberty to a minimum. Two people who used the service told us they appreciated the freedom they had to come and go as they wished.

People who used the service were mainly registered with one local GP practice and both the registered manager and a community nurse spoke about positive working

Requires improvement

Is the service effective?

relationships. The community nurse described communication as “excellent” and said the registered manager was “responsive”. In particular, there was good coordination in respect of people who were using the service for respite care.

A GP attended the service each week to see people with non-urgent needs. Urgent appointments were requested when required. We observed some excellent joint work between the service, a GP and community nurses to sort out complex treatment for someone who was staying with the service on a respite basis. On day one of the inspection the person was distressed and agitated, when we returned they were feeling much better.

We recommend the provider seeks advice from a reputable source to ensure menu items do not present a risk to people with poor teeth or sight and alternative desserts are always available for and offered to those with diabetes; also to ensure all staff are well informed about suitable foods for people with diabetes and other conditions which impact on food choice.

Good

Is the service caring?

Our findings

A person using the service told us, “The staff are kind and always seem to be in a good mood.” Another person said, “There are no bad staff.” A relative told us, “Staff are very kind and speak nicely to my relative.” A care worker told us how visitors could come at any time, “There cannot be set visiting times, this is people’s home.” A person who used the service said, “My visitors … are made welcome.” When we asked one member of staff what they considered to be the best thing about working at Pat Shaw House they said, “The service users; it is all about them.”

Staff were very accepting of people’s lifestyle choices. There was no insistence on everyone fitting in with the routine or abandoning old habits. Throughout the course of our inspection we observed staff speaking to and treating people in a respectful and dignified manner. They did not rush people and gave encouragement whilst supporting them. A care worker told us an important part of their job was “to listen and give comfort, for example, if [a person’s] friend has died”. Care staff spoke kindly and politely to people, even when confronted by behaviour which challenged the service. We saw most staff were able to adapt their approach for each person who used the service, for example, they had a laugh and a joke with those who enjoyed it, yet they spoke softly and gently to others. We saw evidence management was working to address staff attitude issues which had been identified in a very small minority.

We observed a member of staff quietly negotiating with a person about their personal care. The staff member demonstrated tact and persistence. The person was reluctant to engage, so the staff member tried again later and succeeded in persuading the person to shower and change their clothes. Other staff assisted by acknowledging the person’s transformation after the shower; we saw the compliments went down well with the person concerned.

We saw other instances where staff celebrated people’s small achievements, as word spread of them we saw all staff went out of their way to offer congratulations.

A team leader demonstrated sophisticated understanding of the reasons a person had displayed behaviour which challenged the service and spoke with empathy about how the person was feeling. They were able to describe the stresses upon the individual and why they might be reacting in this way. They had prioritised sorting out the physical pain the person was experiencing and were now exploring other factors in conjunction with healthcare professionals. We saw a note to the staff team from relatives of another person who wrote, “Thank you for looking after [our family member]. We know [they] were not very nice at times, but you still cared.”

Staff were aware of the importance of people’s social and emotional well-being, but practical tasks still took precedence for some staff. For example, one member of staff prioritised a routine task over sitting down to talk with someone when they disclosed they were feeling “low”. However, the registered manager personally demonstrated excellent practice in this area. We saw her actively assisting a person to manage their feelings.

Dignity and privacy were maintained whist personal care was provided. Staff told us doors and curtains were always closed prior to providing people with personal care and we saw this was the case during the inspection. Information about local advocacy services was available on noticeboards.

The registered manager and a team leader had recently completed Gold Standard Framework training in end of life care. We saw an email from a member of hospice staff praising them for their “compassion and resourcefulness”. This training would enable them to lead other staff members to deliver end of life care in line with best practice when required.

Requires improvement

Is the service responsive?

Our findings

People told us they were happy with the care they received. One person told us, "Staff are very willing to help me when I need it." Another told us, "I am having breakfast in bed this morning because I had a bad night and staff suggested I rest." A care worker told us, "People get up when they want. They let us know the night before, or ring their bell to let us know." When we arrived at 6.30am we found all the early-risers were people who were keen to get up.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People's care records showed that before they moved into the home their needs were assessed through a pre-assessment and admissions process. We saw copies of these assessments in all of the care files we looked at. A care worker told us, "The manager or a senior care worker do the assessments in people's own homes or in hospital." We found information varied in quality, for example, whilst one assessment was clear and thorough, in another the 'pre-admission routines and preferences' was left blank, despite the fact this information would help to replicate what the person was used to doing when in their own home.

Care plans provided care staff with guidance about meeting people's needs. We saw social and emotional needs were now covered. The care plans were evaluated each month and a care worker told us, "If there is anything of concern we will contact the GP, district nurse or social worker, depending on what the problem is." There was no evidence people were formally involved in reviews of their own care, although staff applied the knowledge they had of people's habits and preferences when reviewing care plans.

Some group activities were provided at the home. A care worker told us how 'petting animals' had been brought into the service in the week before our inspection. During the morning, we saw a member of staff engaging five people in a shape building exercise. There was good interaction and people were stimulated into conversation and laughter. However, the person leading the activity was called away and they left without any explanation to the group. The group expressed confusion as the activity came to an abrupt halt. The inspector enquired about the matter and another care worker sat with the group, but they too had to leave suddenly to attend to another person. By the time the original staff member returned, there was no time to re-engage with the activity as it was time to set the tables for lunch. During the afternoon, a singing session took place in the lounge. However, one person complained that "They brought me down so late that I only got the tail end of the session, three songs."

There was, however, an improvement in the way staff were engaging with people when carrying out routine tasks. Compared to our last inspection visit most staff were chatting more with people and providing explanations for what they were about to do. A relative suggested even more of this was needed, "I wish staff would spend more time chatting with [my relative]." This particular person spent a lot of time in their own room out of choice, so staff had to come into their room to engage with them.

We observed there was a risk people who stayed in their bedrooms missed out on friendly interaction with staff; whilst some staff went out of their way to ensure they were not left out, there was no system to ensure those who did not participate in group activities received regular one-to-one time when less outgoing staff were on duty. Two people told us they missed certain staff members when they were off duty as others only came into their bedrooms to speak to them when carrying out personal care.

We observed two separate handover meetings between shifts and they were not as well organised as they could be; although relevant information was passed on verbally, time was taken up reporting less relevant information. For example, instead of just reporting who had not consumed enough fluids, staff went through everyone who had had a mid-morning cup of tea. Everyone contributed without reference to notes, but when we checked we saw the main issues from each shift were listed in the team leaders' communication book. Care workers relied on the verbal handover as we saw they did not have time to read the daily log for each person before they started assisting people. Even if they did have time to read them, we found the level of recording was variable in quality and, sometimes, illegible. Poor recording hampers good communication and has the potential to impact on the quality of the service people received.

The provider had a system to record concerns and complaints which identified any trends. Complaints leaflets were widely available within the service and people told us they knew how to complain. The service benefited from having a number of people who were very able to put their

Requires improvement

Is the service responsive?

views across. When they told us they had concerns in some areas, we saw they had already mentioned them to the provider who had started investigations. There was evidence of earlier unrelated complaints by other people being followed up and concluded satisfactorily.

Requires improvement

Is the service well-led?

Our findings

The provider's policies were clear and reflected person-centred care, but associated procedures tended to be absent or under-developed, so staff did what they had always done. The screening forms in use did not prompt best practice so staff relied on their own skills and knowledge to decide when to escalate matters. Therefore there was a risk of a variable response to issues.

A member of care staff told us, "We spend too much time recording; systems need to be streamlined." This was illustrated by the provider's 'behaviour mapping' form. It did not aid analysis of behaviour, it required staff to duplicate what they had already written in incident reports and daily records. Other forms also needed to be reviewed, such as the one used to assess pressure ulcer risk; it did not indicate when to make a referral to a healthcare professional or take other preventative action, it only contained the phrase 'the lower the score the greater the potential to develop a pressure sore'.

The provider conducted a range of audits to check the quality of care. We found auditors tended to focus on whether or not appropriate documents were in place rather than the quality of the information they provided; this was a particular feature of the care plan audit. For example, in one care file there was brief information on the 'This is me' form and the person was known to have or have had a spouse and a sibling, but their names were not recorded. Such information could help to stimulate conversations and could also be important during end of life care. The care plan audit noted this section as complete, but made no reference to the fact that the information was inadequate. Some information may be hard to collect on admission, but there was no evidence of further enquiries being made.

We also found several versions of the same documents within the service, for example, different lists of people in residence were on display. Staff who spent time in the office instinctively knew which was the current list, but often they were undated so it was hard for other staff to know which was the most up-to-date version.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A care worker told us, "The manager is always there for us; you can take absolutely anything to her." We found the senior management team to be committed to driving up standards for the benefit of the people who used the service. The registered manager had stayed with the service when the provider changed and provided consistency for staff and people who used the service.

Staff members were well-informed about their own and others' responsibilities, for example, they knew who was responsible for each aspect of the fire evacuation plan, even though it was not written down. They also demonstrated they knew when to refer issues to line management, for example, safeguarding matters.

Strong links were in place with local authority personnel and healthcare providers which benefitted people who used the service, as evidenced by email correspondence and information in care files.

We saw minutes from regular meetings with staff, people who used the service and relatives. There was evidence of information being shared appropriately and learning from accidents and incidents. The provider displayed their last inspection rating in the entrance hall, alongside information about how they were seeking to improve the service.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively in order to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17(2)(a)