Viridian Housing

Martin House

Inspection report

1 Swift Road
Southall
Middlesex
UB2 4RP

Tel: 02032020425
Website: www.viridianhousing.org.uk

Date of inspection visit:
25 May 2016
02 June 2016

Date of publication:
07 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 May and 02 June 2016. The visit on 25 May was unannounced and we told the provider we would return on 02 June to complete the inspection. The last inspection of the service took place in December 2013 when we found it was meeting all of the standards we inspected.

Martin House is a care home providing residential and nursing care for up to 75 older people, some living with the experience of dementia. When we inspected, 67 people were using the service.

The service had a registered manager. 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 one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service may have been at risk of unsafe or inappropriate care as the provider did not follow their recruitment procedures and failed to obtain references for all new staff before they started to work in the service.

You can see what action we told the provider to take at the back of the full version of the report.

The provider had procedures to safeguard people using the service and staff knew how to use these.

People received the medicines they needed safely.

The provider made sure staff received the training and support they needed to work with people using the service.

People told us they enjoyed the food and drinks provided in the service.

The provider arranged for and supported people to access the healthcare services they needed.

The provider made sure staff received the training and support they needed to work with people using the service.

Staff told us they enjoyed working in the service and would be happy if a relative or friend lived there.

People using the service told us they felt staff treated them well.

Staff interacted with people in a caring and friendly way and explained the care or support they gave people to make sure they understood what was happening.

Each person using the service had a care plan that included an assessment of their health and social care needs.

The provider organised a range of individual and group activities that people enjoyed.

The provider had a policy and procedures for people using the service and others about how to make a complaint.

People using the service, their relatives and care workers told us they felt able to approach the management team and felt valued by them.

Throughout the inspection, the atmosphere in the home was open, welcoming and inclusive.

The provider had systems to monitor the quality of the service that people received and to make improvements.

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

Not all aspects of the service were safe.

The provider did not obtain references for all new staff before they started to work in the service.

The provider had procedures to safeguard people using the service and staff knew how to use these.

People received the medicines they needed safely.

Is the service effective?

Good

The service was effective.

The provider made sure staff received the training and support they needed to work with people using the service.

People told us they enjoyed the food and drinks provided in the service.

The provider arranged for and supported people to access the healthcare services they needed.

Is the service caring?

Good

The service was caring.

Staff told us they enjoyed working in the service and would be happy if a relative or friend lived there.

People using the service told us they felt staff treated them well.

Staff interacted with people in a caring and friendly way and explained the care or support they gave people to make sure they understood what was happening.

Is the service responsive?

Good

The service was responsive.

Each person using the service had a care plan that included an

assessment of their health and social care needs.

The provider organised a range of individual and group activities that people enjoyed.

The provider had a policy and procedures for people using the service and others about how to make a complaint.

Is the service well-led?

Good

The service was well led.

People using the service, their relatives and care workers told us they felt able to approach the management team and felt valued by them.

Throughout the inspection, the atmosphere in the home was open, welcoming and inclusive.

The provider had systems to monitor the quality of the service that people received and to make improvements.

Martin 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.

This inspection took place on 25 May and 02 June 2016. The visit on 25 May was unannounced and we told the provider we would return on 02 June to complete the inspection.

The inspection team on 25 May consisted of two inspectors, a Specialist Professional 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. The Specialist Professional Advisor for this inspection was a qualified nurse and the Expert by Experience had experience of caring for older relatives.

Before this inspection we reviewed the information we held about the provider and the service. This included the last inspection report and notifications of significant incidents the provider sent us. Before the inspection, the provider also completed 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. We also contacted the local authority's safeguarding adults and contract monitoring teams for their views on the service.

During the inspection we spoke with 23 people using the service and two relatives and visitors. We also spoke with the registered manager, the Head of Care, nurses and care staff. We also reviewed care records for 10 people, 10 staff records, medicines management records for 28 people and other records relating to the running of the service. These included audits and checks completed by the provider and registered manager, complaints, accident and incident records. At lunchtime 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 with us.

Following the inspection we spoke with the relatives of four people using the service and contacted the provider's Care Training and Quality Assurance Manager.

Requires Improvement

Is the service safe?

Our findings

The provider had systems for recruiting staff to make sure they were suitable to work with people. For example, the provider's recruitment policy required references from previous employers, a Disclosure and Barring Service (DBS) criminal records check and checks on the staff member's identity and their eligibility to work in the United Kingdom. However, we looked at a sample of staff recruitment files and saw that some included no references and others only had one reference. We discussed this with the registered manager who obtained some references to cover the shortfalls we identified. However, there were still gaps which meant that the provider had not always obtained two written references before a person started work at the service. This contravened the provider's own policy on recruiting new staff which the registered manager told us was that two written references were required before staff started work. We discussed this with the registered manager who accepted our findings.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they were cared for safely in the service. Their comments included, "Yes, of course I feel safe here," "It's a very safe place to live, the staff look after me" and "I've never had any worries about my safety."

People's relatives also said people were safe in the service. Their comments included, "I have no concerns, my [relative] is very safe there" and "Absolutely no concerns about safety, it's the safest place my [relative] could be."

The provider had a policy and procedures for safeguarding people using the service and these included the local authority's procedures. Nurses and care staff were familiar with the procedures and were able to tell us what they would do if they had any concerns about someone's safety or wellbeing. The staff had received training in safeguarding adults and they said this was updated regularly.

When we asked staff what they would do if they had concerns about a person being abused, one member of staff told us, "I would make sure the person is safe. Reassure them. Talk to the nurse in charge and tell her what I have witnessed. Record it on an incident form. The matter would go to the management and they would have meetings. Don't mention it to anyone." A second member of staff said, "If you see physical abuse, you should report it to the nurse in charge. She will take further steps. You should also record and document all of it. I had whistle-blowing training in a previous job. It's where you make a complaint. If no action is taken by the manager, you should inform CQC." A third member of staff told us, "If abuse is happening, it is everybody's duty to safeguard the person. I would talk with the person and find out some details then report it to the home manager. I would not tell anyone else but I would make staff aware that they need to protect the person."

The registered manager took appropriate action to alert the local safeguarding authority and the Care Quality Commission of safeguarding concerns. They worked with other agencies to investigate concerns and

took action to put things right when people's safety had been compromised.

The provider had assessed risks to people's safety. For example, people's care plans included assessments of risks related to moving around the home, falls, nutrition and skin care. The staff had recorded detailed observations in each assessment and had updated these monthly. There were plans to minimise the risks and information for the staff about how to keep people safe in different situations. For example, to ensure the safety of a person who was at high risk of falling, the risk management plan instructed staff "to ensure that I'm in the middle of the bed this is to prevent me falling. Staff to check me regularly precisely every hour."

The risk management plans were very specific to the needs of each person and the documentation was clear and evidence based. Staff demonstrated a good understanding of their work and they had adequate knowledge regarding various precautions to take in order to ensure people were kept safe and received the care they needed. For example, they told us about infection control measures, including the use of personal protective equipment, hand hygiene, disposal of waste and care of infected items. Call bells were placed at where people could reach them if needed. We saw one person had their call bell attached to the top of a sleeve. They told us they liked it there because it was easy to reach whenever they were sitting in their wheel chair.

Staff carried out and recorded regular checks of equipment used in the service. For example, there was a record of daily checks of bedside rails, nurse call bells and mattresses.

Staff supported people to take their medicines in a safe way and as prescribed. Nurses followed the provider's procedures, administered medicines safely and ensured people gave their consent and were comfortable. Medicines were stored appropriately and securely. There was additional storage for controlled drugs and the information relating to these was correct. Medicine administration records were up to date, accurate and included the required information. Where staff gave people medicines prescribed as 'when required,' they kept an accurate record of the dose and the reason they administered the medicine. The provider carried out and recorded a monthly audit of the storage and administration of people's medicines. We saw the service's head of care had carried out the audits in April and May 2016 for each unit.

The provider ensured the environment was clean and safely maintained. Staff made sure corridors, communal areas and bedrooms were free from obstructions so that people could move safely around the service. Nurses and care staff wore appropriate protective equipment, such as gloves and aprons when they supported people and they disposed of these immediately after use. Domestic staff attended to spillages and unexpected cleaning duties as well as following a set cleaning schedule. We noted a malodour in one area of the service. We discussed this with the nurse in charge who arranged for domestic staff to clean the area. When we returned at the end of the day, there was no malodour.

The registered manager, head of care, nurses and care staff carried out checks and audits to ensure they delivered care and treatment safely. For example, they completed a weekly audit of the condition of people's skin and made referrals to the GP, district nurses, tissue viability nurses (TVN) and dietician, if required. Staff assessed and managed plans for wound care and care plans for pressure ulcer prevention and wound management were in place with full input from the TVN. We found wound care intervention was effective. For example we saw a leg ulcer wound which was well dressed and the person confirmed that it was well taken care of. A risk assessment was in place, a wound assessment chart was completed by nurses and they also completed dressing evaluation forms. The person's care records included a body map and wound photograph. The repositioning chart and skin care plan were up to date for people who were bed/chair bound. The service provided the necessary equipment for people, for example, pressure relieving

mattresses.

They also carried out a monthly health and safety audit around the service that covered fire safety, the premises and the kitchen and we saw they had completed reports on these checks in April and May 2016. The provider had fitted all windows in the service with opening restrictors in May 2016 to reduce the risk of accidents or intruders and the registered manager told us these would be added to the monthly health and safety checklist.

The provider had a recorded fire risk assessment and plans for evacuation in event of a fire. Each person using the service had a Personal Emergency Evacuation Plan (PEEP) that detailed the support they needed in the event of an emergency. There were regular recorded checks on the fire safety system and equipment. The staff had been trained in fire safety and took part in drills which the provider recorded.

There was evidence of regular checks on the environment, equipment, electrical safety and water temperatures. There was information to show that action had been taken to address any faults and repairs. There was also a record of regular cleaning and monitoring of infection control measures that had taken place.

Good

Is the service effective?

Our findings

People using the service and their relatives told us staff were well-trained to meet people's care needs. One person told us, "The staff and carers are stunning, they know their job and do it properly." A second person said, "The staff are very well trained, the nurses and carers do their job very well." A third person said, "They are brilliant, they are always there for me." Comments from people's relatives included, "It's a good home. People are very well cared for," My [relative] is very happy, it's a good home" and "It's going very well, my [relative] is very well looked after."

The provider made sure staff received the training and support they needed to work with people using the service. The service's training records showed not all staff were up to date with training the provider considered mandatory. This included refresher training for manual handling and infection control. We contacted the provider's Care Training Manager who told us they had arranged dates in June and July 2016 to ensure all staff were up to date with their mandatory training. They told us, "We wish to ensure that all staff should undergo refresher training annually. To support this we have recently trained 5 staff at Martin House to be Manual Handling Trainers and there is another course to expand trainer capacity booked for 11th to 15th July which Martin House has been allocated 3 places. This initiative has allowed Martin House to deliver training in house and the next training is booked in the training calendar for Friday 10th June. We also insist that all staff must undergo Manual Handling training before they are allowed to undertake people handling."

The Care Certificate is a set of standards for social care and health workers. It is the new minimum standard that should be covered as part of induction training of new care workers. The provider told us they were introducing Care Certificate training to ensure all staff received the training they needed to work with people using the service.

Staff told us they felt well trained to do their jobs. One member of staff said, "I have the training I need to work with the people living here." A second staff member told us, "The training is very good."

Whilst the provider had consistently carried out appraisals of staff, including one in April 2016, regular supervision often did not take place. We found issues with the regularity of 1:1 supervision for eight of the 10 staff whose files we looked at. We asked the registered manager about this and she said the provider had a policy of providing eight 1:1, group and as required supervisions per year. We did not see evidence of such a range of supervisions taking place for the eight staff who had not received regular 1:1, or any other form of regular supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that they were. The registered manager had a good understanding of the MCA and DoLS and ensured they applied to the local authority or the Court of Protection if necessary. Where people could not leave the home without support, we found that DoLS were in place, their care records contained information around mental capacity and clearly outlined where a decision had been made in their best interests.

Staff told us they had completed training on the MCA and DoLS and most had some understanding of the principles and the provider's procedures. One member of staff told us, "I have had MCA training. We must assume a person has mental capacity and not make decisions for people. People can make unwise decisions. There should be a professional assessment of capacity. If people don't have capacity then we must act in their best interests." The same member of staff said, "DoLS is where a person's rights have been taken away, for example with a bed-rail. People are not given choices. But you can't just take control of people – that's why there are safeguards against this. You have to record any issues and discuss with management." A second member of staff told us, "I have done MCA training and DoLS training in the past. We need to find out people's capacity to make decisions. If they can't, we must liaise with their next-of-kin or [the person with] Power Of Attorney. If they have no family, we must involve a social worker. We can't take people's liberty away, but if we need to, for example placing them in a dementia unit because of their lack of capacity. But people with dementia can sometimes have capacity too. People could be deprived from having access to their money because they could misuse it."

People told us they enjoyed the food and drinks provided in the service. Their comments included, "There is a choice but I eat what's given to me, it's tasty," "Mealtimes are fab" and "I enjoy the meals, I get waited on and if I don't like the meal choices, they make me a sandwich." Staff told us, "We liaise with the SALT (Speech and Language Therapist) if needed. On nursing we have a care plan for eating and drinking and a nutritional risk assessment. We give a balanced diet and offer lots of fruit and water. We record anything of concern on food and fluid charts. It's the same with a person who is end-of-life care, including what is refused" and "If a person refuses a meal, we try to encourage them. We try to encourage people to eat by getting them involved in a cooking activity. We respect choices, even where these impact on people's health. But it needs to be documented. We take monthly weights for everybody and any concerns are discussed – swallowing difficulties with the SALT or general concerns with the GP. We give people smoothies and extra cream in their diet."

Some people were on various special diets, for example, a soft diet, a diabetic diet and texture modification of food. There was up to date and clear information and recommendations from the dietician and recommendations from the SALT were placed in the person's bedroom.

On a nursing unit for people living with dementia, we found one person was seen by the dietician due to weight loss. The dietician recommended a fortified diet but this was not incorporated into the person's care plan. The dietician also recommended two milkshakes per day but staff were not aware of this and it had not been implemented. We discussed this with the registered manager and the head of care and they ensured nurses updated the person's care plan to include the dietician's recommendations by the end of the first day of our inspection.

At lunchtime we saw staff gave people time to make decisions about what they wanted to eat and drink. Where people needed help with eating their meal, staff did this in a patient and caring way, ensuring they had conversations with people while they supported them. The atmosphere in the dining room was relaxed,

people enjoyed the food they chose and spent time talking with staff and other people while they waited for and ate their meal.

The provider arranged for and supported people to access the healthcare services they needed. People's care plans included details of their health care needs and details of how staff met these in the service. We saw staff supported people to attend appointments with their GP, dentist, chiropodist and hospital appointments. People's comments included, "The GP comes every week, they are very good," "The staff are very good, when I was unwell they called the GP and the optician comes every year" and "I am well looked after when I'm unwell. The staff would fall over their feet to help."

We recommend that the registered manager ensures all treatment plans and advice from health care professionals are incorporated into people's care plans.

We recommend that the provider ensures staff receive support through regular, formal supervision.

Good

Is the service caring?

Our findings

People using the service told us they felt staff treated them well. Their comments included, "Everybody here is nice, you help them and they help you," "The staff here are amazing," "The staff are brilliant, they are always there for me" and "The staff are lovely, they look after me very well." Other people told us, "The care is wonderful, all of the nurses are lovely" and "I'm very happy here, it is a good home."

Comments from people's relatives included, "They do an amazing job, all of the staff treat people like their own family" and "The staff are very attentive, they communicate well and always let me know if there is any change."

Staff told us they enjoyed working in the service and would be happy if a relative or friend lived there. Their comments included, "We should treat people as individuals by providing person-centred care. We do this by having individualised care plans and following these," "Care plans cover diversity, religion and culture, for example religious festivals. We should take account of a person's culture at all times" and "We treat people as individuals because every person has their own needs. We respect wishes at all times. We offer choice of mealtimes – everybody has a right to this. We only do things according to people's wishes." "I am totally happy with the standard of care in this home. I would be happy to have a relative in this home. We try to provide a home from home – we hope people feel they are at home."

Staff interacted with people in a caring and friendly way and explained the care or support they gave people to make sure they understood what was happening. We saw staff supporting people gently and patiently. They listened to people and always treated them with respect. For example, at lunchtime, one person chose not to sit at the dining table with other people. Staff respected the person's choice and ensured they served their meal to them while they sat in an armchair.

Staff also supported people using the service to choose where to spend their time. We saw there was a daily programme of activities provided and some people chose to take part. Other people spent time in their rooms when they wanted privacy and spent time in the lounges when they wanted to be with other people. We saw that staff encouraged people to take part in activities but, where people chose not to take part, staff respected their choices. For example, we saw staff offered people the opportunity to take part in a cookery session and supported those people who chose to take part.

Care records showed staff asked people about their preferences and routines. For example, records showed at what time people preferred to go to bed and get up in the morning, whether they preferred their bedroom door open or closed at night and their preference for the gender of staff that supported them with their personal care. Nurses and care staff were able to tell us about the care needs of individual people using the service, their preferences and daily routines.

Good

Is the service responsive?

Our findings

Where possible, people using the service and/or their relatives were involved in the development of their care plan and other records relating to the person's life. Comments from people's relatives included, "I'm always consulted if my [relative's] care plan needs to change" and "My [relative's] care plan is reviewed regularly and I'm always involved."

Each person had a care plan that included an assessment of their health and social care needs. Assessments covered people's medical needs, mobility, personal care, communication, mental health, continence and skin integrity.

People's care plans included person centred details with information on routines and preferences for example, the person's food likes and dislikes, their usual time of going to bed/waking up, social interests and other activities they enjoyed. Examples of recorded preferences included, "I do prefer female staff assistance," "I would like to eat both Asian and English food," "Night care – staff to offer me a drink whenever I am awake," "I like my tea with not too much milk," "I like eating curries" and "I prefer to keep my bedroom door closed, I do not like noise, I like my own company, I like reading, so staff to provide me with the newspaper."

Staff were able to tell us about people's individual needs and they were familiar with the different characteristics, routines and preferences of people using the service.

The daily care records nursing staff completed included information about people's health care needs, personal care and nutrition and showed that care was delivered in line with people's preferences and care plan.

The provider had appointed an activities coordinator who told us they worked with individual people using the service and also with small groups, with support from the care staff. We looked at the record of activities provided in the service during May 2016. These included reminiscence sessions, board games, floor games, quizzes, exercises, manicures, cookery and sports activities. The provider also arranged visits to the home by music groups, including a group from the local Sikh temple. A hairdresser and podiatrist also visited the home regularly and people were able to book appointments. A relative commented, "I visit regularly and whenever I visit they are doing activities, I always feel like I'm interrupting!"

The activities coordinator had a monthly activities timetable but they told us this was a general guide and activities were flexible according to who was present, people's wishes on the day and the weather. We also saw that the provider organised trips to local places of interest. For example at a meeting for people using the service in May 2016, staff agreed to organise trips to the local Sikh temple and a garden party. They also planned trips to local parks and intended to organise two trips each month outside the service during the summer months.

The provider had a policy and procedures for people using the service and others about how to make a

complaint, along with relevant time lines for responding to complaints. The provider had reviewed and updated the policy in February 2016. We saw the provider displayed the complaints procedure around the home and copies of leaflets were available on each unit to enable people to make a comment or complaint about the service. A person using the service told us, "I'm not sure there's anything to complain about, it all runs pretty smoothly." People's relatives commented, "I'd speak to the manager if I had any complaints" and "The manager is very approachable, I'd speak to her directly if I had any concerns or complaints."

Staff told us they were aware of the provider's procedures and would support people to make a complaint, if necessary. Their comments included, "Viridian has a very good complaints procedure. People and relatives can put their complaints in the box, they can phone or complain on-line. I would liaise with the manager if I got a complaint" and "Complaints are a pathway to improving on our mistakes."

Good

Is the service well-led?

Our findings

There was an open culture at the service. People using the service, their relatives and care workers told us they felt able to approach the management team and felt valued by them. One person told us, "I'm very happy here, the staff and manager are very good, they really care about people." A second person said, "The manager is always around and I can talk to her if I need to." Staff comments included, "The manager is lovely. She is very, very supportive of staff and very supportive of residents. She visits each unit every day" and "The manager is very friendly. We can tell her everything. She is our role model. She deals with everything. The senior staff are also very helpful."

People's relatives commented, "I'm very happy with the carers and I can talk to [registered manager's name] if I need to, she's very approachable" and "The place is obviously well run. They don't know when I'm visiting and everything is always fine whenever I'm there."

Throughout the inspection, the atmosphere in the home was open, welcoming and inclusive. Managers, nurses and care staff spoke to people in a kind and friendly way and we saw many positive interactions between staff and people who used the service.

The provider had appointed a qualified nurse to manage the home and they registered with the Care Quality Commission (CQC) in November 2012. The registered manager and head of care engaged positively with our inspection visit. They told us they were able to keep up with developments in practice through attending local authority meetings for social care providers and attendance at training events.

The provider had systems to monitor quality in the service and to make improvements. For example, they held regular meetings with people using the service and their relatives and the registered manager had a monthly drop in session when anyone could discuss issues about the service. We saw that the registered manager organised meetings for people using the service in February and May 2016, for relatives in June 2015 and January 2016, for nurses and senior care staff in February 2016 and for the whole staff team in March 2016.

The provider and registered manager were active in seeking feedback from people with regard to their experiences of the service and used this to drive improvement. This was done through the process of care reviews and annual feedback questionnaires. The registered manager told us they had sent out quality surveys to people using the service, their relatives and professionals involved in their care in December 2015. They had collated the results from returned questionnaires and produced an action plan to improve some aspects of the service. For example, some people felt there was a need to improve communication between staff and other people. As a result, the registered manager arranged Effective Communication, reporting and recording training and discussed the issue at meeting with nurses and senior care staff and the service's whole staff team. An issue raised by relatives was the need to improve the quality of Indian food provided in the service. The registered manager discussed this with the service's caterers and they made changes to the way Indian foods were planned and prepared. As a result, a relative commented in April 2016, "The quality of the Indian food is much better."