Sanctuary Care Limited

Athlone House Nursing Home

Inspection report

Athlone House
7a Woodfield Road
London
W9 2BA

Tel: 02038265500
Website: www.sanctuary-care.co.uk/care-homes-london/athlone-house-nursing-home

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

We carried out a comprehensive inspection of this service on 15 and 19 January 2016 at which a breach of legal requirements was found in relation to the prevention and control of infection. We also found that people's care records and risk assessments were not always completed accurately or reviewed in line with the provider's policies and procedures.

At a focused inspection on 2 September 2016 we found that the provider was meeting the legal requirements in relation to safe care and treatment.

At this inspection we rated the service 'Good'.

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

The service is set out over two floors and provides nursing and accommodation to 23 adults with continuing and palliative care needs. The home is fully accessible, with a lift serving all floors. There were 19 people living at the home at the time of inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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.

People told us they felt safe and were happy with the care provided. Staff were appropriately trained and skilled to care for people.

Where possible, people were involved in decisions about their care and how their needs would be met. Where appropriate, relatives and healthcare professionals contributed to the care planning process.

Systems were in place to identify and reduce risks to people living in the home. Risk assessments and management plans were in place to mitigate risks in relation to people's mobility, nutrition, personal care,

physical and mental health and well-being.

People were protected from avoidable harm and abuse because the provider had effective safeguarding systems in place. Staff understood how to recognise the signs of abuse and told us they would speak to a manager if they had concerns about a person's safety or welfare.

Staff had a good understanding of mental health legislation. Where possible, staff supported people to make their own decisions and sought consent before delivering care and support.

People's care records included written evidence of best interests decisions having been made in accordance with the Mental Capacity Act 2005 and relevant safeguards.

People's medicines were managed, stored and administered safely. Medicine audits were completed on a daily, weekly and monthly basis.

The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss.

The service employed a full-time activities co-ordinator and a range of one to one and group activities took place within the home.

People were supported to eat and drink. People provided a mixed response when asked if they enjoyed their meals. Food and fluid charts were completed when risk of poor eating and drinking had been identified.

Staff supported people to attend healthcare appointments as required and liaised with people's relatives, GPs and other healthcare professionals to ensure people's needs were met appropriately.

Staff sought advice and guidance from palliative care teams when needed to ensure people remained comfortable and supported at the end of their lives.

People and their relatives, visitors and staff were asked for their views about the running of the service via regular meetings, feedback forms and annual surveys. People and their relatives felt able to raise concerns and were confident that any issues would be dealt with satisfactorily and in a timely manner.

Staff provided care that was responsive to people's needs. The service worked well with external health professionals. Monthly audits were carried out across various aspects of the service. Lessons were learnt from incidents and accidents to minimise a recurrence.

Recruitment practices ensured the right staff were recruited to support people to stay safe. Staff understood their roles and responsibilities.

The home was clean and tidy. However, the management of unpleasant odours was not always effective.

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 remains Good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Athlone House Nursing Home

Detailed findings

Background to this inspection

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

We inspected this service as it was over 24 months since we carried out our last comprehensive inspection. During this period we have received eight notifications relating to safeguarding concerns from the provider. The registered manager had fully investigated all of these concerns.

This inspection was unannounced and took place on 12 April 2018. The inspection was carried out by two adult social care inspectors, a specialist professional advisor who was a nurse with knowledge of older people's care needs 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.

Prior to our visit, we reviewed the information we held about the service. We looked at information we held about the service including registration information and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We received and reviewed a provider information return (PIR). This is information we ask providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

During our visit we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with six people living in the home, one relative visiting a family member, seven members of care staff, three nurses, a domestic services manager, the registered manager and the

deputy manager. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Therefore we spent time observing interaction between people and the staff who were supporting them.

We looked at eight sets of care records of people using the service, medicine administration records, six staff records and records relating to the management of the service.

During our inspection we joined a multi-disciplinary team meeting and discussed people's care with the healthcare professionals present.

Good

Our findings

People told us they felt safe and trusted the staff supporting them. Comments included, "It's a safe place, I'm satisfied with the service, people are good and helpful with everything", "It's a secure home" and "This place is fantastic, I have no complaints."

Staff referred to evidence-based guidance to ensure risks to people's health and well-being were effectively managed. Staff completed a range of risk assessments in relation to people's nutrition and hydration, personal care support needs, level of mobility and risk of falls. Risk assessments specific to people's individual health conditions were also in place, for example, where people required special diets, aids, equipment and/or adaptations. Assessments were completed accurately and reviewed on a regular basis in line with the provider's policies and procedures.

Staff demonstrated a good knowledge of pressure wound prevention and sought appropriate guidance from tissue viability nurses when this was needed. The incidence of pressure wounds acquired within the home was low. Where people had moved into the home with existing pressure wounds, staff ensured people were supported to move and reposition safely when they were unable to do this for themselves. Staff promoted good food and fluid intake and told us they applied creams and dressings where directed. Body mapping charts and wound records were in use and provided adequate information in relation to the ongoing status of people's skin integrity. Staff completed turning charts and weight management records as per guidelines and where this formed part of an agreed care plan.

People were protected from avoidable harm and abuse because the provider had effective safeguarding systems in place. Safeguarding posters were on display throughout the home informing people, visitors and staff of what action they should take if they suspected someone was at risk of harm. Staff completed safeguarding training and demonstrated a good understanding of what constituted abuse; listing verbal and physical aggression, emotional and psychological abuse and financial exploitation as examples. Staff were familiar with the provider's whistleblowing procedures and told us they would report any concerns they may have to their managers. The management team had communicated appropriately with the local safeguarding team to help keep people safe.

People told us they received their medicines on time and as prescribed. Nursing staff completed medicines training and were assessed as competent before being able to administer people's medicines. People's prescribed medicines were stored safely and securely in individual cabinets located in their rooms. Guidance was in place for people who took medicines as required (PRN) so they were administered

according to people's individual needs. Medicines that required storage in fridges or were classified as controlled drugs were stored separately in a room kept locked and where access was restricted to authorised staff. Where people were receiving their medicines covertly (disguised in food or drink), the appropriate medicines management risk assessments had been undertaken and decisions made in accordance with the Mental Capacity Act 2005 (MCA). We sampled medicines administration records (MAR) and found these were completed in full with no evident errors or inaccuracies. A range of medicines audits were completed on a daily, weekly and monthly basis by nurses, managers and external quality monitoring teams. Any unused medicines were disposed of safely.

Staff recruitment practices were robust. Staff records included information relating to the application process, health surveys and copies of employment contracts. The provider carried out appropriate checks before new staff commenced employment including obtaining satisfactory references and carrying out Disclosure and Barring Service (DBS) checks. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

The registered manager had assessed people's needs and determined staffing levels based on these requirements. Staff told us there were usually enough staff available to support people although there were times when they were very busy. Despite this, staff were relaxed and supported people at their own pace. There were plans in place to cover staff absences including the use of bank and agency staff. On the day of inspection we observed sufficient numbers of trained staff were available to meet people's needs. We saw that people had access to call bells and when asked, people told us they knew how to use them and that assistance normally arrived in good time.

The provider undertook regular health and safety checks to ensure the environment was safe for people using the service and the staff working there. This included checks on moving and handling equipment, air mattresses, fire fighting equipment, lifts, electrical appliances and the water supply. There were plans in place to deal with foreseeable emergencies. Staff had received training in fire safety and personal emergency evacuation plans (PEEPs) were in place for each person using the service. PEEPs provide staff with details of the action to take in the event of a fire or other emergency.

People's individual needs were met by the adaptation of the premises. The home was purpose built with lift access to all floors. Clear signage throughout the home directed people to bathrooms, toilets and fire exits. The home was clean and tidy. Staff completed infection control training to ensure they followed good infection control principles. We observed staff using disposable gloves and aprons and saw that hand gels and paper towels were freely available throughout the home. However, in one area of the home, the management of unpleasant odours was not always effective.

Good

Our findings

People's views about the food served in the home was mixed. Comments included, "I like the food, I don't know what I'll eat for lunch, I love surprises!" and "Yes, I like the food." One person told us that if they asked, staff brought them fish and chips from a local takeaway. Another person told us they "always have something to eat such as chocolate and biscuits." People also told us, "The food is very bad" and "I don't like the food."

Staff completed a dietary notification form for kitchen staff when people moved in to the home. This information noted any special requirements, preferences or requests and took into consideration people's religious and cultural needs. Staff told us that people came in to breakfast when they wished and were offered a choice of what they would like to eat. If people did not like what was on the menu then alternatives were always available. At lunchtime we observed staff assisting people with their choices by informing them what was on offer and referring them to the table top menus. Where guidance from speech and language therapists and/or dietitians was provided this was being followed. Staff plated food onto individual trays lined with a laminated information chart. Each chart recorded a person's name and reminders about their specific dietary needs and preferences. Staff told us the charts ensured that people were served the correct food and also acted as a prompt for bank and agency staff to minimise risks to people when eating. People were provided with support as appropriate. Adapted plates and cups were available for people who needed them. Staff supported people to eat at their own pace and in the way that suited them either in their own rooms or in the shared dining area.

New staff completed an induction which included elements of the Skills for Care common induction standards which have now been replaced by the Care Certificate. Staff had the opportunity to shadow more experienced staff until they felt confident in their skills and abilities and were required to complete workbooks to demonstrate their knowledge and understanding. A member of staff told us, "I like it here. We work well as a team, everyone is friendly, they welcomed me and showed me the ropes." Further training was provided via e-learning and in a classroom environment and delivered in line with current legislation, standards and evidence based-guidance. Topics included food hygiene and equality and diversity, safeguarding, infection control, mental health legislation, health and safety and moving and handling. A training matrix was in place which identified when staff had received the training required for their role and when it required updating. Some staff had completed specialist training in dementia awareness, falls prevention, pressure wound and catheter care. There were systems in place to provide on-going support to staff through regular supervisions and annual appraisals. Staff demonstrated a good understanding of people's healthcare needs and told us they received appropriate training and support to enable them to

meet people's needs and achieve effective outcomes.

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. Staff demonstrated a good understanding of consent and capacity issues and were aware that people living with dementia may have fluctuating mental capacity. One member of staff told us, "We keep an eye on things and tell the nurse if we see changes, we monitor and treat [people] as if they have capacity." We observed staff gaining people's consent before supporting them to mobilise, when offering activities and serving meals and during the administration of medicines. One staff member told us, "we know our patients. We seek people's consent before we do anything. [Person using the service] can only nod, but we still ask." People's care records included written evidence of best interests decisions having been made in accordance with the MCA and relevant safeguards.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Some people had been assessed for risks in relation to leaving the building without support, the use of bed rails and for one to one support. The registered manager had submitted DoLS applications where these restrictions had been considered proportionate and appropriate.

People's day to day health needs were managed by the staff team with support from a range of health care professionals such as GPs, tissue viability nurses, occupational therapists, physiotherapists, speech and language therapists (SaLT) and chiropodists. People using the service and their relatives (where appropriate) confirmed their permission was sought before their confidential information was shared with other healthcare and community professionals. People's health needs were documented in their care plans along with a record of medical appointments and related correspondence. Staff were attuned to any changes to people's health and well-being. For example; when people had said they were in pain or staff had a concern about their health, appropriate medical advice had been sought in a timely manner. Staff kept each other updated at handovers and throughout the shift about any changes to people's health and the support they required. Personal information was stored securely meaning people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act.

Good

Our findings

People we spoke with told us staff were kind and caring. Comments included, "Staff are wonderful and very helpful" and "People are very good here, it's like my own house." A staff member told us, "The residents are really lovely. I'd put my Mum here."

Staff were able to tell us about people's individual care needs and preferences for example; what time they liked to get up, what clothes they liked to wear, what they liked to eat and drink and what TV programmes and music they liked. People were able to spend their day as they chose. Seating and dining areas provided people with opportunities to spend time with family and friends. People were supported by staff to maintain their personal relationships and what was important to them. Staff told us relatives and friends were welcome to visit people at any time and there were no restrictions on the length of time they could spend at the service. A garden area with plenty of seating was accessible via the ground floor.

People were treated with kindness and compassion by staff. A member of staff told us, "I really enjoy working here. I feel a good feeling inside because I'm helping people to have a good quality of life. It's what the job gives you; it's not what's on your pay slip." Interactions between staff and people were positive, kind and thoughtful. Staff spent time chatting to people to build up a rapport and were attuned to people's emotional well-being. Staff greeted people with a smile and spoke to them in a cheerful voice. We heard laughter and friendly conversations throughout the day. This helped to create a relaxed, homely atmosphere within the home.

Staff demonstrated a good knowledge of the people they cared for and encouraged them to maintain their usual routines. A member of staff told us, "[Name of person using the service] is so lovely. They remind me of [my family member]. I take [them] downstairs to see the cat and bring [them] to see the fish and the birds. [They] love that. In the Summer we have tea in the garden."

People's privacy and dignity was respected and promoted. Staff were able to explain how they showed people respect saying, "We always close doors during personal care. Everybody has en-suite bathrooms; we make sure we close the doors." People were asked whether they would prefer male or female care staff to support them with their personal care. A member of staff told us, "We ask [people] what they like to wear in the morning, if they want personal care at this time, if they would like a drink, about food and alternatives, we're always providing choices." A hairdresser visited the home regularly and staff members provided weekly pampering sessions. People were well presented in clean clothes to suit their own choice and style.

People's cultural and religious needs were considered when support plans were being developed. Care records stated whether people held a particular faith and where possible people were supported to practice this. A member of staff told us, "We have Catholic services weekly; [they] give holy communion. We do respect people with halal or kosher foods."

Good

Our findings

People and their relatives were involved in the development of their care plans where this was appropriate. Before people moved into the home, managers completed an assessment to ensure the person's needs could be met. Information from the pre-assessment was used to develop care plans and risk assessments when people moved into the home. Support planning documentation was comprehensive in range and included information about all aspects of people's care. Each set of care records contained a brief overview of people's medical history and allergy status and recorded people's needs in relation to personal care, communication, mobility, pressure area risks, nutritional requirements. There was also some brief information about people's family history and individual interests and anything else that was important to them. Where people had specific care needs in relation to wound management or where catheters and percutaneous endoscopic gastrostomy (PEG) tubes were in situ, staff had completed additional care plans, risk assessments and monitoring charts. Care plans were reviewed regularly and updated whenever people's needs changed.

The service employed a full-time activities co-ordinator who organised a range of group and one to one activity sessions. On the day we visited the activities co-ordinator was on leave. In their absence care staff organised activities and encouraged people to take part in the scheduled programme. We observed a staff member offering people a pampering and nail painting session. One person attending the group told us, "The activity co-ordinator is nice, I like the nail painting." Group activities included arts and crafts, music and baking sessions. Some people enjoyed watching television and listening to music in their own rooms or in the lounge areas. We observed staff supporting people to spend time where they wished. Where people chose not to or were less able to join in with group activities the deputy manager told us the activities co-ordinator supported people to enjoy one to one activities. Those people who were able to were supported to go out locally to cafes and shops.

Care plans detailed how to communicate with people and whether people wore glasses and/or used hearing aids. Staff were able to describe how they communicated with individuals who were unable to communicate verbally. This included writing things down and also reading body language and facial expressions. From our observations, staff demonstrated a commitment to ensuring people were able to communicate their choices.

As far as possible people were supported to remain at the home until the end of their lives. The home had gained accreditation in the National Gold Standard Framework for End of Life Care (GSF). The GSF is in place to ensure people nearing the end of their lives receive good quality person-centred care in line with

recognised standards and guidelines. People were asked for their decisions in advance about how they would like to be cared for if they experienced deteriorating health. Where appropriate, end of life care was discussed and planned and people's wishes respected. The provider worked closely with clinicians from the Pembridge Palliative Care Centre and sought advice and guidance when needed to ensure people remained comfortable, pain free and supported at the end of their lives. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed by GPs and hospital consultants. (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). Relatives told us they were kept informed about the health and well-being of their loved ones.

Staff attended regular meetings and were kept up to date and informed about issues, concerns and any plan of action in place to address them. Staff attended a daily morning meeting where issues relating to maintenance, meals, activities, staffing levels and visits from health and social care professionals were discussed. Staff recorded the care they provided on daily monitoring sheets and this information was reviewed when staff began their shifts. Handover between shifts was thorough and staff were able to discuss matters relating to people's welfare and any other issues relating to the service. This meant staff were aware of how people were feeling and were informed about people's changing healthcare needs.

People and their relatives were asked for their feedback about the service through surveys and monthly meetings. Feedback was also obtained daily through discussions with people and visitors and general conversation. The service was responsive to any concerns or complaints raised. The provider had a complaints policy and procedure in place and information on how to make a complaint was on display in the home. One person told us, "I can speak to anyone if I have a concern." We saw evidence that the registered manager responded to complaints quickly and effectively, conducting an investigation and taking disciplinary action if appropriate to do so.

Good

Our findings

The service had a registered manager in post and was supported in his role by a deputy manager, both of whom were qualified and registered nurses with a range of clinical experience. People using the service told us, "I know the [registered] manager, [he] is a very kind, gentle man", "I can chat anytime with the manager" and "The manager is very friendly, I can discuss my personal issues with him."

Staff were positive about the management team and told us, "[The registered manager] is very nice, the best manager I've ever had, easy going, approachable and easy to speak to." Another member of staff commented, "[The registered manager and the deputy manager] are really helpful and easy to get on with. We're a very good team." The registered manager was responsive and understood the legal requirements in relation to his role and responsibilities. The registered manager was visible throughout the home. Throughout the inspection, we saw him visiting and speaking warmly with people who lived in the home and responding to staff in a kind and constructive manner. Registered nurses led each shift and told us that they fostered cooperative, supportive and appreciative relationships among the staff team. Staff told us they worked collaboratively with each other, shared responsibility and resolved conflicts quickly and constructively.

Staff were provided with opportunities for career progression, further training and development. The deputy manager told us about a scheme that was taking shape to support staff into nursing careers and we spoke to two members of care staff who were keen to become registered nurses. Staff were able to give examples of further courses they had attended to develop their knowledge, skills and experience such as dementia awareness and falls prevention courses and most staff had completed health and social care vocational courses at various levels.

There were systems in place to report any accidents or incidents. Records included details of what had occurred and what action had been taken in response to the situation. Monthly audits were conducted by the registered manager and overseen by regional managers so that an analysis of all incidents could be undertaken to establish any patterns or trends. Where appropriate, lessons were learnt and plans implemented to improve future service provision. Responses to incidents had included, closer monitoring, the provision of equipment and/or referrals to specialist healthcare services. CQC were kept informed of any significant events and received notifications in a timely and efficient manner. This meant where needed, we could check that appropriate action had been taken in response to any concerns.

The registered manager completed weekly and monthly audits to ensure he maintained a clear oversight of

the service and the people using it. Audits addressed safeguarding, complaints, incidents/accidents and falls, pressure wounds and infection control. People's care plans and associated documentation was comprehensive in scope and well organised. The registered manager told us there were plans to introduce an electronic care planning system in the near future. Care plans were continuously audited and reviewed to ensure they reflected people's needs. Nurses and senior care assistants also completed daily and weekly medicines audits and shared their findings with the registered manager. This meant any shortfalls in service provision were detected and remedied in a timely manner. We saw evidence that learning from mistakes took place during staff meetings and saw examples of this in relation to medicines errors and care provision.

The provider routinely listened to people in order to improve service delivery. Feedback from people using the service and their relatives was sought through feedback forms and annual surveys. Meetings took place monthly for people using the service and their relatives. Meeting dates were clearly posted in the main reception area.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily access the most current assessments of the provider's performance.