

Service To The Aged

Service to the Aged

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 responsive?

Good



Overall summary

We carried out an unannounced comprehensive inspection of this service on 16, 18, and 19 February 2015. Breaches of legal requirements were found. We served enforcement warning notices on the provider in respect of three breaches that had the greatest impact on people, in the areas of good governance, nutrition and hydration and managing risks. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to all the breaches. We undertook this unannounced focused inspection on 31 July 2015 to check that the provider had followed their plan in respect of the warning notices and to confirm that they now met legal requirements in those areas. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Service to the Aged on our website at www.cqc.org.uk.

Service to the Aged, known as Sage, is a nursing home for up to 60 older Jewish people. Most people who live there have a diagnosis of dementia and many also have significant needs relating to their health. Sage is a purpose-built home located on a main road in Golders Green in London, close to shops and transport. Each person has their own bedroom with en suite bathroom and there is a large communal lounge and dining area on the ground floor with a patio and terrace people can use.

There were 47 people using the service when we inspected. Due to issues that had been identified by the service and the local authority before our inspection, the service was not admitting anyone new when we inspected. The service operates according to orthodox Jewish principles. It is operated by a charity with a board of trustees and a management committee. The charity does not operate any other services.

Summary of findings

There was a new 'Matron Manager' in post and she was in the process of being registered with the Care Quality Commission. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run

We found that Sage had a very open and welcoming atmosphere and was a real part of their local community. Visitors were encouraged and there were plenty of opportunities for religious and other activities.

Appropriate action had been taking place in respect of pressures ulcers, timely referrals were made to relevant healthcare professions and there were risk assessments in place that were updated regularly.

The kosher kitchen of the service provided food that was appetising and always freshly prepared and cooked. We found that improvements had been made to ensure people were supported to eat and drink enough to meet their needs. This included people who needed a lot of support to eat and those who received nutrition and hydration through a percutaneous endoscopic gastrostomy (PEG) tube.

The matron manager had made a number of improvements that the service needed to improve the care and support provided to people, including improved quality monitoring audits.

Overall, we found that the provider had addressed the three breaches of regulations that had resulted in us sending warning notices.

We will undertake another unannounced inspection to check on all outstanding legal breaches identified for this service.

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?

We found that action had been taken to improve the safety of the service.

Risk assessments had been updated and improved.

Appropriate action had been taking place in respect of pressures areas.

While improvements had been made we have not revised the rating for this key question to good ; to improve the rating to 'Good' would require a longer term track record of consistent good practice and other breaches of legal requirements identified in February 2015 would need to be met.

We will review our rating for safe at the next comprehensive inspection

Requires improvement



Is the service effective?

We found that action had been taken to improve the effectiveness of the service.

People using the service were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans and as advised by health care professionals. Staff were up to date with current guidance regarding supporting people with swallowing difficulties to eat and drink.

While improvements had been made we have not revised the rating for this key question to good; to improve the rating to 'Good' would require a longer term track record of consistent good practice and other breaches of legal requirements identified in February 2015 would need to be met.

We will review our rating for effective at the next comprehensive inspection

Requires improvement



Is the service responsive?

The service was responsive

Care planning documentation had been improved and was more person centred and records we looked at were complete and up to date

Staff had received training and understood their roles in relation to effective recording.

Good



Service to the Aged

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.

We undertook an unannounced focused inspection of Service to the Aged on 31 July 2015. This inspection was done to check that the provider had addressed the legal requirements that they were in breach of after our February 2015 inspection and which were of greatest impact on people.

The inspection team consisted of two inspectors, a specialist advisor who was a tissue viability nurse 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.

Before the inspection we reviewed information we had about the service in our records. This included information

about safeguarding alerts, notifications of important events at the service and information from members of the public. We also spoke with an officer from the local authority quality team.

The team inspected the service against three of the five questions we ask about services: Is the service safe, effective and responsive? This was because the service was not meeting some relevant legal requirements in those areas.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and met some people in their rooms. 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. We used the information we gathered to track that the care people experienced matched what was planned in their records.

We spoke with eight people using the service and five people's relatives. We interviewed members of the management team, the cook, six care support staff and three nurses. We looked at sixteen people's care records, staff training records, and various audits used for the purpose of managing the service.

Is the service safe?

Our findings

At our inspection in February 2015, we found that some practices within the home left people at risk of unsafe care and support we found that people were not always protected against the risks of acquiring pressure sores. We found other risk assessments relating to their support such as moving and handling, falls, safe environment and continence were also incomplete and out of date.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 29 May 2015.

We undertook an unannounced focused inspection on 31 July 2015 to check that the improvements required following our enforcement action had been. We found that the provider had addressed this breach.

The manager had made a number of improvements in pressure ulcer management since our last inspection. Everybody had a Waterlow assessment which assessed their risk of getting a pressure ulcer. We read the records of people who were assessed as being at risk of a pressure ulcer. We found that in all cases people had appropriate pressure relieving mattresses and cushions and staff were helping them to change position regularly at night to reduce the risk of ulcers developing. We checked a sample of records for three people who needed to be turned at night and saw these were recorded properly. Records showed two people who had a pressure ulcer previously had been treated appropriately. In all the care plans we looked at a body mapping charts was in place and the Waterlow score was documented. Three care plans had evidence of healed superficial wounds in the past (skin tears and one grade three pressure ulcer).

At the time of our inspection one person had a grade 3 pressure ulcer. The wounds and the ulcer had been photographed, measured and the pressure ulcer was graded. Appropriate equipment was put in place. The three nurses we spoke with about wound management were all able to discuss the importance of diet for wound healing and preventative measures to put in place to minimise risk. Examples given were air mattresses, barrier creams, good hygiene, good hydration of the person, at least two hourly

turning and repositioning of those people unable to do so themselves. We saw from training records that a number of nurses had now been trained in tissue viability. People were assessed monthly or more frequently if relevant, for risk of developing pressure ulcers. If the person was judged to be at high risk then a support plan was put in place and kept under review. The service had implemented a daily check of people's skin integrity where they were at risk of pressure ulcers. Nursing staff audited any concerns with specific areas of the person's skin, along with checks that included pressure care equipment, position changing, application of creams and checks for hydration.

People told us they felt safe. Comments included, "The home is excellent, the overall picture is good. Mum is safe here. I couldn't wish for mum to be in a better place," and "I'm very lucky to be here, it's safe." Assessments of risk to people were in place and there were plans to manage these risks. Accidents and incidents were recorded including action taken to minimise the risk of a reoccurrence. From discussions with staff and observations of practice we found staff had a high level of understanding of the risks people could face, and how they should respond if they felt someone was at risk of harm or abuse. Staff were clear about their roles and responsibilities in protecting people from harm or abuse and knew the roles of others in ensuring people's safety as part of their day to day practice.

The provider had introduced a new format for care plans and risk assessments since our last inspection. The home was in the process of transferring information from the previous format. The Registered manager was able to explain how they had modified the care plan and risk assessment tools and processes. We saw how the provider had reviewed all risk assessments and were on target to complete the review and up-date process for all care plans. We noted each person had a care plan which included holistic information on all aspects of the person. This included pre-assessments, preferences and social and health information. We saw the provider also had smaller care plans for each person that contained information for the daily care and support needs of each person. The latter document stayed with each individual. We saw these had been individualised and information had been sought from the person, their representatives and associated health and social care professionals.

Is the service safe?

We were able to speak with six care and support staff in relation to the above changes. All felt the new system had enhanced the care received and ensured people were kept safe. One staff member told us “information is much easier

to understand and follow.” Staff also explained that the provider had organised specialist training on care planning and risk assessments. We were able to confirm this training had been completed by looking at training records.

Is the service effective?

Our findings

At our inspection in February 2015, we found that people were not always protected against the risks of inadequate nutrition and dehydration; the provider did not have appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans and as advised by health care professionals. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 29 May 2015.

We undertook an unannounced focused inspection on 31 July 2015 to check that the improvements required following our enforcement action had been made.

People using the service were protected against the risks of inadequate nutrition and dehydration. We looked at the care files of eight people using the service. In each file we saw that nutritional needs assessments and swallowing risk assessments had been completed. These assessments had been reviewed each month. Where nutritional needs assessments indicated that people were at high risk of malnutrition, or swallowing risk assessments indicated they were at risk of choking, we saw that referrals were made to the speech and language therapy team (SALT) or dietician as needed. People at-risk of losing weight were weighed weekly and a record of their food intake was recorded. Their care plans highlighted their dietary needs, for example, if they required a soft, pureed, normal or a diabetic diet.

There were appropriate arrangements in place to ensure that people received the correct diet as identified in their care plans and as advised by health care professionals. There were guidelines in place advising staff of people's nutritional needs and how they should be supported with food and fluids. Where required we saw that people were having fortified drinks and were encouraged to eat snacks between meals. Where people were diabetic or were on a low sugar diet we saw this was highlighted in their care files and there were guidelines in place for staff to support them if they became unwell. In one person's care file we saw food and fluid guidance was available for staff advising them to

observe the person swallowing and to encourage meals and ensure fortified meals and drinks were available at all times. People were encouraged and supported to have sufficient to eat and drink and to maintain a balanced diet.

One person said "The food is excellent. They make a note of your requirements; they know I don't like gravy". And another told us "I have put on weight since I've been here, and I am quite happy."

We saw staff took time to encourage and assist people to eat their meals, gently ensuring people ate sufficient amounts. People were offered hot and cold drinks throughout the day, and jugs of water or squash were available throughout the home so people could help themselves. People's nutritional needs had been assessed and recorded. Staff supported people with dementia who were unable to state verbally what their meal preference was. We observed staff showing people individual food dishes to help them recognise the different food choices they had.

The nurses we spoke with told us about the importance of high calorific snacks and food and fluid intake. They recognised weight loss and dehydration as a common concern if people were not prompted and encouraged to eat and drink especially those that wandered. We observed a nurse patiently giving one person his tea and encouraging him to drink and then going out of her way to get his favourite biscuits as there were none on the trolley.

There were two people requiring percutaneous endoscopic gastrostomy (PEG) feeding(feeding by tube). We saw that there were charts on the walls in their rooms that recorded PH testing and tube measurements prior to administering feeds. The nurse explained that "all feeds were given during the day and at least a 30 degree angle to prevent aspiration as per guidelines" this she went on to say "enabled residents to rest properly at night and did not prevent them from joining in on some activities or socialisation". She confirmed that the line was flushed by gravity each time and this was also recorded on the chart.

The home caters for people who follow the Jewish faith and this is reflected in the food offered to people. The provider ensured all food was Kosher and thus acceptable to people who used the service. However within this structure people felt their individual dietary preferences were known and catered for. A person who used the service said, "The cook is great and helpful, does her best, if I want

Is the service effective?

something different I only have to ask.” Another person said, “Staff comes every day to ask my choice.” We saw people’s choices were respected including when these were made just before a meal.

Staff recorded what people had eaten during each meal and monitored people’s weight by weighing them monthly. If concerns arose about weight gain or loss, plans were put into place to increase their nutritional intake and then people were weighed more frequently to monitor this.

Whilst the residential area of the home covers three separate floors most people were encouraged to eat in the main dining area. Many people had their own individual care support staff who worked in conjunction with care support staff employed by the provider. Together they ensured people who might require special diets due to either choice or health reasons were catered for.

Each person had a working document which staff we spoke with called a passport. This document was kept in a small file and had data required by each person indicating how needs such as personal care and food should be met. This file was kept with each person and brought to the main

dining room for all meals. Staff ensured people’s meals were given in accordance to their individual health needs by comparing details within the file to details held in the kitchen by the chef.

We saw by reading care plans how the provider had created a system where key performance indicators were audited on a monthly basis to ensure people’s nutrition and hydration levels remained consistent to their individual care plans.

The audit tools included information on whether people had lost or gained weight; of these how many people had appropriate interventions; contemporaneous nutritional assessments and subsequent action plans; intake and output charts and input from speech and language therapist, dieticians and other associated health professionals.

We were able to follow the above procedure by reading weight charts in people’s files that had lost weight and assessing the subsequent action plans. We saw the provider had initiated a system which quickly identified issues of concern and ensured measures were introduced to address any concern.

Is the service responsive?

Our findings

At our inspection on 16, 18.19 February 2015, we found that the provider had failed to maintain an accurate, complete and contemporaneous record for each person living at the home.

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

We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 29 May 2015.

We undertook an unannounced focused inspection on 31 July 2015 to check that the improvements required following our enforcement action had been made

During our last inspection We found that care plans were not always kept up to date or reviewed, and we noted that people's personal care and support records were untidy making current information difficult to find.

At this inspection, we looked at the actions taken by the provider in respect of the breach of this regulation. We found that the provider had addressed this breach. The matron manager showed us a care plan audit they had undertaken to ensure that all care plans were up-to-date and reflected people's current needs. She told us that she had employed an independent consultant to assist her with this and she was also rolling out a new care planning format. The manager told us that all staff had now received training on care planning. We saw evidence of this on the provider's training matrix. She also showed us evidence where she had performance managed staff who had failed to update information of people's care files following the training. The provider had developed a new care folder for each person who used the service. Obsolete paperwork was archived. We also spoke with care support staff that were complimentary with regard to the changes and to the training. The provider had ensured bank staff regularly employed had also attended the training.

We saw in revised care plans people's needs were assessed and care and treatment was planned and delivered in line with their individual care needs. Work had been completed on the majority of care plans which had improved the amount of person centred care information and practice in place at the home. This meant that people received more personalised care as a result.

Each person at the home had a plan of care based on an assessment of their needs. We looked at the care plans for people to cover a range of people's needs. We saw that the plans had been regularly updated to reflect changes in people's condition.

People we spoke with confirmed that they had been involved in the care planning process. A relative told us, "The home goes through the care plan with me once a month." And another said "I am fully involved with the care plan and it is updated regularly."

We checked sixteen people's care files. We saw that these were detailed, person centred and well organised. Each person had a number of completed care planning documents in their files. These included personal information, assessments, agreement and consent, body maps, and a number of risk assessments relating to falls, dependency, weight management and physiotherapy. Out of date documents had been removed. There were daily notes for both care and nursing. We saw that these were detailed and up to date. The provider produced an action plan, including the transfer of care records to a new format, putting new detailed care plan audits in place, and where possible an additional nurse to be scheduled on shift with time available to update records. There were also spot checks of food, fluid, turning and other care charts.

We found that it was easier to access important information from the new format of care records that had been put in place. The provider was in the process of transferring all care records to the new format, 35 records been transferred to date. Regular monthly care plan audits were being undertaken to ensure that records were completed appropriately and reviewed at least monthly.

Staff told us that they had been involved in improving the care plans and had received training in this area. Comments included, "it's so much better now and information is easy to find," "we understand how important it is to have accurate and up to date information on people, the manager reminds us often," and "we have worked hard and learnt from our mistakes, it's not evidence if it's not written down, then everybody knows what's going on."

People told us they were happy with the changes taking place. "There have been improvements since the new matron came, the general atmosphere among the staff and

Is the service responsive?

crew seems much happier”. And “Angela is a wonderful manager/matron,” and “it’s remarkable what they’ve done. She’s worked wonders with the rest of the staff. They do try their best.”