Care UK Community Partnerships Ltd

Highbury New Park

Inspection report

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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

Highbury New Park is a care home owned by Care UK Community Partnerships Limited providing residential and nursing care service to 53 people. All of the people using the service at present were living with dementia.

This inspection took place on 7 and 11 April 2017 and was unannounced. At our previous comprehensive inspection on 2 February 2015 the service was not meeting one of the regulations we looked at. The service was found to be fully compliant with regulation 9 at our subsequent focused inspection on 28 February 2016.

At the last inspection, the service was rated as good with one requires improvement action in the area of "Safe", the service was found to be compliant in this area at the focused inspection. The service remained rated as Good.

At this inspection we found the service remained Good.

People were kept safe from harm or abuse. If any concerns had arisen these had been responded to properly and thoroughly. The service managed medicines safely and our observations demonstrated that staff who had responsibility to provide medicines, whether they were nursing or care staff, did this safely. Potential risks for people were considered, whether they were environmental or personal risks, and action was taken to minimise any risks that were identified.

All of the people at the home at present were living with dementia. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. This approach was reflected by policies and systems in the service support this practice as did staff training.

Staff were supported in their work through training, supervision and appraisal. Staff we spoke with demonstrated their knowledge and skill in providing care as well as a commitment to doing this in the most effective way that they could.

Staff understood people's characters and personalities. Staff were seen using different approaches with each person that demonstrated that they tailored their approach to people as individuals. Staff were respectful and spoke about people in a dignified way.

Care planning and the support people required were clearly outlined in care plans and other documentation related to how people's needs were met. There were examples of efficient identification and response to people's needs whether these were on going or newly emerging support requirements. The service liaised appropriately with other health and social care professionals in order to ensure people's needs were met.

The service complied with the provider's requirement to carry out regular audits of all aspects of the service

and report monthly on the findings of internal audits to the provider. There on-going three monthly quality assurance overview of the service showed that any areas requiring attention were identified and were responded to.

Our expert by experience noted that they would be happy with one of their relative using the service. They do need to apply "a lick of paint and new carpets" Relatives and people were all complimentary about the home and care provided to people.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good. Staff are trained and aware of what to do in order to keep people safe from harm and how to respond if any concern was raised.

Risks that people may face were considered and action taken to minimise potential risks. Medicines were safely managed and people received the medicines they need.

The home was kept clean and any potential hazards in the home were monitored and equipment was maintained to ensure continued safe use.

Is the service effective?

Good

The service remains Good. Staff were supported in their work through supervision and training.

People have choices about what they liked to eat and drink and were assisted to consume their meals if they needed this help.

People's healthcare needs were monitored and the service ensured that any treatment that people required was provided either by staff at the home or other healthcare professionals.

Is the service caring?

Good

The service remains Good. Staff demonstrated patience and calm when working with people and did not rush what they were doing but gave people time and consideration.

People's right to have their dignity and individuality protected was upheld and staff knew that this was essential in the way they worked with people.

Is the service responsive?

Good

The service remains Good. People's needs were known about and were responded to.

There were ample opportunities to engage in activities both to assist people to remain orientated and for social and leisure time

pursuits.

Is the service well-led?

Good

The service remains Good. The provider had a system for monitoring the quality of care.

Surveys were carried out by the service provider of people using the service, relatives and staff who had all been surveyed in the last twelve months. These surveys showed that people were usually satisfied, or very satisfied, with the service overall and of the standards of care and support that was provided.

Highbury New Park

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.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Friday 7 and Tuesday 11 April 2017. The inspection team comprised of two inspectors 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, and for this service their experience related to care of a person living with dementia.

Before the inspection, we looked at notifications that we had received and communications with other professionals, such as the local authority safeguarding and commissioning teams. We were also contacted by a consultant geriatrician, hospital pharmacist, a community psychiatric nurse and a local GP in response to our request for feedback about the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at risk assessments and care planning processes for five people, medicines administration and handling records for eighteen people and spoke with two nurses, three care staff, the regional quality assurance manager for the provider, the deputy manager and registered manager. We spoke with six people using the service, four of these people had relatives visiting and we spoke together with these people and their relatives. We also looked at five recruitment and induction records for staff recruited since the last inspection and the training, appraisal and supervision dates and frequencies for all of the staff team. We reviewed other records such as complaints information, feedback to the service from visitors via comments made, maintenance, safety and fire records as well as the oversight and governance of the service.

Good

Is the service safe?

Our findings

A person living at the home told us, "Oh yes" when asked if they felt safe. Regarding staff communication they said "They are very busy, but they do wave" and another person thought that at night "They could do with another one [staff member]." Another person told us "Oh yes, it is very safe. There is plenty of people on duty" and when asked if staff respond when they use their call bell, another person said "Oh yes they do respond."

Relatives had a mixed view about whether there were enough staff, some thinking there could be more and others thinking there were enough. Everyone told us they felt their relative was safe, they felt that staff communicated and responded well to keep people safe. Our review of the staff roster and deployment of staff found there were enough staff on duty and the provider operated safe recruitment practices. We tested the call bells on all of the units on each floor to check the response time of staff. The registered manager told us that staff should respond within five rings. Staff responded promptly when the call bell tests were conducted.

Disclosure and barring service, employment history and references were obtained as well as verification of qualifications and registration with the Nursing and Midwifery Council required by registered nursing staff. There had been a recent query raised by two relatives regarding staffing levels but our findings did not show there was any reduction to staffing around the home. In order to check this further we arrived on each day of the inspection whilst night staff were still on duty and found the staff were present as expected on the staffing rota.

The service had the Care UK organisational policy and procedure for protection of vulnerable adults from abuse. They also had the contact details of the London Borough of Islington which is the authority in which the service is located and only this authority places people at the service. Members of staff we spoke with said that they had training about protecting vulnerable adults from abuse and this was confirmed when we looked at training records. Staff were able to tell us what action they would take if they thought anyone had been harmed and evidently knew how to respond to any concerns.

Assessments were carried out with people to identify any risks and provided clear information and guidance for staff to keep people safe. Assessments were specific to individual's needs such as falls/trips, diabetes, leaving the home unescorted and the use of high risk medicines such as warfarin (this is a medicine that is used if people may be at risk of developing blood clots). The risk assessments gave information about how to mitigate a risk and as an example we saw how staff supported someone who was at high risk of falls when unwell and took action to assist them when they were walking. Another example was where people were at risk of developing pressure ulcers, there was clear information about how to monitor skin integrity and what to look for and report if there was a potential that a pressure area may be developing.

For people who may sometimes demonstrate distressed behaviour, risk assessments were completed about how to mitigate risks, which included the steps to be taken to de-escalate situations such as reassuring people, and offering them time and space.

All but one person thought that medicines and healthcare needs were attended to well, for the relative who did raise a question about a person's risk of pressure sores we verified with the staff team that there were no current issues.

Medicines continued to be safely managed. We observed a full morning medicines round and this was diligently managed with the necessary attention being given to each person who required medicines. We looked at eighteen peoples medicines recording, including controlled medicines for those requiring these, for the three months leading up to and including this inspection. All were found to be properly and accurately recorded and were audited by the service.

There were detailed procedures to ensure that the environment for people was well maintained and safe. Staff we spoke with knew who required assistance in the event of a fire and safety of fire equipment, gas and electricity; infection control and prevention of cross contamination were all well managed.

Good

Is the service effective?

Our findings

Two people told us about how the staff had knowledge about their health and care needs. They said, "Yes very well (when talking about staff training)", "Yes, when you explain what you want they remember." A more mixed view was held about food, some saying it was acceptable and others that more could be done. We raised this with the registered manager to examine this further which they said they would at the next resident and relative meeting.

One relative told us they thought the food was "Rubbish" whilst another said, "I think the food is great, plus I bring in little things for (relative)." We also raised these views with the registered manager. We looked at all nursing and care staff training and supervision records. Staff received regular training, supervision at least every two months, and an annual appraisal to ensure they had the support, skills and knowledge to meet the needs of people using the service. Staff we spoke with were positive about the training and support they received and the provider had clear expectations that staff kept this training up to date, and raised any shortfall in keeping training up to date if any staff had fallen behind with updates. Training also included more specialised training about caring for people with dementia, which was carried out in conjunction with a hospital NHS trust department of psychiatry. This was called the "Marque" programme, "Managing agitation and raising quality of life", and we were told that recently almost all staff had achieved the award to be accredited "Marque" champions.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service continued to manage this well and consent was obtained to care and treatment, if not from the person themselves, then from next of kin, or social care professionals if no next of kin was involved.

Each person had an eating and drinking care plan, which detailed if the person was on a specific diet plan, their likes and dislikes and if they required assistance with eating. Nutritional risk assessments were being carried out to identify if people were at risk of malnourishment. For people at risk, food and fluid intake was being recorded and referrals had been made to health professionals such as GP and dieticians. Menus showed a variety of meals options and aside from the menu people were also shown what food choices were available each day, which we saw being done at both lunchtimes during our inspection. Diets, for example halal, for a person of Muslim faith, were catered for and well as personal preferences.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home twice each week, but would also attend if needed outside of these times. Care records showed that people had visits to and from health professionals such as GP's dentists, hospital appointments, speech and language therapists, dieticians and community nurses. Healthcare needs were met effectively and people's physical and mental wellbeing were regularly monitored and responded to as required.

Good

Is the service caring?

Our findings

People told us they thought that the staff at the service were caring. We were told, "Yes they are, very kind and very thoughtful", "Yes they are very good", "Yes I do definitely" and "Yes they are wonderful, they are sweet to everyone." One person said they thought some staff could speak better English but others believed that staff communicated well and that they were caring and respected people's dignity.

People's ability to communicate was recorded on care plans for staff to understand how people communicated. The plans listed how people communicated, example included a person's hearing was partially impaired and their plan stated to communicate with the person facing towards them and speaking clearly. Another person's care plan stated the person can only respond to questions with a yes or a no therefore to ensure to only ask simple questions. Staff were seen using these approaches with people.

Each person's care plan contained an 'Active Living' section providing information on people's daily activities and what they preferred doing during the day. There was also a social history section, which provided information on people's upbringing and family backgrounds. Life histories were compiled which helped people to remember their earlier lives as well as providing valuable information for staff about people's experiences and lifestyle.

Staff we spoke with knew people well and demonstrated just how well during the two morning handovers between night to day staff we observed. Apart from merely talking about people's wellbeing, staff were seen to make comments about how well they knew people and how to work with them, for example if someone had a restless night and was going to be tired during the day.

We asked staff about, and observed how decision making was encouraged. Staff did not merely assume that even though people had dementia that they therefore couldn't make any decisions. We saw good examples of staff being patient and explaining options whilst giving people time to understand options and make choices. The service had a system called "residents of the day" where a person on each floor were selected and special emphasis would be placed on the person whereby their life would be celebrated. If they required anything specific and not part of the routine domestic and maintenance routines they would be asked what they wanted and effort would be focused on achieving their request. Staff across the home, regardless of their role, were seen treating people with dignity and respect. Nothing was seen to be done for the convenience of the service or staff and was focused on what was convenient for people living at Highbury New Park.

When people required palliative care as they came to the end of their life this was provided in liaison with local palliative care specialist nurses. We were shown examples of positive feedback that relatives had provided about how the staff had treated people with kindness and respect.

Good

Is the service responsive?

Our findings

People did not make many comments about the responsiveness of the home but those that did thought there was flexibility, not least about when they could visit and that staff did know what was happening. As an example, a relative told us "He (the deputy manager) personalises our interactions as he remembers what is going on our lives too. For example our cat had been ill and when we next saw him he asked about our cat. It is very nice that he remembers things like this." Most relatives said they were involved in care planning and were kept up to date about their relative's care needs.

People's care plans were personalised and person centred to people's needs and preferences. People's support plans were divided into areas which included end of life, moving and handling, mobility, personal hygiene, sleep and elimination. One person's care plan detailed the time a person woke up and preferred to have a warm shower immediately and listed the temperature of the water that needed to be used. Another person's care plan detailed the person preferred to have their lamp on and drink tea before sleeping. This meant the care plans were not general and were personalised to people's preferences and needs.

In addition to the social history section mentioned in Caring, there was a life story booklet that provided background information, person's upbringing and what makes people feel happy or sad.

If concerns or complaints were made these were listened to. The service responded to people and any complaints made were resolved with no-one having taken complaints further with the provider as these had been managed locally.

People rarely moved out of the home to other services. However, from time to time some people did require treatment in hospital. This was managed well and feedback from local hospital and other healthcare services praised the way that the service communicated and co-ordinated people's continuing care.

Good

Is the service well-led?

Our findings

We did not receive many comments about how well – led people thought the home was. However, a person living at the home told us "I like it here, it's very nice." Relatives overall believed the home was well run, there were some suggestions for improvements although people also believed they were listened to "I like it a lot. It is what I expect."

There was a significant amount of guidance and information sharing between management and staff. We were told, and we observed, constant communication about what was happening at the home and how people's needs were being met. There was flexibility in responding to needs and open communication not only between staff but with visitors, whether they were family members or other health and social care professionals.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff told us, and we observed that they were not at all hesitant to approach the manager or other senior staff to have discussions or make requests.

An internal monthly auditing system was in place. This was required for the manager to report to the provider each month on such things as accidents, incidents, safeguarding alerts and day to day management of care. We looked at the last six months audits and found that these were reporting on matters that had arisen and was an effective means of keeping track of trends and changing needs among the people using the service. Surveys of people using the service (where possible), relatives and staff were carried out and it was shown that any learning points as a result of these surveys were taken seriously with the aim of continuing improvement of the service. It was noted that the feedback from these most recent surveys showed a good deal of satisfaction with the way the service was managed and how positively people viewed the standard of care that was provided.