Sanctuary Care Limited

Princess Louise Kensington Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This is the first inspection we have carried out since the service registered with the Care Quality Commission (CQC) under a new provider in August 2015.

Princess Louise Kensington Nursing Home is set out over three floors and provides nursing and accommodation to 45 adults with continuing care needs. An NHS rehabilitation unit occupies most of the ground floor and is operated as a separate registered service which was not visited as part of this inspection. Two upper floors are divided into four units. The first floor is primarily for people living with a diagnosis of dementia with the second floor providing nursing care and support to elderly frail residents. The home is fully accessible, with a lift serving all floors. There were 40 people living at the home at the time of inspection.

The service had a manager in post that had completed the application and interview process to become the registered manager of the home. 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.

Medicines were not always being recorded and stored safely. Following a discussion with the registered manager we were informed that systems to better manage people's medicines would be implemented to ensure that people consistently received their medicines safely, and as prescribed.

Where possible, people were involved in decisions about their care and how their needs would be met. Where appropriate, family members and health and social care professionals contributed to the care planning process. People using the service and their relatives held various different views in regards to the care their family members received, comments were not always positive in regards to staff and the support received.

Risks to people had been identified and management plans were in place to mitigate these risks. A range of risk assessments were completed in relation to the environment, people's mobility, pressure area care, physical and mental health and well-being.

Steps had been undertaken to help ensure staff were safe to work with people living in the home. Staff were appropriately trained and skilled to care for people and understood their roles and responsibilities. Staff received supervision and guidance where required. Staff confirmed they felt supported by the manager who we were told was accessible and approachable.

Staff received training in safeguarding adults and policies and procedures were in place for staff to follow if they suspected harm. Staff understood how to recognise the signs of abuse and told us they would speak to nurses and the manager if they had concerns about a person's safety or welfare.

Staff had received training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). These safeguards are there to make sure that people receiving support are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

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

People were provided with a choice of food and drink, and were supported to eat when this was needed. However, people's views varied when asked to comment on the quality of the food provided at mealtimes. People's dietary needs and preferences were not always respected and catered for. There were plans to re-install kitchen facilities in the near future so that all meals could be prepared on site.

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

Monthly audits were carried out across various aspects of the service; these included the administration of medicines, care plans, infection control and health and safety checks.

There was a complaints policy which the registered manager followed when complaints were made to ensure they were investigated and responded to appropriately. People and their relatives felt able to raise concerns and were confident that any issues would be dealt with satisfactorily.

People and their relatives, visitors and staff were asked for their views about the running of the service via regular meetings, comment feedback forms and surveys.

We made one recommendation in relation to medicines.

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

Aspects of the service were not always safe.

Medicines were not always being managed and administered safely.

Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) before staff began work.

Risks to people had been identified and management plans were in place to mitigate these risks.

Staff received training in safeguarding adults and policies and procedures were in place for staff to follow if they suspected harm.

Is the service effective?

Requires Improvement

The service was not always effective.

People's views varied as to the quality of the food provided at mealtimes. People's dietary needs and preferences were not always respected and catered for.

Staff were suitably qualified and trained to carry out their duties.

Staff were able to demonstrate a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required.

People had access to external healthcare support as necessary.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

People using the service and their relatives held various different views in regards to the care their family members received. Feedback was not always positive.

Interaction between staff and people living in the home was

minimal and many people spent time alone in their rooms due to poor health or mobility issues.

People's friends and relatives could visit whenever they wanted to and people were able to meet their relatives in the communal areas or in the privacy of their rooms.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care plans were recorded in a consistent format that was easy to navigate.

The service employed a full-time activities co-ordinator who organised a range of group and one to one activity sessions.

People told us they knew who to make a complaint to if they needed to and were confident their concerns would be responded to appropriately and in a timely manner.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager who had been in post since April 2016.

Staff we spoke with were positive about working at the home and felt that the registered manager was accessible and supportive.

Learning from incidents was positively encouraged by the registered manager and there were clear lines of responsibility and accountability within the management structure.

Princess Louise Kensington 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 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 inspection of Princess Louise Kensington Nursing Home on 24 and 25 November 2016. The first day of our inspection was unannounced. We let the registered manager know that we would be returning the following day to complete our inspection. The inspection team consisted of one inspector, a specialist advisor with mental health nursing experience and two experts 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 including notifications we had received. Services are required to tell us about important events relating to the care they provide using a notification. During our visit we spent time observing care and support in communal areas. We spoke with 22 people who used the service, 10 relatives and nine members of staff including the Registered Manager, four nurses and four members of care staff. We also looked at a sample of 12 care records of people who used the service, eight staff records and records related to the management of the service. We spoke briefly to a visiting GP on the second day of our visit.

Requires Improvement

Is the service safe?

Our findings

Most of the people we spoke with told us they felt safe within the home. Comments included, "I feel very safe, never scared" and "Yes, I feel quite safe at night as well as in the day."

The registered manager told us that normal staffing levels during the day consisted of two registered nurses and four care assistants per floor and one registered nurse plus four care assistants per floor at night. However, people's views as to whether staffing levels were adequate to meet their needs were not always positive. We were told, "Sometimes I call in the night and no one comes" and "I rang the bell one night and it was daylight before [staff] came."

We looked at the staff duty rota for two weeks prior to the date of the inspection. The recorded staffing levels were consistent with those described by the registered manager. Staff on duty during our inspection told us they felt there were enough staff to meet people's needs. The service was staffed by permanent and agency staff. With access to agency staff, the service was able to maintain minimum staffing levels in the event of sickness or annual leave. However, some people using the service felt that the use of agency staff meant that their care was compromised. One person commented, "If we had the same staff all the time, they would have a better idea of my care." Another person told us, "Day staff are much better than night staff and most of the time they are agency staff." The registered manager told us recruitment for permanent staff was ongoing and that she hoped to reduce the numbers of agency staff used in order to achieve a more consistent and stable workforce.

Despite people telling us that they got their medicines when they expected them, medicines were not always being managed and administered safely. On the first day of our inspection we observed a member of nursing staff leaving medicines in cups on people's tables and signing MAR (medicines administration record) charts to state that medicines had been administered without first observing that people had actually taken their medicines as prescribed. We spoke to the registered manager about our concerns following our inspection and have been informed that the staff member involved in the above incident has been required to undergo further competency testing and observation. Staff were familiar with covert administration of medicines and told us, "Some residents might sometimes lack the capacity to understand the consequences of refusing to take their medicines. In these situations, it may be necessary for us to act in the best interests of the patient. But we always have to explain, follow procedure, fill out a form and get the pharmacist and GP involved." A broken refrigerator used to store medicines had been reported as out of use and as an interim measure, medicines had been moved to a fridge on the floor below. However, we noted that room temperatures had not been checked or recorded since this issue had been reported. This may have meant that medicines were not being stored at the correct temperature and that people may have experienced delays in receiving medicines stored on a different floor. We recommend that the provider review standard operating practices in line with current best practice in relation to the safe administration, storage and management of medicines within a nursing home environment.

Risks to people had been identified and management plans were in place to mitigate these risks. A range of risk assessments were completed in relation to the environment, people's mobility, pressure area care,

physical and mental health and well-being. Staff told us they were made aware of any identified risks to people's health and safety and knew how to manage these. Where people had fallen, appropriate steps had been taken to prevent further repeat incidents and referrals had been made to appropriate healthcare professionals. The registered manager informed us that there was a low incidence of pressure wounds in the home although people sometimes moved into the home with existing pressure wounds. Care records provided information and photographic evidence where nursing care was being provided specifically for this issue.

Staff received training in safeguarding adults and policies and procedures were in place for staff to follow if they suspected harm. Staff understood how to recognise the signs of abuse and told us they would speak to nurses and the registered manager if they had concerns about a person's safety or welfare. Staff were familiar with the provider's whistleblowing policy and procedures. However, staff were less aware that if needed, they could also report any concerns they may have to the relevant local authority, the police and the Care Quality Commission.

We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) before staff began work. This demonstrated that steps had been undertaken to help ensure staff were safe to work with people living in the home. However, we were unable to find relevant documentation demonstrating that proof of identity and character references had been obtained in four of the staff records we looked at. We have asked the registered manager to send us further information in relation to this matter so that we are able to confirm thorough staff checks are being undertaken.

The home was clean and free from odours. Staff had access to an adequate supply of disposable gloves, aprons and waste bags although staff told us that "bags and aprons are weak. If you look at them, they are made with very thin material and break easily, we could do with better ones." On observation, aprons were seen to be easily torn and did not fully cover the front of the body. The registered manager has informed us that she will be investigating these issues with staff in due course.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs. The service had a comprehensive programme of staff training which included mandatory courses including; moving and handling, first aid, fire safety, safeguarding and various health and safety topics. In addition staff had also had opportunities to access specialist training either through e-learning modules or classroom based sessions in areas such as dementia, falls prevention and nutrition. One member of staff told us, "We had dementia awareness training recently; it helped a lot because there are new studies and new ideas about dementia coming up all the time." Staff spoke positively about the training opportunities that had been provided. The registered manager told us that new staff also completed an induction programme that included the opportunity to shadow more experienced staff until they felt confident.

There were systems in place to provide on-going support to staff. Staff records indicated that staff received regular supervisions and annual appraisals. Staff confirmed that in addition to supervisions, the registered manager was always around to speak to or provide advice. One staff member said "My manager is kind and I can always go to her." Nursing staff confirmed that their training was comprehensive and up to date.

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). Most of the staff we spoke with were able to demonstrate a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. The registered manager had submitted DoLS applications where this had been considered appropriate.

People told us that they felt involved in their care where this was appropriate. Not all relatives had been involved in care planning for their family members but most relatives felt able to discuss any concerns they had with nursing staff or members of the management team. We read in care records that where a person lacked capacity to make a specific decision, appropriate steps had been taken to ensure best interest's principles had been followed.

The home had been awarded a five star rating (the highest rating possible) for Food Hygiene in May 2016 from the Food Standards Agency, an independent government department responsible for food safety and hygiene across the UK. People's views varied when asked to comment on the quality of the food provided at mealtimes. Some people told us that their dietary needs and preferences were not always respected and catered for. Comments included, "They don't cook cultural food, my daughter brings all my food in from home" and "I get no oriental food here, my friends bring it in. I don't like the food here." Other people told us, "The food is ok if you like shepherd's pie" and "The meals are pretty good, but samey." We observed the lunchtime meal on both days of our inspection and saw that there were choices available and that people's

needs were being catered for in terms of soft and pureed diets. However, one relative told us the pureed food was tasteless and that she made smoothies and soups for her relative and brought them in every day. People were offered fruit juice and water during the meal. People who required assistance with feeding were supported by staff although we noted that this undertaking was delayed in some cases until staff were available to assist. The registered manager explained that meals were prepared offsite and delivered chilled each day to the home where they were heated and served. We were told that there were plans to re-install kitchen facilities within the home so that all meals could eventually be made on site which would facilitate more choice and variation.

People were supported to maintain good health and had access to external healthcare support as necessary. Records showed that appropriate referrals were made to healthcare professionals such as doctors, physiotherapists and dietitians. A designated GP visited the home twice a week or more often if required. The service also worked collaboratively with a physiotherapy team who visited the home on a regular basis to support people's mobility and rehabilitation. A visiting GP confirmed that they had good working relationship with the service and praised the organisation and responsiveness of nursing staff.

Requires Improvement

Is the service caring?

Our findings

People's comments about staff and the care they received were mixed. Comments included, "The staff are very kind", "The staff are lovely" and "All of [the staff] are very good." However, other people told us, "I'm not sure they care here" and "Like everywhere there is good and bad, it's ok."

Relatives too held various different views in regards to the care their family members received. Comments included "I feel like we are all family" and "My [family member] seems to be ok and it seems like they are caring for him, but [they] can't speak, so I don't really know."

One member of care staff told us, "I like my job, it gives me happiness, you feel that you are looking after your own parents, there's a sense of love and affection involved." Some staff members had been working in the home for several years which meant they were familiar with people's needs and preferences.

We saw some examples of poor care. We observed and heard two people crying out and who appeared distressed. We did not observe staff attempting to calm and reassure these people when they passed their rooms. One person told us, "I get really hot but they say they can't do anything about the heat." We noted that in some areas of the home the heat was stifling and were told by staff that they found it difficult to regulate the heating as it was an under floor system.

People were not always given choices about whether they wanted a male or female member of staff to care for them and care plans did not contain sections to be completed about how people wished to dress, maintain their self-image and express their sexuality. One relative complained that her family member was never dressed in their own clothes and that clothing often went missing.

Staff we spoke with were courteous but interaction between staff and people living in the home was minimal. Many people spent time alone in their rooms due to poor health or mobility issues. Some people told us, "There's never anyone around", "I don't see anyone, they put my breakfast down and go" and "I only see a nurse when she brings me my tablets."

People had their own bedrooms which enabled them to maintain their privacy and people were encouraged to personalise their rooms. We saw staff call out to people if their room doors were open before they walked in, or knocked on doors that were closed. Staff offered people choices about what they would like to eat and drink we saw the activities co-ordinator explaining what activities were on offer and asking people if they wished to take part.

Staff spoke to people using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. People's friends and relatives could visit whenever they wanted to and people were able to meet their relatives in the communal areas or in the privacy of their rooms.

We saw evidence that people were asked for their views about the care they received and how the service was run. Resident and relative's meetings were chaired by the registered manager on a regular basis. Topics

discussed at previous meetings included staffing levels, food choices, activities, safeguarding and the future refurbishment plans.

People were given information about the service before they moved in. Additional information about the service and other support agencies was also posted on the noticeboard in the main entrance area.

Good

Is the service responsive?

Our findings

People's needs had been assessed and care plans were recorded in a consistent format that was easy to navigate. Care records included an assessment of each person's risks and needs which took account of their health and social care needs. Additional information recorded details about personal care, wound care, weight, food and fluid intake. Repositioning charts were in place for people at risk of developing pressure ulcers. Overall, these charts were being maintained correctly although we did notice gaps in some of the charts we reviewed. Visits and recommendations from health and social care professionals were recorded in people's care records. Palliative care nurses were involved in people's care where this was required and where appropriate Do Not Attempt Resuscitation (DNAR) forms had been authorised and dated by a clinician. Care plans were reviewed on a monthly basis and records were up to date at the time of the inspection. However, there was little information demonstrating how reviews had been conducted and who had been involved in the process.

There was some indication of person centred planning, and some preferences and routines were recorded in the care plans we looked at. For example, we found information about what people liked to listen to on the radio or watch on television. Information about people's personal history or background, hobbies and interests, spiritual and cultural needs was brief and absent in some care records we reviewed.

Staff from across all departments attended a daily 'ten at ten' meeting where issues relating to maintenance, meals, activities, staffing levels and visits from health and social care professionals were discussed. This was also an opportunity for staff to present the 'residents of the day' and discuss people's specific care and support needs. Daily records described the support and care people had received from staff during each shift. Staff told us they reviewed the information in these records when they started their shift at the service. Staff were therefore able to respond to how people were feeling and to their changing health or care needs.

The service employed a full-time activities co-ordinator who organised a range of group and one to one activity sessions. In addition, an art psychotherapy trainee from Goldsmiths University was currently on placement at the service offering group and individual sessions twice weekly to those wishing to participate. The activities co-ordinator told us that the most popular activities were baking, art groups, music sessions and bingo. Noticeboards displayed a weekly activity programme which included musical performances, trips to art galleries, shopping trips, church services and drama sessions. A relative told us, "When a person has a birthday they make a real effort with bunting and cards, flowers, tea cups and cakes." Another relative told us that the activities co-ordinator was planning a trip to see the Christmas lights. Some people told us they didn't take part in activities and preferred to stay in their rooms reading, listening to music or watching television. The registered manager told us there were planned visits for the future from local school and college students who would be working with people to complete various art projects.

People told us they knew who to make a complaint to if needed. One person told us, "If I have any problems, I voice them. If I'm not happy about something, I tell someone and if the issue is not dealt with then I tell them again. Another person told us they had made a complaint and that the matter had been dealt with

immediately. Other people told us they would let the registered manager, their relatives or friends know if they needed to make a complaint about something. A copy of the complaints procedure was outlined in a service user booklet provided for each person living at the service. The procedure was also on display in the reception area and contained information about who to contact within the organisation and externally, such as the local ombudsman.

Good

Is the service well-led?

Our findings

The service had a registered manager who had been in post since April 2016. The provider, the registered manager and the deputy manager took an active role within the running of the home and had good knowledge of the staff and the people they supported. The management team were clearly visible around the home on both days of our inspection and most people using the service knew who the managers were by sight although not all were able to recall names. Relatives described the registered manager as "Approachable" and "Welcoming." One visiting relative told us the home was "Very organised" and that the registered manager was "Very hands on, a woman with a vision to have this place the best it can possibly be."

Staff we spoke with were positive about working at the home and felt that the registered manager was accessible and supportive. Staff comments included, "The [registered] manager is doing her best", "She's doing a good job" and "She's down to earth, she tells you if you're doing something wrong, she guides us, she's fair."

The registered manager told us handovers similar to hospital ward rounds took place room by room at the beginning of every shift. Following this, staff returned to the office to discuss any particular concerns they may have, for example; people who are unwell, accidents and/or incidents, food and fluid charts and mattress checks. Nurses we spoke with had a good overview of the needs and current clinical status of people on each floor.

Staff received regular training and supervision sessions at which they could discuss their performance and workload. In addition, a range of meetings took place on a monthly basis for all levels of staff. Staff told us they attended meetings and found them useful. Minutes of the staff meetings we looked at indicated they took place regularly and relevant issues were discussed such as staff training, rotas, end of life care, meal times and matters relating to people's dignity and privacy .

The provider had systems in place to monitor the quality of the service, such as audits and daily 'walkabouts' across the premises by the registered manager. We saw audits in relation to medicines, care plans, infection control and pressure wounds. Fire equipment, hoists, pressure relieving mattresses and wheelchairs were checked on a regular basis and fit for use. Accidents and incidents were reported and recorded appropriately and audits were used to identify patterns, trends and actions taken. Learning from incidents was positively encouraged by the registered manager and there were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

The registered manager told us that people and their relatives were sent an annual satisfaction survey. The results of the latest 2016 survey showed that 99% of people living in the home were satisfied with their living environment. 91% of people said they were happy with the care and support they received and 89% were satisfied with the privacy and dignity they were afforded. A newsletter was published quarterly providing people and their relatives with information on events and activities.