

NA SS Care Limited

Stanmore Residential Home

Inspection report

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Stanmore
Middlesex
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Tel: 020 8907 4636

Date of inspection visit: 10 December 2014
Date of publication: 19/05/2015

Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

We inspected Stanmore Residential Home on 10 December 2014. This was an unannounced inspection. Stanmore Residential Home is a care home and provides care and support to 27 older people who may be living with dementia. It does not provide nursing care. There were 25 people using the service at the time of our inspection.

There was a registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in December 2013 the service was meeting the regulations we inspected.

People told us that they felt safe and staff were caring and treated them with respect. One person said, "I'm happy here. It's my home."

However some aspects of the service did not meet people's needs. We observed fire doors held open by

Summary of findings

wedges and substances that may be hazardous to people's health were not stored securely. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to regulations of the Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We also found three areas that required improvement but were not a breach of regulations. Paper towels were not available to ensure that hand washing was effective in controlling the spread of infection. Care plans did not provide staff with accurate information on how to meet people's individual needs and preferences and the environment of the premises did not address the needs of people living with dementia. Quality checks had not found that care plans needed to be more person centred and to provide information for staff on each person's individual needs and preferences. We have made recommendations for the provider to address these concerns.

People who used the service told us that there were always staff available to help them when needed. Two visiting relatives said that staff were always available to talk to and there were always enough staff in the home.

People told us they were treated with kindness and compassion and their dignity was respected. We observed a member of staff sensitively encouraging a person to go to their bedroom so that they could change their clothes.

Staff we spoke with were aware of people's cultural needs related to their race or religion, and of any special requirements due to health conditions such as diabetes. A healthcare professional commented, "Staff demonstrated excellent partnership working, excellent communication and excellent person-centred practice."

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and how to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected. The provider notified us that they had made appropriate applications for Deprivation of Liberty Safeguards (DOLS) authorisations and we saw evidence of this.

People told us that they would be able to talk to any member of staff if they had a complaint or concern. The complaints record showed that complaints were investigated and responded to appropriately. Relatives of people using the service said that the registered manager was always available if they wished to discuss anything and they were happy that their comments and concerns were listened to.

The service learned and made changes from concerns and investigations. A safeguarding investigation found that the service did not communicate effectively with health professionals. Health records for people using the service showed that the manager and staff had learned from this outcome and a health professional told us that the service communicated well with them.

We observed that staff and managers worked together as a team. The registered manager and staff showed that they were very dedicated to providing a caring atmosphere for the people who used the service. A staff member said, "This is a friendly home and the service users and ourselves are very well treated."

The registered manager carried out regular audits of health and safety in the home, but the checks did not find the areas of risk to people's safety that we observed during the inspection.

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?

Some aspects of the service were not safe. Two fire doors were held open with wedges and items that may be hazardous to health were not stored securely. Paper towels were not available to ensure that hand washing was effective in controlling the spread of infection.

There were processes in place for safeguarding people from the risks of abuse and staff understood how to safeguard the people they supported. Medicines were administered and recorded properly, to show that people received their prescribed medicines as prescribed and safely.

The provider had staff recruitment and selection processes in place to ensure that the staff they employed were fit to work with people who used the service. There were enough staff to meet the needs of people who used the service.

Requires Improvement



Is the service effective?

The service was effective. People received care from staff who were trained to meet their individual needs.

People were provided with a choice of suitable and nutritious food and drink.

Staff were aware of how to monitor people for risks of malnutrition and took actions when required to address these risks.

People using the service were supported to maintain good health and to have access to appropriate healthcare services.

Good



Is the service caring?

The service was caring. People told us they were treated with kindness and compassion and their dignity was respected. Staff supported people to be independent and to do as much for themselves as they able to do.

Care plans provided information on cultural needs related to people's race or religion.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Good



Is the service responsive?

Some aspects of the service were not responsive. The environment needed review so that the needs of people living with dementia were fully responded to. Staff did not consistently support and enable people to take part in individual activities of their choice.

Assessments of people's needs were carried out before they were admitted to the service, and regularly reviewed. However care plans were based on tasks and provided only basic information for staff to meet people's needs.

Requires Improvement



Summary of findings

Complaints were responded to appropriately in line with the complaints procedure and actions taken to address the concerns.

Is the service well-led?

Some aspects of the service were not well-led. Processes were in place to monitor the quality of the service and action was taken to address any concerns. However these checks were not fully effective. They had not identified shortfalls in care planning and were not documented.

Staff understood their roles and the ethos and values of the service. Staff told us the registered manager supported them and they were able to raise any questions or concerns they had about the service.

Requires Improvement



Stanmore Residential 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.

The inspection team consisted of an inspector and a specialist nursing advisor. We spoke with seven people living at the service and with two visiting relatives. We observed people in the communal lounge using 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 to us. We spoke

with six members of staff, including the registered manager and care workers. We looked at seven people's care plans, and a range of records about people's care and how the service was managed.

Before we visited the home we checked the information we held about the service, including notifications of significant events that the provider had sent to us. No concerns had been raised and the service met the regulations we inspected against at their last inspection on 9 December

2013. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with and received comments about the service from two health professionals who provided treatment for people using the service.

Is the service safe?

Our findings

People we spoke with told us that staff supported them to feel safe in the home. One person said, “I came to live here, and I’m now safe and settled.” However during our inspection of the premises we noted some possible risks to people’s health and safety. During the morning we noted that a fire door on the first floor and the door to the laundry on the ground floor were held open with a wedge. A sign on the laundry room door stated that the laundry room door must be kept closed at all times due to fire risk. In an unlocked cupboard in the laundry room we saw an aerosol canister of furniture polish with a warning symbol to show that it was hazardous to health (Control of substances hazardous to health (COSHH) regulations). This was accessible to people using the service. There was no COSHH risk assessment for the use of the furniture polish. A notice on the door of a storage room on the first floor stated that evacuation sledges were stored there in case of fire. However the room contained broken furniture, and the evacuation sledges were not easily accessible. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people’s needs safely. Relatives told us that staff were always available if they needed any information when they visited the service. We spoke with two people who stayed in their rooms during the day. They both told us that they could call for help if they needed anything, and staff would come to help them. Staffing rotas showed that there were four or five care staff on duty throughout the day and three at night. We observed sufficient staff to meet people’s needs during our visit. Staff told us that they were able to meet people’s care needs and to have time to talk to individuals and spend time with them. We observed staff assisting people when they needed attention, and sitting with individuals to talk with them and give them attention.

We saw evidence that appropriate checks were undertaken before staff were employed, to show that they were fit to work in a care setting. We looked at the files for three people who were employed to work in the home. They held evidence to confirm that appropriate checks were carried out, including written references, criminal record disclosures and proof of identity.

Staff attended training on safeguarding people from abuse. Staff we spoke with confirmed that they had received safeguarding training. They demonstrated a good knowledge and understanding of the home’s policies for safeguarding adults from abuse and for their responsibilities for whistle blowing. The provider responded appropriately to any safeguarding concerns. CQC was notified of six concerns about the safety of people in the home in the last twelve months. There was evidence that the provider had taken the appropriate action by informing the relevant authorities and following their own procedures for responding to the concerns. The outcomes of the safeguarding investigations by the local safeguarding authority showed that one of the six concerns was substantiated and the provider took appropriate actions to ensure that similar events would not happen again.

Individual risk assessments were completed for people who used the service, and provided guidance for staff on how to manage the risks and ensure that people were protected. We saw risk assessments for each person for skin viability, nutrition, moving and handling and falls. One person had a risk assessment that showed that they were at risk of falls because they walked around at night, and they moved to a ground floor room to lessen the risk from using the stairs.

We observed a senior member of staff administering medicines. Medicines were administered safely and recorded properly to show that people had received their prescribed medicines. The medicines trolley was stored securely and regular audits were carried out to check that medicines were recorded accurately.

There was a policy and procedure for infection control that included daily cleaning schedules and the procedures for hand washing. Staff told us that they followed procedures for handling laundry that ensured that the risks of spread of infection were minimised. We observed that the home was clean and that an appropriate standard of hygiene was maintained in the kitchen and bathrooms. However there were no single use paper towels available at the hand wash basins to reduce the risk and spread of infection in line with guidance from the Department of

Health. We observed a member of staff washing their hands very thoroughly at a washbasin in the communal lounge. There were no towels available, and they went to the manager’s office to get tissues to dry their hands.

Is the service safe?

We recommend that the registered person should follow Department of Health guidance on safe washing and drying of hands to prevent the risk of spread of infection.

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. Staff told us that they had continuous training. Staff had regular meetings with the deputy manager for supervision of their work and discussion of any training needs.

We saw the training schedule which included assessment and care planning, administering medicines, the Mental Capacity Act 2005, infection control and management of pressure ulcers. Training for these subjects was by distance learning, with a work book and assessment for each subject. For training that required practical demonstration, such as health and safety and moving and handling, a trainer visited the home and provided a face to face training session. The registered manager told us that they ensured that staff understood and followed the guidance in the training, by discussing training topics in staff meetings and individual supervision, and by observing staff carrying out the procedures.

Induction training followed Skills for Care common induction standards. Staff were registered for a qualification in health and social care when they completed their induction training. During our visit a National Vocational Qualification (NVQ) assessor was in the home to register two members of staff for the qualification.

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and how to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected. We noted that mental capacity assessments were carried out when required and decisions made in the person's best interests. For example we saw capacity assessments and best interest decisions involving family members for the use of bed rails and for supervision due to the risk of falling.

CQC is required by law to monitor the operation of the MCA Deprivation of Liberty Safeguards (DoLS) for care homes, and to report on what we find. Where there is a deprivation of a person's liberty DoLS requires the provider of the care home to submit an application to a 'Supervisory Body' for authority to do so. The registered manager was aware of the 2014 Supreme Court judgements which widened the scope of the legislation. The provider notified us that they had made 17 applications for DOLS authorisations in

August 2014 in light of the Supreme Court judgements and had applied for DOLS for people who were not able to leave the premises without assistance if they should wish to do so and we saw evidence of this during the inspection. An officer of local authority was visiting the home during the inspection to carry out a DOLS assessment. They told us that the manager understood the need for DOLS and made appropriate applications.

People were provided with a choice of suitable and nutritious food and drink. The provider used a system of menus and frozen meals from a catering company, with a trolley and procedures for reheating them appropriately. The menus included a choice of two dishes for each meal.

We observed staff asking each person what they would like before the meal was served. We also observed some people asking for an alternative such as soup or a sandwich when they did not want the main meal. One person with specific cultural needs was provided with freshly prepared food of their choice. One person told us, "We have lots of choice of what to eat, and there are lots of things I like. The food is very good." At lunch time staff sat with people and chatted to them while they ate their meals. We observed them encouraging people to eat and assisting two people by sitting beside them and giving them individual attention. Staff assisted people with limited mobility to move to and from the dining table calmly and at their own pace.

Food was available for specific dietary needs, including for people who were diabetic. Care plans showed each person's food preferences and any special requirements, and these were also displayed in the kitchen to inform staff. For example the care plan for nutrition for one person specified a diabetic diet, and that the person liked sandwiches for lunch and ate small amounts of food at each meal. Reduced sugar desserts were available for people who were diabetic. The relative of a person who did not have capacity to make decisions about their nutritional needs had specified how the person liked to have their meals, with specific drinks and fruit before or after each meal. This information was displayed in the kitchen to inform staff when they were preparing meals and snacks.

Everyone in the home was assessed regularly for the risk of malnutrition. Malnutrition Universal Screening Tool (MUST) assessments were carried out on admission and repeated if

Is the service effective?

there were any changes in people's weight or eating habits. Staff were aware of the signs of possible malnutrition and the actions they should take. We saw evidence that one person was referred to a dietician when they lost weight.

Care plans provided information on each person's physical and mental health needs. We saw up to date records of each person's contacts with health professionals such as GP, community nursing services and mental health services. One of the health care professionals we contacted told us that the staff were very attentive and provided good healthcare. They said that staff accompanied a person to

appointments with health professionals, and staff understood the person's needs. They said, "The positive relationship formed with staff has helped staff to support the person with their care needs." They reported that the person's physical and mental health had improved since moving to the home. Another health professional told us that staff addressed people's health needs when advised, but they were not always proactive in contacting the health professional for advice at times other than pre-arranged appointments.

Is the service caring?

Our findings

People told us that staff were caring and kind. One person told us that they liked to stay in their room, and staff came to talk them throughout the day. They said that staff respected their wishes, and supported them to go to the lounge for their lunch and then to return to their room. Another person said, "I'm happy here. It's my home." Our SOFI observation showed that staff took time to talk with people and responded to their needs. We noted that staff spent more time with some people than with others, but all the people we observed showed that they were alert and aware of their surroundings, and they took an interest in other people and the activities around them.

Care plans contained assessments of people when they were admitted to the home, and some had a personal history with details of the person's family, work and interests to provide information for staff. However care plans provided only basic information for staff on how to meet people's individual needs. Staff told us that they knew each person's needs and preferences because they had worked at the home for long enough to get to know people well.

Staff we spoke with were aware of people's cultural needs related to their race or religion, and of any special requirements due to health conditions such as diabetes. A healthcare professional commented, "Staff demonstrated excellent partnership working, excellent communication and excellent person-centred practice."

We saw that care plans were signed by the people they referred to or by a member of their family if they were not able to sign themselves. Two visiting relatives told us that they were consulted and involved in decisions about their family members' care. Care plans stated that people should be offered choices and staff should obtain their consent before providing assistance with their care.

Staff respected people's privacy and dignity. All assistance with personal care was provided in the privacy of people's bedrooms. People were able to choose their clothing, and we noted that people were dressed in clean and well maintained clothes. We observed a member of staff sensitively encouraging a person to go to their bedroom so that they could change their clothes.

People were supported to be as independent as possible. At lunchtime and while taking part in activities during the morning and afternoon staff encouraged people to do as much for themselves as they were able to.

Is the service responsive?

Our findings

Assessments were undertaken before people were admitted to the service, to identify their care and support needs. Care plans were written from the assessments, detailing how people's assessed needs should be met. We saw that care plans were reviewed as people's needs changed so that staff knew what support people required. However the care plans provided only basic information on the actions staff should take to meet people's needs, and no details of how to assist each person. For example the care plan for one person for personal care stated that they needed the support of one staff member, "to offer support, give choices." The care plans for mental health needs for two people both stated, "Obtain consent and offer choices" with no further information.

Most people who used the service were living with dementia. Staff told us that they had training in understanding dementia, and we observed that they were aware of how to communicate effectively with people and to respond to their needs. However care plans gave little information on each person's specific communication and behaviour needs. One care plan stated the person could be verbally aggressive, but gave no guidance for staff on how to address this behaviour. The environment did not provide clear differentiation of areas to help people to understand their surroundings. There were pictorial signs on toilets and bathroom, but no use of colours or textures in corridors and communal rooms to aid understanding. Chairs were arranged around the outside of the lounge rather than in smaller groups where people could sit in a more social arrangement. There was nothing available for people to

take an interest in, such as familiar items to pick up and examine or use and magazines or books to look at. Staff engaged people in conversation, but people did not communicate with each other.

The activities co-ordinator was not in the home during our visit. Staff led some group activities in the lounge, such as throwing a ball and playing floor Hoop-La. Two people told us that they did not wish to join in group activities, and another person said, "Usually there is plenty to do, such as drawing and writing stories." One person liked to paint in their room, and many of their paintings were displayed in their room. We observed staff sitting and talking with people who were not able to join in group activities, but we saw no evidence of specific stimulating or sensory activities for individuals.

People told us that they would be able to talk to any member of staff if they had a complaint or concern. The complaints record showed that complaints were investigated and responded to appropriately. The last recorded complaints were in May 2014, that a bedroom was cold and that a person was "unkempt". The registered manager told us that lessons were learned from the outcomes of complaints and measures taken to ensure that similar incidents did not happen in future. For example, guidance was given to staff to ensure that bedroom windows were closed at night and about choice of clothing for individuals.

We recommend that the service seek advice and guidance from a reputable source about providing personalised care for people who use the service.

Is the service well-led?

Our findings

Staff understood their roles and the ethos and values of the service. Policies, for example the policy for whistle blowing and the complaints policy, emphasised transparency and fairness for both staff and people who used the service.

Staff told us that they were happy and that the registered manager supported them. One staff member said, “This is a friendly home and the service users and ourselves are very well treated.” Another staff member said, “The manager is great at encouraging staff to develop and providing training opportunities for promotion.”

However there were differing opinions about communication with the service from health professionals. One health professional said that the service provided good communication with them. But another health professional felt that communication could be more proactive. A safeguarding allegation was investigated and substantiated because the service did not communicate effectively with health professionals. Health records that we saw showed that the manager and staff had learned from this outcome, and that any health concerns were communicated to health professionals without delay.

The registered manager held regular staff meetings to communicate any information and guidance about the service. The minutes of the last staff meeting in September 2014 showed that the need for DOLS was discussed, the outcome of safeguarding concerns, and the importance of accurate daily records. The last meeting for relatives and

people using the service took place in May 2014, and the discussion focussed on food choices. However relatives we spoke with said that the registered manager was always available if they wished to discuss anything and they were happy that their comments and concerns were listened to. The provider sent quality surveys to people using the service and their relatives. 14 of the 25 people using the service or their relatives responded to the last survey in September 2014. The provider took action from the comments in providing new activity items, such as the floor Hoop-la that we observed in action.

Quality assurance checks had not identified several risks to health and safety. The registered manager carried out regular audits of health and safety in the home, including fire safety procedures and water temperatures and we saw that actions were taken to address any concerns. However these checks had not found the areas of risks to people's safety that we observed during the inspection. We observed that cleaning substances that may be hazardous to health were stored in an unlocked cupboard in the laundry room and that fire doors were held open with wedges. Care plans and medicines records were checked monthly, but there was no record of a formal audit to ensure that they contained all the information the staff needed to meet people's needs and preferences and to provide safe care.

We recommend that the service seek advice and guidance from a reputable source about carrying out effective audits of records of people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises</p> <p>This corresponds to regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment</p> <p>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because fire doors were not closed and items that may be hazardous to health were not stored safely.</p> <p>Regulation 12 (1) (d).</p>