Care UK Community Partnerships Ltd

Charlotte House

Inspection report

Snowy Fielder Waye
Isleworth
Middlesex
TW7 6AE

Tel: 02087580080
Website: www.charlottehouseisleworth.co.uk

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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

The inspection took place on 24 April 2018 and was unannounced.

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

The provider is registered to accommodate up to 56 older people, some who might be living with the experience of dementia. People were supported with both personal care and nursing needs. At the time of the inspection 47 people were living at the service. The majority of people had dementia and some had physical healthcare needs and disabilities as well. Some people were being cared for at the end of their lives. Charlotte House is managed by Care UK Partnerships, a national organisation who provide social and health care services.

There was a registered manager in post. 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 the last inspection on 28 June 2016 we rated the service Good.

At this inspection on the 24 April 2018 we found the service remained Good.

People using the service and their visitors were happy with the service. They told us that their needs were being met and that they were treated by kind and caring staff. People were given choices and encouraged to make decisions about their care. They confirmed this and visiting relatives told us they had been asked to contribute to care plans.

The staff told us they felt well supported. They had the information and training they needed to care for people. The staff felt the service was well managed and had opportunities to discuss their work and any concerns they had with the registered manager and other senior staff.

We observed that people were cared for appropriately. The staff were polite and attended to people's needs. People had opportunities for showers and baths, their clothes were clean and they had access to a hairdresser who visited the service. The staff worked with other professionals to monitor and meet people's healthcare needs. The GP visited regularly and staff shared information about people's health and wellbeing so that they could receive the care they needed. People received their medicines as prescribed and in a safe way. The provider employed a lifestyle coordinator to support people with social and leisure activities. There were a range of organised events and people had opportunities to participate in these as well as individual

and small group activities. Visitors were welcome at the home at any time and told us they were kept informed about changes in their loved ones health or wellbeing. People had enough to eat and drink.

People's needs and the risks they were exposed to had been assessed and planned for. These assessments and plans were regularly reviewed. The staff kept records of the care provided and these showed that plans had been followed.

People lived in a safely maintained environment, which was clean. The provider had procedures designed to keep people safe and the staff were aware of these. Safeguarding alerts, accidents, incidents and complaints were appropriately investigated and acted on to reduce the risk of reoccurrence. There were enough staff to meet people's needs and keep them safe, and they had been recruited in a suitable way.

The provider understood their responsibilities under the Mental Capacity Act 2005 and asked people using the service, or their representatives, for their consent before providing care and treatment.

There were effective systems for monitoring and improving the quality of the service, for example regular audits and analysis of accidents and incident. The provider's senior managers regularly visited the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Charlotte House

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.

The inspection visit took place on 24 April 2018 and was unannounced. This was a comprehensive inspection and was carried out by three inspectors, an expert-by-experience and a nurse specialist advisor. 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 visit we looked at all the information we held about the service. This included notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider had completed a Provider Information Return (PIR) in March 2018. The PIR 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.

In December 2017 Healthwatch, an independent organisation who audit care services, visited the service and wrote a report of their findings. We looked at this report. We looked at an independent care home review website and the provider's own website. We contacted the local authority contracting team for feedback about the service. We reviewed information people had submitted using our 'share your experience' web-forms, which can be found on our website.

During the inspection visit we spoke with 12 people who used the service and six visiting relatives and friends. We spoke with the registered manager and other staff on duty who included nurses, care workers, the deputy manager, housekeeping staff, the lifestyle coordinator and catering staff. We also met and spoke with the regional director and operations manager.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the whole care plans for seven people and parts of the care records for an additional ten people. We also looked at six staff recruitment files, records of staff training and supervisions, records of complaints, accidents and incidents and other records used by the provider such as quality monitoring audits and reports. We examined how medicines were being managed by looking at storage, administration and records relating to this. We inspected the environment and equipment being used by people and staff.

At the end of the inspection we gave feedback to the registered manager, regional director and operations manager. Following the visit inspection the registered manager sent us some additional information and also updated us on the action taken following our feedback.

Good

Is the service safe?

Our findings

People using the service told us they felt safe there. Visitors also told us this, explaining that they thought people were safely cared for.

There were procedures designed to safeguard people from abuse. The staff received training in these, information about abuse and how to report it was on display and staff discussed safeguarding as part of their individual and team meetings. The staff we spoke with understood about the procedures and knew what to do if they suspected someone was being abused. The provider had responded appropriately to allegations of abuse and worked with the local safeguarding authority to investigate allegations and protect people.

Individual risks to people's safety had been assessed and planned for. Care plans included a range of risk assessments, for example, support with assisted moving, risks of choking, skin integrity, nutritional risks and other risks associated with people's mental and physical heath. The provider used templates for rating the level of risk in each area which helped guide the staff when determining the level of people's vulnerability. The assessments also included plans to show the staff the action they needed to take to minimise the likelihood of harm. The assessments were reviewed monthly and senior managers within the organisation could access these through the provider's electronic care planning system in order to audit them and make sure they were up to date.

We witnessed the staff supporting people to move around the home and transfer between chairs using equipment. The staff were caring and used the equipment safely and in the best way to support people. The staff explained that they had been trained in the use of equipment and in assisting people to move.

The environment was safely maintained and the provider carried out checks on fire safety, equipment being used and the general health and safety of the environment. However, during the inspection we found that a chair had been placed in front of one of the fire exits and a fire extinguisher. This problem was rectified during the inspection and the registered manager told us they had discussed this issue with all staff to make sure they were aware of maintaining safe exit routes. The provider had evidence that equipment was regularly serviced and in good working order. The care staff made visual checks of all equipment before use and reported any concerns to the provider so that these could be addressed.

The provider had a contingency plan which included how the staff should respond to various emergency situations. There was also a fire risk assessment and individual emergency evacuation plans for each person. Information needed for emergency situations was kept in the home's foyer and the staff were aware of how they would support people in event of a fire or another emergency. The assessments and information were regularly reviewed and were up to date.

There were sufficient numbers of suitable staff to support people to stay safe and meet their needs. People told us that staff were available when they needed them and they did not have to wait for care. Throughout our inspection we saw that there were care staff and nurses available and they were assisting people.

However, during lunch we found that some people living on the first floor had to wait for assistance, and some people who would have benefited from additional assistance and support did not receive this. We discussed this with the registered manager who agreed that they would look into this. Following the inspection, the registered manager wrote to us to explain that they had introduced a rota whereby additional staff were scheduled to support people in the first floor dining room each lunch time.

In addition to care staff and nurses, the provider employed a number of staff to carry out other duties, including housekeeping staff, catering staff, lifestyle coordinators (who organised social activities), administrators and maintenance staff.

The provider had appropriate procedures for recruiting new staff to make sure they were suitable. These included checks on their identity, eligibility to work in the United Kingdom, employment history and references from previous employers. The provider also applied to the Disclosure and Barring Service regarding any criminal convictions. The provider had a process for risk assessing staff who had criminal convictions. These assessments were discussed and agreed at senior management level in order to ensure people using the service were safe. All staff took part in an induction which included assessments of their competency and suitability.

People received their medicines in a safe way and as prescribed. Medicines were stored securely and at the correct temperatures. There were suitable procedures for medicines management, which included the use of controlled drugs and PRN (as required) medicines. Medicines were administered by nurses who had received additional training by the pharmacist and the provider. Their competency at administering medicines was assessed each year and following any concerns. We witnessed people being supported to take their medicines and this was appropriate.

Medicines administration charts had been completely correctly and were clear. There were protocols for the use of any PRN medicines and staff recorded the reason for administration of these. Some people were receiving their medicines covertly (without their knowledge). There were multidisciplinary agreements for this practice and clear guidance for the staff.

The provider undertook regular audits of medicines management and, where they had identified problems, there were action plans to put things right.

People were protected by the prevention and control of infection. There were appropriate procedures regarding this and the staff had been trained to understand these and the importance of good hand hygiene, cleanliness and supporting people with infections. The staff wore protective clothing, such as aprons and gloves, when supporting people and these were appropriately disposed of. The provider recorded and assessed information about infections and senior managers were able to view this each month so that they could identify any areas of concern.

The building and equipment was clean throughout on the day of our inspection. However, we noted that some shower heads would benefit from additional deep cleaning because of limescale. The registered manager reported that this had been attended to the day after our visit. There was a schedule for cleaning the service, including deep cleaning. The provider undertook regular infection control audits. Problems identified during these audits had been addressed and there was a record of the action taken.

The provider had systems to learn from incidents, accidents and complaints so that they could improve the service. For example, the templates for recording accidents and incidents included space for analysis of what happened and action taken after the event. The registered manager viewed all records of accidents

and incidents and a monthly analysis of these was shared with the provider's senior managers. There was evidence that there had been learning from complaints which had been received which made a difference to the whole service. For example, one person's next of kin had raised a concern about the condition of their relative's feet. As well as addressing the concern, the provider had spoken with all staff and made posters to remind them to check the condition of everybody's feet when they were providing support with personal care. Other complaints had resulted in similar actions, with the registered manager holding staff meetings and creating visible reminders regarding specific areas of concern.

Good

Is the service effective?

Our findings

People's needs were assessed before they moved to the home and then regularly reassessed to make sure information was up to date. The staff carrying out the assessments had been trained to do so. They spent time with the person and their representatives finding out about their needs, preferences and how they wished to be cared for. Information was clearly recorded and incorporated into care plans.

People were cared for by staff who had the skills, experience and knowledge needed. People using the service and their relatives confirmed this, telling us that the staff appeared to be well trained and knowledgeable. New members of staff undertook training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. New staff also shadowed experienced members of staff. Their competency was regularly checked before they were assigned a permanent role at the service. There were regular training updates for all members of staff. Some of these were classroom based and run by senior staff at the service or visiting healthcare professionals. There was also a range of computer based training the staff were expected to complete each year. The provider supported care staff to undertake vocational qualifications and for nurses to undertake clinical training so they could keep their professional qualifications up to date.

The staff told us they felt the training was sufficient and helped them to understand their roles. In addition, there was information available to assist with learning and keeping up to date with best practice guidance. The staff confirmed they had regular meetings with their line manager both individually and as a team to discuss their work and best practice. We saw minutes of these meetings.

There were appropriate systems to support the staff to communicate with each other, including a handover of information at staff change overs so that they always had up to date knowledge of people using the service.

The care staff and nurses we spoke with had a good knowledge of individual people using the service and how they liked to be cared for.

The environment was suitably designed to meet people's needs. However, the décor and layout did not always confirm with best practice guidance for dementia friendly environments. For example, some areas were difficult for people to orientate themselves, some improvements could be made to the lighting in certain areas and there were limited things for people to touch or handle in communal areas. Having things for people to do and help themselves to can be beneficial for their wellbeing.

Menus were displayed on dining tables and there were notice boards giving some information about planned and past activities, photographs or events and essential information such as the complaints procedure.

Some people had personalised their rooms and people were encouraged to do so. The furniture, décor and

furnishings throughout were relatively well maintained and the registered manager explained there were plans to redecorate some areas, with people using the service choosing the colour scheme.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We checked that the provider was acting in accordance with the principles of the Act and found that they were.

However, we saw that forms used to state that people should not be resuscitated in the event of their heart stopping (DNAR forms) had not always been completed to show that people or their representatives had been consulted or had agreed to this. The forms had been completed by the person's GP and in some cases there was limited information about why this decision had been made. We noted that one person's form stated they had the mental capacity to make this decision but there was no record to indicate they had been consulted. In other examples, the discussion with and agreement of people's representatives had not been documented. This meant that these decisions may have been made without proper authorisation by the person's doctor. In one example, we found that the DNAR form had been completed whilst the person was in hospital before they moved to the service, and therefore was no longer relevant and, if the person or their representatives agreed with this decision, a new form in respect of their care at the service was needed. We discussed this with the registered manager. Following our visit they told us they had started to review all of the DNAR forms to make sure they were only in place where this was the wish of the person, or their representative, and that this was appropriately recorded.

The staff had assessed people's capacity to make specific decisions about their care and treatment. Where people lacked capacity, the provider had consulted with their representatives to make decisions in their best interests. People were invited to take part in reviews of their care plans. The registered manager explained that they wrote to people's representatives when reviews were due to ask for their views and whether they would like to attend a review meeting. Where people lacked capacity and were being deprived of their liberty, the provider had made applications for DoLS. They had a system to track when DoLS needed reviewing. Information from DoLS authorisations were incorporated into care plans.

People were supported to access the healthcare services they needed. The provider employed qualified nurses to work at the service and they monitored people's health needs throughout the day and night. They used appropriate assessments to determine people's wellbeing and if they were in any pain. There was clear information about these and any health needs were incorporated into care plans. There was evidence of regular monitoring of people's wellbeing. The provider had responded appropriately to changes in people's needs or condition. They had made referrals to other healthcare professionals when needed and the local GP visited the service each week. There was evidence of good communication between the staff at the service and the GP. People told us they had regular appointments with their GP and other healthcare services, which included visiting opticians and dentists.

People were supported to have enough to eat and drink. People told us they liked the food. Some of their comments included, "I'm perfectly happy with the food. There's a lot of variety and you get a choice'', "We get different things in food. If I don't like it I can ask for something else; if you're not well they'll bring you your meals in bed'', ''I [have a special diet] and the chef is very helpful and does things especially for me'',

''The food is very good'' and ''The chef is good, if you do not want something on the menu he will bring you something else.''

People's nutritional needs were recorded in their care plans and where people were at risk there was a plan to make sure this risk was minimised. For example, people had been referred to the dietitian and had specific plans in place to meet their nutritional needs. Food and fluid intake was monitored and recorded and people were regularly weighed to make sure any changes in their eating habits or weight were responded to.

People were able to make choices from a menu which was varied and reflected their preferences. The chef met with new people when they moved to the home to discuss their likes, dislikes and needs. They had detailed information about each individual and were able to tell us about their needs. The chef also attended mealtime service and spoke with people using the service about their enjoyment and monitored how much people ate. They regularly met with the nurses and management team to discuss people's needs. The provider had organised catering meetings where the chef met with a small group of people who lived at the service to discuss and plan menus. The chef maintained a clean and well-ordered kitchen, where there were effective systems for stock rotation, temperature checks and cleaning.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. They told us that they had good relationships with the staff and that they felt well looked after by them. Some of their comments from people and their relatives included, "I'm perfectly happy here; they treat me very well. I'm very comfortable really and the best thing is the people that run it", "They're very kind'', ''I'm quite content with the way they care for me", ''You can have a shower or a bath when you like and they give you all the help you need'', ''The carers are really caring, they are fond of [my relative]'', ''As far as I can see the quality of care is good, the interaction from the chef to the handy man, they all know people's names, they are all very kind'', ''The [staff] here are lovely. I can't fault the care and attention'', "They look after me very well, they're very nice and caring and kind. Nothing's too much trouble – it is all very good" and ''Nothing could be better, it is very nice here.''

We observed the staff being kind and polite towards people. They were attentive when people asked for assistance and they addressed people in a caring way.

People told us that they were supported to make choices about their care and be as independent as possible. One person told us, ''I am allowed to get up and go to bed when I want.'' Another person said, ''They encourage you to ask and speak up for yourself, they get me anything I need and tell me what they think, but they let me make choices, for example if I want to have a shower.'' A third person explained, "I like to do as much as I can for myself. The more you try to do the more you use your limbs." People's preferences and wishes were recorded in their care plans. There was evidence they had been involved in discussions about these during regular reviews of their care. For example, the provider operated a ''resident of the day'' system where they reviewed each person's care on a set day once a month. During this review the person had the opportunity to speak with the chef, housekeeping staff, lifestyle coordinator and nurses about how they felt their needs were being met and any changes they wanted.

People's privacy was respected. The staff addressed people using appropriate language and their preferred names. They knocked on doors before entering and made sure personal care was provided behind closed doors.

People's religious and cultural needs were recorded in their care plans. The staff caring for people, including the catering staff, were aware of their needs so these could be met. Alternative menus were provided where people had a specific dietary need. Representatives from the local churches visited the service.

Good

Is the service responsive?

Our findings

People told us that they received personalised care which met their needs. They, or their representatives were consulted when care plans were developed and reviewed. We saw that care plans included personalised details about how people wished to be cared for, their preferences and individual needs. There was evidence the staff had responded to changes in people's needs and care plans had been updated to reflect these. The staff completed logs of the care they had provided. These showed that care plans had been followed and people's needs were being met.

The registered manager told us that they had recruited a physiotherapist to work at the service twice a week because they had identified people needed assistance with physiotherapy exercises and being supported to keep active. The physiotherapist met and worked with individual people, provided guidance and training for staff and spoke with any relatives who wanted information or to share their concerns about people's mobility.

Relatives of people who used the service told us they were involved in planning and reviewing people's care. They said they were informed about changes in their relative's wellbeing and they were welcome to visit whenever they wanted.

The provider employed a lifestyle coordinator who was responsible for planning and running organised and individual social activities. There was a vacancy for a second lifestyle coordinator and at the time of our inspection the current lifestyle coordinator told us it was difficult to ensure everyone's needs were being met. We saw that throughout the day many people were not engaged in a social or leisure activity. Some people remained in bed and people in the lounges spent the majority of time watching television. The lifestyle coordinator offered some people individual support through sitting and talking with them and reading to them. They also ran some short group activities, including a quiz.

People told us they liked the entertainment and organised activities and events. Some of their comments included, ''We have lessons [things to do] every day, the quizzes are my favourite'', ''We can go outside [into the garden] but we have to have someone with us and we go on trips in a minibus sometimes'', ''We went to the shops at Christmas and had a nice cup of coffee'', ''We can watch films with popcorn, or throw a ball and painting sessions'', ''There are a few activities; I love the gardening" and "They have lots of things to keep you occupied… I like to play games sometimes.'' "We saw photographs of some special events, which included visiting entertainers and celebrating traditional holidays. There was a time table of planned events which was displayed for people to view.

The lifestyle coordinator told us that she tried to visit all the people who remained in their bedrooms every day to speak with them providing individual sessions in the morning and organised group activities each afternoon for one hour.

Life Story books, created with the person and their family, were kept in individual rooms and divided into a life history section and current life in Charlotte House. These were designed with the aim that staff would

initiate conversation and get to know people's personalities as well as their care needs.

People using the service and their representatives told us they knew how to make a complaint or raise a concern. Those that had shared a concern with the provider were satisfied that this had been dealt with appropriately. The complaints procedure was displayed in communal areas and was available in people's bedrooms. The provider had a record of complaints. This showed how they had been investigated and responded to. There was evidence that the provider had apologised to people when things went wrong and had taken steps to put things right.

Some people were being cared for at the end of their lives. There were care plans relating to this which included information about people's wishes for care at this time. The staff worked closely with the local palliative care teams to make sure people received the right support, comfort and pain relief when needed.

Good

Is the service well-led?

Our findings

People using the service and their visitors told us they felt the service was well managed. They said that they felt they could speak with the registered manager and that any concerns would be addressed. Some people said that they would recommend the home to others.

The staff we spoke with were positive about working at the service. They commented that there had been improvements in the numbers of permanent staff working there, team work and communication. They said that the registered manager was effective, visible and approachable.

Feedback on an independent care home review website was also positive with 14 reviews since 2016 all stating that they were likely or extremely likely to recommend the service. Four reviews had been left in 2018 from relatives of people who lived at the service. Some of their comments included, ''Staff are hardworking and treat residents with care and dignity'', ''I am confident my [relative] is well cared for'', ''The home is clean and tidy with a friendly, homely atmosphere'', ''Warm, welcoming, friendly yet professional'' and ''Each resident is very much seen as an individual and each care plan is specific to them.''

The registered manager had worked at the service since 2016. They had previously managed other residential care homes and had a management in care qualification. They kept themselves updated with best practice and changes in legislation by attending conferences organised by the provider and others, liaising closely with other organisations and subscribing to updates relating to health and social care provision. They told us they were in the process of reviewing how information and data about people using the service and staff was stored in line with changes in legislation which were about to come into force.

There was a suitable leadership team supporting the registered manager, which included the deputy manager, unit leaders and managers of different departments within the service. They regularly met to discuss the service and any improvements which were needed.

The provider had effective systems to monitor the quality of the service and make improvements. The staff at the service undertook regular audits regarding the environment, health and safety, cleanliness, equipment, records, medicines management and the care being delivered. The registered manager analysed audits and we saw they had developed action plans to address areas that needed improvement. The provider evaluated reports of accidents, incidents, complaints, deaths, infections and other significant events to make sure they identified and responded to any causes of these and trends.

The provider kept the records required to manage this type of services. However, we noted that some information was difficult to track because the staff were not always consistently recording information in the same place. For example, when people had been referred to healthcare professionals the outcome of this referral had not always been recorded in the same place. We also saw some duplication of records and the staff told us they sometimes found they were writing the same information in several different records. This practice presented a risk that important details were not recorded in the right place. We discussed this with

the registered manager during our feedback and they told us they were in the process of auditing how staff recorded information.

People using the service and other stakeholders were invited to give feedback through annual satisfaction surveys, by using a comments book which was situated in the foyer and by attending organised meetings for people using the service, relatives and staff. The provider also employed a customer relations manager who worked at this and one other Care UK service. The registered manager explained that their role included running sessions for relatives and members of the public to inform them about key issues. They told us recent sessions had included a talk about dementia and they were planning a talk about end of life care in the near future. The service had participated in the national care home open day which took place shortly before our inspection. Members of the public were invited to the service where they found out about what living in a care home might entail.