Care Quality Commission

Ganymede Care Limited

The Chiswick Nursing Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 14 and 15 October 2014. The first day of the inspection was unannounced and we told the manager we were returning on the second day. At our previous inspection on 13 December 2013 we found the provider was meeting regulations in relation to the outcomes we inspected.

The Chiswick Nursing Centre is a 146 bedded care home with nursing and provides care, accommodation and support for older people and younger adults, people who are living with dementia, people with mental health needs, people with physical disabilities and people with learning disabilities.

The service was managed by a registered manager. 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.

Summary of findings

People and their relatives felt the service was a safe place to live. There were individual risk assessments in place which were based on how to keep people safe, taking into account their needs whilst promoting their entitlement to independence and choice. People and relatives told us they felt there were enough staff on duty to keep people safe. We saw that staff answered call bells and attended to people in a timely manner. Staff recruitment was robust, although we noted that full details of prospective employees' previous employment dates were not sought on the service's application form. The systems for managing and auditing medicines were thorough and staff told us they had suitable training.

People received effective care from staff, who had appropriate training and supervision. People were provided with choice in regard to food and drinks, and their nutrition and hydration was monitored. People had access to visiting health care professionals, including GP's, dentists, opticians and dietitians. The service employed a physiotherapist and two physiotherapy assistants, and people told us this was beneficial. Staff were aware of the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS), which care homes are required to meet. The service acted within the legal requirements when determining whether people needed to be deprived of their liberty in order to keep them safe.

We observed that people and their representatives had positive relationships with staff, who demonstrated their understanding of people's diverse needs and their life histories. People were spoken with and treated by staff in a respectful and kind manner and their privacy and dignity were promoted. For example, we saw staff knock on bedroom doors before entering and close doors when providing personal care. People's end of life wishes were recorded and the service was working with people, their representatives and medical professionals to make sure that resuscitation instructions were discussed and recorded where required. Staff had some training regarding how to meet palliative care needs, although the provider was seeking additional training for staff.

Care plans were regularly reviewed, involving people and their representatives. People and their representatives told us they were asked for their views about the quality of the service and had an opportunity to express these, for example, through attending meetings and completing surveys. There were opportunities for people to take part in a wide range of activities and entertainment within the service, and to go out on local trips. People received visits from local ministers of worship and a service was held each week at the home. During the inspection we saw that staff had enough time to respond to people's needs in a timely way. People and their representatives knew how to make complaints and said they were confident that complaints were taken seriously.

The manager was described by people and their representatives as being visible and approachable. We saw the manager interacting well with people who used the service and people confirmed they regularly spoke with the manager on his visits to the individual suites. The staff told us they felt well supported by the management team and they felt the manager had positively changed the culture within the service. Staff were supported through regular formal meetings and also used 'handover' meetings between shifts, which meant any concerns and important information could be shared with colleagues. There were systems in place to monitor the quality of the service and there was evidence that learning took place from the results of audits and complaints investigations.

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?

Good

The service was safe. People who used the service and their relatives told us they felt safe, and the staff we spoke with knew how protect people from being abused. There were appropriate risk assessments within people's care plans, which were kept under review. Staff recruitment was generally thorough, although we noted the service did not seek the dates of employees' prior employment. Medicines were safely managed, including the checking and auditing of medicines and charts. There were systems in place to make sure adequate staffing levels were in place. The premises were clean and hygienic.

Is the service effective?

Good

The service was effective. People and their relatives were involved in their care planning and the delivery of their care. The care plans showed that people were asked about their preferences and staff received the training they required to meet people's needs and wishes. Staff understood the Deprivation of Liberty Safeguards and the Mental Capacity Act (2005) and the provider acted in accordance with legal requirements when people did not have the capacity to consent.

The care plans demonstrated that people's health care needs were identified and addressed. People accessed support for their health care needs from staff at the service, and external medical and health care professionals.

Is the service caring?

Good

The service was caring. During this inspection visit we saw that staff treated people with dignity and kindness. People were offered a range of activities and entertainment, which they could choose to participate in.

People and their representatives were asked their views about their end of life care and their views were recorded in their care plans.

Is the service responsive?

Good

The service was responsive. We found that the service assessed people's needs and recorded suitably detailed guidance and information so that staff knew how best to meet these needs.

People and their representatives were asked for their opinions about the quality of the service, through surveys, meetings and care planning discussions. The service used complaints as a way of learning from mistakes in order to make necessary improvements.

Is the service well-led?

Good

The service was well-led. People told us that the manager was approachable and accessible, which we observed during this inspection. Staff told us they liked working at the service and said they felt supported. They were confident that the manager would respond in an open and professional manner if they raised any concerns about the service.

Records showed that staff were supported through regular meetings, which also offered opportunities for discussing areas for improvement. Frequent audits and checks were carried out to assess the quality of the service and any identified shortfalls were remedied.

The Chiswick Nursing Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 October 2014. The first day of the inspection was unannounced and we told the manager we would be returning for a second day.

The inspection team consisted of three inspectors, a specialist professional advisor with experience in the nursing care of older people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in the care of older people.

Before the inspection we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications of incidents reported to CQC and the last inspection report of 13 December 2013 which showed the service was meeting all regulations covered during the inspection. We also looked at a Provider Information Return (PIR) we asked the provider to send us before the inspection. 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.

During the inspection we spoke with 22 people using the service and 13 relatives and friends. We interviewed 10 staff, observed care in communal areas and reviewed records. The records we looked at included 18 people's care plans, medicines records, staff records and records relating to the management of the service.

Some of the people living at the service had dementia and were not fully able to tell us their views and experiences. Because of this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with a representative of the Clinical Commissioning Group (CCG) responsible for funding placements in the service, a CCG continuing care nurse responsible for assessing people's care and supporting staff in the service, a GP with patients in the service, a NHS pharmacist with responsibility for carrying out medicines audits in the service and an Independent Mental Capacity Advocate (IMCA) who supported people living in the service who were not able to make decisions about their own care.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said, "Most people here are extremely approachable, whether residents or staff. I love coming back here after hospital appointments. I feel safe." Another person told us, "The staff look after me very well and I always feel safe." A relative told us, "The staff are very, very pleasant. I watch them a lot as I visit four times a week and I've never seen any unpleasantness or anything untoward."

We spoke with nursing and care staff about their understanding of how to keep people safe from the risk of abuse. Staff were able to tell us the actions they would take if they thought a person was at risk of abuse and they understood how to use the provider's whistle blowing policy. The training records demonstrated that staff received regular safeguarding training, which was usually provided internally but staff were sent to local authority safeguarding training whenever it was available. The manager told us he was on the local safeguarding adults serious case review panel and therefore had in-depth knowledge about safeguarding issues. The service had a safeguarding document that was in an easy read format so that people using the service were able to understand the action they could take if they were worried about their safety. There was a central record of safeguarding incidents. We could see that these were updated as required to show what action had been taken and the outcome of any investigation.

The manager told us that staff were able to access the local community mental health teams if they were concerned about the mental well-being of someone using the service as well as other specialist healthcare professionals. He was able to give an example of how training had been arranged to support staff in identifying triggers for behaviour that challenged the service so that strategies could be put in place to diffuse these situations.

There were systems in place to identify any risks to people's safety and develop appropriate plans to manage risks. We looked at 18 care plans, which all had up-to-date and individualised risk assessments. There were risk assessments for health care needs such as mobility, tissue viability, nutrition and falls prevention, and also risk assessments specific to people's health conditions. We saw risk assessments which had been updated following incidents and new preventative actions had been put in place. Staff were able to describe how they supported people to keep safe whilst enabling people to make choices and where appropriate, take informed risks.

Staff files generally contained evidence of all of the required recruitment checks such as proof of identity, criminal records checks and a minimum of two verified references. However, we noted that the application form completed by prospective staff asked for their employment history but did not ask for their dates of employment. This meant that gaps in employment were not identified and therefore could not be explored to ensure the person was suitable to work at the service. We discussed this with the manager and the director of nursing who said they would look into adding the dates of employment to the application form.

The manager told us that there was a rolling recruitment programme so that new staff were employed to cover any vacancies and to ensure there were enough staff to meet people's needs. The staffing arrangements ensured that there was always a nurse on duty on each unit and a staffing ratio of one staff member to every five people using the service. There were also arrangements in place to provide one to one support for those people who required this support to maintain their safety and that of other people using the service. We viewed duty rosters covering a period of one month and these confirmed what the manager had told us. They also clearly evidenced any changes that had been made. The manager told us he was in the process of recruiting a housekeeper to be responsible for ensuring the environment was maintained to a satisfactory standard but also to become the infection control champion for the service.

There were appropriate medicines policies and procedures in place. A senior manager attended the service to carry out medicine audits on a weekly basis and we saw reports that confirmed this. There was also evidence that action was taken to address any identified shortfalls. Senior care workers were provided with training by a pharmacist and were permitted to administer medicines once they had been deemed competent. However, this was almost always done with a qualified nurse present. We spoke with a senior care worker who had been trained to administer medicines, who was able to explain how their training, followed by competency assessments, had prepared them for their role and responsibilities. The service received

Good

Is the service safe?

support from the Integrated Care Programme (ICP) within the local NHS Trust. The manager told us that a pharmacist from the ICP attended the service on a regular basis to review medicines within the home. We spoke with the pharmacist who told us the service managed medicines well, and staff were approachable and co-operative. Staff also received support from the pharmacy that provided medicines to the service with regard to medicines training, advice and support.

We observed medicines being administered at lunchtime on one suite. Staff explained what the medicines were for and when a person refused the medicine they were offered, the staff member respected the person's wishes and recorded their refusal. We also checked how the service stored medicines on two other suites, including the arrangements for the safe disposal of medicines no longer required. We looked at a sample of medicine administration record sheets (MARS) and found they were appropriately completed in accordance with the provider's medicines policy.

There was a programme of refurbishment that was in the process of implementation to ensure the environment was maintained and kept safe for people using the service. There were plans in place for foreseeable emergencies such as fire, flood and loss of power, which provided clear guidance for staff. Staff were able to describe the actions they would take in the event of an emergency. The home was clean and equipment was hygienic and well maintained. A relative told us, "We haven't had any problems with cleanliness. They keep his room beautifully clean." Staff told us they had unlimited access to personal protective equipment such as disposable gloves and aprons, as well as wall mounted units containing hand washing liquid and supplies of alcohol gel. We saw these items being used during the inspection and staff told us they had received infection control training. We found an unlocked store room on the fourth floor suite in which there was an unlocked cupboard containing bleach. We informed a nurse who immediately took appropriate action.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained for their role and responsibilities. One person using the service said, "The staff I speak to are certainly trained. I get a really great feeling of satisfaction when I can do something on my own and they encourage me to do this." A relative of another person told us they were generally pleased with the knowledge and performance of staff but thought some staff needed support to learn some commonly used English expressions, when it was not their first language.

The manager told us that changes had been made to improve the training provided for staff. He said that all training was completed using face-to-face training facilitated by external trainers who specialised in particular topics. For example, the manager had also asked the trainer who provided safeguarding training to use different ways of conveying the training materials to make it more interesting for staff as this training was repeated annually to ensure the knowledge and skills of staff was kept up to date.

Training records showed that moving and handling, safeguarding, food hygiene, infection control and Mental Capacity Act (2005) training was taking place annually. Fire safety training was taking place twice a year. Training had also been completed during the past 12 months in a range of topics such as supervision, falls prevention, challenging behaviour in dementia, gastronomy tube care, dignity in care, dysphasia awareness, equality and diversity and report writing. A nurse told us, "There was less training and induction when I joined a few years ago but now there is an emphasis on training and checking the competencies of nurses and care workers."

The manager had introduced a one week induction process for new staff. This included the completion of a workbook that covered the Skills for Care common induction standards.

We saw a supervision matrix in place to plan and monitor one to one sessions between staff and their line manager that were organised to monitor staff performance, discuss any concerns and identify training needs. A new supervision system had been introduced and the expectation was that staff would receive a minimum of eight one to one meetings with their line manager each year. Staff records confirmed that these were taking place.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been arranged where staff were concerned that a person's decision making was putting their well-being at risk. Specialists had been involved in this process where it was felt needed, for example, in one instance a neuro-psychologist had been involved. The manager was able to demonstrate that he had considered the Supreme Court ruling in relation to DoLS. He had discussed this with the local authority and a meeting had been arranged to discuss the arrangements in place at the service and any need to apply for DoLS authorisations. At the time of this inspection there was one DoLS authorisation in place, which the CQC had been previously informed about. We spoke with the Independent Mental Capacity Advocate (IMCA), who had been involved with supporting this person. An IMCA works with vulnerable people who lack capacity to make important decisions and do not have relatives or friends in a position to represent their views. The IMCA told us the service had demonstrated a caring, open and helpful approach.

People told us they liked the food and received the support they needed to enjoy their mealtimes. One relative said, "Food wise staff are absolutely brilliant. I think food is very well cooked. The nutritional assessment at admission showed [my relative] was underweight and staff involved us in the care planning". A person using the service told us, "I like the food, it's very good and you can always have second helpings. I can have two puddings if I ask." Other comments from people included, "The food is good and I am fussy about food" and "I do have some criticism of the kitchen but they do a good English breakfast." Another relative told us the refreshments trolley was brought around very regularly, however, they thought food portions were too big for their relative and felt meals might be more appetising to some people if smaller portions were offered. We observed mealtimes on both days during this inspection. We saw people were offered choices, and provided with assistance in a dignified and discreet manner. The dining rooms were bright, cheerful and very well laid out with tablecloths, serviettes and flowers on the table along with the menu. Records showed there was a four weekly rotating menu with a choice of meat, fish and vegetarian options. There were also records to evidence safety checks such as food, fridge and freezer temperatures were carried out daily.

Good

Is the service effective?

The care plans showed people were supported to access healthcare, with a GP visiting regularly. The manager told us that a chiropodist visited the service on a weekly basis and that people could arrange to see the chiropodist for a fee. Referrals could be made to NHS services if people did not want to pay this fee; however, the manager said that there was usually a delay in this service which meant most people preferred to pay privately. The service had its own physiotherapy team that consisted of one registered physiotherapist and two physiotherapy assistants. One relative told us the physiotherapy service had, "really helped [my relative] get back to normal and walk again with a frame." We received positive comments from people about their access to medical and healthcare services. One relative told us, "The new GP service is wonderful, brilliant, and the tissue viability nurse (TVN) has been involved and done a grand job. We have also seen the podiatrist and been referred to the dietitian, all in a short time of being here." Relatives told us people could remain with their GP service prior to admission but this had not been possible as they no longer lived within the agreed geographical boundaries. During this inspection we spoke with a visiting GP who told us they had been visiting the service since July 2014, when the service switched to using their practice. The GP said they were working with the service to improve the systems for referring people and the use of Do Not Attempt Resuscitation (DNAR) documents.

Good

Is the service caring?

Our findings

People told us they were supported in a caring way by staff. One person using the service said, "I am treated like a prince" and another person said, "The staff are very nice. You can talk to them."

Comments from other people included, "They look after me very, very well. I've got no complaints whatsoever. The staff are excellent and have got a good sense of humour", "I'm comfortable and as well as can be expected. On the whole staff are kind and caring" and "The staff are awfully nice. They always ask for consent when they help me to get dressed and encourage me to be as independent as I can. I do think this is a very good place".

We observed positive interactions between people using the service and staff. Staff demonstrated they understood people's individual needs and limitations. People were communicated with in an empathetic and appropriate manner, with staff taking time to make eye contact, speak slowly and clearly and listen carefully so they understood what people wanted. During our lunch time observations we saw a person ask for a carrier bag to carry their belongings in, which staff responded to in a prompt and friendly way. Three courses were served and people were asked what they would like at each course, and when they would like their food served. Staff were observed letting people know what they were going to do and telling them what they were having to eat before they assisted them, and we saw requests for additional condiments were met. One person did not like their requested choice of main course and staff made arrangements with the chef for an alternative 'off menu' dish to be sent to the dining room. One person started to choke on their food; staff were very prompt at attending to this person and demonstrated sensitivity as well. They monitored the person closely after this and cut their food up to ensure they were able to manage as the person wanted to continue eating their meal.

The care plans we looked at showed how people and their representatives were consulted about their daily routines, likes and dislikes, and their cultural and religious needs. People signed their care plans to demonstrate their involvement or their care plan was signed by a relative. We spoke with a person who had travelled extensively and led an interesting life. A member of staff joined our conversation and knew about the person's life and the importance of celebrating their accomplishments. People looked clean, well dressed and tidy. Some people attended the hairdressing salon within the service during the inspection and we spoke with people who told us they had frequent appointments for hair washing and styling in the salon. People told us they would ask a member of their family to act as their advocate and a few people told us they used a solicitor. The manager of one of the suites told us about a person who was currently accessing advocacy support and explained how staff provided comfort and understanding to this person during a difficult experience. The service had details of local advocacy organisations to provide to people; however, the manager told us that generally people were not interested in using advocates.

Staff were able to describe how they supported people in a way that promoted their privacy and dignity for example, knocking on bedroom doors before entering and ensuring doors were shut before delivering personal care. Observations showed that staff spoke with people in a dignified way. The relatives we spoke with said the visiting hours were flexible, and they were welcomed by staff and offered a drink.

Training records showed staff had received some training in how to meet people's end of life care needs. However, the manager told us they wanted to improve upon the quality of staff members' end of life care knowledge and had made arrangements for staff to attend additional training. The service was able to access support from NHS community palliative care services to assess people's needs and provide advice and guidance for staff. The care plans contained information about people's end of life wishes, for example, information about funeral arrangements and any specific guidelines to be followed for religious and cultural reasons.

Good

Is the service responsive?

Our findings

People told us they were asked for their views about the quality of the service. Comments from people included, "I don't think the staff could do any better. They take what you say seriously and don't skim over it" and "They do surveys every six months". Another person said, "I know how to complain and feel confident they would use complaints to make things better."

The manager said that some complaints were managed informally. He gave an example of a concern that had been raised by relatives during our visit about their family member's dental hygiene. This had been resolved by the suggestion of the use of an electric toothbrush that the manager had been able to provide. There was a suggestion box in the reception area and complaints forms people could complete and put in the box if they wished to do so. These were then read and were usually promptly addressed. We saw a letter that had been sent to people who use the service and their relatives asking for suggestions about the summer menu that was being planned earlier in the year. The manager told us that people using the service were involved in choosing and shopping for accessories for bathrooms that had been recently refurbished.

Information about how to complain was provided in the welcome pack people received when they were admitted to the service. However, we noted that this was not produced in any easy read formats; the manager confirmed that this was the case at present. We looked at the complaints records and found that complaints had been responded to promptly. There was a complaints log sheet in place at the front of the record to monitor the progress and outcome of complaints to ensure these were resolved satisfactorily. We saw an example of a complaint made by a person who used the service. This had been responded to point by point and some changes had been made as a result. For example, a meeting had been arranged with the catering manager so that the person could discuss their dietary requirements.

The service was moving towards an electronic based and more personalised care planning system that could be updated in real time at different points throughout day and night shifts but this had not yet been implemented. The care plans we looked at contained comprehensive assessments of people's needs and any identified risks. The assessments also took into account factors including people's preferences, cultural needs, interests, religious practices and family relationships. We saw one care plan which explained how a person liked to be supported with their daily personal care needs, which included hairdressing and manicures. It stated they should be offered choices of clothing and jewellery. The person's family had been involved in the care planning and their life history document provided insight regarding their long-standing interest in personal styling.

There was an activities coordinator employed for each of the five units to plan and organise leisure and social events that met people's needs and took account of their interests. The service had recently created a cinema room that people could access to watch movies of their choosing. Activities programmes were in place that included newspaper reading, cooking, pet therapy, use of the sensory room, pub visits and a fortnightly religious service.

Good

Is the service well-led?

Our findings

People using the service and their relatives told us the manager was visible within the service and easy to contact. Comments included, "I see the manager around quite a bit. He's very approachable" and "It's very easy to approach the managers."

The registered provider carried out quarterly monitoring visits to the service. The last visit had taken place in July 2014 and we saw the report for this. The manager of the service was expected to respond to the report to demonstrate how any shortfalls had been addressed.

Management review meetings were also taking place at regular intervals where the management teams across the two services operated by the provider met to discuss any issues, any changes in legislation or best practice guidance. For example, during the meeting in July 2014 they had discussed changes within the Care Quality Commission and Health and Safety Executive.

Heads of departments also had regular meetings and then unit meetings were also taking place so that staff were kept informed about any issues or changes taking place and to give all staff the opportunity to be involved.

We saw the minutes of four unit meetings that had taken place. Topics that were routinely discussed included safeguarding, accidents, training, clinical issues, complaints and customer care. There was an expectation that these meetings took place every two months in each unit but this was not always achieved.

We saw a range of audits that were completed to monitor the service and address any shortfalls and areas for development. These included infection control audits, medicines audits and care plan audits. We saw that action points had been identified and there was an expectation that senior staff signed to state that these had been addressed by the timescales specified. Generic audits were also completed monthly and different areas were chosen each month. These included areas of practice such as response times to call alarm bells, staff engagement and quality of care.

We saw that the management team analysed incidents and accidents and coded these in a way that helped identify any patterns arising. This meant that action could be taken to reduce the likelihood of incidences reoccurring and promote people's safety. In particular we saw an analysis of falls that had taken place to look at the correlation between these and the occurrence of urinary tract infections. This led to further follow up action to address the health needs of two people using the service. The service also completed out 'Take 10' audits. These were 10 minute audits that were carried out with individual staff members and covered topics such as safeguarding and their knowledge of individuals using the service.

Annual satisfaction surveys were sent to people who use the service and their relatives. We saw that 88% of people and relatives had returned completed surveys and the results of these had been analysed. The manager was able to demonstrate that changes had been made in relation to the food choices available as a result of the issues raised in the surveys and improvements had also been made to the accommodation.

The service produced a quarterly staff newsletter and had introduced an employee of the month award. Staff, people using the service and visitors could all nominate staff for this award with more weight given to those votes cast by people who used the service. The manager said that this had helped to improve staff morale at the service. Staff told us they felt positive about the open culture at the service and believed that the registered provider actively sought to improve staff morale.

Meetings were held for people using the service and their relatives to share information and give people the opportunity to express their views about the service on a quarterly basis. We saw the records for a recent meeting during which GP arrangements for the service, staff training and redecoration had been discussed. During this meeting relatives had raised a concern about the lack of tea and coffee available after meals. The manager had listened to these concerns and talked to staff about improving this. The manager also told us that he had considered holding meetings at different times of the day so that more relatives could attend and had consulted with relatives about this.

The manager told us that he was supported by the provider and that one of the directors arranged one-to-one meetings with him at regular intervals. He also said he had access to training to support his professional development.

We saw evidence that the management team had considered university research to inform practice at the

Good

Is the service well-led?

service. For example, the effect of uniforms on people with dementia was being considered as recent research has shown that people living with dementia respond better to staff who do not wear uniforms.