Havering Care Homes Ltd

Upminster Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 5 and 6 April 2017. Upminster Nursing Home is a purpose built 35 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited, 30 people were using the service.

The service had 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 and associated Regulations about how the service is run.

At our last inspection of this service on 27 January 2016 we found that the provider met regulations but there were some areas that needed improvement. These were in relation to the availability of snacks and hot drinks during the night, making the internal environment more dementia friendly and responding to people's needs in a timely way. At this inspection we found improvements in all these areas.

Systems were in place to minimise risk and to ensure that people were supported as safely as possible. The staff team worked closely with other professionals to ensure that people were supported to receive the healthcare that they needed.

People told us they felt safe at Upminster Nursing Home and that they were supported by kind, caring staff who treated them with dignity and respect. We saw that staff supported people patiently, with care and encouraged them to do things for themselves. Staff knew people's likes, dislikes and needs. They provided care in a respectful way.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The provider monitored the service provided and people were asked for their feedback about the quality of service. When issues or concerns were identified action was taken to address these. The management and staff team were committed to developing and improving the service.

People were happy with the food and drink provided and their nutritional needs were met. If there were concerns about their eating, drinking or weight this was discussed with the GP and support and advice was received from the relevant healthcare professional. People were offered refreshments throughout the day and night.

Systems were in place to review staffing levels in line with people's needs and staffing levels were adjusted accordingly.

People's care plans were reviewed and updated to ensure that they contained the necessary information to enable staff to support them safely.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

Arrangements were in place to meet people's social and recreational needs.

Staff suitability to work with people who need support was checked before they started their employment at the service.

People lived in an environment that was suitable for their needs. Improvements had been made to make the environment more 'dementia friendly'. Systems were in place to ensure that equipment was safe to use and fit for purpose.

Staff received training and support to carry out their duties and felt that this was the right training for the job they did.

The arrangements for administering medicines were safe and people received their medicines as prescribed.

Staff were trained to identify and report any concerns about abuse and neglect and felt able to do this.

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. There were sufficient staff on duty to meet people's needs.

People received their medicines safely.

Systems were in place to safeguard people from abuse. They were protected by the provider's recruitment process which ensured staff were suitable to work with people who need support.

The premises and equipment were appropriately maintained to ensure they
were safe and ready for use when needed.

Risks were identified and systems were in place to minimise these and to keep people as safe as possible.

Is the service effective?

Good

The service was effective. People told us that they were happy with the food and drink provided. They were supported by staff to eat and drink sufficient amounts to meet their needs.

People were supported by staff who had the necessary training, skills and knowledge to meet their needs.

Systems were in place to ensure that people's human rights were protected and that they were not unlawfully deprived of their liberty.

People's healthcare needs were identified and monitored. Action was taken to ensure that they received the healthcare that they needed to enable them to remain as well as possible.

The environment met the needs of the people who used the service.

Is the service caring?

Good

The service was caring. People were treated with kindness and their privacy and dignity were respected.

People received care and support from staff who knew about their needs, likes and preferences.

Before staff provided care and support they took time to explain to people what was going to happen. Staff were attentive to people's needs and spent time chatting to them.

Staff supported people in a kind and gentle manner and responded to them in a friendly and patient way.

Is the service responsive?

Good

The service was responsive. When any issues or concerns were raised action was taken to address these.

People were supported to be involved in a variety of activities of their choice.

Systems were in place to ensure that the staff team were aware of people's current needs and how to meet these. Care plans contained details of people's needs, wishes and preferences.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Complaints were taken on board and action taken to address any concerns or issues.

Is the service well-led?

Good

The service was well-led. People were happy with the way the service was managed.

Staff told us that the registered manager was accessible and approachable and that they felt well supported.

The provider sought people's feedback on the quality of service provided and their comments were listened to and addressed.

The management team monitored the quality of the service provided to check that people's needs were met and they received the support they needed and wanted. When this did not happen action was taken to address any shortfalls.

Upminster Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 5 and 6 April 2017 and was carried out by one inspector, a specialist nurse advisor 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 service. At the last inspection on 27 January 2016 the service was rated requires improvement with no breaches of regulations.

Prior to the inspection, 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. Before our inspection we received feedback from a social worker, a care manager and a local authority quality monitoring officer. We also reviewed the information we held about the service. This included notifications of incidents that the provider had sent us since the last inspection.

During our inspection we spoke with six people who used the service and observed the care and support provided by the staff in the communal areas. We also spoke with six staff, the registered manager, the managing director and six people's relatives. We looked at eight people's care records and other records relating to the management of the service. This included three sets of recruitment records, duty rosters, accident and incident records, complaints, health and safety and maintenance records, quality monitoring records and medicine management records.

Good

Is the service safe?

Our findings

People and their relatives thought Upminster Nursing Home was a safe place to be. Relatives felt their family members were safe and well cared for and this meant they did not worry about leaving them. One person said, "They are on the ball with safety." Another said, "They stop you from falling." A relative commented, "I feel [family member] is safe here."

Medicines were securely and safely stored in appropriate metal trolleys and there were also appropriate storage facilities for controlled drugs. We checked the controlled drugs and found that the amount stored tallied with the amount recorded in the controlled drugs register. Keys for medicines were kept securely by the nurse in charge to ensure that unauthorised people did not have access to medicines. Medicines requiring cold storage were kept within a locked fridge. Temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were also kept at safe temperatures to remain effective. Any unwanted or unused medicines were recorded, safely stored and disposed of. In line with good practice opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the prescribed time once opened.

Systems were in place to ensure people received their prescribed medicines safely and appropriately. Medicines were usually ordered, stored and administered by nursing staff. Senior care staff who had received medicines training and had been assessed as competent assisted when needed. They completed the necessary records to confirm that medicines had been given. Medicines Administration Record (MAR) charts were correctly completed and up to date. They included people's photographs to check that medicines were given to the correct person. Allergies were also indicated.

Some medicines taken 'as needed' or 'as required' are known as 'PRN' medicines. We saw that although protocols were in place for the administration of PRN medicines they needed to be more detailed with the necessary information for staff to follow to administer these safely, effectively and consistently. The registered manager and senior nurse told us that they would be updated.

Staff were aware of the risks to people and took action to minimise these. For example, by the use of bed rails, pressure relieving mattresses or moving and handling equipment. Risk assessments were in place relevant to individual need and included bath temperatures, continence, nutrition, mobility and falls. People who were unable to use call bells also had risk assessments and were checked at agreed intervals depending on need and the level of risk. For some people this was hourly and for others two hourly. In addition there were pictorial signs in these people's rooms in order to quickly alert staff on the need to check on them.

From our observations and from looking at staff rotas we found that staffing levels were sufficient to meet people's needs and to support them with what they chose to do. The provider used a computerised system which recorded people's risk assessments and care plans plus staff interventions. This software system was also used to assess and monitor staffing levels in relation to people's needs. During the day there was one nurse and six care workers on duty. In addition there was a part time care planning coordinator and an

activity coordinator. Staff were supported by domestics, catering staff and a handyperson. At night there was one nurse and three care workers on duty. People felt that there were enough staff to support them. They said that call bells were answered promptly. One person said, "They take care of everything. I can ask and they will get it for me."

Staff had received safeguarding training and were aware of the safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse. They knew what to do if they suspected or saw any signs of abuse or neglect. People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider's recruitment process ensured that staff were suitable to work with people who need support. This included prospective staff completing an application form and attending an interview. We looked at three staff files and found that the necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom.

The premises and equipment were appropriately maintained and systems were in place to ensure they were safe to use and fit for purpose. Records showed that equipment was serviced and checked in line with the manufacturer's guidance. Gas, electric and water services were also maintained and checked to ensure that they were functioning properly and were safe. The records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were safe and in good working order. Staff told us that pressure relieving mattress pressure settings were checked daily. We checked pressure mattress settings in four rooms and found them set properly. They were set to ensure that people were getting their recommended pressure relief based on their weight so as to reduce the chance of developing pressure ulcers.

Systems were in place to keep people as safe as possible in the event of an emergency arising. Staff had received emergency training and were aware of the evacuation process and the procedure to follow in an emergency. A 'fire safety' emergency box was in place. This contained a plan of the building including where extinguishers and call points were situated, details of cut off points for gas, water and electricity and emergency numbers. Each person had a personal emergency evacuation plan which provided information about their needs to assist the emergency services in the event of an evacuation. Therefore emergency information was readily available should the need arise.

Providers of health and social care have to inform us of important events which take place in their service. Our records showed that the provider had told us about such events and had taken appropriate action to ensure that people were safe.

Good

Is the service effective?

Our findings

People and their relatives were happy with the service provided. One visitor told us, "We looked at other homes, with better reports, but this place had such a welcoming way. We were so worried but they have been wonderful." A social worker said, "The family have no concerns regarding their relatives placement and have fed back that the home take good care of them."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Most staff had received MCA and DoLS training. Staff were clear that people had the right to and should make their own choices as far as possible and understood the importance of seeking consent when supporting people. Staff told us they always asked for consent before delivering care and we observed this in practice. One staff said, "We never use force. We give people choice and always ask. If they refuse we try gentle persuasion. If that fails we try again later. If that fails we try another member of staff."

Systems were in place to ensure that people's human rights were protected and that they were not unlawfully deprived of their liberty. The registered manager was aware of when and how a DoLS application should be made. For people with DoLS in place, these had been agreed by the relevant supervisory body. Applications had been made for other people. The registered manager was waiting for responses for these. Senior staff were aware of people where a DoLs authorisation was sought.

People were provided with a choice of suitable nutritious food and drink. A pictorial menu was available to enable people to choose what they wanted. They told us they were happy with the quality of food and the choices available. One person said, "The food is top notch." A relative told us, "[Family member] loves the food. It's hot and there's choice." A catering survey had been carried out and responses to this were positive. People had also been asked what they would like to see on the menu and this had been facilitated.

At the time of the inspection none of the people who used the service had a specific dietary requirement due to their culture or religion. However, a variety of dietary needs were catered for. For example, diabetic, low fibre, soft and pureed diets. People's menu choice and dietary needs were recorded on a colour coded chart. This enabled the cook and care staff to quickly and easily identify what people needed and wanted and lessened the risk of any errors being made. People were provided with meals that met their needs.

People were supported to eat and drink sufficient amounts to meet their needs. Staff monitored and kept

records of the dietary and fluid intake for people with specific dietary requirements as a result of a medical condition or other need. When there were concerns about a person's weight or food intake advice was sought from the relevant healthcare professionals. A system called fluid watch had been introduced and this flagged up people at high risk to alert staff of the need to encourage them to take more fluids. In the afternoon people on fluid watch were given jelly and cream as a snack. A member of staff told us that this was another method of supporting people who needed more fluids. A relative told us they were very pleased their family member had put on weight since they started using the service. At lunchtime some people ate independently and others needed assistance from staff. We saw that staff appropriately supported people to eat and that they were not hurried.

People were supported to maintain a balanced diet. Staff were aware of people on special diets and those with swallowing difficulties. We saw nutritional risk assessments in place and referrals to the speech and language therapists as well as dietitians were made, via the GP, when required.
For people on food and fluid, intake monitoring staff immediately entered the quantity of food eaten on the electronic system. Cold and hot drinks and snacks were offered in between meals. One person told us, "I can get a sandwich before going to sleep." Another said, "They bring you drinks."

People's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible. The GP visited weekly and opticians, podiatrists and dentists also reviewed people. People saw professionals such as tissue viability nurses and speech and language therapists when needed. One relative told us, "They [staff] called the GP straight away when [family member] was sick." Another said, "There is such an improvement in [family members] physical health, since they have been here." Records were kept of healthcare professional's visits with a summary and any recommendations made. We saw that when one person had started to use the service they had a pressure ulcer and that this was now healed. In addition a 'turning' mattress had been purchased and was being used to ensure another person received their turns regularly so as to reduce the risk of developing pressure ulcers. People's healthcare needs were met.

Staff told us and records confirmed that they received the training they needed to support people who used the service. Training included safeguarding, infection control, moving and handling and mental capacity. Staff had recently attended dementia training provided by an external organisation. One staff told us, "The recent dementia training has helped me to understand people better. It made me put myself in their shoes and helped me understand how unsettling and scary a new environment can be to someone who is already losing control over what they can remember." Nurses had been trained to carry out more complex tasks that people needed. For example, catheterisation and administering medicines via a syringe driver. A relative told us, "The staff know exactly what they are doing, very professional." In addition, staff received supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service) approximately every three months. They also had an annual appraisal and attended staff meetings. People were supported by staff who received appropriate training, support and guidance to enable them to provide a service that met their needs.

The service was provided in a large purpose built building in a semi-rural area. There were four floors with a lift to each floor. Adapted baths and showers were available as was specialised equipment such as hoists. Improvements to the environment had taken place since the last inspection including a new wet room and a new bathroom. All 35 bedrooms had ensuite facilities and there was also a 'dementia friendly' garden. At the last inspection we recommend the provider review the environment and surroundings and make appropriate improvements in line with guidance on this from the Alzheimer's Society. Since the last inspection changes had been made to support people living with dementia. This included changing toilet seat colours, coloured borders around light switches, colourful signage and themed decorating on each floor. The provider was working towards achieving a sensory charter mark and further improvements were

planned as a result of this. For example some lighting changes. The environment met people's needs.

Good

Is the service caring?

Our findings

Three people said that very recently they had not been as happy as usual with the way they were treated by specific staff. They had felt comfortable to raise this and it was being addressed by the registered manager and the managing director. However, overall people and their relatives were positive about the care and support they received. They told us staff were kind and caring. Comments included, "Two thumbs up for staff," "All the staff are great both men and women" and "Staff is lovely. [Staff member] on nights is caring and takes an interest."

We observed that staff supported people in a kind and gentle manner and responded to them in a friendly and patient way. They acknowledged and engaged with people as they went around the service. In response to a feedback survey a healthcare professional had written, "Upminster Nursing home is one I have confidence in. I always enjoy observing the close and friendly relationship between staff and residents."

People's privacy and dignity were maintained. We saw that doors were closed during personal care and staff knocked and waited for a response before they entered peoples rooms. One person told us, "Staff are very respectful. They always knock. They ask before they do anything." In a feedback survey a relative had said, "There is space for my [family member] to have privacy and to mix with fellow residents."

People were encouraged to remain as independent as possible and to do as much as they could for themselves. Mobility aids were left within reach and we saw staff encouraging people to mobilise and to eat independently.

People were supported by staff to make daily decisions about their care as far as possible. We saw that people decided what they did, where they spent their time and what they ate. 'Residents and relatives' meetings had taken place and minutes of the meetings were displayed on the notice board. People were asked for their opinions about what happened at the service and to them.

People were supported to have a pain free and dignified experience towards the end of their life. Staff provided caring support to them and to their families. This was in conjunction with the GP and the local hospice. Nursing staff had received training to enable them to effectively administer pain relieving medicines to people at the end of their life. This helped to ensure that people were comfortable and as pain free as possible. Staff told us the steps they would take to ensure people's last wishes were respected. One staff said, "We work closely with people, their families and other healthcare professionals such as the hospice, GP to ensure people are comfortable." Another told us how they had honoured a person's last wishes by reading them a passage from a religious book of their choice. We saw thank you cards from bereaved relatives. One had written, "Thank you for allowing us as a family to spend time with [family member] and for being there for them at the end." Another had said, "Thank you for looking after [family member]] in their final weeks. I could not have asked for better." We also had the opportunity to speak to a recently bereaved relative. They told us, "The care and love, especially near the end was really good and supportive to the family. Absolutely fantastic."

Do Not Actively Resuscitate (DNAR) forms were in place for those who had wanted this or for whom this had been agreed was in their best interest. When this was the case discussions had been held with relevant family and professionals and the GP had signed the necessary form. The computerised system indicated if people had a DNAR in place so that this information was readily available to all staff. Advanced care planning was also in place outlining people's wishes of how they wanted to spend the last days of their life. People benefitted from the support of a caring staff team.

Good

Is the service responsive?

Our findings

People who used the service and their relatives were positive about the way the staff responded to their needs. Staff responded to people's calls for assistance in a timely manner. We saw staff offer people cardigans and blankets when they verbally or non-verbally indicated they were cold. A reviewing social worker told us, "I visited the home and found no problems. The family for the person I saw were really happy with the care their loved one received." A relative had written in a survey, "All members of staff are attentive and can be called upon to give help whenever needed."

People's individual records showed that pre-admission assessments had been carried out by the registered manager or trained staff. Information was also obtained from other professionals and relatives. The assessments indicated the person's needs and gave staff the initial information they needed to enable them to support people when they started to use the service. Once at the service another assessment was carried out and a temporary care plan put in place until risk assessments were completed and comprehensive care plans developed.

People's care plans were person centred and contained details of their likes and dislikes, needs and preferences. For example, in one plan it said that the person liked to have their teeth cleaned before breakfast. In another plan for a person with a pressure ulcer the frequency of dressing changes, type of dressing to use and input from tissue viability nurse were all included. There was a stable staff team and staff knew the people they supported well. They told us about people's needs and how they met them. The electronic care planning system drafted care plans based on risk assessments. If there was an error then this was pulled through in all relevant care plans. We did find some examples of this which were discussed with the registered manager and managing director. They undertook to review this and to put a system in place to minimise the chance of this happening.

We saw that care plans were reviewed each month and updated as and when necessary. They were completed with the person and their relative where possible. Care plans and assessments were computerised and the system automatically flagged up when information needed to be reviewed and if this was not done then it was flagged up as overdue. This meant that staff could clearly see what needed reviewing and the management team could monitor this very quickly and easily. Changes in people's care needs were communicated to staff during the handover between shifts and recorded on the system. This enabled staff to have current information about people's needs and how best to meet these.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. When able, they chose where to sit, what to eat and what to do. We saw that people were consulted and staff asked their permission before doing things for them.
One person told us, "I can stay in my room and have my meals they don't make me join in." Another said that they chose not to join in activities and that this was not a problem. A relative told us that when there family member 'moved in' they had been able to put up different curtains and make the room how they wanted it.

Arrangements were in place to meet people's social and recreational needs. In a feedback survey one relative had written, "Everyone tries to keep people active and their minds working." An activity coordinator was employed and we saw photographs of a variety of celebrations and activities displayed around the building. People were supported to participate in activities that suited their needs and likes. We saw one person go out with their relative. Another person told us, "I go to club every week." There was also an active knitting club which knitted hats for premature babies at a local hospital. We observed the activity coordinator playing dominoes with one person, play a word game with another and later making crafts for Easter. We also saw a memory tree where people were encouraged to write their favourite memory. Some people had helped with planting the planters in the garden. They also made birthday cards and Easter chicks that were sold to raise more funds for activities. There was happy and relaxed atmosphere where discussion was encouraged. Relatives who were present were invited to join in the activity.

People were encouraged to maintain social contact. Relatives told us that they were made welcome and could visit when they wanted for as long as they wanted. One relative said, "I can come in the evening and stay till [family member] goes to sleep." Another told us, "I am here all the time. Staff are very welcoming and supportive. They keep me up to date and look after me. I can make a hot drink in that corner."

People used a service where their concerns or complaints were listened to and addressed. The complaints procedure was displayed on notice boards in communal areas around the building. Complaints were logged and actioned by the registered manager. People and their relatives were confident that any issues or concerns would be addressed by staff and the registered manager. A social worker told us, "The person I went to see was happy with the care they received and if there were any issues they were dealt with quickly."

Good

Is the service well-led?

Our findings

People were happy with the management of the service. They and their relatives commented on how they quickly they had settled in since they started to use the service. They said they had concerns before arriving but found the experience much better than they could have imagined. In a feedback survey a relative had written, "It feels like a home and not a medical facility or institution."

There were clear management and reporting structures. There was a registered manager in overall charge of the service and in addition to care staff and senior care staff, there were nurses who led each shift. Staff reported good team working and a happy staff group. They told us they felt well supported by the registered manager and the managing director.

People were provided with a service that was monitored to check it was safe and met their needs. The registered manager and the managing director monitored the quality of the service provided. This was by direct and indirect observation and discussions with people who used the service, relatives and staff. There was also a system of audits and reviews. For example, monthly directors audits, which included care plan audits infection control and reviewing audits carried out by staff. The computerised recording system enabled the management team to check at a glance that required interventions had been carried out. This and other details of what was happening in the service were displayed on the computer screen in the registered manager's office. Any overdue or uncompleted tasks were automatically flagged up. Both the registered manager and the managing director visited the service unannounced outside their normal working hour, including night time visits. External consultants also carried out quarterly quality audits and made reports of their findings and recommendations for improvement. Required actions from audits and monitoring were included in an operation plan which was colour coded to indicate the importance of each task. We saw that this was a working document and was updated as and when tasks were completed.

People were consulted about what happened in the service. They were asked for their opinions and ideas. Meetings for relatives and people who used the service were held and minutes of these were displayed on the notice board for those who were unable to attend. At the meeting in March 2017 they had discussed what was happening in the service and how should some money raised be spent. The provider sought feedback from people who used the service and their relatives through quality assurance surveys. Feedback was also formally sought from staff. In addition 'relatives and residents' meetings took place. People used a service which sought and valued their opinions and these were used to improve and develop the service further.