Battersea Place Retirement Village Ltd

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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 inspection took place on 8 May 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection of the service since it registered with the Care Quality Commission (CQC) in March 2016.

There was a registered manager at the service. 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.

Battersea Place Retirement Village Limited provides a domiciliary care service for older people living in 105 apartments on site. At the time of the inspection, out of the 105 occupied apartments, only eight people were receiving personal care.

People and their relatives were satisfied with the service. They said the healthcare assistants understood their needs, were caring and they felt safe in their presence. They said they were always on time and stayed beyond their allocated time if they needed more help.

People were able to maintain relationships that were important to them. Family and friends were encouraged to visit and a guest apartment was available for people to book in advance if needed.

People led independent lives, making use of the opportunities on offer in the way of entertainment and activities such as a gym, swimming pool, cinema, craft room and library. Activities included aqua aerobics and Tai chi.

Staff recruitment procedures were robust and staff files included completed application forms, interview evaluation forms, references, proof of identity and address and DBS checks.
Healthcare assistants received a thorough induction based on the Care Certificate, which prepared them well for their role. They demonstrated a caring attitude and told us they felt well supported by their colleagues and managers.

Healthcare assistants said they liked working for the organisation and in their conversations with us it was clear they understood the organisation's values.

People told us they were involved in their care plan reviews and were able to make a choice and have control over the support they required. They said the provider was flexible and accommodated their needs.

The provider utilised an electronic care plan system and each healthcare assistant was issued with a smartphone which they used to clock in and out, and checked off their tasks every time they visited a person

to support them. This system allowed the managers to have an overview of when visits were carried out and if healthcare assistants attended visits on time. It also provided them with real-time information about the personal care tasks that had been provided at any particular time.

There were both long and short term care plans in place for people, short term plans were used to manage a specific aspect such as managing pressure sores or wound care. Each aspect of care, whether long or short term included the current need, outcome and action.

Standard risk assessments such as waterlow for pressure sores, moving and handling and the risk of falls were in place and reviewed regularly. If any areas indicated a high risk there was an associated care plan in place to manage the risk.

People's healthcare needs were met by the provider. People were able to either retain their existing GP or to register with the visiting GP. There were two clinic rooms on site which were available for the visiting GP to use. Care records included people's medical histories and observations. Daily record charts documenting visits from doctors, nurses and other healthcare professionals were maintained.

There was an open culture within the service. People and their relatives were aware of the managers within the service and said they felt comfortable approaching them.

The provider had systems in place to monitor the quality of service and drive forward improvements. These included monthly clinical governance reports, any compliments or complaints, care plan and medicines audits and monitoring of response times to call bell alerts.

The provider had just completed a resident's survey about their views of the service. We reviewed the raw data from the survey and noted that feedback about the service people received was positive.

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 told us they felt safe in the presence of healthcare assistants.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures were robust.

People were supported to take their medicines in an appropriate manner. Healthcare assistants were trained and competency assessed in medicines administration.

Standard risk assessments were completed for people and care plans were in place where an area of high risk was identified.

Is the service effective?

Good

The service was effective.

Healthcare assistants completed an induction which was based on the Care Certificate.

People's consent was sought and their care plans developed with their agreement

People's healthcare and dietary needs were managed appropriately.

Is the service caring?

Good

The service was caring.

People told us healthcare assistants were caring towards them.

People were able to maintain important family relationships,

People led independent lives, supported by the provider through a range of entertainment options and activities.

Is the service responsive?

Good

The service was responsive.

A paperless care plan system allowed tasks to be updated in real-time, reports to be generated and alerts set up when care plans were due for renewal.

Long and short term care plans were in place and contained information on how healthcare assistants could support people.

People said they were satisfied with the service. They were given information about how to raise informal and formal complaints.

Is the service well-led?

Good

The service was well-led.

There was an open culture within the service.

Healthcare assistants felt supported and told us they worked well as a team.

A number of quality assurance checks such as clinical governance monitoring, care plan and medicines audits were in place.

Battersea Place Retirement Village Limited

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.

We undertook this comprehensive inspection on 8 May 2017. The inspection was announced, the provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with two people using the service and one relative. We also contacted two relatives after the inspection and heard back from one of them. We spoke with two healthcare assistants, one nurse, the registered manager and the director of care. We looked at four care records, staff records, training records, complaints and audits related to the management of the service.

Good

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe in their flats. They said the healthcare assistants were kind and considerate and they felt safe in their presence.

Healthcare assistants were aware of safeguarding procedures and this was covered in their training programme.

There was a computerised care plan system in place. Healthcare assistants scanned their smartphones when they entered and left a flat to carry out personal care. This uploaded data onto the care plan system so the registered manager was able to view real time information about when people had been supported. The system also allowed for alerts to notify if a visit was late or had been missed.

Risk assessments were updated frequently and included Waterlow, personal emergency evacuation plan (PEEP), nutrition, moving and handling, falls risk, continence assessment and the Barthel index. The waterlow risk assessment was used to assess the risk of a person developing a pressure sores. The Barthel index is a scale used to measure performance in activities of daily living (ADL).

The system was automated so when clinical staff completed a risk assessment, if the data inputted indicated a high risk there was an associated care plan in place to manage the risk. For example, one person had been identified as being at high risk following a waterlow risk assessment and they had an appropriate skin integrity care plan in place to manage the risk of developing pressure sores. Another person identified as being at high risk of falls had a mobility care plan. These were reviewed monthly by clinical staff which helped to ensure the risk was being managed appropriately.

We found there were enough staff to meet people's needs. At the time of our inspection, eight people required support with personal care. On the day of our inspection, there were four healthcare assistants on shift, alongside one nurse and the clinical lead. A person told us, healthcare assistants were, "Always punctual, always on time."

Staff we spoke with said they had sufficient time to complete their tasks, one said "There are four of us today, we are allocated people at the beginning of the day. We have enough time." Care workers used a QR barcode to clock in and out at each visit. Reports could also be generated to monitor the times that healthcare assistants clocked in and out at every visit. People were issued with call pendant alarms to alert staff if they needed help. Notifications flashed up on all the staff's phones when people activated their alarms. The system was designed so that staff were able to talk to and reassure people via their smartphone while they were waiting for them.

Staff recruitment was robust. We reviewed four staff files. These contained peoples CVs, application forms, interview evaluation forms and their contract. Potential employees provided details of two referees to contact, proof of identity and address and completed a right to work checklist. Staff files also contained evidence of training completed prior to their employment.

DBS checks were also in place for all staff. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

There was a three month probationary period for new staff after which the registered manager completed a probationary review assessing their performance and how they demonstrated the organisation's values.

People using the service and their relatives said they were happy with the support they received in relation to their medicines.

All medicines were stored in people's individual flats and people were asked if they needed support with medicines or if they could manage them themselves. If people needed staff to administer medicines, MAR charts were completed appropriately and records of staff signatures kept.

Healthcare assistants told us they had received medicines training. Medicine competency assessments were seen for staff which tested their knowledge of medicines, policies and a competency summary assessment. One healthcare assistant said, "The nurse came and observed me."

Good

Is the service effective?

Our findings

People were supported by staff who received appropriate training which meant they could support people effectively.

Staff praised the quality of the training they received, telling us it was very thorough. Comments included, "We did the Care Certificate when I started", "We did the Care Certificate as part of the induction, since then I've done moving and handling, fire awareness and health and safety" and "The training has been excellent."

We spoke with the director of care who went through the induction process with us. Induction was a four day process during which the value and ethos of the organisation were explained. They told us that all staff completed the Care Certificate regardless of their role. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

Each standard of the Care Certificate was covered over the induction period. All courses were face to face except for food hygiene which was e-learning. Training was delivered by the director of care, the registered manager and external training organisations. In addition to this, staff also received training in moving and handling, first aid, food hygiene and completed a completed level two certificate in preparing to work in adult social care.

Nurses completed additional training which included advanced medicines - competency assessment, auditing and managing medicines incidents, catheterisation, priorities of care, drugs at end of life and venepuncture training. Nurses had current registration with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. One nurse said, "Our revalidation has been done, through training and case studies."

Staff received regular supervision and an annual appraisal. Action points from previous supervision sessions were discussed, training and development, key worker responsibilities and any new actions for the supervisee or supervisor. In their appraisal, staff were asked how they demonstrated the organisation's values - outstanding care, authentic choice and unrivalled hospitality. They were also asked about how they were meeting CQC's five key questions and any learning and development needs.

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.

A healthcare assistant told us, "Mental capacity is when you look at an individual and see if they can make a

decision or do they need help."

People using the service and their relatives told us they were consulted when planning their care and their views were taken into consideration. They told us they were in control of the level of help they required. One person said, "We went through the care plan, everything was agreed and updated."

Care records included a number of consent forms for photos and care plans. People had fully consented and had purchased their flats so there were no people being supported who did not have the capacity to consent.

Care records contained information related to people's mental capacity with statements such as 'is able to make informed decisions', 'can make choices' and 'can make decisions but likes support from [family member].'

People's healthcare needs were met by the provider.

People were given the opportunity to retain their existing GP or to register with the visiting GP who visited the service every two weeks and held a clinic on-site. There were two clinical rooms on site which were available for the visiting GP to use. One person told us, "I'm seeing the GP tomorrow. [The clinical lead] arranged that." A relative said, "I was able to change doctors, no problem."

Medical histories were taken and documented in people's care records. Observations such as temperature, pulse, blood pressure, blood oxygen, respiration and weight were recorded and could be analysed for any changes easily as they were presented electronically in a graphical format.

Daily record charts documenting any visits from doctors, nurses, and any other healthcare professionals were maintained.

The electronic care plan system was able to generate a hospital passport if needed. The aim of the hospital passport is to provide hospital staff with important information about people and their health when they are admitted to hospital. Any relevant notes such as therapy or GP reports were scanned into the system.

There was a restaurant on site that people were able to utilise and was open daily for breakfast, lunch and dinner. People were also able to request room service. The menu was changed seasonally. A café was open daily, providing morning and afternoon teas and light meals.

Care records contained details of meals that people had eaten. Some people told us they bought food and prepared it themselves or asked healthcare assistants to do this for them.

Good

Is the service caring?

Our findings

People using the service and their relatives were satisfied with the care they received and told us that healthcare assistants were attentive to their needs and were very caring towards them. Some of the comments included, "Very kind and caring", "I can call on them if needed for anything extra", "They are very good", "Very accommodating" and "The carers are wonderful."

The registered manager told us they were flexible in meeting people's support needs so even if certain hours had been agreed for healthcare assistants to visit, if people needed more support or help they would provide this. Relatives that we spoke with confirmed this would happen and they could call upon the staff to assist them outside of their agreed hours. People that had not purchased their 'care package' were still able to use the service if they needed occasional help, for example if they were feeling unwell.

Healthcare assistants showed empathy and spoke about how they cared for people, telling us, "I put myself in their shoes, I treat them like family" and "If someone needed more help I will stay past the time allocated."

The registered manager and the director of care confirmed to us that all staff, regardless of their role were trained in the Care Certificate. This meant that staff who were non-clinical or healthcare such as concierge, housekeepers and restaurant staff were trained in care. This was so they would have an understating of care and were able to support people in their own way, such as identifying changes in people's health and/or wellbeing and they could alert care staff if people needed some support. The director of care who was involved in training staff said, "We tell them about safeguarding because they are often the eyes and ears of the organisation" and "I often get restaurant staff telling me so and so is not feeing themselves, so we can then follow that up."

People told us they were able to maintain relationships that were important to them. People were able to book a room within the restaurant for any private parties. Family and friends were encouraged to visit and a guest apartment was available for people to book in advance if family or friends wanted to stay over.

People led independent lives, making use of the opportunities on offer in the way of entertainment and activities.

Good

Is the service responsive?

Our findings

People had purchased the flats they were living in on the understating that if personal care was required, it would be assessed and provided by the provider. People understood that if they needed care workers to come and support them, they would pay for this service. People were given the tariff rates as part of their documents and contracts when they moved into their flats.

There were a wide variety of entertainment opportunities available for people using the service to enjoy. There was a restaurant, gym, masseuse, swimming pool, cinema, craft room, billiards room, library and hair salon on site. People were able to book a 'club room' within the restaurant if they wanted to hold private functions or parties for families and friends.

In addition, a list of activities was on offer to people including shopping trips, computer sessions, aqua aerobics, ballet exercise and tai chi. Information on these activities was made available to people. A minibus was available for people to utilise in addition to private cars and a chauffeur service.

The clinical lead told us, "My responsibilities include overseeing systems and ensuring care plans are all up to date." The provider used an electronic, paperless care planning system with a mobile application that was used by the healthcare assistants. Care records were created, updated and maintained electronically. The front page of each record had a summary and a checklist and the time of when personal care tasks had last been completed. This provided a visual confirmation of the last time that people had been supported.

There were standard long term care plans in place for all people along with short-term ones to manage specific aspects of people's care such as managing pressure sores or wound care. Each care plan, long or short term included the current need, outcome and action. Long term care plans covered a range of areas such as communication, daily life, mobility, medicines, skin integrity, nutrition and personal care.

Healthcare assistants carried provider issued smartphones with a mobile application to access people's care plans. This included a list of tasks to be completed at each visit. Once a person had been supported, healthcare assistants completed the task as marked on their smartphones which updated the care plan system.

Healthcare assistants completed care notes at the end of every visit and were also able to complete care notes for handover in case they needed to pass any relevant information to the healthcare assistant who was due to visit them next.

The system was set up so that care records were reviewed monthly, alerts were set up to notify staff when they were due to be renewed. This meant that they were kept up to date with relevant information. Healthcare assistants told us their views were taken into consideration when care plans were reviewed, one told us, "We do have an input, if we notice a change we report it to the nurse and update the care notes." One person told us, "My care is reviewed. It's all up to date."

People using the service said they were satisfied with their care and had no complaints. Comments included, "I couldn't suggest any improvements, everything is fine" and "I do not have any complaints."

A record of complaints was kept which included the details of the complaint, a summary of the action taken and the outcome. All associated investigation reports were attached to each complaint, providing a clear audit trail of the investigation and any other evidence gathered. Each person was given a compendium, providing details of the complaints process. People were encouraged to speak with the general manager in the first instance and if after this they wished to take it further, to follow the complaint policy and procedure. Each apartment was provided with a copy of this.

Good

Is the service well-led?

Our findings

A general manager was responsible for the whole service who was supported by a director of care, the registered manager and clinical lead. The clinical lead was responsible for overseeing the clinical staff and healthcare assistants.

Healthcare assistants said they liked working for the organisation and in their conversations with us it was clear they understood the values of the organisation to provide outstanding care, authentic choice and unrivalled hospitality. They said they worked well together as a team and they felt valued. Comments included, "Teamwork is good", "It's good", "Really happy" and "[The manager] is easy to speak to."

Regular staff meetings were held for both clinical and healthcare assistants. A range of topics were discussed including sickness, staffing and recruitment, training, medicines.

There was an open culture within the service. People and their relatives were aware of the managers within the service and said they felt comfortable approaching them. Both the registered manager and the director of care were familiar with people using the service which was evident in the way they spoke with them. The general manager also kept in contact with people through a weekly email.

The provider had systems in place to monitor the quality of service and drive improvements.

The registered manager carried out night visits once a month to ensure people's needs continued to be met and to also engage and hold meetings with night staff.

The clinical lead completed a clinical governance report every month. This report looked at occupancy levels, any infections within the service such as wounds, any infections, incidents and accidents including any falls with injury, without injury and skin tears, and other clinical indicators such as weight loss/gain and pressure sores. They also reviewed any safeguarding incidents, compliments and complaints.

Care plan audits were completed looking at resident details, risk assessments, care plans, evidence of person centred care and evidence of health promotion.

Medicine audits were completed monthly looking at policies and procedures, record keeping, ordering and supplies, storage, self-administration of medicines, disposal, recording, advice and training.

Staff response times to call bells alerts could potentially be monitored as they logged electronically and the system allowed for reports to be generated and time keeping to be monitored.

The registered manager told us that they had a recent mock CQC inspection for which they were awaiting the results. She said the verbal feedback they received was positive.

The provider had just completed a resident's survey about their views of the service but the results had not

been analysed, we saw the raw data from the survey and saw there was positive feedback with people satisfied with the service.