Magicare Limited

Priscilla Wakefield House

Inspection report

Rangemoor Road
London
N15 4NA

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08 March 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days on 1 and 8 March 2017 and was unannounced. The last inspection took place on 25 January 2016 and was an unannounced responsive focussed inspection triggered by concerns raised in notifications to the CQC. At the last comprehensive inspection on the 19 February 2015 the service rating was Good.

Priscilla Wakefield House is based in Tottenham and provides residential and nursing care for up to 112 people. At the time of our inspection there were 106 people living at the service. There are five units in the service. Copperfield and Havisham for people requiring nursing care; Nickleby for residential care. Dorrit unit for people with dementia and nursing care and Pickwick for younger adults who may have dementia, brain injury or physical disability and who required nursing care and rehabilitation.

Priscilla Wakefield House requires a registered manager to be in post as part of its registration requirements from the Care Quality Commission. There was a registered manager in post but on extended leave at the time of inspection. Suitable arrangements had been made to ensure the service was safely managed and the deputy manager was filling in as an interim manager until the registered manager returned from extended leave. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we found breaches of regulations relating to person centred care and good governance. Since this inspection the provider has addressed these issues and is no longer in breach in these areas.

People felt safe in the home and there were robust safeguarding processes in place to try and prevent harm coming to people. All staff had been on safeguarding training and knew how to report suspected abuse.

On the first day of the inspection people told us staff were rushed and we saw this throughout the inspection, on some units they had no time to spend other than on care tasks rather than the person. By the second day of inspection more staff were on shift.

The home was clean and infection control measures were being followed. Housekeeping and care staff knew how to prevent the spread of infection for people receiving barrier nursing.

Staff all had good knowledge and understanding of the principles underlying the Mental Capacity Act 2005 and had all attended training for this. Deprivation of Liberty Safeguards had been applied for where it was appropriate.

There was a choice of food and it was freshly cooked, with snacks and home-made cakes on offer in

between meals. A range of drinks was on offer, recording of fluid intake was not consistent in places.

People and their relatives thought staff were caring and respected their dignity. We saw kind interactions between staff and people. Staff told us they loved their jobs and cared for the people on their unit.

Activities for people who were mobile were good. There was an improvement plan to get to know people better and provide more one to one and tailored activities for people who did not want to or could not join in group activities.

Staff felt supported, were well trained and had regular supervisions. Staff were positive about the management team and management systems were robust.

At this inspection we found a breach of regulations relating to safe care and treatment. Some medicines were managed safely but errors had been made and not reported and people were not being moved and handled safely when provided with care.
You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Some units in the home managed medicines safely whilst others did not.

The home was clean and followed infection control procedures. There was a dedicated housekeeping service.

Safeguarding systems were robust and safeguarding issues investigated and managed to reduce the risk of further harm.

People said staff were rushed and there could have had more staff on shift. By the second day of inspection a plan had been put in place to have more staff.

Is the service effective?

Good

The service was effective. Staff and the interim manager had a good understanding of the Mental Capacity Act 2005 and DoLS.

All staff had attended basic training in areas to support them to do their job. There was additional specialist training so staff could meet the needs of people.

The home worked in partnership with health care professionals to try and prevent hospital admissions.

The kitchens provided a range of healthy food which people enjoyed.

Is the service caring?

Good

The service was caring. Relatives and people said staff were kind and friendly.

We saw caring interactions throughout both days of inspection and staff knew the people they were caring for.

People were treated with dignity and respect and staff knocked on doors and announced themselves when they entered people's rooms.

Is the service responsive?

Good

The service was responsive. Regular opportunities for feedback into how the service was run were given to people. Meetings for people who lived in the home were held monthly.

There were regular activities and the home had a plan to improve these to make them more individualised. The home recognised that it needed to spend more time with people who stayed in their rooms.

There was a complaints procedure and people knew how to complain and felt comfortable doing so.

Peoples care files were not always person centred. The interim manager was aware of this and improvements were underway when we inspected.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led. We found that shortfalls identified during the inspection in relation to safe medicines management and moving and handling had not been identified or addressed by the providers quality monitoring systems.

The management team were organised and proactive and aimed to provide high quality care.

The interim manager had oversight of the whole home and had systems in place to monitor the effectiveness of each unit.

Staff felt supported. Where there were any disciplinary issues the management team worked efficiently to action them and support staff to improve practice.

Priscilla Wakefield House

Detailed findings

Background to this inspection

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

The inspection took place on 1 March 2017 and 8 March 2017 and was unannounced.

The inspection team was made up of four inspectors, a pharmacist inspector, a nurse specialist adviser and two experts 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. Before the inspection we reviewed previous inspection reports and information on notifications we had received from the service.

During the inspection we spoke with 21 people and observed interactions between care staff and people in communal areas. We spoke with seven family members. We interviewed 32 care staff and nurses, and the interim manager. We tracked the care records of 15 people and looked at nursing and daily care records. We looked at personnel files for six staff members, training records, complaints, safeguarding records and quality control documents.

We also contacted social workers and health care professionals and had feedback from the local authority.

Requires Improvement

Is the service safe?

Our findings

People felt safe. They said "Oh yes I am safe. I would shout and complain if I wasn't" and "I've never had the opportunity to be unsafe" and "I feel safe because I know the people [staff] are good." Relatives we spoke with felt their family members were safe. One relative said "Yes I think he is safe. I have no concerns."

We looked at whether medicines were managed safely. Medicines rooms on all floors were locked and well maintained. Medicines fridges on all units had their temperature recorded. One of the fridges had recorded a temperature of 11 degrees Celsius between 8 February 2017 and 8 March 2017. This was not followed up and the home policy on medicine fridge temperatures was not followed. People's medicines may have lost their effectiveness if they were stored for a period of time in a higher temperature than they should have been.

Medicine Administration Records (MAR) were filled out correctly for most people. We saw some people had hand written entries, where the nurse wrote the details from the prescription on to the MAR. These entries were not always countersigned by another nurse or a witness to say they had been written on the MAR correctly. The hand written entries were of varying quality across the units, with one unit following best practise guidance and another not. One person was prescribed Buccal Midazolam 2.5mg for their epilepsy, and had a hand transcribed MAR chart dated 20 February 2017. This had a carried forward balance which had not been countersigned. We found the hand written MAR documented there were currently two syringes in stock when there were six as confirmed in the controlled drug register. A further supply of four buccal syringes had been received on the 24 February 2017 but had not been added to the MAR chart. A dose had also been given on the 22 February 2017 with no record completed on the back of the MAR documenting effect. The recording of medicines on some units was not in keeping with the provider's policy.

We saw from MAR one person was not given their heart medicine for four days due to an error made by nurses and this was not reported to the interim manager or the medicines error procedure followed. This person was put at risk by not receiving their medicine for four days and then put at further risk by it being re started without the advice of a medical professional on how it might affect the person and how they felt. The provider's own policy stated "staff must be encouraged to report any medication error immediately to their line manager …. Advice from GP must be sought."

We noticed some units were using a highlighting system on MAR charts to remind nurses of when to administer medicines. Nurses were relying on the highlighted colour as a reference rather than the individual information for each prescribed medicine on the MAR chart. Two people had received eye drops at the wrong times when this system was being used rather than checking the prescribed times.

Controlled drugs in stock were checked against those recorded in the Controlled Drug Register and all drugs were reconciled in place. Medicines requiring an opening date were labelled and urine testing sticks were in date. The home kept returns books for medicines that needing returning, these were not always signed as completed or collected.

Some people on medicine administered covertly had paperwork in place to document the process. Original

decisions had detailed information on how medicines could be prepared safely, and included review dates. However they were not in place for every person. For four people additional medicines had been added on to the covert medicine list since the decision to administer medicines covertly had been made and the new medicine had not been reviewed. One of the medicines added to three people's list was Alendronic acid. This had not been checked as safe for crushing and on the box it stated it was not safe to crush because of a risk of oropharyngeal ulceration (where an ulcer forms on the oesophagus which can be very painful).

We looked at records for people who received medicines through a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, to provide food and medicines. There was information relating to the medicine and the PEG on the provider's medicines care plans stored with the MAR. However the MARs did not always record the medicine was to be administered via the PEG. For one person their MAR did not match the hospital PEG schedule attached to the MAR. We asked a nurse about this and they said this was an old document and needed updating.

PRN protocols were in place for medicines to be administered as and when they were needed. Homely remedies, for medicines not prescribed, had a record of use and amounts of medicines balanced. We saw there were large boxes of prescribed paracetamol in homely remedies supplies and fed back to the interim manager these were not with the people who had been prescribed them but were being used for homely remedies. The home removed these on the second day of inspection.

Medicines audits for January and February 2017 were completed but did not generate learned outcomes. Not all aspects of medicines management were covered and where one error with eye drops was noted, no action was recorded or taken afterwards so the error continued to take place after the audit was completed.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff talked to them about their medicines and any health concerns. One person said "They tell me what it is and they tell me what I can eat and what I can't because I am diabetic." Another person said "I have painkillers when I ask. They told my son all about me." A relative told us "They discuss it all with me. I think I ask them a lot of questions though so they tell me because they know I like to be kept informed."

Moving and handling assessments did not always specify people's hoist sling sizes in order to demonstrate that an assessment had taken place before choosing the sling size. We checked people's rooms and found hoist slings were clean. However in two out of four rooms checked the sling was not available. When we asked, care staff could not readily find the sliding sheet although they said they moved people using it. Staff eventually found the sling for one person in a drawer within their room.

One person complained of pain in their shoulder and showed us where the skin was tender to touch. They said it was where staff grabbed when trying to help them roll over. We asked this person if a hoist or any sliding equipment was used. They responded no. This person's moving and handling risk assessment 2 February 2017 stated "standing hoist to be used. Requires full assistance with personal care." We also observed a manual handling practice where we saw a person supported to sit back in their chair using a technique that was unsafe. We fed this back to the interim manager who said they would look into this straight away.

We spoke to the trainer and they told us and showed us that staff on that unit had up to date training and a

few were on the list for an upcoming moving and handling training refresher. They confirmed sliding sheets and slings were for individual use. However this was not consistent with what we observed which put people at risk of avoidable harm and discomfort due to incorrect moving and handling procedures.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding systems were robust. We looked at how the home managed suspected abuse and kept people safe from abuse. Every staff member knew signs of abuse and to report it straight away, all staff had attended training. The interim manager talked through several recent safeguarding concerns and gave a step by step account of how each case had been reported and investigated. The interim manager showed us where the home had learned from incidents and how to keep particular individuals safer and wider learning that had taken place. The home looked for trends in safeguarding and incidents and we saw evidence of discussions with unit managers on how incidents such as falls could be reduced.

Risk assessments were in place and reviewed regularly, some specific risk assessments such as risk assessments for diabetes were in place. Where this was the case information on how to manage the diabetes was included in other parts of the care plan. Risk assessments were updated after an incident. For example for one person we saw after they had a fall their risk assessment went from low to medium risk of falls and actions were put in place to try and reduce the risk of it happening again. We saw risk assessments for moving and handling, medicines, nutrition and hydration, and bed rails. People had individualised fire evacuation plans in the event of an emergency.

Staff told us pressure relieving mattress settings were checked and recorded once a day. These pressure mattress checks were not always recorded on the daily log sheet. There was a system in place where a sticker was put near the mattress setting monthly to indicate what setting the mattress needed to be. We checked stickers in four rooms and found them completed properly. Three out of four mattresses were set at the most recent weight. This was to ensure people were getting recommended pressure relief based on weight to reduce the chance of developing pressure sores. For the mattress that had moved to the wrong setting, staff quickly rectified it and explained that is why they did the daily checks.

For people at risk of developing pressure sores, care plans outlined the frequency of turns and checks. Turn charts and hourly checks were completed at the assessed intervals. Waterlow risk assessments were also in place and reviewed monthly. For those assessed as high risk pressure relieving aids were in place. Two people had pressure sores on one nursing unit, these were hospital acquired, dressed regularly and improving according to care records, and wound measurements were reviewed. Body maps and photographs were used where people had bruises, cysts, injuries or wounds. Care plans were developed where appropriate including how to mitigate any identified risks. For people unable to verbalise pain a system was in use to work out if they needed pain relief or not. Pain scores were completed monthly and action taken where the score indicated pain.

During the inspection call bells were answered promptly. Several people had risk assessments that stated they were unable to use call bells. These people depended on staff walking around regularly to check they were ok. We saw hourly checks had been completed for such people to ensure they were comfortable. We asked people if their call bells were answered promptly and they said, "They do come if you press the bell night and day but you have to wait for 45 minutes sometimes, especially in the morning." Another person said "I use the bell. They do come but you wait quite a while. They are short staffed all the time. You don't see much of them and they are late doing things. Its 11.30am and I am still in bed in pyjamas. I want to get up and go to the toilet but they say I can't because they can't support me as they need two people so I have

to use my pad." A relative said, "I walk and go and get them. They say they will come as soon as they can and sometimes you wait 10 minutes but they do come." Another relative said "Well he can never reach the bell and I can't even see it now."

We looked if there were enough staff in the home to meet people's needs. Comments throughout the day from people frequently mentioned there not being enough staff and staff being friendly and kind but always rushed. One person said "They are so rushed." Staff we spoke with said, "We need one more staff member, we don't have time for person centred care although we do try our hardest." We saw the impact of staff rushing around and at lunchtime observed two people eating their lunch with their hands because there was not another staff member to support them. One person waited until 1.45pm to eat their lunch because no staff member was available to provide them with assistance when eating.

We looked at staffing levels across all units and saw that staffing pressures were higher on the units for people with dementia and more complex support needs. Staff on these units were rushing and were not able to spend time with people talking or sitting with them but they did have their basic care needs met. Dorritt unit had 37 people living there, with two nurses and eight care assistants. This was one of the busiest units, with some people with advanced dementia and some people becoming distressed and calling out frequently.

We asked the interim manager how they worked out staffing levels. They showed us a basic hours calculator which they used with a dependency tool. The interim manager said that provides a basis to build the rota around and they use their common sense to always add in extra hours to meet individual needs. The interim manager explained that unit managers were not included in the rota and so were supernumerary. They explained part of this role was to take pressure off of nurses and care staff by completing tasks that take away from time spent providing care such as chasing prescriptions, calling relatives and contacting health professionals.

We fed back some people were at risk of not getting their needs fully met on some units. On the units where staff said they felt rushed and people told us staff were rushing errors in medicines had been found and unsafe moving and handling techniques had been used.

On the second day of inspection we asked if the home was going to take any action around staffing levels. The interim manager told us a plan had already been agreed to have extra staff. We saw that an extra nurse was in the home and the aim was to always have one extra nurse floating around the home so they could cover any sickness, or if there were dressings that needed changing they could do this. We saw where a discussion had taken place to show that one extra staff member was going to be provided on each unit, in addition to the floating nurse post.

Recruitment procedures were robust. Staff files contained applications, and interview and competency documents, enhanced criminal records checks and references. This meant staff were considered safe to work with vulnerable people.

We saw evidence of an error made by staff which resulted in a risk of harm to a person. The management team had met with the staff member, investigated the matter and taken appropriate disciplinary action.

On both days of inspection we found the home looked clean and hygienic. There was a dedicated housekeeping team who were organised and efficient. We saw staff wearing gloves and aprons and there was soap and warm water throughout the home for staff and people to wash their hands. People said "I think it is quite clean, they are always busy cleaning" and "It is always clean and tidy."

Good

Is the service effective?

Our findings

People's rights were protected as staff understood their responsibilities under The Mental Capacity Act 2005 (MCA). The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Staff consistently asked for people's consent to care and explained what they were doing before approaching them. For example we heard one staff member say "Here is a blanket for you, you said you were cold so I have brought you a blanket. Can I put it over your legs?" and "It is lunchtime in five minutes. Do you want lunch? I will get your wheelchair in a minute and take you to the dining room for your lunch. Is that ok?" Staff said they always asked for consent and we observed this in practice throughout the day. One staff member said, "We give people choice and always ask. If people refuse to have their medicine, or eat, we don't force but go back later, or ask another person to try." Care staff, nurses, and managers all had knowledge of the MCA and demonstrated an understanding of supporting people who might lack capacity to make decisions. Training records also reflected care staff had completed training in the MCA and DoLS.

Consent for care was recorded in most care files and it was recorded whether a person had been assessed as having capacity or not. Most people had specific decisions assessed such as the covert administration of medicines. There were some gaps in care files where a best interests decision was not documented or where a 'do not attempt cardio pulmonary resuscitation' (DNACPR) form was filled out but omitted to say whether people or their relatives had been consulted during the decision making process. We fed this back to the interim manager and they said they would look at all of their DNACPR forms. We saw evidence that relatives were consulted and in several cases had approved a care plan. We fed back that in some cases it wasn't clear if the relatives had lasting power of attorney to approve decisions or they had just been involved in the care planning process.

Staff were aware of people subject to a DoLS and we saw that appropriate documentation had been completed in order to ensure that people were only deprived of their liberty when it was in their best interests to do so. The interim manager provided us with the tracker they used to check whether DoLS authorisations had been made or not and if they needed reviewing. Applications were made in a timely way and renewed when they were near expiry.

Supervision notes showed that supervision was taking place every two to three months in line with the homes policy. Staff said they felt supported and found supervisions helpful. Safeguarding, training, any concerns about care and performance were discussed during supervision. We saw recent appraisals had

taken place to review performance over the last year and plan development actions for individual staff for the year ahead. Staff said without exception they felt supported. One staff member said their unit manager "will always listen" and another is "very approachable."

There was an in house training manager who co-ordinated training in the home and ensured staff were up to date with inductions and on line training. Face to face training was offered in moving and handling, pressure care solutions, safeguarding awareness, end of life care and person centred care. Training for specific needs such as dementia and diabetes care was provided. Training records showed that training was up to date and future dates had been booked in for staff to develop in new areas and attend refresher courses in areas they had already learned about. Staff told us that training was good and they felt equipped to do their jobs, one staff member said "The training is good quality here; it's like going back to university." People and relatives told us they thought staff knew what they were doing. When we asked people if they thought staff had enough training to help them do their jobs they said "Yes" and "Oh yes they wouldn't employ a zombie."

The interim manager said the service was working towards trying to reduce hospital admissions so that people could be nursed in their home by nurses who had more specialist training. For example, all nurses had syringe driver training and the interim manager described how they were supported by a local hospice. We saw partnership working with local health services and where people had been supported to attend outpatient appointments and access healthcare services out in the community. The home had a GP that visited once weekly and was on call the rest of the week. The rapid response team were called for anyone who required more urgent medical attention. We saw in care records that health professionals were sought out promptly if people became unwell. When we spoke with people they felt happy that a doctor was called if they asked for one or if staff thought the person needed one. Staff were given a sheet at every shift with people's diagnosis, transfer needs, diet needs, DNACPR status, and what care they needed so they were equipped at the start of the shift with the knowledge of people's immediate healthcare needs.

We reviewed records for people receiving nutrition through a PEG and found that the nutritional support was given as advised by the dietitian. We spoke with a speech and language therapist and dietitian. Both professionals said the home followed their advice but there had been a misunderstanding about what constituted soft food. This was fed back to the unit manager and was now resolved as staff had been further supported to understand the consistency the food needed to be for a soft diet.

We observed breakfast and lunch on the first day of our inspection and saw that staff were attentive and made sure people were comfortable when they were eating. We spoke with the chefs who said they were very proud of providing food to people in the home and said "I love it here, I enjoy making tasty food." When we visited the kitchens they were clean and well organised and two types of cake had been baked that morning ready to be served with tea in the afternoon. The home employed a chef to cook Caribbean and African food two days a week to cater for the cultural needs of some of the people living in the home and to provide a variety of foods for people to choose from.

Two people we spoke with were unhappy with the food but most people enjoyed the food and said there was enough of it. One person said "Food is good" and another "People talk to you, it's great you have lots of food." Menus were visible and people were asked at the start of the day what they would like to eat. We saw an alternative being cooked for someone who didn't like the menu that day, and for people with pureed food it was in separate servings on the plate so it looked more appetising. For people unable to tell staff what they would like families were also consulted about what people enjoyed eating throughout their lives and what their favourite foods were. We asked people if they had snacks in between meals if they got hungry. One person said "we get anything we like" and another said "we get biscuits and fruit."

We saw a range of drinks on offer and people had juice or water within reach. For one person we noted they had an empty cup out of their reach, they rang the call bell and staff brought them a drink when they asked for it. The drinks trolley had pictures of the range of drinks on offer so people could point to the picture if they were unable to say what they wanted. Care staff told us more drinks had recently been introduced such as mango juice and hot savoury drinks after they had been requested and relatives had said that was what people might like to drink. We looked at fluid charts and saw staff were filling these out without gaps using the tablet system in hallways. We fed back that some fluid charts were not specific in how much fluid was needed to be consumed in a 24 hour period, and some entries were not specific about how much a person had to drink. The interim manager said they would look into this.

Good

Is the service caring?

Our findings

We asked people if they found staff caring. They said "they're kind and accommodating", "yes they are to a certain extent", and "yes they are very nice. They make sure I am looking after myself." Another person said "they do their job but they don't have time for much else." Relatives we spoke with said "yes mostly. Some are lovely but they are very busy" and "yes they are very kind and reassuring to him, especially when his [relative] was sick."

Staff interactions with people were gentle and kind. One person who was settling in to the home became upset. Staff sat with them and made gentle physical contact by stroking their hand and expressing sympathy for what they were feeling. The person became calmer and began asking staff for things to make them more comfortable which they did by bringing them drinks and a blanket. Every staff member we spoke with expressed they cared for the people they were supporting and enjoyed their job. One staff member said "I love my job", this was echoed by many of the other staff members we spoke with.

Staff responded to verbal and non-verbal cues from people and knew what the non-verbal cues meant. When we spoke with staff they told us about people's needs and what things they liked and disliked, this matched up with their care files. People felt the regular staff knew them and said "well, they know what I need help with and how I like things done." People told us when there was a change in staffing this was disruptive. One person said "[They know me] quite well but the change of staff happens a lot and that is when they don't know and there is a communication breakdown." A relative said "[They know him] quite well. The change in staff causes communication breakdowns so they all do it differently and he gets stressed."

Staff were discreet, they quietly asked people if they wanted to use the toilet and tried to explain to confused people what was happening. People had clean hair and nails and dressed so they were warm, comfortable and covered appropriately. We saw that doors were closed during personal care and staff knocked and waited for a response before they entered peoples rooms. Care plans stated if people preferred same gender care staff. One plan read "female staff only for personal care." Staff were aware of this and told us they respected this. We also noted only female staff assisted this person throughout the inspection. A dignity tree was in place on one unit with comments from four people. One comment said "I wish I could stand on my two feet. Oh and some Caribbean food would be nice." We saw that the home had listened to the wishes of people and employed a chef to cook Caribbean food twice a week. We saw people were encouraged to eat independently during mealtimes.

When we asked people if they were treated with dignity and given privacy, they said "They treat me with very basic dignity but you don't get much privacy in the bathroom. They do knock on doors" and "they knock on the door and they ask me if I would like them to step outside when I use the toilet. They lean over me a lot when assisting and don't always tell me why." Another person said, "Yes I get lots of privacy and they treat me with dignity but I would tell them if they disrespected me. I lock my door." Relatives confirmed that when they visited care staff knocked before entering the room. We saw people were given choice and control over some areas of their lives. For example people were asked what they wanted to eat and were offered choices.

Staff explained what the choices were. Staff told us they tried to introduce choice as often as possible throughout the day for what people wanted to wear, how they spent their time and what food and drinks they had.

Care plans showed peoples religious preferences and if they had any needs related to their culture. For example, one person had a named nurse who spoke the same language as them. Where people had been identified as practising a particular religion and were not able to verbalise their preferences, their relatives had been consulted on how they practised. There was a fortnightly service for practising Christians and local Rabbis and Imams were available to visit for people who wished to be visited.

End of life wishes were discussed as part of care planning and reviews. The interim manager said "We are striving for excellence in end of life care; we are working towards the gold standard framework." The language in care plans indicated the home was in the early stages of working towards the Gold Standards framework, a proactive, systematic evidence based approach of delivering quality end of life care.

We observed some rooms looked sparse with very little or no personal effects. One room had family pictures and personal effects; the family visited regularly and told us that they put pictures up to make the room feel more homely. Activities staff told us they were working on supporting people to make their rooms more personalised if they wished to do so.

Good

Is the service responsive?

Our findings

We found the home was responsive to the needs of people. We saw care staff getting people drinks, blankets and supporting them to the bathroom as soon as they requested it. Staff told us if they made any suggestions the home "acted straight away" if it would improve the quality of care or experience of people living in the home.

The interim manager said the home was working to improve the person centred nature of their care plans. An external quality consultant was supporting the home in monitoring the quality of the care and had arranged to do one workshop a week with staff on writing person centred care plans. Staff had been on person centred training and all knew what it was. One staff member told us they had attended a seminar on empowerment recently and their unit had changed the way they worked to value the interaction with people more than the task. They gave the example of not just asking a person to have a shower when they saw them, but interacting with them first and then suggesting a shower if they would like one.

Care plans were detailed and covered a range of needs such as emotional and mental wellbeing, diabetes, nutrition, medical needs, continence, skin integrity and sleep. One unit manager told us care plans were completed within 48 hours of people moving in. They said body maps and observations were completed within the first six hours. Care plans were reviewed monthly using a person of the day system, where the changing needs of that person and how to meet them were discussed. However we noted that some of the wording was generic and not person centred. For example the diabetes care plan for four people with diabetes on one unit was identical apart from name changes. The normal blood sugar range was not stated within the care plans. Care plans stated "Ensure sugar levels are maintained and monitored."

Care plans outlined people's needs and how to meet them but some lacked detail. For example for two people whose primary form of communication was not English, care plans did not always outline how staff communicated effectively with these people or what communication aids were in place to support mutual understanding. The home was in the process of reviewing all care plans to make them more person centred. The ones that had been recently updated were more person centred than the ones that had not been reviewed but some general language still remained. We saw there were information sheets with peoples life stories within their rooms stuck in A4 plastic wallets by their bathroom doors. These gave a brief overview of people's likes and dislikes and past social and career history and were used by the activities staff to engage with people.

There was an activities schedule in place and people took part in group activities such as exercise sessions, sing along, and parties for people' s birthdays. There was a dedicated team of activities staff who we saw engaging positively with people on both days of the inspection. The activities lead said "Everybody in our team are committed and enjoy what they do and make a difference" and "When a person is admitted we do a life and social profile and speak to family to get a better understanding of people's likes and dislikes." People said "I have my hair done here and go to cafes. I like that. I would like more activities in my room as I spend time there a lot" and "The new tuck shop is great and we run it ourselves."

We saw group activities for people were well attended for those people who were mobile and well. We fed back that some people were isolated in their rooms, and whilst some people told us they did not want to take part in activities there was not an alternative where they could spend time with other people doing things they enjoyed. The interim manager told us that this was an area for improvement the home had already identified and activities staff were being supported to work with people on particular units to get to know them and what they enjoyed doing more on a one to one basis. The external quality consultant told us relatives had recently been consulted around a pet therapist bringing animals in to the home for people who enjoyed keeping animals.

We were told about and saw a member of housekeeping staff took time out to sit with a person who loved poetry and read to them and on some units when staff had time they did sit and talk with people. The home had an arrangement with a local college so that students studying health and social care could come and do work experience with the activities team and spend one to one time with people. On our second day of inspection six people were waiting in the lobby area to be picked up by a minibus to go on a trip to a museum. One person told us, "The activities where you go out are very good. They do trips to the Christmas lights, cafes and garden centres."

Monthly meetings were taking place for each unit for people who lived in the home. People had fed back during these meetings they felt they could not buy anything without leaving the home and they missed that aspect of daily life. People came up with the idea and were encouraged to set up a tuck shop where they bought in sweets and other things people wanted to buy and sold them to other people. We saw that for people who preferred to stay in their rooms or were too unwell to come to the meeting, the unit manager had visited them in their room and asked for their feedback on the services and any activities they would like to take part in. We asked people about these meetings and if they were kept updated with what was going on in the home. People said "They tell you about parties, lunch and you choose but I do think communication is poor. They tell you things just before they happen. You can't prepare or plan" and "I get told about resident meetings and you just sit there and they ask if everything is okay and what you would like on the menu or to do. Sometimes I see they do it." We also saw notes from relatives meetings that had taken place where relatives had fed back about food, and care and activities. Where suggestions had been made there were actions and a deadline for a named staff member to make sure they were completed by.

The home maintained clear and accurate records of complaints. We looked at the complaints logs and found there were records of correspondence and all complaints barring one had been responded to in a timely manner and as per the provider's complaints policy. We asked the interim manager about the complaint which wasn't responded to within their time frame. They told us the complaint was made via a solicitor, so the home had to respond through their legal team and this was why their response was slightly delayed. We asked people if they knew how to make a complaint, one person said "oh yes, to the manager or my key worker or daughter." Another person said "yes I think they would listen." Relatives told us they thought they would be listened to but that things were sometimes slower than they liked to get resolved.

Requires Improvement

Is the service well-led?

Our findings

There were some aspects in which the service was not always well led. We found two breaches of regulation around unsafe administration of medicines and moving and handling practices related to specific units. The provider's quality monitoring systems had failed to identify or address these issues which may have put people at risk of harm.
However, other than this the management team were strong in their leadership of the home. Every staff member said they felt supported by their unit managers and the management team. We saw support structures were in place for staff with regular supervisions and a training programme designed to develop staff and ensure they were confident doing their jobs. Staff said "the deputy and manager are committed and enthusiastic" and "the management team is very strong."

The provider had a system for quality control in place with audits being done for medicines, call bells, risk assessments, observations and care planning. We identified some gaps during both days of inspection and fed individual issues back to unit managers and the interim manager so they could be followed up and recording improved. The interim manager responded positively to feedback throughout both days of inspection and acted swiftly to rectify any issues that affected care.

The interim manager told us the structure of the management in the home was to create a small home feel on each of the units. The unit manager was accountable for the care on that unit and all staff on that unit reported to them. Unit managers in turn completed audits, and compiled key information on care and staffing for the interim manager so they could monitor the progress of the service. Unit managers met weekly with the interim manager to discuss what things were going well on their units and review the data they had put together to identify any trends or issues that were arising.

The interim manager discussed which areas of the service they felt could be further improved around activities and person centred care planning and was already implementing plans in these areas. There was clinical oversight of the home from the interim manager who was a registered nurse and understood the clinical needs of people and what good nursing practice looked like. There was a focus on improving the care experience for people, the interim manager said the "aim is to provide really good, holistic, positive care." There were plans to have a refurbishment to improve the facilities for people to create more open communal spaces and a café area so the tuck shop set up and run by people could be expanded.

Staff confirmed that they attended monthly team meetings which were "very helpful" as this gave them an opportunity to discuss people's needs, changes to policy or any concerns. Comments from staff included "I have a lovely manager." And "I like working here. I've worked in other care homes, here you have full support." Staff were cheerful on every unit throughout both days of inspection and engaged with people and other care staff with a smile. We were repeatedly told there was good teamwork on all units. One staff member said "amazing staff team, they work together, work hard, and are very empathetic."

We saw evidence of partnership working. The home had employed an external quality consultant to give them an objective perspective on care in the home and who was based in the home for three days a week.

We saw in care records advice taken from healthcare professionals and advice sought from other professionals so the best course of action could be taken for a person's treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide care and treatment in a safe way by dong all that is reasonably practicable to mitigate risks when people are being moved and failed to ensure the proper and safe management of medicines. (12) (1) (b) (g)