Bondcare (London) Limited

Coniston Lodge Nursing Home

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 23 January 2018 and was unannounced.

This was the first inspection of the service since it was registered with the provider Bondcare (London) Limited in October 2017. Previous to this the service was owned and managed by another provider.

Coniston Lodge Nursing Home is registered to accommodate up to 92 people who require support with personal care and nursing needs. At the time of our inspection there were 41 people living at the service. The majority of people were over the age of 65 years, although there were some younger adults. People had a range of complex health conditions, some people had physical disabilities, some people were living with the experience of dementia and some people were being cared for at the end of their lives.

Bondcare (London) Limited were part of the Bondcare Group, a national provider of care services in the United Kingdom.

There was a manager who had been employed by Bondcare (London) Limited. They were in the process of applying to be registered with the Care Quality Commission. 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.

We have rated the service Requires Improvement overall and in the key questions of Safe, Caring, Responsive and Well-Led. We have rated the key question of Effective as Good.

People liked living at the home and felt their needs were being met. They told us they were cared for by kind staff. People felt they had been involved in planning their care and were given choices. They liked the food they were offered.

The staff felt supported by the manager and told us they had the training and support they needed. Some of the staff did not feel there were enough of them to meet people's needs and keep them safe. The staff told us the manager was approachable and they could discuss their concerns with them. We observed that the staffing levels at the service were sufficient to meet people's basic care and health needs. However, people did not always have access to company and opportunities to spend time with staff other than during practical support tasks. In addition, the staff did not always work efficiently as a team when communicating and meeting people's needs.

We observed some practices where people were being placed at risk. For example, one person who was at risk of choking was not given the support they needed when eating one of their meals. We also found that medicines were not always being safely managed.

The staff did not always care for people in a kind and considerate way. We saw that the staff also tended to focus on the tasks they were performing rather than the feelings of the people they were caring for. However, we also saw examples where individual staff members were kind and thoughtful.

People did not always receive personalised care and support which met their needs. For example, some people had to wait for personal care and they did not always receive the care which had been planned. In addition, whilst some people had opportunities to take part in organised social and leisure activities, others did not have the same level of opportunity for entertainment, leisure and social events. The care plans did not always include clear guidance on meeting people's needs. Although, the provider had recognised this and was taking action to make improvements in this area.

The provider's systems for ensuring people received the support and treatment they needed had not always been operated effectively. The risks of people receiving unsafe care had not always been mitigated.

We found breaches of four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

In most cases, the procedures for controlling the spread of infection were appropriate. However, we found that the audits of the service had not identified a damaged and malodourous mattress. The staff had carried out suitable risk assessments for people. The environment was safely maintained and the provider ensured checks on safety and suitability were regularly carried out. The provider had a contingency plan for when things went wrong and there was evidence they learnt from adverse events, such as accidents and incidents.

People's needs had been assessed and planned for. They were able to contribute their ideas and had consented to their care and treatment. People's healthcare needs were monitored and met, with the staff working closely with other healthcare professionals. People had access to a range of nutritious food and drinks.

People being cared for at the end of their lives had the support and care they needed.

The provider had introduced changes to help improve the service. They carried out regular audits and had made changes as a result of these. People using the service and their representatives were able to contribute their views about their experiences. They knew how to make a complaint and felt they had opportunities to meet with the manager.

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

Some aspects of the service were not safe.

People were put at risk because the staff did not always follow guidance when supporting people to eat and drink.

Medicines were not always managed in a safe way.

There were enough staff to keep people safe, although the staff were not always available to provide support other than with practical care tasks.

There were suitable procedures for the recruitment of staff.

There were suitable procedures for preventing the spread of infections, although checks on equipment did not always identify problems.

The provider had systems to learn from mistakes and when things went wrong.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were skilled, trained and were knowledgeable. However, improvements were needed to ensure the staff always worked in a coordinated way.

People's needs and choices had been assessed and planned for in line with current good practice guidance.

People had consented to their care and treatment and the provider acted in accordance with the Mental Capacity Act 2005.

People lived in a suitable environment, however the provider had not always followed best practice guidance for the provision of dementia friendly environments.

People's healthcare needs were being met.

People were given a choice of nutritious food and drink.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Not all the staff treated people with respect, compassion or kindness.

Some of the staff supported people in a way which focussed on the task rather than the person's wishes.

However, there were staff who were kind and treated people in a respectful way. People using the service and their representatives told us they felt they were treated by kind and caring staff.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care which met their needs and reflected their preferences. In addition, some of the information about people's needs had not been clearly recorded.

People knew how to make a complaint and felt confident that these would be acted on.

People being cared for at the end of their lives received the support and care they needed.

Is the service well-led?

Requires Improvement

Some aspects of the service are not well-led.

The provider had failed to identify, monitor and mitigate risks of people receiving unsafe and inappropriate care.

The provider had started to make improvements at the service and was working with other organisations to make sure these were appropriate and met the needs of the people who lived there.

Coniston Lodge 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 January 2018 and was unannounced.

The inspection team included two inspectors, a pharmacy inspector, a nurse specialist 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 care service.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and safeguarding alerts. The provider had completed a Provider Information Return (PIR) on the 8 December 2017. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with representatives of the local Clinical Commissioning Group who gave us their feedback regarding the service.

During the inspection we spoke with eight people who lived at the service and six visiting relatives. We also spoke with two visiting healthcare professionals.

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

We met the manager, representatives of the provider, and other staff on duty who included nurses, care

assistants, senior care assistants, activities coordinators and catering staff.

We looked at the whole care plans for five people who used the service and parts of the care records for an additional 18 people who used the service. We looked at staff training and support records and the recruitment records for three members of staff. The manager explained that only one member of staff, in addition to the manager, had been recruited since Bondcare (London) Limited took over the service, and we looked at this person's recruitment records. We also viewed other records the provider used for managing the service, which included records of complaints, meeting minutes, safeguarding information, audits and applications for Deprivation of Liberty Safeguards. The pharmacist inspector viewed how medicines were managed which included observations of administration, storage, record keeping, training of staff and care planning around medicines needs.

At the end of the inspection we gave feedback on our findings to the manager and provider's representatives.

Requires Improvement

Is the service safe?

Our findings

Most of the people living at the service and their relatives told us that they felt safe at the service. Their comments included, ''I feel [person] is very safe from abuse during [their] care here'', ''I feel [person] is safe in this environment and free from abuse'' and ''No abuse at all they are very kind.''

The staff did not always follow best practice guidance for supporting people who were at risk of choking to eat and drink safely. For example, we observed one person being supported to eat their breakfast. They were not seated in an upright position. The person's care plan included instructions written in January 2018 by an external professional explaining that the person must be seated at a 90° when eating to avoid the risk of choking and must remain in this position for at least 30 minutes after eating. The instructions also stated the person must not be left alone with food or drink without supervision. However, shortly after we saw the person being supported with their breakfast we observed they had been left unattended in bed with a bowl of food, a drink and a plate with some food on it left on a table above their bed and within their reach. There were not any staff nearby and no member of staff returned to collect the food or continue to support the person for over ten minutes. Therefore, the person was at risk of choking.

The practices around medicines management did not always ensure that people received their medicines in a safe way and as prescribed. On our arrival in one part of the home we found that the medicines for one person had been left in a small pot beside them whilst they ate their breakfast. No staff were available in this room and the person responsible for administering medicines was in a different part of the home. The person did not have a risk assessment to show that they could administer their own medicines and their care plan stated that staff would administer these. Therefore there was a risk that the person would not take their medicines as prescribed and the staff would not necessarily be aware of this. In addition, other people who had a diagnosis of dementia and were disorientated to time and place were also in this area of the home and could have mistakenly taken the medicines without staff knowledge.

The staff kept charts designed for recording the administration of prescribed medicines. In most cases the charts we viewed had been completed correctly. However, there were gaps on the January 2018 charts for two different people where the administration of medicines had not been recorded and there was no explanation to show if and why the medicines had not been administered. Therefore it was not clear whether these people had received their medicines as prescribed.

We carried out audits of a sample of medicines held at the service. We found the supply of three people's medicines did not tally with the records of these. In all three cases, the amount of medicines exceeded the expected amount according to the records of administration. Therefore the medicines were not being administered as prescribed.

One person's records stated that they were allergic to penicillin. The person had been prescribed a penicillin containing medicine and there was a care plan in place for the staff to monitor side effects. However, the care plan and medicines administration chart had not been updated to indicate that this medicine was safe

for the person to use.

We found one bottle of eye drops which had passed the expiry date. These were removed from the service when we alerted staff to this. The first aid supplies held on each unit contained sterile bandages and other items which had passed their expiry dates, some by several years. We discussed this with the manager who agreed to remove these items and update the supplies.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that protocols were in place for the administration of PRN (as required) medicines. These explained the circumstances under which medicines should be administered. There was also information to explain how the staff should judge when each person was in pain, if they could not verbally communicate this, so they could be administered pain relieving medicines. The staff had kept correct records of medicines received and disposed of.

There was clear information about the use of topical medicines and food and fluid thickeners for each person. The staff used appropriate systems for monitoring variable doses of medicines.

Medicines were stored appropriately and securely. The staff carried out checks on the cleanliness and temperature of storage areas and these were recorded.

We saw evidence that the staff had received relevant training and their competency when administering medicines had been regularly assessed. There was clear information for the staff about medicines procedures, up to date medicines alerts and information about individual medicines and their side effects.

People living at the service and their relatives told us that call bells were not always answered promptly. One person said, ''The bells do go on a bit and sometimes it takes a long time for the staff to answer.'' However, people told us that they were usually able to reach their call bells whether they were in bed or chairs. We saw that most people had access to their call bells which were placed within easy reach. However, we noted that one person's call bell was placed out of their reach behind them. The person had a sign in their room stating that they should always have access to their call bell. We explained this to the manager and provider's representatives who agreed to make sure the staff regularly checked people could access their call bells. In addition we noted that some of the alarm cords in bathrooms and toilets had been tied so they did not reach the floor. The manager agreed to change this practice so that the cords could be reached by someone who had fallen.

People living at the home and their relatives told us they did not always feel there were enough staff at the service. Some of their comments included, ''I am concerned that [person] does not get the help they need and [they] are at risk of falls'' and ''I think at times there are enough staff but at times they could do with more staff to help – for example in the mornings and at weekends.'' The staff we spoke with gave mixed views telling us that a high number of people required the support of two care workers for transfers and support with personal care and this meant it took a long time to support everyone. We observed that during our inspection some people did not have support to get washed and dressed until late morning just before their lunch. We also observed that the staff did not spend time talking with people or helping them other than with practical care such as personal care and support during mealtimes. This meant that some people were left in their bedrooms alone without any company for several hours at a time. The staff checked on people's wellbeing but did not spend time with them during or after these checks. However, people's basic care needs and health needs were being met. The provider's representatives told us that they used a

recognised tool to work out staffing levels according to people's dependency. They explained that they would continuously review staffing levels to make sure people's needs were being met. At the time of our inspection there were staffing vacancies and staff absences due to annual leave and sickness. This meant that a considerable amount of the staffing at the home were temporary staff, who did not know people well. The manager told us that they were in the process of recruiting more permanent staff to address this issue.

The provider had appropriate systems for the recruitment and selection of staff. These included checks on their identity, eligibility to work in the United Kingdom, references from previous employers and checks from the Disclosure and Barring Service regarding any criminal records. Where staff had a past criminal conviction the provider undertook a risk assessment so they could make a judgement about whether the staff member was suitable. The staff completed application forms and attended an interview at the service to determine their suitability and skills. Therefore the provider had taken appropriate steps to ensure that staff who were recruited were suitable to work at the home.

During our check of the environment we found one mattress which was in use in a person's room which was damaged and malodorous. We discussed this with the provider's representatives who agreed to check and have the mattress replaced. They told us that mattress checks took place regularly. We saw evidence of an audit of mattress cleanliness. However, the provider's checks on the day of the inspection had failed to identify problems with this mattress.

The provider undertook audits of cleanliness and infection control. They recorded any problems identified and took action to rectify these. The staff wore protective clothing such as gloves and aprons when providing care and support and when cleaning. The cleaning staff had systems to code cleaning equipment to minimise the risk of spreading infections. Cleaning products were stored securely. All of the staff had training regarding the spread and control of infection and were able to described good practice to us.

The provider had procedures designed to protect people from the risk of abuse. Information about these procedures and local authority guidance was available for the staff, as well as people living at and visiting the service. The staff received training in safeguarding adults and were able to tell us about different types of abuse and how they would report these. The staff were able to tell us about a flow chart which described the action they should take if they suspected someone was being abused. The provider had worked with the local authority to investigate allegations and to help protect people when things had gone wrong. There were clear records showing action taken and changes that had been made to help improve the service following safeguarding alerts.

The staff had created individual risk assessments for each person. These included guidance for the staff on how to minimise the risks and support people. The assessments covered risks associated with falls, people's mental and physical wellbeing, nutrition, skin integrity and the use of equipment. These had been regularly updated and information from the assessments had been incorporated into care plans. Additionally, guidance from health care professionals had been included where relevant.

The provider undertook checks on the health and safety of the environment. These were recorded and action had been taken to ensure the building and equipment used were safe.

The provider had a contingency plan which included different emergency situations and how these should be dealt with. There was an appropriate fire risk assessment and individual evacuation plans for each person living at the service. The staff recorded accidents and incidents. These records showed that they had taken appropriate action following these. There was evidence that these incidents were used for learning and making improvements at the service. The manager recorded all adverse events on a system which could

be viewed by the providers' representatives so that the whole organisation could share learning from when things went wrong.

Good

Is the service effective?

Our findings

People's needs and choices had been assessed by the provider. The assessments included recognised good practice tools for judging people's needs, such as their nutritional needs, risks to their wellbeing and care needs. The provider had carried out suitable assessments prior to admission and had liaised with the person, their representatives and healthcare professionals at this time. Assessments of individual needs were regularly reviewed and recorded. The judgements made during these assessments were based on observations and knowledge for the person by the staff who were caring for them.

The staff had the skills, knowledge and experience they needed to deliver effective care and support. People using the service and their representatives told us they thought they were appropriately trained with one person stating, ''In my opinion all the care workers act professionally and seem to have had the training them need.''

The staff explained that they had opportunities for training and they felt supported by the manager and provider. The provider had an appropriate training schedule which included opportunities for the staff to learn about specific care needs of the people who lived at the service. The nurses were supported to maintain their clinical knowledge and expertise and care staff were able to undertake vocational qualifications.

New members of staff were provided with training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

All the staff had opportunities to meet their line manager individually and as a team. They had regular handovers of information, team meetings and individual supervisions and appraisal sessions where they could discuss their work. There was sufficient written information about different aspects of the service and the staff roles and responsibilities. The provider made sure the staff were kept up to date with best practice guidance and alerts about safe care and treatment.

The layout of the building was suitably designed, the environment was warm and well lit. Communal rooms were appropriately positioned and bedrooms had en suite facilities. People had personalised their bedrooms. One of the communal rooms was used as a sensory room, with lights, seating and music designed to provide sensory support and relaxation. In addition some areas of the building had themed pictures and ornaments. Some of the corridors had scarfs for people to touch and hold. However, not all aspects of the building met best practice guidance for dementia friendly environments. We discussed this with the provider's representatives. They acknowledged that improvements to the environment were needed and told us that these were planned.

We undertook an audit of a sample of pressure relieving equipment and found that this was suitable and had been maintained at the correct pressures. The staff undertook checks of this equipment and recorded

their findings daily. People who required assistance had access to hoists and had their own slings to support them to move safely.

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

People told us they were involved in making decisions and had been consulted about their care. We saw that the provider had undertook mental capacity assessments relating to different decisions people made. These had been recorded and the provider had taken appropriate action when people did not have capacity. For example, they had consulted with the person's representatives to make decisions in their best interests. They had also applied for DoLS authorisations. However, we saw that they had not received a response from the local authority regarding the majority of applications. There was some evidence that they had followed these up but the provider's representatives acknowledged more action was needed to make sure the authorisations were granted when restrictions were in place.

People were supported to live healthy lives by the staff working with other healthcare professionals. The home employed nurses throughout the day and night to monitor people's healthcare needs. They worked closely with other healthcare professionals. The local GP surgery carried out regular visits. Communication between the staff at the service and the GP surgery was good and helped to ensure that any changes in people's health were identified and acted upon. The provider had signed up to local NHS procedures to support people with a smooth transition to hospital if needed so that information about their healthcare needs was appropriately shared.

People's healthcare needs were clearly recorded in care plans. Their health was monitored each day and changes in health were recorded. The staff had equipment in place to provide emergency support and treatment when needed. Following changes in people's health and condition the staff had reviewed care plans and increased monitoring when needed.

People had enough to eat and drink and enjoyed the food they were offered. Some of their comments included, ''The food is good and, I am often here at mealtimes and I see that there is enough for [person] and everyone else'', ''My relative has a choice of meals and snacks'', ''[My relative] enjoys their meals'', ''The food is very good and tasty'' and ''We have a good choice of meals.''

People's nutritional needs had been assessed. The catering staff had information about people's individual needs and preferences. People were able to make choices about the food they ate. People had plenty to drink and access to food and drinks whenever they needed. The kitchen was appropriately organised and clean. Food was freshly prepared at the service each day.

Requires Improvement

Is the service caring?

Our findings

People using the service and their representatives told us that they were treated with kindness. Some of their comments included, ''They [staff] are very kind and caring'', ''The care workers treat [person] and myself with respect and dignity'', ''I come three or four times a week and the carers are very caring'', ''The carers are very good and we are treated very well'', ''We are shown kindness, care and compassion'' and ''They treat person with respect and are very helpful.''

However, we observed that the staff did not always treat people with kindness and respect. In one instance a person asked a member of staff if they could be supported to get out of bed. The member of staff responded by telling them, ''You are going to stay in your bed and just watch the telly.'' The member of staff then left the person's room. We also saw the same member of staff supporting someone to move but without proper explanation of what they were doing. They moved the person's legs but did not speak with them or reassure them. We discussed these examples with the manager and the provider's representatives who agreed the staff member had acted inappropriately and they told us they would act on this.

In other examples we saw that the staff did not always focus on the person they were supporting. For example, we saw the staff supporting a person in a wheel chair to enter a room. The staff then discussed amongst themselves where the person should be seated. They decided to take the person into a different room. However, they did not discuss this with the person or explain what they were doing. The conversations were held behind the person's back so they could not see the staff who were talking about them. In another instance we heard the staff telling a person they would support them to move from their wheelchair into an arm chair. However, the staff then started to attend to other tasks and did not return to support the person.

We saw that people were left in their beds and in chairs wearing protective tabards which had not been removed after mealtimes. In two cases people wore these for the entire morning. We witnessed a number of instances when the staff walked into people's bedrooms to complete paperwork or another task but did not speak with or acknowledge the people in these rooms.

People using the service and their representatives told us that they had not been asked whether they wanted the same gender care workers to support them with intimate personal care. Their preferences had not been recorded.

This was a breach of regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we observed that some staff treated people with kindness and compassion. We heard staff sharing a joke with people and speaking with them in a gentle tone. In particular the staff employed as activities coordinators demonstrated a caring attitude and their interactions with people showed that they knew them well, liked and respected people.

People told us that they were able to express their views and had been involved in making decisions about their care. They explained that the staff offered them choices, such as what they wanted to wear or eat. People's views were included in their care plans. In some cases we saw that information about people's lives before they moved to the service had been recorded, such as people, places and events that were important to them. However, when we asked the care staff and nurses about individual people, the majority of them were not able to tell us any information apart from their current care needs.

People told us they were supported to be independent if they were able. We saw care plans reflected this with a focus on the things people could do for themselves. People's religious and cultural needs were included within care records. However, we noted that although two people's care records stated the importance of their religion and religious communities, neither of these people's records of daily care included any indication that they had been supported in these areas during December 2017 and January 2018.

People's privacy was respected. The staff provided care behind closed doors and ensured that they were not disturbed. We saw the staff knocking on doors before entering.

Requires Improvement

Is the service responsive?

Our findings

People old us their needs were met. Most relatives agreed, although one relative commented, ''The care and support helps [person] a bit. But [they] could do with more help to enable [them] to do more for [themselves].''

There were care plans for each person although these sometimes lacked details meaning there were risks that people's care needs might not be properly met. For example, one person whose care plan we viewed had been identified as at risk of dehydration. The staff recorded how much this person drank each day. However, the care plan did not record a target amount and when we discussed this with the nurse in charge of the person's care they were not able to give us a clear answer about the amount of fluid the person needed. Therefore the staff could not judge whether the person had received sufficient fluid each day. In addition, we noted that in the six days preceding our inspection the person's intake had dropped significantly from previous records and included two days when they had drank less than 600ml of fluid. There was no evidence that the low intake of fluids on these two days had been flagged as a concern and no action had been taken in respect of this.

Another person whose care records we viewed required repositioning to avoid the risk of developing pressure ulcers. The charts recording when this had happened were inconsistent and showed that sometimes they had been repositioned every four hours and sometimes every two hours. We were not able to find specific guidance in the care plan to state how often the person should be repositioned. There was no evidence that action had been taken in response to variation in the length of time between repositioning. Therefore this person might not have been receiving the support they needed and there was no proper guidance for the staff about how to provide pressure area care in a consistent way.

The majority of people living at the service spent the day in their rooms. We carried out regular observations to see how people were spending their time. People in their rooms were offered care and support with personal care and at mealtimes only. They were not offered things to do or opportunities to speak with the staff or others, apart from those who received visitors. The staff checking on people's wellbeing looked at them but did not spend time with them and in most cases did not speak with the person. We looked at a sample of the care records for people who spent the majority of time in their rooms for January 2018 and December 2017. These indicated little variety to this. Some people told us they enjoyed watching television in their rooms or reading, and we saw this to be the case for a small number of people during the day. However, for the majority of people they were sleeping, sitting or lying awake with no activity, or speaking to themselves. The records we viewed suggested that this was usually the situation.

The records of personal care provided to each person indicated that people did not always receive support with oral hygiene, shaving or hair care. There were gaps in people's individual records where no care had been recorded. In addition, we heard members of staff discussing with each other that they regularly found some people's care needs had not been met by staff the previous day. For example, one member of staff commented that men had not been supported to shave. One person's care plan we viewed stated that they would like to be offered two showers each week. However, the records of care provided for January 2018

indicated they had received only one shower in the month. Another person's care plan stated they would like a shower weekly. Records of this person's care indicated they had also only been offered one shower during January 2018.

People's care notes included a record of activities they had participated in. For all of the people's records we viewed we found over half of the days in January 2018 and December 2017 recorded no activity. The additional daily care notes gave no evidence of any social activities.

Therefore, people were not always receiving care in a personalised way which met their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we found that people were clean and well presented. They were in clothes of their choice which were appropriate for the temperature and their activities. People's hair and nails were clean. We observed that the staff provided support for all people to have a wash during the day, although this took a long time and some people did not receive support until almost lunchtime. Some care records indicated that a small number of people were offered regular baths and showers.

The provider told us they had recognised that care records needed review and updating. They had a new format for recording care needs and this was appropriate and clear. They were in the process of transferring and updating all care plans to their new system.

In instances where people had specific care needs which required a high level of nursing intervention, we found these care plans to be well documented. For example, people who had a wound. There was evidence of the care and treatment needed and when the person had received this. In addition, the care plan included reference to external healthcare professional guidance. Similarly, we found information about people's swallowing difficulties had been well documented. There was clear guidance for the staff on the texture and consistency of food and drink the person required and the support they needed. Although we observed one incident where the staff were not following this guidance.

The provider employed activities coordinators who organised small group activities and special events. We saw that people in the lounges were supported to participate in activities on the day of our inspection. The activities coordinators arranged different activities according to what people wanted to do. They asked their opinion and responded to feedback from people. The activities coordinators told us they spent time visiting people in their rooms to offer individual support. A physiotherapist visited regularly and people were able to access this service.

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People using the service and their representatives told us they knew how to make a complaint and who they would speak with about any concerns. There was information about the complaints procedure displayed on notice boards and within the service user guides. The provider maintained a record of complaints and how these were investigated and responded to. We saw that appropriate action had been taken to investigate all complaints and to make changes to improve the service as a result of these.

Some people living at the service were being supported at the end of their lives. The provider had created care plans in respect of this in conjunction with families, palliative care professionals and people's GPs. We spoke with a visiting palliative care professional who spoke positively about the work of the staff in this area. They felt people received support in a calm and caring environment. The staff had received relevant training so that they knew how to care for people. People who needed specialist medicines associated with pain

relief and comfort had been prescribed these and the staff had a good awareness about when such medicines may be needed.

Requires Improvement

Is the service well-led?

Our findings

People using the service and their representatives told us they were happy with the service and living at the home. Some of their comments included, ''I am very happy with the care and support [my relative] receives'', ''I am very happy with the care and support received from the service'', ''I am happy here and do not mind living here'' and ''I am very happy for [person] to be here.''

The external professionals who we spoke with told us they felt things had improved at the service. One professional said, ''Our concerns about the service have lessened and [the provider] seems to be working very hard to improve things.'' Another professional explained, ''The staff seem much more confident and knowledgeable about people's needs. They communicate better with us and this is for the benefit of service users.''

The provider's systems for monitoring and assessing the service had not always been operated effectively. For example, the checks on quality and safety had failed to identify or mitigate risks, such as the staff not following guidance about supporting people to eat and drink safely, medicines not being managed appropriately and people not being able to reach their call bells. In addition, the failure of staff to accurately record guidance about people's needs had not been identified or acted upon, such as the lack of a target fluid intake for a person at risk of dehydration. The records of care provided included gaps, where no personal care had been recorded or there was no evidence about how people had spent their time. The provider had organised for regular checks of these records but no action had been taken to show that gaps were identified or that these were a concern.

The provider operated a system of 'resident of the day', designed to ensure people's care needs were appropriately reviewed. The format for the review included reviews of care, nutritional needs, the person's environment, activities and care plans. The completed forms which had been used when people had been the 'resident of the day' only included reference to the social activity the person did that day. There was no indication that any area of the service they received had been reviewed and no information from the nurses, care staff, chef or housekeeping staff had been recorded. People using the service and their relatives were not aware of the system of 'resident of the day' and had not been invited to contribute their views or opinions.

Some of the staff raised concerns telling us that there was a ''Culture of blame'' and a lack of teamwork. They explained that they did not always feel supported by each other and lacked clear direction about how they should perform each day. We observed that the staff did not always work in a coordinated way. For example, we overheard some staff disagreeing with each other about tasks. We also heard the staff expressing frustration because other members of staff had not carried out specific duties. We noted that there was very little communication between the nurses and care staff about how people should be cared for. The staff on duty during our visit tended to work as individuals rather than a coordinated team. This meant that people living at the service sometimes waited for care or did not get the service they needed.

Therefore the provider had failed to operate systems effectively in order to ensure people's needs were

being met and risks were mitigated.

This was is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had employed a manager at the service. They were a registered nurse and had experience managing other care homes. The manager was in the process of applying to be registered with the Care Quality Commission. The manager told us that they undertook daily walk-arounds of the service, meeting people and viewing how they were cared for. One visitor we spoke with told us, ''The manager and senior staff are very nice to me and [person using the service].'' The staff told us they felt supported by the manager. One of them explained, ''[The manager] tells us his door is always open and we feel it is if we need him.''

When Bondcare (London) Limited took over the management of the service they had placed a voluntary embargo on admissions to the home whilst they made improvements to the service. The provider had started admitting people and had worked closely with the commissioning authorities to make sure these placements were appropriate. At the time of the inspection the service had fewer than 50% occupancy and two of the floors were not in use. The provider's representatives told us that would review and increase staffing as they admitted more people to the service.

The provider had made improvements at the service since they took over the management of the service. They had plans for further improvements. The provider's senior managers regularly visited the service. They had implemented a number of audits and checks which had identified where improvements were needed. From our discussions with the provider's representatives and the manager they evidenced they had a clear understanding of the required improvements and had plans for these.

The provider had worked closely with the local commissioning authorities. For example, they had implemented training and ideas suggested by these other agencies and had demonstrated a commitment to working in partnership.

People using the service and relatives were invited to share their views and experiences of the service through meetings, discussions about their individual care and also new initiatives which involved them in the audits of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that care and treatment was provided in a safe way because: They had not done all that was practical to mitigate risks to the health and safety of service users. Regulation 12(1) and (2)(b) They had not ensured the proper and safe management of medicines.

Regulation 12(1) and (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems to assess, monitor and improve the quality and safety of the services or assess, monitor and mitigate the risks relating to health, safety and welfare of service users. The registered person had not always maintained accurate, up to date and contemporaneous records in respect of service users. Regulation 17(1) and (2)(a), (b) and (c)