The Brendoncare Foundation

Brendoncare Ronald Gibson House

Inspection report

236 Burntwood Lane
Tooting
London
Sw17 0AN
Tel: 020 8877 9998
Website: www.brendoncare.org.uk

Date of inspection visit: 10/02/2015, 12/02/2015, 16/02/2015
Date of publication: 15/04/2015

Ratings

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

Overall summary

This inspection took place over three days on the 10, 12 and 16 February 2015. The first day of the inspection was unannounced; we told the provider we would be returning for a second and third day.

At the previous inspection in August 2014 we found breaches of the regulations in relation to care of people using the service and medicines management at the home. Following that inspection, the provider sent us an action plan telling us about the improvements they were going to make. During this inspection we found the provider had taken appropriate steps to improve the care given to people but we still found areas of concerns in relation to medicines management.

Brendoncare Ronald Gibson House is a care home with nursing for up to 56 people. There are three units at the home, all overseen by a head of care. Windsor unit is

Summary of findings

based on the ground floor and is an intermediate care unit, providing short term re-ablement services for people discharged from hospital before they go back to their own homes. There were 14 people on this unit on the day of our inspection. Wessex unit, also on the ground floor, is a 16 bedded unit for people living with dementia, it was fully occupied when we inspected. Warwick unit on the first floor is a 24 bedded unit for frail or older people, some were receiving palliative, end of life care. At the time of our inspection 20 people were in residence there.

There was a registered manager who had been employed at the service since April 2014. 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.

We found medicines management at the home was not safe. Some people did not receive pain relieving medicines as prescribed in the correct manner which put them at risk of discomfort.

People's care records were not always updated. There were gaps in risk assessments, fluid charts and a lack of documented evidence to show that recommendations from health professionals were always implemented.

People using the service told us they were very happy living at the service and that they felt safe. They told us that staff had a caring attitude, looked after them and made appointments for them if they had concerns about their health.

We saw that the provider made referrals to healthcare professionals such as the GP, tissue viability nurses, and chiropodist if required. Where people displayed behaviour that challenged the service, specialist advice from the community behaviour assessment team was sought. Feedback from healthcare professionals was positive, they said the service was well run and staff made timely referrals to them.

There were enough staff to meet people's needs and staff received training that was relevant to the care they provided and they received regular supervision. They displayed an excellent understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they were used to ensure that decisions made on behalf of people who did not have the capacity to consent were in their best interests.

The registered manager of the service was approachable and was seen speaking with people throughout the inspection. Areas of improvement had been identified and plans were in place to ensure these were met.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicines management and record keeping. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The provider was not administering medicines for some people in the correct way. This had been identified at a previous inspection, but it had not been rectified.

People using the service told us they felt safe living at the home and staff were familiar with the steps they would take if they had concerns about people.

The provider carried out assessments on people who were at risk and managed their needs.

The provider followed robust recruitment procedures and there were enough staff to meet the needs of people using the service.

Is the service effective?

Good

The service was effective.

Staff received training that was relevant to their role and received support and formal supervision.

Staff were familiar with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people had some restrictions placed on their movement to keep them safe, the provider followed legal requirements and obtained the necessary authorisation for their actions.

People were offered choices during lunch and staff were seen to be offering them drinks and snacks throughout the day.

Is the service caring?

Good

The service was caring. People told us that staff had a caring attitude and respected their dignity. There was a designated dignity champion at the home.

We saw some good examples of a caring attitude of staff when observing lunch and activities at the home.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

There were concerns about some of the record keeping at the home. There were gaps seen in some of the care records, including fluid and turning carts.

There was a programme of activities at the home which people enjoyed, some of which were run by a group of volunteers.

People told us they felt able to raise concerns and we saw that the provider responded to complaints in a timely manner.

Summary of findings

Is the service well-led?

The service was not always well led.

The provider had identified areas of improvement and we saw actions plans were in place to monitor these. However an action plan from a previous CQC inspection had not been fully implemented.

There was an open culture at the home, people told us the registered manager was approachable and visible throughout the day.

Quality monitoring at the home was carried out by evaluating responses to feedback questionnaires, monthly recording of incidents and accidents and team meetings.

Requires Improvement

Brendoncare Ronald Gibson 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

At the previous inspection in August 2014 we found breaches of the regulations in relation to care of people using the service and medicines management at the home. Following that inspection, the provider sent us an action plan telling us about the improvements they were going to make.

This inspection took place over three days on the 10, 12 and 16 February 2015. The first day of the inspection was unannounced; we told the provider we would be returning for a second and third day.

The inspection team included an inspector, an expert by experience, a specialist advisor and a pharmacist inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a nurse with extensive experience of caring for older people in a nursing home.

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

During our inspection we spoke with nine people using the service, two relatives, two visitors, 10 staff including the registered manager, head of care, the practice educator and the activities co-ordinator. We also spoke with some professionals who were visiting on the day including a tissue viability nurse, two GPs and four visitors from the Friends of Ronald Gibson House. We carried out SOFI observations at lunchtime and during some activities.

We looked at nine care records, four staff files and other records related to the management of the service including staff meeting minutes, training records, 20 medicine records, audits and complaints. We contacted health and social care professionals such as commissioners and social workers to ask their views about the service during and following the inspection.

Inadequate

Is the service safe?

Our findings

People using the service did not raise concerns about their medicines. They said, "I get my medication when I expect it", "The nurse comes and gives me my medication", "They gave me pain killers when I asked for them" and "I get my medication on time."

Despite these comments from people, we found that they were not protected against the risks associated with the unsafe use and management of medicines. There was a previous breach of the regulations in medicines management and we found concerns during this inspection as well.

Controlled drugs were sometimes not recorded and administered correctly to people who used the service. One person receiving palliative care had been prescribed pain relieving patches to be applied every 72 hours (three days). The controlled drugs register and the medicines administration record showed this was not being done. Records showed this person had a patch applied on 3 February 2015 and again on 7 February 2015, which was a four day gap between doses. A patch was then applied on 10 February 2015 and not changed again until 16 February 2015, after the pharmacist inspector had prompted staff.

Staff were also not recording where the patch was applied on the body map chart. This was required to ensure the same area was not used each time and was stated in the manufacturer's instructions.

These oversights meant that the person received inadequate pain relief that would have resulted in discomfort as they had not received their medicines as prescribed.

The provider failed to have suitable arrangements in place for the recording and safe administration of controlled drugs. This amounted to a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other aspects of medicines management were satisfactory. Controlled drug stock balances were checked daily and quarterly medicines audit were undertaken, the last one had been completed on 13/1/2015. Medicines were stored securely and fridge temperatures monitored daily. We checked a sample of 20 Medicine Administration Record (MAR) charts, and they were completed by staff.

People using the service told us they felt safe living at the home and it was a safe place to be. Some of the comments from people included, "We are safe here, there are always people about", "This looks after me and keeps me safe because I fall a lot", "I've definitely felt safe from intruders" and "I've felt completely safe."

There was a safeguarding policy at the home and training records showed that safeguarding training had been delivered to all staff and was kept up to date. Staff were aware of what to do if they had concerns about people's welfare and knew they had a responsibility to report safeguarding issues. They stated that they would escalate concerns to senior managers if they were not addressed by the unit manager. Staff told us, "People are safe", "We had training in safeguarding" and "We always discuss safeguarding concerns."

The provider took appropriate action when concerns had been raised and there had been incidents in the past where the service had worked with investigating authorities to ensure that people were kept safe.

People using the service told us they were free to move around the home which we observed during the inspection. One person told us, "They [staff] treat people with kindness" and "I'm completely free to move about."

Care records had risk assessments in place for a number of areas, including falls, manual handling, risk of pressure injuries, malnutrition, and bed rail use. Some people had pressure relieving mattresses and appropriate risk assessments were in place to ensure they were used correctly. Pressure relieving mattresses were set at correct levels according to peoples' weights and individual needs and these were recorded and monitored.

Some people on the dementia unit displayed behaviour that challenged the service. Where this was the case the provider used Antecedent Behaviour Consequence (ABC) charts, to record and manage behaviour. There was a restraint policy, the scope of which was governed by the Human Rights Act 1998. The policy spoke about the need for preventative and de-escalation measures to be used before restraint was considered. Restraint was not used at the home. Staff demonstrated this in their discussion with us, one staff member said, "We try and talk them round, offer them a cup of tea or divert their attention."

Referrals were made to the Behaviour and Communication Support Service (BACS) to provide more specialist advice

Inadequate

Is the service safe?

where this was required to manage behaviour that challenged the service. We saw some examples of BACS reports which contained detailed guidance for staff about ways in which they could manage people's behaviour. Feedback from the BACS team was positive and stated, "Staff are compassionate and attentive."

We checked recruitment procedures at the home. Staff files contained a checklist which had confirmation of criminal record checks, references, contact details, proof of identity, professional qualifications, visa status and other pre-employment checks. Potential employees were required to complete an application form and written references were required prior to commencing employment. This demonstrated that the provider undertook robust recruitment checks in order to ensure staff were suitable to work with people who use the service and keep people safe.

There were some nursing vacancies at the time of our inspection. The provider was recruiting for a unit manager in the Warwick Unit and a nurse to cover the night rota. In the interim the unit manager vacancy was being covered by the head of care.

People using the service did not raise major concerns about waiting for staff to support them. Most thought there were enough staff about. They told us, "Staff levels are OK", "When you have a hospital appointment, someone goes with you", "I will go to the dining room and then they take me to the lounge. There is always someone with me" and "The response to a call is quite quick.". However, one person said, "I have to wait sometimes for help for a long time but that's because they are busy."

Some staff indicated that, in their opinion, work was pressurised at certain times. One staff member said, "People have physical and mental health needs which sometimes can be difficult to manage." A nurse told us they were the only nurse on during the day on their particular unit which meant that there were interruptions when administering medicines and spending time with GP, liaising with health care professionals and supervising staff. During our inspection the nurse did have to spend time with visiting GP in the morning and a continuing care assessor.

Response times to call bells where observed to be prompt. Call bell records were monitored and we were shown a printout of response times that showed calls bells had been answered within a few minutes.

We looked at staffing levels across all three units. The registered manager told us that a dependency tool was used to determine staffing levels which were flexible to meet people's support needs. A 'staffing ladder' was used as a framework to determine the minimum number of nurses and care staff required across the three units. The operations manager and the registered manager showed us how they used the dependency tool and staffing ladder. The number and type of staff on duty matched the recommendations made by the tools.

People requiring one to one support were assisted by additional care workers, so this did not have an impact on the staffing level for the rest of the unit. A staff member on Windsor unit confirmed to us they had an extra care worker on duty due to the high needs of people on the unit.

Good

Is the service effective?

Our findings

People using the service told us they had no concerns about the staff. One person said, "The staff are brilliant with the people here." A relative told us, "I could not have asked for better treatment for [my family member]."

We saw the induction checklist and a workbook that all new staff were required to complete when they started employment with the organisation. All of the staff spoken with said that the standard of training available to them was good. We observed staff carrying out their duties without supervision. One staff member said, "Training is good, we always get letters and reminders about upcoming training." In relation to the support they received, they said "We have a good team, we communicate well together" and "I'm always kept up to date when I come on shift.".

Training was delivered in a number of ways, including e-learning and face to face sessions. It was also delivered by both in-house and external trainers. Records showed that staff had attended training that was relevant to supporting people living at the home including dementia care, responding to behaviours, dignity, diversity and tissue viability. The learning and development programme for the previous year and the year ahead was seen which detailed dates and times of planned training for staff.

Staff received regular one to one supervision in which their progress towards objectives was monitored and new objectives were identified. The registered manager kept a record of staff development through a matrix which showed that the majority of staff had received a supervision session every quarter.

Throughout the inspection we observed staff gaining the consent of people before administering care and providing support, for examples at mealtimes. People told us that staff discussed issues with them and they were aware that they had a care plan. Some of the comments included, "I have a care plan and have seen it", "I'm sure [staff] would discuss things with me" and "Yes, I have a care plan." Care plans included Do Not Attempt Resuscitation (DNAR) forms which indicated that relatives were consulted where people did not have capacity to make a decision for themselves; these were countersigned by a GP who made the clinical decision.

People told us they were free to move around the home which we observed throughout the inspection. There was a consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy seen at the home which were used to govern decision-making on behalf of people who did not have the capacity to make particular decisions for themselves.

Staff had attended training in the MCA and DoLS and demonstrated a good understanding of the act and how to implement it. Staff members told us, "If someone has dementia, it does not mean they cannot consent to anything; they can tell you what they want to wear or eat" and "Mental capacity is about telling whether they have the capacity to make decisions. If I feel they don't understand, I would speak to the nurse."

Staff had requested DoLS authorisations when they thought it was in people's best interests to be deprived of their liberty. Examples of this included, restricting people from leaving the dementia unit and when people were being supported with one to one care and did not understand the reasons why they were being supervised. Staff gave us examples of best interests meetings that had been held which included input from family and health and social care professionals.

The provider took steps to ensure that people who were restricted from leaving the unit had their restrictions minimised. For example, they were able to leave the unit with staff when they went to run errands, attend activities and day trips or go out with their families. The unit was also connected to an outdoor space which people were able to access, more so in the summer.

People using the service and their relatives were generally positive about the food at the home. They said, "The food is very good, plenty of it and you get tea and biscuits all day. The suppers are good too", "The food is not always to my liking. If I don't fancy the menu, I can ask for something else", "The food's not marvellous, we eat in the lounge or I can eat in here", "The food is very good, I've enjoyed everything I've had", "They give me and others a supplement", "They do make sure I have water" and "They get us tea and coffee as well as water." A relative told us, "[staff] feed those who can't feed themselves" and a visitor told us, "The food is nutritious and well presented."

The menu was on display at the home and was well-balanced. For example, on the first day of inspection there were meat, vegetarian and fish options available. We saw that in addition to the three main meals of the day,

Good

Is the service effective?

post lunch tea and cake and evening drinks were given to people. During the inspection, we saw that people were offered drinks throughout the day. Tea or coffee and biscuits were served to them in the morning, afternoon and evening.

The dining area was welcoming and clean, juices and beverages were available for people to help themselves. We observed lunch in the main dining room and on the Wessex (dementia) unit and saw that people were supported to eat and drink if required. They were offered a choice of main course, along with desserts and drinks. Alternative choices were available for those who did not want any of the main options. There were enough staff available to support people and they were seen to be offering choices to people. The food looked appetising and was served hot, the portions were adequate.

We spoke with the head chef who told us, "We have enough budget for food and enough supplies" and "I get told of any special requirements, for example if people need to put on weight." There was a list of people's choices and requirements in the kitchen. It also recorded whether people needed a soft diet or if their relatives provided a lunch from home.

The kitchen was clean. There were four fridges and three freezers each was used for a different purpose, for example, the storage of cooked meats, raw meat or fruit and vegetables. Food was labelled with the date it had been opened and when it was to be used by. The dry store room was well stocked with juices, cereal and snacks. Open food was kept in sealed containers. The kitchen had achieved a hygiene rating of five in November 2013 (the top score). Records showed that there had been a deep clean of the kitchen on 25 January 2015. There was a daily and weekly cleaning schedule and cooked food and fridge temperature checks were made daily.

People using the service told us their healthcare needs were met. One person told us, "I had visits from the chiropodist, the optician, the hairdresser and the doctor and [staff] arranged it all." Another person said, "If you feel you need to see the doctor, you can." One staff member told us, "We involve the GP or dietitian if we have concerns."

The unit managers were responsible for ensuring people who were on their unit had their nursing needs met. All people were registered with a GP who visited the service twice a week. Staff made referrals to healthcare professionals if required, for example we saw evidence that referrals had been made to the speech and language therapist (SALT) team, to the community therapy team and to the tissue viability nurse (TVN) for those who were at risk of pressure injuries. Care plans contained health monitoring records such as food and fluid charts, turning charts for people at risk of pressure ulcers and other records. One person on PEG feeds (a feeding tube direct to their stomach that is used when people are unable to safely eat and drink orally) had their needs reviewed monthly for the last six months.

We spoke with some healthcare professionals during our inspection. One professional told us that since the head of care had been employed, care was more organised as there was better continuity of staff. Another professional told us the service was good and that staff were able to provide an update on people whenever they visited. A GP who was visiting the service on the day of the inspection told us that nurses contacted them if they had concerns about people.

There was good support from the local hospice for end of life care and people were usually reviewed by the hospice team within 24 hours of referral. Advice was also available over the telephone. People identified as needing end of life care, had an advanced care plan, a Gold Standards Framework (GSF) profile and DNAR in place. The GSF, if followed, is an assurance of good quality end of life care. We saw that specialist palliative care contact details were appropriately recorded in two people's care files.

There was evidence that the provider took a proactive approach in relation to trying to manage behaviour that challenged the service. Referrals were made to the behaviour and communication support service (BACS), part of the local older people's community mental health team. The service provides support to care homes to use non-physical interventions as a first line of response, and offers psychologist led assessment and treatment to people who present with behaviour that challenges, including those with a diagnosis of dementia. One staff member gave us examples of people who received support from the BACS, they told us, "We communicate with the BACS team at Springfield" and "We work with the BACS team to gather their history and speak to relatives."

Good

Is the service caring?

Our findings

People using the service told us, "[Staff] are alright", "They are extremely kind", "They are very good with all residents, they joke with us all", "Most staff are so lovely here", "Generally they are very polite and kind" and "It's a nice place with friendly staff."

Relatives and visitors to the service told us they were always made to feel welcome at the home. We observed this to be the case, there was a lively atmosphere at the home with people spending time in an open seated area on the ground floor near the dining room, helping themselves to beverages.

People were supported to maintain ties with family and friends. People told us, "There are no restrictions on visitors". Visitors told us, "When I visit [my relative], I can stay for a meal every day and I pay for it", "They make me welcome and always offer a cup of tea", "I think [my relative] is looked after very well", "Staff are here for the residents" and "Residents take precedence."

Our observations during the inspection were that care was provided in a kind and sensitive way. Dignity and privacy were respected and people using the service confirmed this. Staff were seen to interact positively with people using the service when in their company and we saw many examples of a caring attitude throughout the inspection. We observed some good examples of staff consideration at lunch. Staff asked people, "Shall I get you a drink?", "Are you OK?", "Can I push you closer so you are more comfortable?" People were assisted with their meals if required and those who were not eating were gently encouraged to taste the food by staff.

Some people told us that they had their care plan explained to them. They said, "The staff do talk to me about my care", "I get to see the minister sometimes" and "At Christmas churches visited and we had some parties." It was evident that people were given the choice in everyday matters such as what they wanted to do during the day, what they wanted to eat and their level of participation in activities.

Care records contained correspondence from previous placements and also input from family members identifying likes, dislikes and preferences. Staff members told us this helped them to get to know people. The head of care showed us new forms called 'Daily Home Life Summary' that were in the process of being completed for all people staying on the Warwick unit. These recorded people's preferences and were completed with the assistance of family when possible. It focussed on the more personal aspects of the person's daily routine, such as how they liked to be supported in the morning and evening and how they liked their meals.

People and visitors told us that staff respected their right to privacy and dignity, "They would knock on my door before coming in", "They do give me privacy, they knock and shut the door", "They always announce themselves", "They always take people to their rooms to carry out personal care". A visitor said, "When changing dressings, we are asked to leave the room."

We looked at some bedrooms and saw that they were ensuite and personalised. One person said, "The cleaners are very good, they clean my room every day."

The service was undergoing accreditation to confirm its compliance with the Gold Standard Framework (GSF) for end of life care and had established good links with a local hospice in order to support people who were nearing the end of their life. This demonstrated that the provider was aware of the importance of providing end of life care in a caring and respectful manner in line with nationally recognised best practice.

The activities co-ordinator was a 'dignity champion' at the home, along with two other members of staff. They told us their role was about "raising awareness" amongst the staff. The promotion of dignity throughout the home was part of the process to achieve GSF accreditation. We saw that there was a 'dignity day' advertised at the home. Staff were aware of the importance of respecting people's dignity when caring for people. Staff told us, "It's about making [colleagues] aware of the small things such as offering them choices and giving them independence", "Asking people to help with meal preparation such as laying the table – giving people a meaningful life", "I treat them how I would treat my family."

We also spoke to some volunteers who were part of 'The Friends of Ronald Gibson House', a voluntary organisation whose aim is to enhance the enjoyment and quality of life for people. They were visiting on the day of the inspection. They told us they helped to run activities and organise

Good

Is the service caring?

fundraising events for the home. They were positive about the care that people received and said, “The atmosphere is different now, it’s lively”, “You walk in and you don’t feel like a stranger.”

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving unsafe or inappropriate care as records relating to their care were not always accurate or kept up to date.

People who had been identified as being at high risk of falls were supposed to have a secondary falls risk assessment carried out to manage this risk. We saw that this secondary falls risk assessment was not always completed fully. In some cases, the actions that staff needed to take to manage the risk were not recorded.

Food and fluid charts were not always completed to ensure that people's nutritional intake was monitored where a risk of malnutrition had been identified. In one example, a fluid chart covering the period, between the 31/01/2015 and 09/02/2015, the total amount of fluid taken in over a 24 hour period had not been calculated on some days and a nurse had not signed the records on six days within this period. In another example, between 31/01/2015 and 08/02/2015, the fluid chart had been completed but not signed off by a nurse on five days within this period. Fluid intake had only been added up for four out of seven days in two other records seen. Without these totals it was difficult for nursing staff and visiting healthcare professionals to assess whether the person had been consuming enough fluids to prevent dehydration and health complications.

A person who had been identified as being at high risk of pressure sores had a '24 hour repositioning chart and pressure relieving devices check' document in place. We found significant gaps in this document. Between 25/01/2015 and 08/02/2015, there were no staff entries between the hours of 12:00 and 19:00 on 25/01/2015. On 26/01/2015, there was no record after 20:00, on 28/01/2015, there was no record for whole 24 hour period and on 01/02/2015 and 04/02/2015, there was no record between 20:00 and 07:00.

A re-positioning chart for one person on the Warwick unit showed that two hourly turns during the day and four hourly turns during the night, as documented in the care plan, had not been documented on the repositioning chart at the correct time intervals. Re-positioning was documented four hourly during the day and on the morning of the inspection there was no date or recording on re-positioning form. The nurse on the unit confirmed these had been done, but failure to accurately record this meant that staff were unable to effectively monitor that people had received the care they required to meet their individual needs.

We also saw a report from a physiotherapist following a referral for neck pain which recommended some exercises. The nurse confirmed that staff did these and said this should have been recorded in the daily care records. We looked in the daily care records and there was no reference to these exercises.

One person's care plan on the Warwick unit stated daily observations should be recorded but this was being done weekly. We informed the head of care who explained that weekly observations were being completed and were appropriate and that the care plan needed to be adjusted accordingly.

According to the notes written by the tissue viability nurse (TVN) and nurses, people's needs were being managed well but some of the record keeping was poor as described above. Staff told us that records were not always completed, one staff member told us, "When we have agency staff they don't always know what records they have to complete." A healthcare professional that we spoke with told us that some of the scoring on the risk assessments was not correct, although they had no concerns about the care that people received at the home. They said people were referred on to them appropriately.

These examples demonstrated that the provider did not maintain accurate records in relation to the care and treatment provided to people. This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of record keeping were satisfactory. All the people using the service had a food/fluid chart and various risk assessments were reviewed monthly. Moving and handling risk assessments were specific dependent on the assessed activity, for example, bathing, showering, walking and out in the community. The falls risk assessment considered contributing factors such as age, sex, mobility, gait, medicines and medical history and scored accordingly. The malnutrition universal screening tool (MUST) was used to identify people who were malnourished, at risk of malnutrition, or obese. It also

Is the service responsive?

included management guidelines which were used to develop care plans. People were also assigned a Waterlow score which gave an estimated risk for the development of pressure injuries. We saw that people who were identified at high risk of this had an associated care plan.

We spoke with the unit manager on Windsor unit (re-ablement unit) about the referrals and admission process. This process looked at the needs of people from both a nursing and therapies point of view to ensure people's needs could be met and they could be rehabilitated within the unit to return home after a stay in hospital. The average stay of people on this unit lasted between four to six weeks. A therapies staff member based at the hospital did the admission assessment, but staff from the home were able to attend if required.

We looked at records on this unit which contained an assessment form from both therapies and nursing staff which indicated both teams involvement in assessing people's care needs. All the risk assessments that we saw on the Windsor unit were completed on the day of admission. Care plans contained reports and recommendations from healthcare professionals. Multidisciplinary team (MDT) notes were completed daily and there was evidence that referrals were made to the TVN for wound management in the case of serious pressure injuries. A dietitian visited the unit every Wednesday. Care plans were reviewed monthly and covered areas such as continence, eating and drinking, mobility, skin integrity, mental capacity and night care. People had a hospital passport to be used in the event of a hospital admission.

There was a sensory room in the Wessex (dementia) unit which opened out into an enclosed outdoor space to allow people who were restricted from leaving the unit some sense of freedom. Rooms on this unit had a memento box outside the door, as a reminder of people's history and to identify their bedroom. There was an art and poetry board on display. The activities board was displayed in a pictorial format so that people could understand what activities were available on a particular day.

We spoke with the activities co-ordinator. They told us, "We do activities seven days a week, throughout the year", "It's important for people to have meaningful activities" and "We leave some unstructured slots for one to one time for people who prefer to stay in their rooms." People using the service had a 'my daily life activities' record which was completed by staff and which gave an overview of the structured activities that people took part in.

We saw that people were assisted upstairs by staff if they expressed a wish to take part in an activity. Some of the activities were well attended and the provider made excellent use of volunteers to support staff when running activities. The home made excellent use of volunteers to support the activities team. The volunteers were local people of different ages, from school children to older people. People using the service told us, "The volunteers are brilliant." People using the service also attended local school plays. Some examples of volunteer led activities included flower arranging with a retired florist, pet therapy and coffee mornings. Staff told us, "[the volunteers] are very close to the residents. They do things like reading, painting nails."

The activities were open for all people in the home regardless of which unit they lived in. We observed some activities and saw that people were engaged and encouraged to participate. People told us they were given a choice to attend or not. One person told us, "There is enough to do. We have asked for a film to be shown on Saturdays and they are going to organise it." One staff member said, "All activities are open for all residents, it's good for them to mix."

All the people we spoke with said they had no complaints about the quality of care but would tell staff if needed. Some of the comments from people were, "I've never complained, but would even if it is not too serious", "The maintenance man is very good, he would fix anything for you and quickly", "The laundry is good and they don't usually lose anything", "If I was fed up about something, they would look into it", "I've not complained, I would if it was serious", "Never complained, if I did it would be to the manager".

'Residents and relatives' meetings were held. A relative told us, "They have relatives' meetings and they did act on issues." We saw minutes of 'residents and relatives' meetings and saw that people were given an opportunity raise concerns and we saw that these were acted on?

Complaints records showed that formal complaints received by the provider showed that people's complaints

Requires Improvement

Is the service responsive?

were recorded, investigated and responded to. If necessary, complaints were seen by managers at the head office and in some cases, concerns were passed onto the local authority who carried out their own investigations.

Requires Improvement

Is the service well-led?

Our findings

We were shown the business plan for the year 2015-2016 which looked at ways of improving the service quality, staff development and the environment. Some of the key priorities for the year included improving medicines management, documentation, leadership on the units, redecoration and refurbishment.

Actions plans and resources needed to meet these objectives had been identified, but actions required around the safe administration of medicines following our previous inspection had not been fully implemented by the time of this inspection. This put people at risk of harm as we found that people were not receiving their medicines as prescribed.

People using the service and their relatives were complimentary about the management of the home. Most thought the home was managed well and said the staff worked as a team. People told us, "They all work well together", "The staff work well in the dining room."

One person said, "The manager visits the unit, he is extremely nice", "The manager and the unit lead are very approachable, his door is always open". Another person said, "The manager is very nice, he is always around" and "This place is well managed". The staff spoken to felt supported and enjoyed working at the service. Some of the comments from staff included, "I enjoy working here", "You don't feel alone, there is always someone to help", "[the registered manager] is very approachable", "He has a good management style, he is hands on."

There was an open culture at the service which was apparent in our conversations with people who used the service, their relatives and healthcare professionals. The home encouraged the use of volunteers and the involvement of the 'Friends of Ronald Gibson House'. The manager and staff were familiar with the people living at the home and the senior team were seen out on the units, speaking to people and visitors.

There were a number of management meetings held, these included monthly unit meetings, regular heads of department meetings, core staff team meetings, multidisciplinary meetings between Ronald Gibson house staff and therapies staff and operations meetings to discuss concerns and share good practice. We checked minutes of these meetings and saw that areas of good practice and those areas that needed to be improved were discussed and where required, actions were assigned for staff to follow up, areas of good practice and those areas that needed to be improved were discussed.

Some of the senior team, including the registered manager and the head of care had only been in post a relatively short period of time. We spoke with the head of care who had been in post since October 2014. Since joining the service they had been focussing on building up team work, and offering support to staff by working on the units alongside them. Nurses told us that the head of care visited the units every day and was very supportive.

The head of care told us about their priorities in the first few months of their role. These included monitoring people's safety and setting up systems for detecting deterioration and changes in people's condition early by implementing weekly blood pressure monitoring and weekly weight checks. Records confirmed that these checks were taking place. They had also negotiated changes to the timing of GP visits to meet the needs of people more effectively.

The management team were working towards improving care plans and designing a new format for these. Another area of improvement identified was more focus on care plans and working with the operational manager to design new forms. There were plans in place to implement the new care plans for person centred care and medicines by the end of March 2015. We were also shown documentation about plans to introduce a named nurse system so that people had a nurse who had responsibility for ensuring the needs of particular individuals were met.

We saw some positive examples of collaborative working between the service and other agencies. The provider had offered the use of the training room to the local authority so clinical training in areas such as continence management, pressure sores could be made available to other services. This allowed them to share good practice with other care homes. Ronald Gibson House was also a pilot location for a dementia initiative, running in conjunction with the local authority and a GP practice, and working towards early diagnosis of people with dementia.

Requires Improvement

Is the service well-led?

The home was participating in several accreditation schemes. It had been recognised by Investing in Volunteers (IiV) since 2009. IiV is the UK quality standard for good practice in volunteer management. We saw this good practice taking place during our inspection.

The home was also working towards GSF accreditation, working with the GSF co-ordinator in trying to achieve this.

The registered manager completed monthly audit reports identifying any trends around pressure injuries, people's weights, nutrition, falls, unexpected deaths, safeguarding and staffing issues.

The home was transitioning to a new IT system for incident reporting and analysis. The practice and staff development manager demonstrated this system to us and how it would be utilised in the future. People's details were being uploaded onto the system so that all related incidents, accidents and near misses could be linked to the individual concerned. We saw that the process of transferring information had begun, the timescales given for completion was the end of April 2015.

A residents and a relatives survey had been completed for 2014, we looked at a sample of responses and saw that both people and their relatives overwhelmingly felt safe, respected and cared for. A high percentage said they would recommend the home to others.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment as there was not an accurate record maintained in respect of each service user that included appropriate information about the care and treatment provided to them. Regulation 17 (2) (d).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider was failing to protect service users against the risks associated with the unsafe use and administration of medicines. Regulation 13.

The enforcement action we took:
A warning notice was issued with a deadline of meeting the requirements of the regulation by 31 March 2015.