Bondcare (London) Limited

St Johns Wood Care Centre

Inspection report

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09 January 2020
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13 January 2020
17 January 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Johns Wood Care Centre is a care home providing personal and nursing care to 69 people aged 65 and over at the time of the inspection. The home can support up to 100 people.

The service provided nursing and personal care on five floors. People have their own en-suite bedrooms and share other bathrooms and shower rooms, as well as lounges and dining rooms on the floor where they live.

One floor specialised in caring for people with dementia, however, people living with dementia also lived on other floors of the home. Another floor specialised in caring for mostly younger adults with acquired brain injury or other conditions limiting their ability to live independently.

People's experience of using this service and what we found
At the time of our inspection the service was in the process of improving care planning. however, care plans we reviewed were still complex and lacked clarity. The nursing and care staff we spoke with, in almost all conversations, knew people they cared for well. Updating the current assessment of need for each person using the service had begun prior to this inspection. However, much needed to be done to fully assess all people and to understand the current and most accurate care and support needs.

People overall were protected from potential harm, although elements of risk for some people were not always clear and some were contradictory. For example, risk associated with medical or psychological conditions. Some people required monitoring to ensure that they drank enough each day although this was not always documented or evaluated fully.

Medicines management was safe and was given the necessary oversight by management of the home. The use of insulin was monitored appropriately, and this had improved since our previous inspection.

People were supported to have maximum choice and control of their lives. Staff usually supported people in the least restrictive way possible and in their best interests; the policies and systems in the home supported this practice. Consent, if not obtainable from some people using the service, was being sought from people who had power of attorney although some people's reason for having best interest decisions made on their behalf needed clarification.

Most people and relatives we spoke with felt able to raise things they wanted to with management or other staff at the home. People usually felt that staff were caring. We observed a number of caring interactions and staff treated people with respect.

The recently registered provider was able to demonstrate their awareness of issues that had been prevalent at the service for some time and informed us of their plans to make improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
This service was registered with us on 4 November 2019 and this is the first inspection. At the previous inspection in May 2019 there were multiple breaches and two warning notices were issued against the previous provider. At that time the service was rated as Inadequate.

Since this rating was awarded the registered provider of the service has changed. We have used the previous rating and enforcement action taken to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part due to the home being rated as inadequate as a result of an inspection the CQC in May 2019. The previous provider cancelled registration of the home in November 2019 and a new provider, Bondcare (London) Limited, took over operation of the home on 4 November 2019. A decision was made by CQC to inspect the service in order to check if the service was safely caring for people in light of the previous rating and a new provider having taken over the running of the home..

We have found evidence that the new provider had undertaken a review of the safety and wellbeing of people using the service. They had developed a detailed action plan to address the known and emerging issues about the day to day operation of the home.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Johns Wood Care Centre on our website at www.cqc.org.uk.

Enforcement
We have identified a breach of Regulation 9 (Person Centred Care) in respect of care planning not suitably assessing or identifying some people's current care and support needs. We issued a warning notice in respect of Regulation 9 to be complied with by no later than 30 April 2020.

We also identified breaches to two other regulations as follows. Regulation 12 Safe care and treatment and Regulation 14 Meeting nutritional and hydration needs. Risk assessments were not fully completed, updated or followed up for some people using the service and some people's fluid intake was not being appropriately monitored or evaluated.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

St Johns Wood Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. This comprehensive inspection took place on 9, 10, 13 and 17 January 2020.

Inspection team
The inspection team comprised of three inspectors, an inspection manager, a pharmacist, a specialist advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Johns Wood Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A new manager came into post at the home on 6 January 2020 and had made an application to register with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We sought feedback from the local authority where the service is located and other authorities that also place larger numbers of people at the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our

inspection.

During the inspection
We spoke with 16 people using the service and 4 relatives about their experience of the care provided. We spoke with 22 members of staff, including nurses, care workers and the chef. We also spoke with the newly appointed manager and four regional support managers representing the provider.

We reviewed a range of records. This included nine people's care records and 46 medicines records. We looked at the providers information for verifying disclosure and barring checks in relation to staff recruitment. We also looked at a variety of records relating to the management of the service, including a range of policies and procedures.

After the inspection
We continued to gather further information from the provider, for example, staff training and supervision, quality assurance audits and a range of policy and procedure documentation.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, when the service was operated by a different provider, this key question was rated as Inadequate. This was the first inspection under the new provider. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At the previous inspection there had been failure to robustly assess the risks relating to the health safety and welfare for people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection some improvement had been made although more work was needed to fully follow through with aspects of the risk assessment process for some people.

- Risk assessments were completed for most areas of potential risk that people faced. However, we found that the necessary follow through of information on specific people's care plans had not resulted in some areas being fully risk assessed. A person had complex medical needs, however there were no risk assessment in place in relation to these health conditions. Another person was diagnosed with a mental health condition, but there was no evidence of a risk assessment or consideration in their care plan record. The nurse we spoke with was not aware of any issues having arisen from this enduring mental health condition. They were not aware of how this condition affected the person or how this was managed.
- The risk assessments had been reviewed since the new provider took over the home. Most risk assessments had been completed in full. However, there was evidence to show that when risk was reassessed, this was done automatically, without checking if the risk had changed or stayed the same. This suggested a tendency to review documentation without fully verifying if the situation had changed in terms of deterioration or improvement.

We found no evidence that people had been harmed however, the provider was not ensuring that risk assessments were fully completed or updated to fully reflect risks identified due to some people's care needs. This is in breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- The provider had implemented a number of measures to ensure that medicines were handled and administered safely. Medicines management, not least in terms of the use of insulin, had improved since our previous inspection in May 2019.
- Medicines were usually administered correctly. However, on 9 January 2020 we found one tablet had been given in the morning to a person who should have had six tablets of a particular medicine. This was an error by a nurse which was corrected when our inspecting pharmacist queried this, and the correct dose was then administered. Another person had not received a full supply of a liquid medicine to cater for a whole four weeks administration. We verified this had been corrected. We checked these situations again through

the course of our inspection and no further errors had been made.
● There was clear guidance in place for people who had insulin administered, which had been a serious concern at our previous inspection. The provider had implemented a daily check process with two nurses being required to be present when insulin was administered.
● We saw six people could have their medicines administered covertly if required. All the required assessments had been completed and were reviewed each month.
● Nursing staff kept written records when they administered medicines Staff were trained and deemed competent before they administered medicines, and regular checks had been established to ensure people received their medicines safely.
● Staff supported people with dignity and knew how people preferred to take their medicines.
● Care plans were in place describing the level of support each person needed to take their medicines. Procedures in place for 'as required' medicines included how to identify when they were required, for example to help manage pain. The effectiveness of the use of these medicines was also recorded. No medicines were being inappropriately used to control people's behaviour and controlled medicines were managed safely.
● There was a daily meeting which included all nursing staff on duty, one of which we attended. This meeting was held to obtain an overview of how people were on the day and as a part of this meeting medicines charts were checked in order to identify if errors had occurred.

Systems and processes to safeguard people from the risk of abuse
● People and relatives we spoke with had a mixture of views about how safe they felt at the home. One person told us they did not feel safe, although they did not elaborate on this, we discussed the person's comment with a regional support manager to look into.
● People told us, "They're great here the staff. At night I sleep, I don't know if they are there but when I press the bell they appear. I get tucked in and go to sleep" and "yes, the staff keep me safe"
● A relative told us, "The staff change. When [nurse] is not working there is agency staff. I would like to have regular staff. [member of staff] is fantastic but he's not here every day. He's the key worker. He's here three days a week." Two other relatives told us that staff change and one said they think there are not enough staff.
● Staff shortages had been acknowledged and were being addressed by the provider who was able to evidence that the use of temporary staff was reducing.
● Staff had access to the providers policy and procedure for protection of people from abuse. This was a detailed policy introduced by the provider when they took over the home in November 2019. They also had the contact details for the safeguarding team at the local authority. The members of staff we spoke with said they had training about protecting people from abuse, which we verified on training records.
● Care staff were all aware of types of abuse and knew that they needed to report to the nurse or a senior manager if they had been told about possible abuse. They knew that they would need to report to the local authority safeguarding team, CQC and police if the management did nothing. There was a flow chart describing the safeguarding procedure displayed for staff on each floor of the home. Staff knew about whistleblowing and all said they would always speak up/report any poor practice.
● Safeguarding concerns that had been apparent at the time the current provider began operating the home had been addressed in consultation with the local authority. The provider had worked well at familiarising themselves with each situation and liaising with social care colleagues to address these issues. Where there were ongoing issues the provider continued to work collaboratively with health and social care colleagues, as well as others, to move these situations forward in terms of conclusion and to take any action required.
● We looked at staff training records and found that 96% of staff, were up to date with safeguarding of adults training.

Staffing and recruitment

● The provider operated safe staff recruitment practices. We saw evidence that checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with vulnerable adults. Four new nurses had been recruited since the current provider began operating the home. We saw that background checks, including nurse's registration with the Nursing and Midwifery Council had been undertaken to verify the suitability of these new staff.

● Although some staff had left the home since our previous inspection, the remaining staff had remained the same. The benefit of this is that these staff knew people and were familiar with the home.

Preventing and controlling infection

● The cleanliness and standard of infection control at the home improved since our previous inspection and the home was clean and odour free.

● Infection control audits had taken place in November and December 2019. The first of these carried out by the new provider gave a rating of 56% which improved to 89% at the time of the December audit. This showed marked improvement in the large range of areas.

● One person had a long term illness that could change and become potentially infectious to other people. There were no recorded details about what should be done to minimise this a potential risk . However, we did see evidence that the service had liaised with other healthcare professionals when it was thought an issue may be emerging about this condition which was being monitored.

Learning lessons when things go wrong

● The provider had developed a detailed action plan in response to the significant issues the home had encountered under the previous provider. Progress was being made and the provider acknowledged that significant work remained in order to place the home in a stable position and to move forward for the benefit of people using the service.

● Staff had reported concerns about people's welfare whenever these arose. The provider had established an 11 at 11 daily meeting. The lead nurse on duty from each floor, the clinical lead nurse, the chef, the newly appointed manager and a regional support manager attended. We observed this meeting. People's care and wellbeing, staffing and events planned to take place that day. At the end of the meeting each nurse checked another nurses' medicines charts for their floor in order to identify if any recording or other queries about medicines needed to be addressed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection, when the service was operated by a different provider, this key question was rated as Inadequate. This was the first inspection under the new provider. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At the previous inspection the provider had failed to robustly plan for the care and welfare of some people using the service. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection some improvement to recording had been made although care planning remained an issue for at least some people using the service. This was in breach of Regulation 9.

- We were shown the electronic care planning system that was being introduced by the provider and during our inspection nursing staff commenced their training about using this. However, we identified issues in relation to the thoroughness of the current care plans, the way these were written, and care planning information was unclear about the exact nature and response to some people's care and support needs. For example, one person had a skin integrity care plan dated March 2018, but this had not been updated since that time. A person had a continence care plan the guidance was written April 2018, but nothing had been added or amended since. A person had a mobility care plan which did not refer to their medical conditions or the impact on their mobility. A care plan for pain indicated that a person could not express their pain but did not suggest using the Abbey pain scale to assess pain although that was mentioned in the summary. This plan did name some generic non-verbal signs of pain.
- People told us "I have no relatives left. I have one friend, but not involved in care planning" and "My family know I'm here, they are part of my care plan."

Supporting people to eat and drink enough to maintain a balanced diet

- There was a lack of clarity in most care plans that we looked at in relation to people drinking enough each day. The provider's own policy about hydration referred to 1500 to 2000 millilitres a day being a good range of fluid intake. However, in most care records that we looked at the amount of fluid taken was either not recorded consistently or had not been evaluated consistently.
- Although no evidence of people suffering harm due to diabetes was found, there was a lack of consistent follow through about those living with specifically type 2 diabetes. Where diabetes was referred in care plans, information was not always followed through with the potential consequence of this for people's dietary needs. This could pose a risk for people if their diabetes management needs changed.

We found no evidence that people had been harmed however, the provider was not ensuring that people's fluid intake or dietary needs, due to diabetes, was fully reflected or accurate on care records. This is in breach of Regulation 14 (1) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● People using the service told us "Some of the food it is nice", "Food is good sometimes and sometimes not" and "The food is good."
● Relatives said "[relative] has diabetes. Yes, I believe the food is adapted. Tea without sugar. No sweet foods. They look after him and he tells me" "We come every day, [relative] has enough drink every day. I'm happy for the care."
● On each day of our inspection we observed that there were usually enough staff available to assist people who required help to eat their meals. This was the situation whether people ate meals in the dining rooms or in their own bedrooms. However, on the first day of our inspection we noted on the lower ground floor that it took quite some time to serve people with their meal and to assist those that needed to have help to eat.
● We spoke with the chef and looked at the kitchen. They told us that there were five kitchen staff in total. This included themselves, an Assistant Chef and three kitchen assistants. They told us the new provider had provided training and they had been told their budget would be increased and they would have more freedom to buy food they thought people wanted. The provider's senior management representatives also told us the same thing.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Most of the care plans we viewed showed consent having been obtained from either the person, their family or other health and social care professionals when relevant. This was an improvement since our previous inspection. These included consent to care, aspects of daily support and sharing information. However, it was not always clear if lasting power of attorney had been obtained in a small number of cases. We spoke with a regional support manager about this and were shown evidence of what was being done to verify these situations, some of which had been ongoing prior to the provider taking control of the home in November 2019.
● The service had worked to clarify the situation for each person regarding DoLS. We were shown information about what was being done to progress long standing DoLS applications for a small number of people using the service.
● Best interest's decisions were usually recorded but in a small number of examples it was not clear what decision was being referred to, who had been consulted or what decisions people could make for themselves. There was work needed by the provider to improve this although it is noted that since our previous inspection mental capacity needs were clearer for most people and that no one was being illegally deprived of their liberty.

Staff support: induction, training, skills and experience

● Staff training, and supervision, was improving since our previous inspection. We asked a regional support manager to provide us with evidence of staff supervision and training, which they supplied. Supervision had commenced for some staff, just over half of the nursing and care staff team had already had a supervision session with a senior manager. We were told by a regional support manager that the remaining staff would also have supervision shortly.
● Care workers told us that they had all received a helpful induction when they had first started at the home, but this had been when operated by the former provider. They said they felt very well supported by their team and the current senior staff. They spoke of discussing best practice issues during supervision and during their shifts.
● A nurse told us, "[The new management of the service] are supportive, they are spending time with us on each floor and we are observing and feeding back about practice." Another nurse said "[daily] meetings are working well, and these include us checking medicines."
● We were told that no new members of staff had begun working at the home since our previous inspection in May 2019. We were unable to therefore assess staff induction at this inspection but will do so when we inspect again in the future.
● The provider had a database system for monitoring staff training and compliance. At the time of this inspection compliance was in the region of 85 to 96 percent in areas such as equality and diversity, infection control and mental capacity. We note that staff we spoke with, regardless of their role, made positive comments about the training they had undertaken since the new provider took over in November 2019.
● Among the staff team as a whole we received feedback from staff in different roles, whether nursing or care positions, about the amount of training that was being provided. This was seen as positive and useful and training about relevant areas of care and support needs was happening across the staff team.
● Commissioners and other professionals we spoke with both before and during this inspection told us that staff knowledge had improved.

Staff working with other agencies to provide consistent, effective, timely care
● The service maintained close contact with other health and social care professionals. Due to the significant concerns that had arisen last year the service had been placed on an establishment concerns process by the local authority. As a part of this care and welfare of people using the service was regularly scrutinised. The views of the professionals we were in contact with was notably more positive about how people's care and welfare were addressed by the new provider.

Adapting service, design, decoration to meet people's needs
● The provider ensured that fire safety procedures were well managed. Personal evacuation plans were in place which told staff how to support each person in the event of potential evacuation being necessary. On the first day of our inspection we had initial concerns about elements of electrical safety, however, we saw engineers visiting on another day of our inspection which had been arranged by the provider but as planned work and not because of concern that we had raised.
● There was suitable furniture on each floor although at times the first and second floor dining rooms were used for staff training which meant that these rooms were unavailable for people to us. We saw this on one day although we did also see more people using the first floor dining room at mealtimes which was a marked difference to what we had found during previous inspections.
● The décor of the home needed improvement, although pleasant in certain parts it was evident that refurbishment work was needed to other areas.
● On the third day of our inspection we found an office on the lower ground floor a room containing care records was unlocked despite a note on it stating it should be locked at all times. This could compromise the right of people to have their personal information kept confidential. We saw other instances where doors with the same keep locked signs on them were being left open for at least a short period of time.

Supporting people to live healthier lives, access healthcare services and support

● People were usually supported to maintain good health. Nurses were on duty at the service 24 hours a day and a local GP visited the home twice each week and would also attend if needed outside of these times.

● We found that referrals were made to external healthcare professionals when needed, for example speech and language therapists if people were experiencing swallowing difficulties. Although it was evident that emerging healthcare issues were noticed it took some time to identify if referrals were followed up. This is another area of recording issues as with other care planning information.

● When we asked people about their healthcare needs a relative told us staff had not informed them about a toe infection their relative had but the infection had cleared up since. Other relatives said "They [the staff] keep in touch" and "[relative] goes to hospital every three weeks. The nurse goes with him [which was confirmed by the person living at the home]."

● People who were at risk of developing pressure ulcers had these risks assessed.. Pressure relieving equipment such as cushions and mattresses were used. We did, however, see a small number of instances where checking and setting of the mattresses needed to be more thorough. It is noted, however, that the provider has undertaken to purchase further pressure relieving mattresses that will make it easier to keep these set correctly.

● There was a system in place for regular review with other healthcare professionals regarding people's physical health. Multi-disciplinary team [MDT] visits and meetings to review people's conditions and needs took place. We looked at the minutes for the two MDT meetings that had taken place since Bondcare took over the service in November 2019. Changes being planned for the service were discussed as well as nutrition, tissue viability, falls and infection control. People also had access to a range of visiting health care professionals such as dentists, optician's and podiatrists. People told us they were helped to brush their teeth or dentures if they used them.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection, when the service was operated by a different provider, this key question was rated as Requires Improvement. This was the first inspection under the new provider. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us, " I get everything here. I'm happy. I like the room", "Staff are good. It's a community, I'm happy" and "Staff respect for my [religion] and culture." Another person told us that they had magazines available at the home which are specific to their religious faith.
- A relative told us, "Staff ask before they do anything, they're very good at it. The staff listen, are nice and helpful. Our family speaks with the nurse." Another relative said, "The care staff tell me every day: 'we did this, we did that'. [Nurse] tells me everything."
- Where people had made their preferences known about whether they would wish care to be provided by male or female staff this was respected, and we saw evidence of this being made clear where someone had asked for specific same gender care, although we found one occasion where it was not clearly recorded on a person's care plan what their wishes were.

Supporting people to express their views and be involved in making decisions about their care

- It was unclear in some instances how people and their relatives, if relevant, had been involved in their assessment of needs reviews or care planning.
- We were told by senior management representatives of the provider that as the electronic care planning system gets underway it would include re-assessment of people's care needs, including diversity and inclusion, in consultation with the individual person and their families if appropriate. It was too early for us to judge this as the process had yet to be started, however, we will do so again when we next inspect the service.

Respecting and promoting people's privacy, dignity and independence

- The provider and staff team had improved upon people's right to privacy and to be treated with dignity were respected.
- We observed warm and caring interactions between staff and people using the service. The communication with people was good. The staff who were providing one to one support appeared to have a good relationship with the person they were with and were able to tell us in detail about the person and their needs. The activities' person we saw with people on one floor was particularly friendly and kind with people, reacting to individuals' needs and involving them. There were four full time activities staff employed at the service.
- There were some good detailed social history and personal information (me and my life) which included a little about people's history, likes and dislikes and routines. This was person centred, however people's daily

records did not include how staff supported people's preferred activities, so it was not always clear how this was considered. However, on one floor where most people did spend a lot of time in each other's company it was evident through interactions and the way people responded that staff knew how to engage with different people.

● Care plans reminded staff to respect people's privacy and dignity when supporting them. Care plans also reminded staff to talk with people when providing personal care so that they were involved and knew what staff were doing to support them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection, when the service was operated by a different provider, this key question was rated as Requires Improvement. This was the first inspection under the new provider. This key question has been rated Requires Improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People we spoke with told us that either they or relatives hadn't been involved in planning their care or they could not recall if they had been.
- Monthly evaluations were taking place more consistently in most, but care plan files continued to hold a lot of information, much of it no longer relevant or duplicated. The care plan files were disorganised, and this posed a risk that nursing, and care staff may not be able to quickly locate the current and most relevant information.
- Staff we spoke with told us that they were aware that a new care planning system was being introduced. During our inspection some staff commenced training about using this electronic care plan process.
- Some nursing staff had commenced care planning training during our inspection. One staff member said, "Yes, they [people] are. Every care plan is written relevant to the person, they are person centred" and another told us, "Yes, they make sense to people all their needs and wants are recorded."
- Care workers told us that they got to know about people's needs by talking with them, listening to handovers, and reading the summaries. One said, "I am always learning from people that live here."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Some staff were more knowledgeable than others about specific people's method of communicating with people. We met a person whose first language was not English. The person was unable to understand what was said despite the nurse saying the person did understand English. A care worker spoke some words to the person in their first language that the person responded to. Another care worker told us about another person who spoke no English. They told us they used signs with them and showed choices. As an example, a person's communication care plan including guidance that said to use 'flash cards' but a care worker told us they did not do so.
- Pictures and words were used on information boards throughout the home, informing people about activities and events that were planned.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● People told us, "I prefer to stay here. I can choose what I want to do" and "Activities are Good. I watch TV and I have friends who visit."

● We met some relatives and other visitors to the home during our inspection. Visiting times were flexible within usual limits, as an example not too late at night or too early in the morning.

● The service provided opportunities for people to engage in both group and individual activities although some people were being nursed in bed so the activities staff visited people individually. There were limited amounts of activity for people to participate in as a group although we did see the four activity staff spending amounts of time with people individually. On one floor of the home were more group orientated activities taking place. We were told by a regional support manager that a review of activities would be taking place.

Improving care quality in response to complaints or concerns

● The provider had a clear complaints process that was accessible for people using the service, families and others. We looked at the complaints record, and this showed that no new complaints had been received since the provider began operating the service. Two compliments from relatives had been received about care and support.

● People told us, "yes, they answer my complaints" and "I have no complaints, I would complain to staff."

● The provider's complaints policy clearly set out what would be done in response to complaints.

End of life care and support

● The provider's end of life policy was detailed and placed emphasis on focusing on the dying person's needs and those of their family. This was not only in terms of physical care but also emotional support.

● We saw there were advance care plans on some people's care records where this had been discussed. Not all of these contained sufficient detail. For example, some care plans didn't contain specific instructions such as explaining or identifying if a person's wish to have a minister of religion had been identified, or other ways in which end of life wishes would be supported, including the use of anticipatory medicines if needed.

● It was reported to us by a regional support manager that no-one was actively receiving end of life care at the time of our inspection, although it was not uncommon for people to be receiving palliative care at the home.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection, when the service was operated by a different provider, this key question was rated as Inadequate. This was the first inspection under the new provider and this key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- There had been a detailed review since Bondcare (London) Limited took control of the home from the previous provider. Improvements, such as the management of medicines and positively engaging with people and their families had been made.
- The provider could demonstrate that when improvements were identified the necessary action was taken in a timely way. We viewed copies of the quality audits of the service since 4 November 2019 and were shown what changes had taken place, for example with hygiene and medicines.
- As Bondcare (London) Limited became responsible for the home approximately nine weeks prior to this inspection it is too early for CQC to judge the overall effectiveness of improvement measures being implemented. However, we noted the provider had understood the wide-ranging need for improvements to areas of practice at the home which had arisen under the former provider.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Although we did not observe overall poor outcomes for people during this inspection, there was a significant work required to ensure the service improved. The new provider had recognised this and had developed a detailed action plan as a result. This action plan was being regularly monitored by the provider and local authority. It was too early to judge the overall impact and effectiveness of the action being taken in the longer term although it is recognised that much had already been done to take action.
- A relative told us, "I don't know if there is a key worker. They say we'll find out, still they don't come back to us. For other things we usually get answers the same day." Other relatives said "We don't go to meetings. We go to the head nurse or the regular nurse" and "I don't know who the manager is. I think there is more than one, but we don't know."
- In all the conversations that we had with nursing and care staff they usually demonstrated a good knowledge about the people they cared for and their needs.
- We asked staff about how well they felt supported by the provider and by internal management of the service. Overall staff were positive about changes that they had seen and how the provider was taking action to improve the service. The general theme was that staff felt it was too early to make a judgement but were cautiously optimistic that the service would improve.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● A manager was appointed and began their induction at the home on 6 January 2020, three days prior to this inspection beginning. We met this person who told us they were beginning their application to be registered with CQC.
● Nursing and care staff we spoke with were clear about their roles and who they needed to report to during their work.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was able to confirm that the duty of candour had been fully met since Bondcare (London) Limited took control of the home in November 2019. The provider was registered with the CQC to operate the service on 4 November 2019. In the intervening nine weeks, prior to this inspection commencing' actions had been taken to address some urgent issues that had been identified at the previous inspection in May 2019.
● The provider was maintaining close and co-operative contact with commissioning authorities, including the local authority where the home is located and who largely commission placements at the home. During this inspection the provider's management representatives that we met acknowledged the range and complexity of the issues that had been identified. It was accepted by the provider that a large amount of work was needed to improve the standard of care at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since the provider had taken over operating the service, meetings had taken place with people using the service and relatives to discuss the transfer of the home and the plans for improvements.
● The service had good links with other groups in the community. We were told that ministers of religion from the Anglican, Catholic and Jewish faiths visited the home regularly, an Anglican church service was held each month and a person of Muslim faith attended a local mosque each week.
● The service having good links with a local primary and secondary school. Pupils from the secondary school visited weekly to spend time talking with people.

Working in partnership with others
● Prior to this inspection two commissioning authorities, and one visiting professional we spoke with during this inspection, told CQC that the quality of responses to people's care and support had improved, although care planning and record keeping was an issue. The overall view of those who provided feedback to CQC was that steps were being taken by the provider to communicate effectively with partner agencies.
● Feedback we received from the main authorities that placed people with the service followed a theme of much work had been done in the few weeks that the provider had been responsible for the service. It was also stated that the commissioning authorities were encouraged by the positive approach being taken by the new provider to making the service safe for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not fully completed, updated or followed up for some people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Some people's fluid intake was not being appropriately monitored or evaluated.