Bupa Care Homes (CFChomes) Limited

Heathgrove Lodge Nursing Home

Inspection report

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Date of inspection visit: 16/10/2015
Date of publication: 18/12/2015

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

Overall summary

This unannounced inspection took place on 16 October 2015. Our previous inspection, of 3 January 2014, found there to be no breaches of regulations.

Heathgrove Lodge Nursing Home is a nursing home up to 36 people. There were 30 people using the service when we inspected, and we were informed that their maximum practical occupancy is 33. The service's stated specialisms include dementia. The accommodation is purpose-built with passenger lift access to all floors.

There was a registered manager in place at the service at the time of our inspection. 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.

The service tried to respond to people's requests. The basis of this was a comprehensive assessment of needs

Summary of findings

and preferences. However, whilst people's care plans were regularly reviewed, care plans were not promptly set up for new people using the service, which may not have ensured safe care and treatment for these people.

Whilst there was prompt healthcare support in some circumstances, we found that reasonable actions to address wound care needs were not always being taken. Records of care and treatment delivery did not consistently demonstrate safe care and treatment of people.

Some complainants' experiences and inconsistent staff training demonstrated that an effective complaints system was not always being operated at this service.

The service was not consistently well-led. This was because the breaches we found were foreseeable, and effective systems of governance should have identified and addressed the consequent risks to the health, safety and welfare of people using the service.

The service's strengths included that staff attended to people in a friendly manner, people were offered care choices, and people's choices were listened to. People were treated with respect, and we found that positive relationships were developed.

People received meals that were appetising and freshly prepared. They received support with eating and drinking enough. People's medicines were adequately managed, and there were enough staff deployed to keep people safe.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety.

Staff received support to deliver care to people appropriately, including through regular training and supervision. The service was promoting a positive, open and person-centred culture, and a number of audit tools were in use to help ensure service quality.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider and registered manager for one of these breaches because of the potential impact on people using the service. You can see what action we have 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?

The service was not consistently safe. Care plans were not promptly set up for new people using the service, which may not have ensured safe care and treatment for these people. Records of care and treatment delivery did not consistently demonstrate safe care and treatment of people.

People's medicines were adequately managed, and there were enough staff deployed to keep people safe.

The service had safeguarding procedures in place, and staff knew what to do if they had concerns about people being abused.

Requires improvement

Is the service effective?

The service was not consistently effective. Whilst there was prompt healthcare support in some circumstances, we found that reasonable actions to address wound care needs were not always being taken.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety.

People received meals that were appetising and freshly prepared. They received support with eating and drinking enough.

Staff received support to deliver care to people appropriately, including through regular training and supervision.

Requires improvement

Is the service caring?

The service was caring. Staff attended to people in a friendly manner, people were offered care choices, and people's choices were listened to. People were treated with respect, and we found that positive relationships were developed.

Good

Is the service responsive?

The service was not consistently responsive. Some complainants' experiences and inconsistent staff training demonstrated that an effective complaints system was not always being operated at this service.

The service tried to respond to people's requests. The basis of this was a comprehensive assessment of needs and preferences. The service provided regular activities led by a designated activities worker.

Requires improvement

Is the service well-led?

The service was not consistently well-led. This was because the breaches we found in other areas of this report were foreseeable, and effective systems of governance should have identified and addressed the consequent risks to the health, safety and welfare of people using the service.

Requires improvement

Summary of findings

However, the service was promoting a positive, open and person-centred culture, and a number of audit tools were in use to help ensure service quality.

Heathgrove Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 16 October 2015 and was unannounced. The inspection team comprised of two inspectors, a specialist advisor on nursing care, and an expert by experience which is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including notifications they had sent us and information from the local authority.

During the visit, we spoke with seven people using the service, ten people's relatives and representatives, four community healthcare professional, eight staff members, the registered manager, and the deputy. We observed care delivery in communal areas, and we looked at various parts of the accommodation.

We looked at care records of nine people using the service, along with various management records such as quality auditing records and staffing rosters. The registered manager sent us further documents on request after the inspection visit.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and secure in the service. For example, one person told us that they felt staff would pick up on unsafe practices and address the concerns. They also felt the registered manager was approachable if they needed to report anything directly. A relative added, "They are very vigilant."

However, we found concerns with how the service ensured that people were provided with safe care and treatment. Although people's needs were assessed, the service did not ensure that all reasonable actions were taken to address identified risks.

One person had been using the service for 36 hours when we checked their care file. We found that although they had had a detailed assessment of needs before moving in, most risk assessments around their care, for example, for falls, nutrition and pressure care, had not been started, and the manual handling assessment only stated that two staff and a hoist were needed. The guidance document stated that the assessments were to be completed within six hours, which had not been achieved for this person. Additionally, the pre-assessment document stated that the person was not at risk of falls. However, a bed-rail risk assessment had been written for the person stating that they were at risk of falls and hence a bed-rail was needed. The assessment was blank for the section entitled 'safe fitting,' meaning if used, the specific rails may not have been checked to ensure they fitted the bed safely. Risks to the health and safety of this person had not been properly assessed in support of providing them with safe care and treatment.

For two people who moved into the service a week before our visit, whilst risk assessments had been documented, many parts of their care plans were not in place. For example, one person's pain assessment tool and plan for pain management was not yet filled in, however, the person was admitted with a number of minor injuries and had specific wound care plans in place. They had no communication plan in place, despite being recorded as having dementia and us being told they did not communicate much. We overheard the person raising their voice when being assisted with personal care, but did not know if that meant they were in pain. They were assessed as being at very high risk of developing pressure ulcers, however, their skin care profile and care plan in this respect had not been written.

This person's nutritional risk assessment rated them as being at high risk, and they had a low weight on admission. There was a record of the person 'eating poorly' the day after they moved into the service. However, there was no plan in place for eating and drinking, and we saw that their food and fluid intake was not being specifically monitored. The person's care plan had not been developed to address identified risks to their health and safety, and so was not supporting staff to provide safe care and treatment to them.

The registered manager confirmed that the provider's expectation was for care plans to be in place within three days of people starting to use the service. A '72 hour care plan checklist' was available to audit that appropriate and safe care plans had been set up for new people. It was filled in three days after our visit for the above person, which was ten days after they moved in. It listed 16 out of 31 aspects of the care file that were found not in place. This included that the care plan had not been completed in full, an oral care assessment had not been set up, a pressure care risk assessment had not been accurately and fully completed within four hours of admission, and that a food and fluid intake and output diary had not been implemented and completed accurately.

Many people living at the service were assessed as requiring hourly health and welfare monitoring, which was documented as taking place on specific charts. One person told us that this occurred. However, a recent safeguarding case had established that this process was not always taking place hourly and being documented accurately. During our visit, records of these checks were accurate and complete, indicating that the service had taken action to address this identified shortfall. However, we found that other monitoring charts were not being completed accurately, which may have compromised people's safety.

When we looked at care delivery records for five people, we found concerns relating to the safe delivery of care and treatment. For example, repositioning charts for the prevention of pressure ulcers were in use since one person started using the service a week before out visit. However, these did not stipulate the expected frequency of repositioning. No record was made of support with repositioning overnight on six out of seven occasions. No daytime repositioning support was recorded for a period of over nine hours on one occasion, and over six hours on another. At 10:59 we heard staff on the second floor saying

that they would attend to the above person for care purposes. The repositioning chart for them was signed at 06:30 then 11:30, which raised concerns that they were not supported to get dressed for the day until 11:30. There were similar gaps in repositioning the person on two of the seven previous mornings. This did not demonstrate care and treatment of this person that addressed pressure care risks.

We checked other people's repositioning records and found similar concerns. The frequency of repositioning was not clearly stated and the records showed that practice varied considerably from day to day. For example, one person's records showed they were repositioned three times on one day but seven times on another, during the week before our visit. Another person's repositioning frequency varied between two and eight times a day. A third person's chart showed no record of repositioning from 14:00 the day before our visit, a period of 18 hours. All the charts we looked at showed that the number of times people were repositioned was inconsistent and the periods of time between repositioning varied considerably. This did not demonstrate safe care and treatment of these people that addressed risks to their safety and welfare.

Records of the application of topical creams were also inconsistent. For example, one person required a particular cream to be applied twice per day. However, across the eight days before our visit, the cream was not recorded as administered on two days, only once on three days, and four times on one day. Another person's pain-relieving gel was recorded as prescribed three times per day. However, it was ordinarily recorded as administered twice a day, and on one occasion, once a day. We saw that the prescription for this gel was for application up to three times a day; however, the medicines administration chart documented that it had been delegated to care staff for application three times each day, in contrast to the topical application records. This did not demonstrate safe care and treatment of these people that addressed risks to their safety and welfare.

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

In two of the care plans we reviewed, the hand-writing of staff was extremely difficult to read. We pointed this out to the registered manager who accepted that the legibility of the hand-writing was a problem. Important information from these people's care plans was not readily available to staff members, which put those people at risk of unsafe care and treatment.

We saw that most medicines administration records (MAR) demonstrated that people received their medicines as prescribed. However, the MAR for one person who moved into the service a week before our visit demonstrated that for two medicines used for constipation, more of each medicine had been administered than had been recorded on the MAR as delivered into the service. Accurate and complete records of care and treatment for this person were not being maintained, which put them at risk of unsafe care and treatment.

Although we noted that hourly health and welfare monitoring records were completed accurately during our visit, information arising from a safeguarding process showed us copies of monitoring chart records that demonstrated care delivery recording that was inaccurate, incomplete and not contemporaneous. For example, one chart showed that two consecutive hourly checks had not been recorded as undertaken. A copy of the same chart from a later date had the checks for those two hours retrospectively recorded in, at least seven hours later. Another record demonstrated that the checks had been recorded as completed over three hours in advance.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All medicines were securely kept. Medicines cupboards were clean and well-organised. There was clear stock-checking of controlled drugs so that all could be accounted for. We saw a message that one person's medicine was nearing completion but further stock was needed. MAR showed that the stock was acquired in time for the person to continue with the medicine as prescribed.

Aside from people newly using the service, people's care files included assessment for risk of pressure ulcers, malnutrition, immobility and pain. These assessments were updated monthly. Many people were identified as at risk of falls and so bed-rails were commonly used. Risk assessments for the use of bed-rails were carried out in all the files we checked.

Most people said that staff promptly attended to activations of the call-bell. Comments included, "Generally

Requires improvement

Is the service safe?

it is quite good." Applicable people had call-bells which were accessible to them should they need to call for assistance. Staff had call-bell fobs by which to be directly alerted of activations. We saw a number of staff respond urgently to an emergency activation of a call-bell that turned out to be a false alarm. We checked call-bell records and saw that the majority were answered within a couple of minutes. The registered manager told us that call-bell records were checked daily, to ensure that responses did not take longer than five minutes, which records confirmed.

The registered manager told us that an additional staff member was working during the mornings. Whilst there was no staffing tool used to formally determine appropriate staffing levels, the registered manager told us she informally reviewed staffing levels weekly based on feedback received, for example, from daily checks of call-bell response times and reports on people's health needs. Recent rosters showed that the service's planned staffing levels were being adhered to, for example, of six care staff working mornings, five during afternoons, and three at night, along with nursing staff and staff in other roles.

Staff told us they had been trained on safeguarding. Most members of staff were able to describe the various ways people living at the service could be at risk of abuse, and what they would do if they had a concern about a possible safeguarding matter

A safeguarding oversight document provided information on each safeguarding case at the service in 2015, including actions taken and investigation outcomes. There was a record of lessons learnt, for example, providing nursing staff with an action plan from a safeguarding meeting, and making a referral to a professional regulator. The registered manager also told us examples of this, such as refresher training for staff on safeguarding and manual handling. Some new slings had been bought on the recommendation of the safeguarding trainer, and a new hoist was being considered.

The registered manager said that, following the recent safeguarding cases, there was a service emphasis on being transparent about anything that may be of concern. For example, we were told that a recent redness on one person's face was reported to the local safeguarding team, but was taken no further when the concern was established to be eczema. We received a recent notification about a prescription that was not acquired promptly, resulting in an avoidable hospital admission. The evidence indicated that the service had taken all reasonable actions to acquire the prescription. The management team told us they had raised a formal complaint with a stakeholder about the matter.

Requires improvement

Is the service effective?

Our findings

People's spoke positively about the service's effectiveness. Comments included, "It's been excellent so far" and "Most of the time it's very good here. I like it." Some people's relatives told us how the service had helped improve the person's quality of life. One relative told us that the "great care" provided at the service had "transformed" the person so that they were now much more able. Another relative told us that the service had supported their relative to regain mobility and confidence. People's representatives' recent comments about the service on a care website were also positive.

However, we found the service not to be consistently effective, because of concerns with how people's wound care needs were met. One person was documented as having a skin tear wound in the service six weeks before our visit. The dressing was to be changed every three days. Whilst there were records of gradual improvement in the size of the wound, most reassessments of it did not take place within the planned timescale, the longest being nine days after the previous assessment despite a plan for assessment after two days. At the time of the inspection, the last reassessment was a week old and hence five days overdue. When we checked the medicines administration record for this person, we found their dressings were signed as administered every three days except for the day before our visit, indicating no change of dressing for four days, which we informed nursing staff about. This did not demonstrate that safe healthcare was provided to this person, as reasonable actions to address wound care needs were not always being taken.

People's wounds were discussed at the daily nurses' meeting during our visit. However, one person was not mentioned despite moving into the service a week before our visit with documented wounds, and for whom a wound care plan was in place. The plan included for changing a dressing on a skin tear wound on alternate days. The next assessment of the wound was recorded as due four days before our visit, but there was no record of this taking place. Another wound was documented as a leg ulcer, again for change of dressing on alternate days. One reassessment of this wound had taken place five days after the initial assessment, and gave indication of improvement in the condition of the wound, however, that reassessment was three days late. Nursing staff told us they used the diary and handover file to ensure people's wounds were reassessed as planned. However, we found no entries in respect of this for the above person. Safe healthcare was not being provided to this person, as reasonable actions to address wound care needs were not always being taken.

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

The deputy told us that the dressings were on an as-needed basis for the above person, in response to their eczema needs documented within pre-admission records. Therefore, the record of a leg ulcer within the care plan was not accurate. A nurse added that this dressing was changed two days before our visit. The deputy also told us the skin tear had healed, however, the wound care plan did not reflect this. Accurate and complete records of care and treatment for this person, and decisions about this, were not being maintained, which put the person at risk of unsafe healthcare.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three community professionals fedback positively about healthcare at the service. They felt the service contacted them appropriately and acted on their recommendations. However, one other community professional had some concerns about the quality of staff training and record-keeping.

Most relatives said that the service kept them informed if anything happened. For example, one relative said that as soon as her mother developed a chest infection she was informed. Another relative told us they were immediately informed when an accident occurred. They added that the GP was called and the service responded in an appropriate, "risk averse" manner.

One person was attending a hospital appointment on the day of our visit. An additional staff member was provided in support of this, which the registered manager said occurred when a person's representatives could not attend. We were told the person received an early breakfast so as to be ready in time.

We heard the management team discussing emerging health concerns as part of daily meetings in the service. For example, about one person's eye condition and another

Is the service effective?

person's ongoing immobility. Nursing staff were asked to take actions to address the concerns. One new person wanted to keep their GP. Whilst there was a principle of enabling this, the management team were keen for the person to allow the service's contracted GP to meet them and undertake a basic health check during our visit, as the person's GP was not available for that purpose until the following week. We also saw an entry in the diary to register a new person with the GP and the dentist shortly after they moved in. This all demonstrated prompt healthcare support.

People fedback positively about the food and drink provided. Comments included, "Personally I think the food is terrific" and "the food is excellent." One person explained that there was a choice of two main courses, with the choice made the night before. They added that two cooked meals a day were available, and that portion sizes were good. We saw that the lunch was freshly cooked, and heard people making compliments about it.

One person told us that although they tended to stay in their room, staff never forgot their meals and always brought what they chose. Additionally, they had requested cranberry juice which was supplied. Our checks across the day indicated that people received support with food and drink where needed. We saw staff encouraging people to eat meals, and supporting them to do so, both in the dining area and in their rooms.

A relative was pleased that their relative had put on weight since moving into the service. We checked the service's weight records for people and found only one person to be losing a significant amount of weight recently. The concern was noted at the staff handover on the morning of our visit, which helped assure us that action was being taken to try to address it. We later had feedback that the GP had visited them that day and that dietician input indicated that action was being taken.

During the afternoon we saw that people were provided with a home-made fortified milkshake and cake. The registered manager told us that all meals were freshly cooked and that the service avoided using frozen foods. A new menu for the winter months had been set up, including pictures of the choices available.

We found that staff had sufficient knowledge and skills for their roles and responsibilities towards people's care and treatment. Staff told us of the various training courses they had undertaken, including manual handling, fire safety, safeguarding, infection control and food safety. Four members of staff were new to the service. They said they had to shadow another staff member before being allowed to provide care alone, which staffing rosters confirmed. There was a separate induction process that lasted three days which covered a variety of training as well as the provider's key policies. The registered manager told us formal induction training took place monthly. Evidence was provided of previous training certificates where one new staff member started work in the service before attending the formal induction training.

We checked training oversight records and found that the majority of staff had completed all essential training courses recently, for example, for safeguarding, manual handling, and infection control. Most staff had also completed courses relevant to their roles and responsibilities, such as for use of bed rails, pressure care, and nutrition and hydration.

Staff confirmed that they received supervision every three months. They said that the meetings were helpful, for example, "It's useful to get feedback on my work and raise concerns." They said the service acted on any concerns raised. One example concerned teamwork and the staff member said that this had improved following the supervision meeting. Staff who had been at the service for more than a year said that they had an appraisal. A supervision oversight record demonstrated when each staff member had been supervised in 2015. This included quarterly individual meetings, occasional group supervisions, and care practice observations.

The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty for their own safety. We were shown an oversight tool that summarized the DoLS status of each person using the service. It clarified when an application was made, the progress, whether the application was granted or not, and when renewal was needed. However, we noted that none of the applications and approvals had been notified to us. The registered manager told us that she would ensure this now occurred, and this started occurring shortly afterwards.

A community professional confirmed that the service had engaged with them about DoLS earlier in the year. Records

Requires improvement

Is the service effective?

demonstrated a number of more recent DoLS authorisations, indicating that the service was working more in line with the principles of the Mental Capacity Act 2005 (MCA) following the support provided.

The training matrix indicated that most staff had completed training on the MCA. Nursing staff told us that one person was receiving covert medicines. They showed us capacity assessments and best interest decisions that established this process as the least restrictive to prevent harm to the person.

Good

Is the service caring?

Our findings

People using the service and their relatives were complimentary about the staff. People's comments included, "The care is excellent day and night. They are patient-orientated, patient care comes first", "A lot of the staff are genuinely helpful" and "They do their best." Relatives told us, "The staff are lovely" and "I'm generally impressed with the carers and there are no alarm bells." A relative liked the fact that they could visit at any time, and we saw people visiting throughout the inspection visit. One relative told us of liking the personal touches that the service provided, such as staff celebrating the person's birthday with songs and a cake.

Staff we spoke with were all able to talk about how they cared for people and how they helped people make choices such as about what clothes to wear. We overheard staff speaking with people in a caring manner during the course of the visit, for example, "Let's do it slowly darling" and "How are you?" For one person who could not hear well, the registered manager took the time to write down what she wanted to say on a pad, to make sure the person understood.

One person said there were some communication problems with some members of staff, where sometimes they couldn't understand the staff and at other times the staff couldn't understand them. But another person said about the staff, "They all speak excellent English." Most staff we spoke with or observed could communicate effectively.

During the handover between night and day staff, staff showed concern for people, for example, expressing disappointment that a hearing appointment for one person had not resulted in an improvement in the person's condition. During a management meeting, there was discussion on ensuring a condolence card was sent to the family of a recently deceased person.

Staff clearly and politely communicating with people using the service. However, we noticed that staff tended not to have time to sit and chat with people, which a few people using the service told us was an area for the service to improve on. One person said, for example, "They only chat when they are doing care."

Most of the people we met looked clean and well cared for. One relative said their mother was always nicely dressed and said the laundry service was "brilliant." People's rooms were clean and tidy and there were no lingering malodours.

One person said that they could get up and go to bed when they wanted. They told us that staff "always get what you want, and if you don't like it that will get you something else.' We saw one person having their mail delivered to their room.

Most people were still in bed in their rooms when we arrived at 07:30. Some people's doors were ajar, whilst others were closed. We saw a number of notices on people's doors indicated their preferences regarding their privacy. For example, one notice reminded staff to knock and wait for an answer before entering. One person described staff as "patient" and confirmed that they knocked on doors.

However, at one point we noticed that two male staff were providing personal care to a new female resident as they had not quite shut the person's door. The person's care plan had not been completed so as to establish whether or not they had a preference for the gender of the staff providing personal care. We brought this to the attention of the management team, as the care may not have reflected the person's preferences and did not ensure the person's privacy.

We saw that lunch was served to people as soon as they arrived in the dining area, so no one had to wait. Staff were helpful towards people during lunch, asking them if they wanted condiments and responding to requests for support.

One person told us that they received a contract and brochure when they moved in. We saw these welcome packs in people's rooms, which helped to involve people in making decisions about the services provided. The registered manager told us that spiritual advisors such as a Rabbi attended the service in support of people's faiths.

Requires improvement

Is the service responsive?

Our findings

We found the service to be inconsistently responsive to people involved at the service. Whilst there was evidence of responding to some people's complaints in an appropriate manner, two relatives informed us of their dissatisfaction with responses. One relative told us, for example, that despite putting a complaint in writing, a written response was not received until two months later. We found this to be in contrast to the provider's policy of 21 days. The response from a senior manager was copied to us. It did not give information on what the complainant could do if dissatisfied with the response, either directly with the provider or using external bodies, despite the provider's complaints policy stating that this was to occur.

Another relative informed us of being dissatisfied with responses to two separate emails they had sent the registered manager that complained about the standard of service they and their relative had recently received. They showed us the first response received from the registered manager, which did not respond to all their points, and which did not inform them about what they could do if dissatisfied about the response. The relative found a way to escalate their complaint.

We were also concerned about staff training in the area of complaints. The training oversight record showed that, for complaints handling, 20 of the 45 listed staff had completed the course, a further six had started the course, but 19 were marked as overdue. This included 12 staff listed on the current roster as care or nursing staff. The matrix had a target date of 11 February 2015 for all these staff members to complete the training. We also noted that complaints handling was not listed as included on the induction record of new staff members.

These two complainant's experiences in response to their complaints, along with the failure to ensure all staff know how to respond to a complaint, demonstrates that an effective complaints system was not always being operated at this service.

The above evidence demonstrates a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said they found staff to be "very apologetic" when they raised a concern. We noted that the concern was respectfully referred to at the morning handover meeting, to help ensure that it remained addressed.

The service held regular meetings for people and their families or representatives. The notes from these meetings showed that people chose to raise a wide variety of service issues. Minutes of the last two staff meetings showed that these issues were discussed with staff. One such issue involved some people feeling that night staff were unwilling to provide drinks for people during the night. We saw a notice in the staff room which reminded night staff that they were to offer hot drinks during the night for people who were restless.

One person who had recently moved into the service told us how impressed they had been with their pre-admission assessment the previous week. They said, "I was surprised by the detailed information they asked about. It was all very thorough and very reassuring." Pre-admission records we saw confirmed a good level of detail about people's varied needs and preferences.

The staff handover informed us that a new person had requested a specific breakfast and warm drink. Nursing staff had also recognised that the person needed a lot of support for taking their medicines. Their recent pre-admission assessment identified that they preferred breakfast at around 06:00. It was reported all these points had been attended to, and that the person themselves later praised the service for responding to their request.

People using the service were aware of the two activity co-ordinators employed. Their comments about activities included, "Very good and very organised" and "Brings in a lot of volunteers." A relative told us, "The activities co-ordinators try." We saw activities taking place in the lounge during the afternoon that a number of people engaged with. This included a keep-fit session that was adapted to people's needs and abilities. A word game was also played, to activate memory. The service had a weekly activities programme that was advertised to people.

Requires improvement

Is the service well-led?

Our findings

People spoke positively about the management of the service. Their comments included, "It's very nice, it's well led" and "The manager is very good; she addresses the problem immediately, and comes back and asks." Most relatives provided similar comments, such as, "The management has got better and they've been very helpful." Another relative said, "The manager is very good and efficient. She cares, is ambitious for herself and her staff, she's empathic and runs a good show." We saw the registered manager checking up on and talking with various people during our visit. It was evident that people using the service recognised her and could talk with her.

Whilst we found the service was well-led in a number of ways, it was not consistently well-led. This was because the breaches we found in other areas of this report were foreseeable, and effective systems of governance should have identified and addressed the consequent risks to the health, safety and welfare of people using the service.

The provider had a '72 hour care plan checklist' by which to audit that appropriate and safe care plans had been set up for people newly admitted into the service. After we found that two people did not have care plans fully set up a week after moving into the service, we reviewed the use of these checklists for the last six people who moved into the service. This review, two weeks after our inspection visit, found that for the three people who had moved into the service within the week before our visit, it took ten, six and five days respectively to undertake the check. These checks identified a number of action points for two people, in line with what we found, although there was evidence that these actions had been promptly signed off as completed. For the three people who moved in after our visit, two checklists were promptly completed, and identified that no action was needed. However, the registered manager confirmed that no checklist had been completed for the third person, a week after moving in. We understood that complaints had been raised about this person's care. The checklists continued not to be effectively used.

A clinical review meeting from two months before our visit was supplied within copies of documents provided to us following the inspection visit. It prompted the lead clinician, the deputy, on a number of topics that were reviewed with two nurses; however, it was not completed in full. For example, none of the identified actions were recorded as completed in the relevant column. The "72 hour documentation check" was simply marked as "check your floors" in the "findings" column, with no actions recorded. Effective follow-up of this point may have helped ensure the '72 hour care plan checklists' referred to above were embedded. The review meeting also had no entry against the "Safety" row, so failed to show any review of accidents, incidents and the service's safeguarding tracker, for example.

When we asked the registered manager what the expected frequency of the clinical review meetings was, we did not receive a clear answer. For example, we were told that weekly clinical meetings would be taking place; however, there were no records made available to us in support of this. These clinical meeting processes did not assure us of effective oversight of clinical matters in the service. For example, effective clinical auditing may have identified the wound care concerns we found at this inspection and ensured they were promptly addressed.

The registered manager told us that, although an independent organisation surveyed the views of people using the service in 2014, the report arising from it was issued in May 2015. This was not a timely response so as to take action from the feedback of people's experiences. The report showed the key strengths and weaknesses identified from the feedback of the 15 people involved. The two identified strengths of the service were for treating people as individuals, and the quality of people's room. An action plan had been set for the weakest areas, of care quality, punctual responses, and the quality of staff. Some aspects of the action plan, such as the use of a permanent sixth staff member, and the use of staff meetings to consider specific care quality, showed that action had been taken to try to address concerns. However, these actions were not taken promptly due to the delay in analysing people's feedback and producing a report on the findings. This was not effective operation of a system to monitor and improve the quality and safety of services provided to people.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the daily management meeting taking place in the service after lunch. This included discussion of who would benefit from the new hoist that was being ordered, any emerging health concerns amongst people using the service, checking that planned staffing levels for the next

Requires improvement

Is the service well-led?

few days were covered, and maintenance matters that had been addressed. We also saw that staffing rosters indicated that the deputy worked every other weekend. The registered manager told us that she occasionally worked weekends. These processes helped to ensure the service's care delivery quality.

Audit and oversight tools in use at the service included audits of health and safety, falls, care files and medicines. Actions were recorded to address any concerns arising from these. For example, monthly audits of pressure ulcers demonstrated actions taken in response to ulcers that had developed in the service or which the person had on moving into the service. There was evidence of community professional involvement where needed, and of ulcers healing.

The registered manager completed a monthly tool that considered data relating to key risk factors such as weight loss, pressure sores, infections, medicines errors, and unplanned hospital admissions. This enabled trend analysis across the last six months, and therefore scrutiny of service delivery.

The staff we spoke with said that they thought the service was well managed. They felt supported by the management team and that there was a team spirit, which contributed to the wellbeing of the service. The registered manager told us that she was proud of there being good team-work at the service, that the service was fully occupied, and that "hiccups were not brushed under the carpet" in reference to some recent safeguarding concerns.

The provider's 'speak-up' whistle-blowing policy was on display in the staff room. The registered manager told us that it had been used once in respect of a new staff member who had overstepped professional boundaries. We saw that new staff signed to confirm that they were aware of the policy as part of their initial induction process.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person failed to effectively operate an accessible system for identifying, receiving, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.** Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes were not established and operated effectively to ensure compliance with the relevant regulations. In particular, this included failure to effectively operate systems to:** • assess, monitor and improve the quality and safety of the services • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users • maintain securely an accurate and complete record in respect of each service user Regulation 17(1)(2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. In particular, this included failure to: • assess the risks to the health and safety of service users of receiving the care or treatment; • do all that is reasonably practicable to mitigate any such risks; Regulation 12(1)(2)(a)(b)

The enforcement action we took:
We served Warning Notices on the Registered Provider and Registered Manager to become compliant with the regulation by 22 December 2015.