Gateway Housing Association Limited

Pat Shaw House

Inspection report

50 Globe Road
Bethnal Green
London
E1 4DS

Tel: 02077027500

Date of inspection visit:
28 April 2016
29 April 2016
04 May 2016

Date of publication:
27 July 2016

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

The inspection took place on the 28, 29 April, and 4 May 2016 and the first day of the inspection was unannounced. We told the registered manager that we would be coming back over the next few days. At our previous inspection on 25 and 27 August 2015 we found the provider was in breach of one regulation relating to good governance and was rated 'Requires Improvement'.

Pat Shaw House is a care home without nursing which provides accommodation for up to 38 people across three floors. At the time of our inspection 28 people were living in the home. People who develop nursing needs have them met by the local community nursing teams. The service does not admit people who are living with dementia but it continues to care for them if they develop the condition once they have moved in.

There was a manager in post at the time of our inspection who had applied to the Care Quality Commission to be the registered manager for the service and was waiting for their interview. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection the service was in a period of transition. A consultation period was just coming to an end about staff having to be reassessed and they were concerned about their positions, which led to a feeling of low morale amongst the staff team. Management were aware of this and had meetings to try to reassure staff as best they could.

People told us they felt safe using the service and staff we spoke with had a good understanding of how to protect people from abuse. Staff were confident that any concerns would be investigated and dealt with. All staff had received training in safeguarding adults from abuse and the provider wanted all staff to understand their responsibilities in regards to identifying and reporting any concerns.

A new care plan contents page had been designed and was being introduced into people's care folders. It was detailed with a number of individual care plans, screening tools and risk assessments, however some risk assessments in place to manage the areas of risk lacked detail and had conflicting and out of date information in place which could lead to people not receiving the correct level of care.

The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service. Due to the upcoming staff reassessment programme the provider was using a higher number of agency staff than normal until they had fully recruited to all positions. They had just started advertising for temporary bank staff to help cover shifts and to reduce their reliance on agency staff.

People who required support with their medicines received them safely from staff who had completed

training in the safe handling and administration of medicines. Staff completed appropriate records when they administered medicines and these were checked on a regular basis to minimise medicines errors.

Staff were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood the importance of asking people for consent. However they were unaware when people's DoLS applications had expired and there was no evidence of another application being made.

Staff were aware of people's dietary needs and food preferences and had made improvements since the last inspection. People had regular access to healthcare services as a GP visited on a weekly basis and sent medical reports to the service. However this information was not always available in people's care records for all staff to access. Staff told us they contacted other health and social care professionals, such as occupational therapists and speech and language therapists, if they had any concerns about people's health.

People and their relatives told us staff were kind and compassionate and knew how to provide the care and support they required. All staff understood the importance of getting to know the people they worked with and showed concern for people's health and welfare in a caring manner. People were spoken with and treated in a respectful and kind way and staff respected their privacy and dignity, and promoted their independence.

An initial assessment was completed from which care plans and risk assessments were developed. We could see that care plans were in the process of being updated but people's care records were disorganised and information was in several different places that bore no resemblance to the index page. Out of date information that should be archived was placed in front of current information. Of the documents that were hand-written, the level of recording was not consistent throughout files and at times illegible.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. The provider listened to complaints and made sure people were confident their complaints would be taken seriously. There were meetings and surveys in place to allow people and their relatives the opportunity to feedback about the care and treatment they received.

There were quality assurance systems in place to monitor the quality of the service provided and understand the experiences of people who used the service however they did not always identify the issues related to the quality of care plans, risk assessments and consistency of recording within people's files.

Despite the low morale within the staff team, they spoke positively about the new deputy manager and felt supported in their work. People and their relatives commented on this and could see improvements were taking place since they started.

Accidents and incidents were logged and followed up however the provider failed to notify the CQC about a death and a safeguarding incident involving the police which is a legal requirement of the provider's registration.

Whilst we could see that improvements had been made since the last inspection and work was in progress to improve the service, there were still a number of issues which remained.

We identified two breaches of the Regulations in relation to good governance and notifiable events. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments in place to identify the areas of risk lacked detail and had conflicting information which could lead to people not receiving the correct level of care. Recording of information was not consistent throughout people's care records.

Staffing levels were in the process of being addressed to meet the needs of people in the service. A higher number of agency staff were being deployed due to a restructuring process.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm.

People received their medicines safely. Medicines were administered and recorded by staff who had received relevant medicines training.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not fully aware of their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards as they were unaware some DoLS applications had expired and needed to be reviewed.

Staff spoke highly of the training and supervision they received to support them to meet people's needs. The provider is investing in the Care Certificate for all appropriate staff and this is scheduled to start from August 2016.

People were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs.

Staff were aware of people's health and well-being and responded if their needs changed. People had regular access to a GP and other health and social care professionals, such as occupational therapists and speech and language therapists however records were not always updated or easily accessible

for staff.

Is the service caring?

Good

The service was caring.

We saw that staff treated people with respect and kindness, and promoted their dignity and independence. People told us staff were kind and compassionate.

People, and their relatives where applicable, were informed about their health and well-being and staff showed concern if their health deteriorated.

The service was able to support people to access independent advocates. They also supported people and their families during end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were disorganised and lacked detail so staff could not be sure how people liked to be supported. The information was not always easily accessible for staff or updated if there were any significant changes.

Group activities were available but they depended on how much time care workers had available to carry them out. People were supported to organise and get involved in planning events.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The provider gave people and relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Requires Improvement

Not all aspects of the service were always well-led.

The provider did not meet the Care Quality Commission registration requirements regarding the submission of a notification about a safeguarding incident involving the police and a death notification, for which they have a legal obligation to do so.

There were audits and meetings to monitor the quality of the service and identify any concerns however information was not always accurate, up to date or of a sufficient standard.

Staff spoke positively about the deputy manager and felt supported in their work.

Despite a period of uncertainty on the horizon due to a staff competency reassessment programme due to start, the provider offered opportunities for staff to prepare well for these basic tests

Pat Shaw House

Detailed findings

Background to this inspection

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

The inspection took place on the 28, 29 April, and 4 May 2016 and the first day of the inspection was unannounced. We arrived at 7am on day one. We told the registered manager that we would be coming back over the next few days.

The inspection team consisted of two inspectors, one was present for one day of the inspection, the other was there for all three days. We also had an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience in the care and support of older people in residential, nursing and dementia care services.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included statutory notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 25 and 27 August 2015. We contacted the local authority safeguarding adults team and Healthwatch before the inspection and also looked at the local authority's recent monitoring report and the providers' action plan that was sent in after the last inspection.

During the inspection we spoke with 14 people using the service, three relatives and 18 staff members. This included the registered manager, the director of resident services, the interim head of care, the deputy manager, two team leaders, four agency workers, five care assistants, the catering manager, the housekeeper and the resident engagement coordinator. We also spoke with two health and social care professionals who were visiting the service at the time of the inspection. We looked at five people's care plans, eight staff recruitment files, staff training records, staff supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so we used the

Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We carried out these observations during different parts of the day.

Following the inspection we spoke with three health and social care professionals who had worked with people using the service for their views.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home and when they were receiving their care. One person said, "I don't have any problem with safety here." Another person said, "I do feel safe here. Even though I suffer from anxiety, I feel fine here." Two relatives we spoke with had no concerns about the safety of their family members. One relative told us there had been a time when their [family member] had run out of their medicines and staff were not aware of it which had put them at risk of not receiving their medicines as prescribed.

Staff had received training in safeguarding and were able to demonstrate how to keep people safe from the risk of abuse. Staff we spoke with understood how to recognise the signs of abuse and told us they would speak to the manager or senior staff if they had concerns about a person's safety and/or welfare. Staff were aware that they could also contact other appropriate organisations with any concerns. One care worker said, "I do feel people are safe here. We carry out the right checks and we work as a team to discuss issues." We saw training records that showed staff had training in safeguarding however some staff members had not had a recent refresher. We spoke to the manager about this who told us that due to the current staff reassessment programme that was scheduled further training was on hold until they had completed this programme and would aim to start again in June/July of this year.

There was a procedure to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs was carried out by the registered manager or another senior member of staff, which identified any potential risks to providing their care and support. A range of risk assessments were completed in relation to the environment, people's mobility and personal care support needs. Dependency assessments were carried out on a monthly basis covering areas including nutrition and individual support with feeding, continence care and skin integrity. However, the records we viewed did not always evidence that risks were being managed appropriately in order to keep people safe. In one person's care plan there was a very out of date occupational therapist assessment at the front of the file. Different documents such as the risk assessment and mobility care plan contained differing information on the number of staff they needed to support with transfers. It ranged from 'independent with supervision' to 'two staff'. The most recent risk assessment had been updated to say they should be supported by two staff, however support logs from this date onwards were only signed by one staff member. In another person's care plan the risk assessment said that they should be supported by two staff when using the hoist, which was to be used when personal care was given. We reviewed the support logs for the last week and found eight occasions on which only one care worker had documented they had given personal care so we could not be sure if they were receiving the correct level of care. One person had been assessed as being at risk of pressure sores. We saw the relevant assessments in place and information from healthcare professionals on how to manage the risk however the pressure care chart was started two days after a care plan was put in place by district nurse. Where the person needed to be checked every 3 to 4 hours, there were some gaps in place where nothing had been recorded. We spoke to the deputy care manager about this who confirmed that the detail in recording needed to improve.

At the time of the inspection the provider was using a higher number of agency workers due to the staff

reassessment programme. Although some people felt there was enough staff, most people we spoke with told us at times there were not enough staff and said they had different agency workers supporting them. Comments included, "I think they are a bit short of staff sometimes" and "They are working to get regular staff in and when they do it will be great. It's still developing." One team leader said, "We are using agency staff and we do try to request a consistent service with this until we have fully recruited the staff we need." The director of services told us that they would shortly be recruiting a pool of bank staff to use as cover so they did not have to be so reliant on agency staff. We saw that the provider had addressed the issue from the previous inspection and modified their dependency tool to check they had enough staff hours within the service. However we saw that some people's care plans still had the previous dependency tool which meant there could be confusion over the correct number of hours of support people needed. We looked at the staff rota for the previous four weeks and the following week and saw staffing levels were consistent with those as described by the registered manager and the staff we spoke with.

We saw that a new nurse call system had been installed throughout the building and saw how staff reacted when people rang the alarm. The system was able to show which care worker had attended to the call and how long it took to respond. Throughout the inspection we saw that calls were answered in a timely manner and could only be de-activated by going into the person's room. One person said, "Generally, they are very quick to respond to it."

Appropriate checks were undertaken before staff began work. The staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place to help safeguard people. We saw evidence of photographic proof of identity and all Disclosure and Barring Service (DBS) records for staff were available. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. The provider asked for two references, one being their most recent employer, and people couldn't start work until they had been received. Candidates were given a scenario based questionnaire before the interview to assess their competency. There was a recruitment checklist at the front of each file to make sure all relevant documents had been received before employment commenced. This meant that people were supported by staff who were suitable for their roles.

There were appropriate medicines policies and procedures in place. We observed medicines being administered one morning of the inspection. The provider was using agency staff at the time of the inspection who were solely responsible for administering people's medicines. They were observed to check with each person and follow accurately each step of the administration process. The staff member was not rushed and was patient with people during the round. People confirmed that their individual requirements were met. One person said, "I have my medication and they watch me take them." Staff confirmed they had shadowed a senior member of staff before administering medicines on their own. We asked the staff if they had enough time to carry out the rounds on their own. They said, "It can be busy in the morning but it will be better when the extra staff start."

We checked how medicines were stored, including controlled drugs and the safe disposal of medicines no longer required. Random checks of several medicines including controlled drugs were carried out and we found that the quantity in stock matched the records in the controlled drugs register. This provided additional assurance that people were receiving their controlled drug medicines as prescribed. We looked at a sample of 18 medicine administration record (MAR) charts during this inspection. 16 of the MAR charts had a picture of the client to assist staff in identifying the correct person during medicines administration. We spoke with a team leader about this who rectified the issue during the inspection. There were no gaps on the MAR charts that we looked at and there were records to explain why any doses of medicines had not been administered. Senior staff completed monthly medicines audits to check that medicines were being

managed safely. We saw evidence that the audits picked up medicines issues appropriately. For example, we saw when an agency worker had made a medicines error, the provider had requested that the staff member not be sent to the service again.

Requires Improvement

Is the service effective?

Our findings

People told us that they thought staff were well trained and were able to meet their needs. They focussed mainly on the permanent staff at the service as some people had reservations about the number of agency staff that was currently being used. One person said, "The regular staff are good at their jobs and are trained well. Another person said, "The permanent staff are great, but sometimes it's not the same with the agency ones".

The registered manager told us that after the completion of the staff reassessment programme, all staff who were successful or newly recruited staff would go through the Care Certificate as part of their induction. The Care Certificate sets the standard for the skills and knowledge expected from staff within a care environment. A team leader explained the induction process for agency staff. They always ensured agency staff had previous experience and understood the importance of trying to keep the same staff. Staff had a tour of the building and went through a range of policies and procedures, including fire safety before being introduced to people. They shadowed permanent or senior members of staff first before carrying out care tasks on their own. We saw the induction checklist for the last three agency staff which showed that an overview of the service had been given and important information, such as the emergency response policy, dealing with incidents and accidents, raising concerns and understanding of moving and handling had been covered. One agency worker we spoke with was able to talk us through the fire evacuation procedures and gave us detailed information about somebody they had supported. This showed that agency staff were given the information and support to meet people's needs.

Staff spoke positively about the training that they received and how it helped them to carry out their role. One care worker said, "The training is really good, they do look after us like that. We do get it refreshed when it is time to be renewed." Mandatory training that was delivered to staff included moving and handling, safeguarding, fire safety, first aid, infection control and dementia awareness. We did see some gaps in the training matrix where some training had expired and the provider was aware of this. They explained to us that once the reassessment programme had been completed all mandatory training would start to make sure all staff had refresher training. We saw records that specific training sessions had been organised to start from June 2016.

We saw records that showed care workers and care assistants had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. Items discussed included safeguarding, training, well-being, how to improve the service along with any recent issues involving people they supported. One care worker told us they were able to discuss training options they thought would be useful. They added, "I asked about training on challenging behaviour to help my understanding of some of the service users and it was really good." A care assistant said, "I'm happy with the supervision that we receive, we are able to bring up any problems we are dealing with." One team leader told us that they also carried out daily spot checks on staff and throughout the building however the information was not always recorded as they were unable to show us what recent checks had been carried out.

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We discussed the requirements of the MCA with the senior management team and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records in people's files that showed best interests meetings had taken place and when mental capacity assessments had been completed. Guidance for staff had been updated since the previous inspection and the care home manager was responsible for advising staff and making referrals for mental capacity assessments.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides safeguards to protect people from being deprived of their liberty unless it is in their best interests to protect them from harm. In two people's care plans we could see that a DoLS application had been made and agreed, however they had both expired and there was no evidence of another application having been made. When we brought this up with the team leader they were unaware of this. Although staff we spoke with had a general understanding of their responsibilities of MCA, two care assistants told us that they had not received any training in the MCA or DoLS. We saw from the training matrix that six members of staff had received training in this area. We spoke with the registered manager about this who confirmed that once the reassessment programme had been completed refresher training would be booked for all remaining and new staff.

Staff told us they always asked for people's consent prior to providing personal care for them and understood the importance of it. Feedback from people was positive, one person said, "The staff do speak to me and always ask permission to do something" Another person said, "They do ask me when they are doing something with me." One care worker said, "It's really important to give people a choice and let them know what you are planning to do."

Since the last inspection, the provider had recruited a catering manager to address the issues that had been highlighted. Previously, where care workers had limited information about people's meal preferences, each floor now had an individual overview of people's specific dietary needs and allergies. Dietary preferences of people were available and those who had individual menus had been highlighted. The kitchen staff were aware of people's preferences and the menu now included a wider variety of dessert options for people who were diabetic. Diabetic and soft diet choices were also available, including cultural options.

The home had been awarded a four star food hygiene rating at its last inspection in July 2015. The catering manager told us that once they had been appointed they contacted the Food Standards Agency and requested a site visit to discuss the previous inspection. We saw records of this and that the advice had been actioned.

We observed lunch over the three floors during our inspection. Staff helped people to their seats and asked them where they wanted to sit. People could also have lunch in their room if they wanted to. People we spoke with complimented the quality of the food provided and told us that they always had a choice of what to eat at every meal and if they did not like the options then alternative meals could be provided. Comments included, "The meals are lovely and very nice. Portions are big enough and it comes hot. If I didn't like what was being served up, I could ask for something else" and "The food is excellent and I like most things. I can drink tea all day too." One relative said that her family member liked the food and was happy at mealtimes. We sampled the food over the course of the inspection and found it to be of good

quality, fresh and ample in portion size. People also had the opportunity to give their views on the food as the catering manager carried out weekly spot checks and supported people to complete feedback forms. We saw a sample of feedback forms where they listened to people's views about food preferences and included positive comments about the quality of the food. The catering manager said, "We always try to get the views of people about their food preferences." Where people or relatives were unhappy with the food, we saw records that showed information had been recorded and meetings arranged to discuss the issues.

Staff said they supported people to manage their health and well-being and would always speak with team leaders or the deputy manager if they had any concerns about the person's healthcare needs. The majority of people were registered with the local GP who visited on a weekly basis. District nurses also visited up to three times a week to support people with extra nursing needs. We observed a morning handover between a night care worker and the deputy manager where any issues that occurred during the evening were discussed and followed up. We saw that the GP was contacted due to concerns that were raised. The handover also highlighted that staff were aware of healthcare visits or appointments for the day and supported people to go for these.

People told us they were supported to maintain good health and had access to healthcare services. One person said, "I get to see the doctor if I'm not well and if I go to the hospital for a test a carer will go with me." Another person told us that medical appointments were always arranged and that they did not have to worry about getting there as hospital transport was booked. One person told us that they had an appointment in the afternoon and that a care worker was taking them. We spoke with the care worker who was aware of this along with the team leader, who had covered the shift with an agency worker as the appointment was during the busy lunch period. We saw information in people's care records where people had involvement with a number of health and social care professionals, including GPs, occupational therapists, speech and language therapists (SALT) and district nurses. There were contact forms in people's files for visits to be recorded however some had not been updated. One person had a record that showed the last visit made by a SALT was in October 2015 however we saw records within the file that a SALT had made recommendations in January 2016 but the form had not been updated. Medical information for another person was recorded in several different places which was confusing and difficult to follow. We spoke with a team leader about this who showed us that recent medical information was sent from the surgery and kept online, then printed out some samples to show us the most up to date information, however this information was not readily available in people's care records to ensure that staff had access to the most current information.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received at the home and spoke positively about the staff who supported them. Comments from people included, "The staff are caring, kind and respectful and they look after us well. They come up to me and ask if I'm OK", "The care is very good here. My friend died and the staff came to comfort me" and "The staff are all lovely. If you have a problem at night, you can press the button and they come quickly." A relative said, "My [family member] is really happy and settled here."

Throughout the inspection we observed positive interactions between people using the service and staff. Staff were always observed to be polite, compassionate and interested in the needs of the people they supported. Whilst observing some activities people were very relaxed and comfortable with staff. When people seemed agitated or distressed we saw staff react appropriately to the situation. One person was particularly distressed one day whilst receiving their medicines but the staff member involved was very reassuring, patient and spoke in a calm and caring manner. During an exercise activity, staff encouraged people to get involved and we could see that people felt comfortable taking part. When staff required the use of a communal room for the staff reassessment meeting, we saw the deputy manager ask people for permission if they could use the room and apologised for the inconvenience.

Staff we spoke with knew the people they were working with and were able to give information about people's personal histories. Some people commented that permanent staff knew them better as agency staff had not had enough time to get to know people properly. One person said, "Some staff know me well but others don't." Management were aware of this and did try to keep regular agency staff to provide a consistent service until their reassessment programme was complete. We spoke with one agency worker who had worked at the home for three weeks. They said, "I'm working with people and getting to know them. I know I need to make time and offer what I can." Within people's care plans we saw personal fact files, life history, personal preferences, interests and achievements. One person had a very detailed overview of their life history, going back to when they were a child and detailing their major life events. Another person had a separate document for routines and preferences which was detailed and included information such as preferred getting up time, preference between having a bath or shower and favourite colours. However a two page section about their life story had little information or detail.

On the second morning of the inspection, one person had had a fall and staff had been waiting for emergency services for over an hour. We saw that a member of staff stayed with the person to reassure them and make them comfortable whilst another care worker got the relevant documents ready that the paramedics might need. This showed that staff responded to people's needs and showed concern for their wellbeing.

The people using the service and relatives we spoke with confirmed they were involved in making decisions about their care and were able to ask the staff for what they wanted. One person told us about their care plan and that they were involved when it came to the review. The registered manager told us when they carried out initial assessments and reviews they always made sure, where appropriate, a relative was

present with the person. People were also supported to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. Nobody we spoke with during the inspection told us they had support from an advocate but information about local advocacy services was available for people to read. One care worker we spoke with had a good understanding of when somebody might need to use one.

People told us staff respected their privacy and dignity. We heard positive comments about how staff were respectful to people when they supported them and helped them to be as independent as possible. One person said, "They do give me privacy when talking to me." Another person said, "They are respectful. They always knock before they come in." We observed staff knocking on people's doors and announcing their presence during our visit. People were asked if they wished to speak to us and if they were happy for us to see their rooms. We saw staff treating people with dignity at mealtimes, being very reassuring and patient despite it being a busy period. All staff had a good understanding of the need to ensure they respected people's privacy and dignity. One staff member said, "It's important to respect people and I ensure I do this when giving them personal care. I make sure the doors and curtains are closed and let them have as much privacy as possible." Information from last year's people and relatives' annual survey showed that 69% of people and 85% of relatives thought they were treated with respect.

People who had made advanced decisions regarding end of life care had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place and this was highlighted in their care plan. We did see one form that had been completed in 2013 and had not been reviewed. We spoke with a team leader about this and even though there is no legal requirement for a review, as the person's condition had not changed it would be good practice to speak with the person about reviewing it.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care and support they received from staff and that they were listened to. One person told us, "I do get what care I need". Another person said they felt that the care they received was individual to their needs. They added, "I do get given a choice about my care." A relative told us that they were happy with the care their family member received and had settled in well. "We know who to talk to if we weren't happy but we've got no concerns."

We spoke with the registered manager about the process for accepting new referrals into the home. People could either be assessed on site or they would visit people at home or in hospital, whatever was easiest for the person and their family. Relatives were encouraged to be present at the pre-admission assessment and also during the initial assessment. The manager said, "We make sure people and their families are involved from the beginning." New referrals had a full and complete assessment and the provider's policy was that person centred information was gathered within 24 hours of admission. After this the care folder was developed which included relevant risk assessments and care plans.

At the time of the inspection people's care plans were in the process of being checked and reviewed and the registered manager showed us a copy of the new care plan contents page which was to be used in all care plans. It was very detailed and covered areas such as nutrition and hydration, continence, mobility, personal care, emotional wellbeing and end of life care. Even though we could see care plans were in the process of being updated, the care plans we looked through were disorganised and it was difficult to tell what information was the most up to date for that person. One care plan we looked through had two different dependency tools in place. One stated that the person was independent when eating but needed prompting at times, whereas the other stated they required support with food and needed a soft diet. This information had not been recorded in the nutrition plan. The same person had contradictory information within their mobility care plan. It was recorded the person needed one care worker to observe and assist with moving however the person needed a wheelchair and the use of a hoist. Care plans were reviewed monthly by staff but for a number of individual care plans, we noted that staff had written exactly the same text each month, and at times it was illegible. For example, for one person a care worker had recorded on a monthly basis 'his pressure area continues to improve' however we saw from other records within the care plan this was not the case. In another person's communication care plan, the only information recorded in the monthly evaluation was 'give all the support she needs', without giving any further information about what was the best way to communicate with them. We spoke to a team leader about the care plans and they were aware that they needed to be updated. Therefore we could not be assured that people's individual needs would be met as there was not always accurate or up to date information in their care records.

We saw that there were some group activities provided at the home. On one afternoon we observed a quiz taking place on one of the floors with a high turnout of people involved. We also observed one care worker carrying out an exercise activity with four people on another floor. The interim head of care told us that they no longer had an activities coordinator and it was left for staff to carry out daily activities when they had time. Other than the activities we observed, there was no set schedule if care workers were carrying out personal care, getting ready for mealtimes or doing paperwork. People we spoke with generally felt that

there was enough to do however we did receive two comments that stated there was little in the way of activities.

We saw that the home held events throughout the year, including celebrating people's birthdays. On the final day of our inspection there was a cocktail party being held which was well attended. We saw pictures on noticeboards of previous events that had taken place. One person told us that they liked to organise events and showed us a quiz they had prepared for the next event. They added, "We plan special events for special days. On Derby day we will do something special like a sweepstake and a BBQ." We saw that the management team supported people to organise events. We saw the deputy manager speaking with the person about a planned event and made a list of items to buy for an upcoming raffle. People were also supported with more specific cultural or religious needs. Three people told us that a local church minister visited once a week and we saw it advertised on the noticeboard. The catering manager also showed us records where they tried to cater for people to enjoy food that met their cultural needs.

We spoke with the resident engagement coordinator who told us it was a new role and they were looking into projects and opportunities for people in the home. They told us that they were planning a 'photo walk scheme' and had started a relationship with Stepney City Farm through the 'Furry Friends' project. They were also planning to link with Contact the Elderly to organise monthly afternoon tea parties.

The provider listened to people's views and concerns through quarterly residents meetings and a quarterly relatives' forum. People told us that they felt listened to when they attended the meetings. One person said, "There are meetings for us every three months but I've got nothing to moan about." We saw copies of the most recent minutes of the quarterly relatives' forum which showed relatives had been kept updated with developments and had the opportunity to discuss any issues or concerns they had.

People and their relatives said they were happy with the service and would feel comfortable if they had to raise a concern. One person told us that that they had been supported to make a complaint. They added, "They provide you with a complaint form if you need it." Another person said, "I've never needed to make a complaint." One relative brought up an issue with us during the inspection. We discussed this with the interim head of care who reacted positively about it and made plans to speak with the relative so they could find out more information and resolve the problem.

We saw records which showed there had been seven complaints since the last inspection. We looked through the complaints folder and saw the complaints records included details of the event, what action had been taken and the outcome. We saw one complaint that was still in the process of being resolved. Staff were aware of the importance of making sure that the issues were fully resolved and we saw there was regular contact with the person involved. We saw in the minutes of the most recent relatives' forum that the complaints policy and procedure was explained to people and highlighted each way people were able to make complaints.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager had applied to be a registered manager with the Care Quality Commission (CQC) and was waiting for the interview. He was present each day we visited the service and assisted with the inspection, along with the director of resident services and deputy care home manager.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw records during our inspection about two significant incidents which should have been reported to us which had not been. These were an allegation of abuse that was reported to the police and a death notification that was related to a safeguarding incident. The management team were open about this and admitted that it had been an oversight on their behalf.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the previous inspection it was highlighted that auditors focussed on whether or not documents were in place rather than the quality of the information they provided. The provider had internal auditing and monitoring processes in place and told us that they had completed their recruitment process of senior staff to help improve the quality of the service. We could see that people's care folders were in the process of being audited and updated however the files we saw were still disorganised and lacked up to date information for staff to be aware of and work from. In all of the files that we looked at we found out of date information that should have been archived was placed in front of current information. As the provider was using a high number of agency staff at the time of the inspection, it could mean that staff would not be working from the most up to date assessments.

In one person's care folder we saw that the monthly review of care plans had not been completed since August 2015. When we saw monthly care plans had been reviewed, in most cases staff had written exactly the same text which had not been picked up. One person's monthly review said 'their health continues to get better and better' even though they had had four UTIs in the past four months and a health care professional involved told us that the provider wished to have them admitted to hospital. In another person's care records we saw information where their medicines needed to be crushed to reduce the risk of coughing or choking. The advice from the speech and language therapist was not easy to find within the file and this information was not in the medicines care plan, even though the individual care plans had been updated within the last week. There were daily, monthly and quarterly cycles of audits throughout the service which covered staff supervisions, medicine administration records (MAR) and care plans however we found some issues of poor recording had not been followed up. We saw gaps and poor recording in one person's turning chart and fluid chart which had not been addressed or followed up.

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

At the time of the inspection there was low staff morale within the service due to the upcoming improvement programme that was due to be carried out the following week. Staff had to undertake a

reassessment programme which was based on the needs and dependency levels of people living at the home. Care workers we spoke with said they were worried about their jobs if they were unsuccessful in the competency assessments. On the first day of the inspection the provider was holding a care staff and consultation feedback meeting about the improvement programme and we were invited to sit in and observe. It was explained why the programme was going ahead and that the current system of using agency staff to cover for care workers was unsustainable. A HR advisor reiterated that the main principle was to retain talented staff within the service and people leaving the organisation would be a last resort. The director of the independent training organisation responsible for carrying out the competency tests reassured staff that the assessment was not difficult and gave an overview of what staff could expect. Staff were also offered support from an employment and training coordinator before the assessment was due to start. One care worker said, "I can see that they are looking to improve the service and quality of care." A team leader said, "I think it is positive that improvements are being made and management are trying to drive improvement within the service."

Since the last inspection, the long standing registered manager had left and a new deputy care home manager had been recruited within the past few months. People using the service and their relatives were happy with the way the service was managed and had reported improvements since they had started. Comments included, "The new manager is a breath of fresh air", "The manager is very nice, she always comes round and shakes my hand" and "Since the new manager came, there have been some good changes." One relative said, "I sense there have been some improvements recently and there are changes happening which are for the better."
One health and social care professional said that they found them to be very cooperative and enthusiastic about working closely together but highlighted there could be miscommunication at times.

Despite some low morale, staff spoke positively about the new deputy manager and felt supported by them in carrying out their duties. One team leader said, "I get a lot of support from her and always feel I'm listened too. I've never had a problem." One care assistant said, "She's really organised and always listens to us. She is never too busy to talk to us if we need to and gives us support." We spoke with the director of resident services about the restructuring of the organisation and they appreciated that it was a challenge at present but felt the reassessment would have a positive impact upon the service. They added, "Staff can hopefully see the direction we are going in and we won't give up on them, teamwork is very important and we all need to work together to achieve the same goals."

The provider carried out an annual survey for people who lived in their schemes. At the time of the inspection they had not started carrying out research for 2016, mainly due to recent restructuring and the upcoming assessment programme but we saw a copy of the 2015 survey. The survey asked people a number of questions about their experience living at the home, including whether they felt safe, respected, enjoyed the food and whether they were satisfied with the service received.

All accidents and incidents were recorded and kept in a central file. We saw evidence that when an incident or accident had been recorded, the relevant people had been notified and plans put in place to minimise the risk of it happening again. We saw that where trends were found learning took place. We saw from their most recent care homes overview report that after analysing the number of falls, they decided to get staff to carry out paperwork in communal areas to have more presence and be more aware to reduce the number of falls. We saw evidence of this throughout the inspection. However we did see two similar incidents had been recorded and there was no evidence that the issue had been followed up. We spoke with the management team about this who said they would follow it up immediately.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(c)