Care UK Community Partnerships Limited

Muriel Street Resource Centre

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced 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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

The service was last inspected on 17 January 2014 after warning notices were served in October 2013 for major breaches of regulations of the Health and Social Care Act 2008 relating to care and welfare of people who use services, management of medicines, assessing and monitoring the quality of the service provided, and records. These breaches of the regulations were not appropriately addressed, and a condition to limit admissions was imposed on the service by CQC to ensure people's safety and welfare. The provider agreed an action plan with CQC and the local authority to address these issues, and when we visited on 14 July 2014 we found the provider had taken appropriate actions to address the breaches. We have taken action to lift the condition limiting admissions to the service as a result.

Summary of findings

The service is a care home with nursing providing accommodation, nursing care and support with personal care for up to 63 people. Most of the people who live in the home are elderly, and many have dementia. Some of the people who live there also have long-standing mental health conditions. At the time of our visit, 39 people lived in the home due to the admissions limit previously imposed by the local authority and CQC. The service is provided over three floors in a large, purpose-built building in landscaped grounds near the Regent's Canal in Islington.

At the time of our inspection on 14 July 2014, the service did not have a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. However, a manager had been very recently recruited for the service and was due to start shortly, and a deputy manager/ clinical lead had also started at the service two weeks before our visit. The service was being supported by a regional quality manager from the provider organisation until the newly-appointed manager could start.

Many improvements had been made to the service since we last visited in January 2014, and a lot of resources had been allocated to the service to facilitate changes. We found that people's care needs were appropriately identified and met, in ways that ensured their safety and welfare. Care for people's specific needs, such as pressure sore prevention and management, continence, diabetes and people at high risk of falls, was assessed, planned for and provided in cooperation with specialist services and using appropriate tools.

Medicines were stored, administered and managed safely and according to guidelines, and the service's premises and equipment were well-managed and well-maintained. Specialist equipment, such as pressure-relieving mattresses, was checked daily and appropriate stock kept so people always had the equipment they needed.

The service ensured people had a wide range of stimulating activities to choose from, and included activities specifically to support people with dementia to encourage and stimulate memories. People were provided with appropriate and nutritious food and drink, and were supported to eat enough. Specialist advice was sought when staff identified concerns about a person's nutrition.

The service welcomed visitors, and the care provided to people was kind, compassionate and unhurried. Staff were trained for their roles, and supported through supervision, appraisal and systems designed to reward good practice.

The home had a relaxed and friendly atmosphere, and a variety of spaces for people to use for personal time or with groups.

There were appropriate systems in place to assess and monitor the quality of the service that people received.

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?

Good

The service was safe. People's needs were met safely. Care plans identified people's needs and risks associated with their support, and provided guidance for staff on how to mitigate any risks. People with specific conditions were provided with specialist support and equipment to ensure their safety and welfare.

People were protected from the risks of abuse. Staff were appropriately vetted before starting work to ensure they were suitable people to be working with vulnerable adults. There were enough staff to ensure people's needs were met.

The requirements of the Mental Capacity Act 2005 were followed in all but one of the records we viewed, and the provider had guidelines in place to ensure staff were aware of the procedures necessary to apply for the Deprivation of Liberty Safeguards (DoLS) should that be required to ensure people's safety.

Is the service effective?

Good

The service was effective. People were provided with suitable and nutritious food and drink, and the service sought assistance from specialist services to ensure their health needs were met. Staff were trained and qualified for their roles, and received appropriate support through supervision of their work. Appraisal meetings had been scheduled for all staff, and some had taken place.

Is the service caring?

Good

The service was caring. Staff were very kind and caring to the people who lived in the home. They took the time to sit and chat with people, and we saw that they met people's needs without rushing. Care was provided with dignity and compassion in mind, and people were supported to maintain their independence as much as possible.

Staff supported people to maintain relationships with their family and friends. The home was particularly welcoming to the family and friends of people being supported through their last days, and had comprehensive plans to ensure people's preferences, needs and wishes were respected.

Is the service responsive?

Good

The service was responsive. The service provided a range of stimulating activities both inside and outside the home. Consideration was made for people with dementia to be able to participate in activities.

People were supported and encouraged to participate in the tasks of the home, and changes were made to people's care and support quickly when their needs changed.

The service had a system in place to gather feedback from people and their relatives, and this was acted upon.

Is the service well-led?

Good

The service was well-led. Many resources had been allocated to the service to improve the quality of the care and support people received. Audits and checks were undertaken regularly, and improvements made as a result.

Summary of findings

The culture was open and transparent, and systems were in place to reward staff for innovation and good practice. Although the service did not have a registered manager in place as required by the provider's registration with CQC, a manager had been recruited and a deputy manager/ clinical lead had started shortly before we inspected.

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Detailed findings

Background to this inspection

Prior to this unannounced inspection, which took place on 14 and 16 July 2014, we reviewed information that we held about the service and the details of a Provider Information Return (PIR) that the provider had completed. A PIR is a document that we ask providers to complete that tells us about the operation of the service, what they do to meet people's needs and any proposed improvement plans. We also spoke with commissioners and quality monitoring staff from the local authority and local clinical commissioning group, and reviewed information they provided.

The service was previously inspected on 17 January 2014 after enforcement action was taken in October 2013 for major breaches of regulations of the Health and Social Care Act 2008 relating to care and welfare of people who use services, management of medicines, assessing and monitoring the quality of the service provided, and records. These breaches of the regulations were not appropriately addressed, and a condition to limit admissions was imposed on the service by CQC to ensure people's safety and welfare. The provider agreed an action plan with CQC and the local authority to address these issues.

We used all of the above information to plan this inspection. The inspection team consisted of a lead inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

During our inspection we spoke with 12 people who use the service, and two relatives. As some of the people who live in this home had advanced dementia and were unable to tell us of their experiences of the service, 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 spoke with six care workers, four unit managers, one team leader, two kitchen staff, the maintenance worker, one cleaner and an activities coordinator. We also spoke with the deputy manager and the provider's regional quality manager who was overseeing the service when we visited, and attended a daily managers' meeting.

We looked at 10 people's personal care and support records, nine staff personnel files and seven staff training files. We also looked at other records relating to the management of the service, such as menu records, audit records, quality monitoring visit and spot check reports, accident and incident reports, records of feedback provided to the service through residents' and relatives' meetings, and formal and informal complaints records.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. One person said, "They always answer the call bells quickly", and we observed this during our visit. During our previous visit on 17 January 2014, we found that call bells were not answered quickly by staff, and some were placed out of people's reach. During this visit, we saw that each person was easily able to access their call bell, and when they were used, staff responded quickly and attended to people's needs.

Where people could not use the call bell, due to physical mobility issues or advanced dementia, plans were in place to ensure that people's safety and well-being were appropriately monitored. For example, one person's care plan stated that the door of their room was to be left slightly open through the night so staff could check on them without disrupting their sleep, as they were unable to use the call bell.

Where there were risks associated with people's support, we saw these were appropriately assessed, and measures were put in place to ensure people's safety. For example, each person's records contained an assessment of their skin integrity and risks of acquiring pressure sores, and strategies to ensure these risks were reduced. These strategies included using inflatable pressure-relieving mattresses, reclining wheelchairs and supporting people to change position frequently when they were unable to move themselves. We asked the staff member responsible for maintenance about pressure-relieving equipment. They told us they had a contract with a new supplier who provided mattresses within 24 hours of request, and the home had several unused mattresses in stock so they were readily available when necessary. They told us maintenance staff checked each mattress in use every day to ensure there were no problems and they were working safely. Care staff we spoke with confirmed this.

During our visit on 17 January 2014, we found that skin integrity and pressure sores were not appropriately assessed and managed, and the provider told us they would introduce a prevention tool known as the SSKIN bundle (Skin inspection, Surface, Keep moving, Incontinence and Nutrition). During this visit, we found that this tool was in use. Staff had been trained in tissue viability and pressure sore prevention, and each person assessed as being at high risk of developing pressure sores had a prevention care plan in place. We also saw that people had been referred to the community Tissue Viability Nurse when necessary, and any concerns about skin integrity had been properly documented by care and nursing staff with body maps.

Guidelines were in place to support people to safely move around the service, and to move to and from their wheelchair to a chair or a bed. We observed staff following these guidelines. We saw staff observing people to ensure their safety when they were using mobility aids such as walking frames to move around the service. We saw staff physically supporting and gently guiding people when they were walking without using aids. Each of the care plans we look at assessed the person's risk of falls and identified measures to reduce these risks. Staff training records showed that all staff had been trained in moving and handling within the last year and their competency assessed. A 'manual handling champion' system had been introduced in the home to monitor moving and handling techniques.

Some people who used the service exhibited challenging behaviours at times. These are behaviours that may pose a risk of harm to property, other people or themselves. Where there was a risk of such behaviours, this was identified in people's care plans, with identified triggers to the behaviours and strategies to reduce the likelihood of the behaviours occurring. There were guidelines for staff to appropriately respond to the behaviours and keep people safe. Incidents of such behaviours were appropriately documented, and we saw that the service sought guidance through referral to a psychiatrist or psychologist who specialised in the needs of the elderly and people with dementia. Staff told us they had been trained in challenging behaviours and response techniques, and we saw records that confirmed this. Staff told us they felt safe redirecting people to reduce the likelihood of such behaviours occurring, and had enough training to respond when such behaviours occurred. One staff member said, "You get to know people very well, and understand what sets them off. It's all about redirecting them to make sure everyone is safe, or taking them for a walk to calm down. You know they do it because they're frustrated or upset."

The provider had a safeguarding policy and procedure in place, and staff we spoke with knew how to report concerns. One staff member told us, "If I had any concerns, I would tell my manager straight away, or another manager

Good

Is the service safe?

if mine wasn't available, or the senior person in charge. I know I can report it to the local authority if I need to as well." Staff training records showed that all staff had been trained in safeguarding adults, through their induction and regular refresher training facilitated by the provider.

CQC monitors the Deprivation of Liberty Safeguards (DoLS), which apply to care homes. The senior staff member in charge of the service demonstrated a clear understanding of the DoLS and their function, and guidance was available for staff should they have concerns if the manager wasn't available. Two people who used the service had been subject to DoLS in the two years prior to our visit, and the use of these was managed and recorded appropriately. There were no DoLS applications in place or pending when we inspected on 14 July, and we did not see any indication that people who used the service were being deprived of their liberty unlawfully.

One relative told us, "Recently, staff numbers seem to have stabilised and there are enough." Staff told us that, although they were busy at times, they rarely felt rushed to complete tasks in a timely manner, and we observed that staff were not rushed when providing support and responded quickly when people needed them. We noted, however, that the home was only at around 65% capacity due to the admissions restriction imposed by CQC and the local authority after our inspection in January 2014, and asked the staff member in charge of the service how the staffing levels would be assessed and managed when the service had fewer vacancies. They told us that they had a plan in place, and the ratio of staff to people who use the service would not change once the admissions restriction was lifted.

Staff personnel records showed each staff member had been appropriately vetted before starting work to ensure they were suitable people for their roles. Each of the nine staff records we looked at included a completed application form detailing their work history and reason for leaving previous jobs in health and social care, and at least two written references that had been verified by the recruiting manager. The provider maintained a record of Disclosure and Barring Service checks for each staff member, which demonstrated they were not barred from working in social care. Interview records were also kept in each staff member's file, showing the skills and knowledge they brought to the service when they were employed.

After our visit on 17 January 2014, we found that the service did not have safe arrangements in place for handling some medicines, and that appropriate systems were not in place for medicines audits. During this inspection, we found that the arrangements for the management of medicines were safe. We found medicines were stored safely and effectively, for the protection of people who used the service. We found arrangements were in place to record when medicines were received into the service, given to people and disposed of. These records provided an account of medicines used. However, we found that when medicines were given at different times to those printed on the medicines record forms, the actual time it was given was not recorded. This meant that there was a risk that some medicines may be given too close together. This issue had been identified in a medicines audit conducted by the service's deputy manager/ clinical lead the week prior to our visit, and arrangements were in place to address it.

We observed medicines being given to some people during lunch time and saw that this was done with regard to people's dignity and personal choice.

Where people were prescribed their medicines on a 'when required' basis, for example, for pain relief, we found detailed guidance for staff on the circumstances these medicines were to be used. We were therefore assured that people would be given medicines to meet their needs.

The deputy manager told us that they carried out weekly checks on the quality and accuracy of medicine records. We looked at the records of these checks and verified that they were done each week. There were suitable arrangements in place to identify any medicines errors promptly. We saw that these checks had picked up some omissions in the recording of medicines but that these had been investigated and resolved. We looked at the records of staff training on the safe use of medicines for six staff members. We saw that the training was up to date and that each staff member had been assessed that they were competent to handle medicines. We were therefore assured that people were given their medicines by suitably qualified and competent members of staff.

When we visited on 17 January, we found that the service did not have appropriate diabetes management plans in place, and staff were not aware of the signs to look for to ensure people with diabetes received the medical attention they needed in the event of hypoglycaemia and

Good

Is the service safe?

hyperglycaemia. When we visited on 14 July, we viewed two diabetes management plans and found these contained appropriate information for staff. Staff training records demonstrated that all staff had been trained in diabetes awareness since our visit in January, and care staff we spoke with told us the signs they looked for to ensure people with diabetes got the help they needed quickly if their blood sugar levels were of concern.

The service had appropriate plans in place in case of emergency, and we saw that suitable equipment was available to use in the event of a fire or other emergency. Evacuation plans were on display on each landing in each stairwell, and we saw that several evacuation mats were also available on each landing for people with mobility limitations. The service used a coloured dot system to indicate the level of support each person needed to evacuate safely, and these were displayed on the door of their bedroom with their name and a photo. Fire extinguishers were serviced regularly, and staff we spoke with were aware of their roles in the event of an emergency.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us that staff were capable and good at their roles. One person said, "I can't fault the staff. They are all pretty helpful." Another person told us, "They look after you very well." A relative said, "The staff all do their best."

One relative told us they were concerned that staff could not understand or respond appropriately to their relative's care needs because their English language skills had deteriorated as their dementia progressed. We checked this person's care and support records, and noted that their care plan included information about other types of communication they might use, such as body language and gestures. However, we saw the mental capacity assessment conducted to decide whether the person had capacity to understand and agree to a Do Not Attempt Resuscitation (DNAR) order. We noted that the person had been assessed as not having capacity due to the fact they no longer spoke English without any other indication they would not understand if the information was presented in another way. We raised this with the senior staff member in charge of the service, and they told us that the DNAR was due to be reviewed the week after our visit and another capacity assessment would be conducted prior to this. Other capacity assessments we viewed included more appropriate information as to why the person did not have capacity, and we noted that 'best interests' decisions were made and documented according to the requirements of the Mental Capacity Act 2005.

We observed that food and drink were available to people throughout the day in each of the lounges and communal areas. Each area had a fruit bowl and a tray of biscuits or cake, and jugs of water and squash with cups so people could help themselves when they wished. Most people and their relatives we spoke with told us they enjoyed the food, with only one person expressing dissatisfaction with the fact they did not have their favourite type of cuisine at each meal. They told us the food was "edible". Others told us the food was "lovely, I enjoyed every bit of it" and "my relative loves the food".

During our inspection on 17 January, we found that people were moved into the dining room and left to sit and wait for up to an hour and a quarter before receiving their food. During this visit, we observed lunch in all three of the dining areas, and noted that the atmosphere in each was relaxed and friendly and staff provided people with appropriate support to eat when they needed it. People were supported to move into the dining room in a timely manner, and some people were supported to eat in their rooms or in the lounge areas according to their preference.

We checked the food in the kitchen, and saw that fresh fruit and vegetables were regularly used. The food we saw served looked and smelled appetising. The menu was varied throughout the month, and records demonstrated that special diets were provided according to people's needs and guidelines provided by a dietician or a speech and language therapist. Records we looked at showed that people who were assessed as being at high risk of malnutrition or dehydration were monitored closely, and advice sought from a dietician when necessary.

Some people preferred to keep their own food, and they were supported to do so. Fridges were available in the dining room on each floor and we saw these were used. The cook told us kitchen staff provided ingredients for people to mix and bake as an activity once per week. Relatives told us they were welcome to share a meal with their relative, and were free to make hot drinks and toast when they wished to.

People told us they were supported to access health and other services in a timely manner when they needed to. One person said, "I tell them if I feel ill and the GP comes quickly." Another person told us, "I'm going to the hospital today. Staff always go with you." Records we looked at confirmed this, with each medical appointment or visit documented in the person's notes. Referrals to specialist community services, such as the dietician and the speech and language therapist, were made quickly by nursing staff when they had concerns about people's health.

Staff received training regularly in topics relevant to their roles, such as pressure ulcer management and prevention, dementia awareness, effective communication, safeguarding adults, fire safety and first aid. The service kept a training matrix and individual training files for each staff member.

The provider organisation had a comprehensive induction training programme each staff member attended prior to starting their role. This was based on Skills for Care's Common Induction Standards and included a reflective journal staff completed to demonstrate their understanding of their role. Staff were also supported to

Good

Is the service effective?

undertake relevant qualifications through the provider organisation, such as the Diploma in Health and Social Care to level two or three for care workers, and to level five or seven for unit managers and team leaders.

The service also maintained a supervision matrix documenting when supervision meetings had been held, and each meeting was recorded. Supervision meetings occurred every two months, and staff we spoke with told us these were mostly effective. One care worker told us, "I have regular supervision. I can raise issues and these are taken seriously the majority of the time, but it depends on the issue really." Another care worker told us, "Supervision is great, it's my opportunity to offload. I can raise any concerns and know my manager will listen to me. They're very supportive."

The senior staff member in charge of the service had started annual appraisal meetings, with 16 of 64 staff having had meetings at the time of our visit. All staff of the service, including cleaning, maintenance and kitchen staff, were scheduled to have an appraisal meeting, which involved review of the previous year's work, competency and values checks, and setting objectives for the coming year. Each meeting resulted in a development plan which included training, coaching and peer support.

We saw records that demonstrated that, where concerns had been raised by people and their relatives about the care and support provided by staff, the provider had taken appropriate action. We saw that the provider organisation had a comprehensive disciplinary procedure, and saw reports of a number of investigations into staff conduct that had taken place. These were thorough, transparent, and took people's concerns into account to ensure staff were providing the support that people needed, to a high standard.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us the staff were kind. One relative said, "I can't praise the staff enough." Another relative told us, "Some of the staff have been here for a very long time, and they know my relative very well."

We observed that staff took the time to sit and chat with people about their lives, current affairs and what was going on in the home. The atmosphere in the home was relaxed and staff used humour to assist people to feel at ease, and at home. One care worker told us, "We always try to have a laugh, and to make the residents laugh." Another care worker said, "I'm always really aware that this is their home, and think about how I want to be in my home –relaxed and comfortable and happy." A team leader said, "It's about treating people as I would want to be treated, or as I want people to treat my mum if she needed care."

Staff were attentive to people's needs, and provided one-to-one support that was not simply task-oriented. For example, we saw one care worker give a person, who had very limited mobility, communication and cognition due to advanced dementia, a hand massage for 15 minutes. On another occasion, we saw a care worker observe that a person was walking in the hallway with only one slipper on, and the care worker stopped the person, supported them back to their room to find the other slipper and to put it on. On another occasion, we saw a unit manager stop to chat with a person, then play a game of draughts with them at their request.

On another occasion, we observed a staff member talking to a person who exhibited signs of distress, crying and raising their voice. The staff member hugged the person to comfort them then supported them to go for a walk in the grounds to give them some space and time to calm down. A visiting professional told us, "The staff are lovely, and caring. I give this home 10 out of 10. It is always calm and welcoming."

We observed staff respecting people's privacy and dignity. On one occasion, we saw a care worker telling a person they had something to show them in their room, rather than telling them their incontinence pad needed changing. The service participated in the 'dignity in care network' and had a main dignity champion for the service, as well as several for each floor. The dignity champions were trained to promote dignity in care in the service, and challenge practice that doesn't promote dignity for the people who use the service. Most staff whose training records we viewed had been trained in the principles of dignity when providing personal care.

Relatives told us they were involved in making decisions about their relative's care, and people's records showed that people were involved in planning and agreeing their care whenever possible, to the extent their mental capacity allowed. Staff told us, and we observed, that they ensured they informed people of what they were doing when supporting them, and asked for permission before doing so when the person could give it. When people were unable to verbally give their consent, we observed staff looking at their facial expressions and body language to ensure they agreed to the support to be provided. Staff encouraged people to maintain their independence whenever possible. For example, we observed a staff member assist a person to change the way they held their cutlery, so they could eat more easily without support.

People and their relatives told us that people who used the service were supported to maintain relationships with their family and friends, and there were several areas in the home and large grounds in which people could take their friends and relatives for private time alone, without having to stay in their room. A relative told us they were always made to feel welcome at any time of the day or night. A staff member told us they often supported people to phone their family and friends, and gave them privacy if they wished and provided them with physical support such as holding the telephone handset for them if they were unable to hold it themselves.

Special events were routinely celebrated, and we saw many photos displayed on the walls of special events that had taken place over the years such as a party for the Queen's Diamond Jubilee and religious festivals. One relative told us parties were held for people's birthdays and staff made a particular effort to make people feel special on their birthday.

Where people were supported by the service at the end of their life, records showed that their family and friends were encouraged to spend a lot of time with them. One person's daily logs showed that several members of their family

Good

Is the service caring?

were with them continuously in the weeks prior to their death, and the senior staff member in charge of the service told us this was encouraged to ensure people were surrounded by their loved ones in their last days.

Each person's personal care and support records that we viewed contained a plan detailing their wishes and preferences for their last days and arrangements for death. These were comprehensive and personalised, and contained contact details for all necessary parties such as preferred funeral directors. People's preferences for pain relief and resuscitation were also included, and one person's daily logs showed these were followed. Records also showed that this information was passed on to hospital staff if the person was admitted to hospital before passing away.

Good

Is the service responsive?

Our findings

People were routinely asked for their views about the service, and these were acted upon. One relative of a person who used the service told us they attended the regular relatives' meetings, which we saw were scheduled five times per year. The relative told us, "Staff take notice of what is said" in the meetings, and "they always listen".

The team leader we spoke with told us they had recently changed people's keyworkers to ensure that people had their preferred care worker as a keyworker. They told us, "We always take preferences into account – some residents prefer one staff member to another for whatever reason and we have to acknowledge that."

Changes were made to the service as a result of the feedback people provided through residents' meetings. For example, we saw that people had raised issues with the laundry in these meetings, such as clothes going missing. As a result of the feedback, a laundry basket system was introduced in which each person had their own basket in the laundry, labelled with their name. A laundry log book had also been introduced to track people's clothes. However, one relative told us they were still not happy with the laundry service. They said "they tend to spoil their clothes" by washing them on too hot a setting.

Complaints were encouraged by the service, and responded to appropriately. We looked at the service's complaints folder and saw that each complaint received was documented with the service's response and outcomes and learning for the service noted. We saw that the provider had taken appropriate action in response to complaints, and people and their relatives told us they were aware of the complaints procedure and what to do when they were unhappy about any aspect of their support. One relative said they were "comfortable talking to staff about any issues we may have about care".

During our visit of 17 January, we found that people's care plans did not contain appropriate information needed to support them safely and according to their needs and preferences, records were incomplete, and care plans held on the provider's computer system were inconsistent with those found in their files. When we visited this time, we found that all care plans had been rewritten and reviewed in the three months prior to our visit, contained appropriate information and any changes made on the computer system had been printed and added to the person's file in a timely manner so they were accessible to all staff. Training records showed that nurses and team leaders had been trained in record-keeping and documentation, and their competency assessed through audit and evaluation of their files. Care workers we spoke with who had responsibility for keyworking told us that the nurses and team leaders had trained them in the appropriate standard for care plans and record-keeping.

People's care plans were regularly reviewed to take into account any needs or preferences that had changed. Each of the care plans we looked at had been reviewed monthly, and we saw that changes were made in a timely manner. Staff we spoke with were aware of these changes.

When we visited on 17 January 2014, we found that some people were not supported with the personal care they needed to maintain an adequate level of personal hygiene. During this visit, we looked at daily records and noted that people were supported with personal care according to their care plans and preferences. We observed that staff were attentive and responded quickly to ensure people's personal care needs were met.

The service provided a range of stimulating activities for people. There was a full timetable of activities displayed on the noticeboard for the week of our visit, and the service employed two activities coordinators to facilitate participation. Organised group activities we observed when we visited included an ice lolly afternoon tea party in the garden on a very hot day, and an exercise class. Other activities we observed included people being supported to listen to an audio book followed by a discussion, colouring, games such as draughts, backgammon and card games using large cards, and people being supported to listen to a piece of classical music followed by a discussion. One person who used the service told us they had a topical discussion about events in Northern Ireland a few days prior to our visit, in which technology was used to display a map and a video from the internet on a television to provide a visual aid for the discussion. Activities took place outside the service as well. People told us they had been on day trips to London Zoo, Olympic Park, Buckingham Palace, the seaside, plays at the theatre and films at the cinema. External services were contracted to provide activities such as exercise classes, and personal grooming services such hairdressing, manicures and aromatherapy.

Good

Is the service responsive?

Specific provisions had been made to support people with dementia to participate in suitable activities. We saw there was a sensory room on the top floor of the service, with equipment such as lights, music and interesting items to touch and smell. The activities coordinator we spoke with told us this room was used by small groups or as a one-to-one activity, or people could use it on their own. There was a memory bank of items available on the first floor, consisting of objects from the past such as ration books, tools, toys, sewing equipment and food packaging, and staff told us they used these to stimulate discussion and reminiscence. People told us they were regularly supported to attend local groups and facilities for people with dementia, such as a café run by the Alzheimer's Society and a Singing for the Brain group.

People were encouraged to participate in the daily life of the home. We saw people clearing the tables after meals and being supported to make tea and hot drinks for themselves and their visitors. One relative told us their relative cleaned their room and made their own bed, and "staff encourage them" to do so.

Good

Is the service well-led?

Our findings

When we visited on 17 January 2014, we found that the service did not have appropriate systems in place to monitor the quality of the service that people received. Audits had been undertaken and improvements to the service had been identified, however these were not always acted upon appropriately. When we visited this time, we found that the service had a robust quality monitoring and improvement programme in place. The service had benefitted from close monitoring and governance by the provider organisation, and this was evident in the actions taken and improvements made since our visit in January.

We saw that the provider organisation had undertaken a quality and governance support visit at least monthly from which an action plan had been developed, and there was clear progress evident on the areas in need of improvement. We saw that a programme of clinical audits had been established and was followed, involving four audits of different areas each day. These audits ensured that the work of the staff was monitored to improve the quality of the care and support that people received. We saw that medication audits had been undertaken weekly since the clinical lead had started their role two weeks prior to our visit, and they told us they would be conducting these weekly for the foreseeable future. Records held by CQC showed that all required notifications were appropriately submitted.

The senior staff member in charge of the service at the time of our visit had undertaken a quality assurance audit in June, and we saw that most of the actions identified had been implemented by the time of our visit.

Incidents and accidents occurring at the service were reported, recorded and responded to appropriately. Each incident and accident was documented on the service's computer system and a paper copy printed out and placed in the service's incidents and accidents folder for review of actions and overall trends. We saw that clear outcomes were noted for each incident or accident, and the system allowed for ongoing monitoring and follow-up details to be added. Appropriate actions had been taken as a result. For example, we saw that one person had suffered a fall, and an action for staff was to "update FRASE assessment as a result of each fall" (Falls Risk Assessment tool), and we saw this had occurred and changes made to their support as a result.

Care plans and documentation of people's care needs and support were also regularly audited through the use of a care plan tracker document. We saw these had been completed for every person who used the service. Audits of specific care plans, such as wound management and continence, had also been undertaken recently. These ensured that people were receiving appropriate care for their specific needs and conditions.

Daily managers' meetings were held to identify and discuss people's specific needs, the needs of each floor and the service as a whole, and for the managers of each unit to support each other. We attended one of these meetings, and found that senior managers were supportive and caring, and thanked the unit managers and team leaders regularly for their work. Humour and a relaxed atmosphere were evident throughout the meeting.

In the month before our visit, a points system had been implemented in which teams could gain or lose points depending on the quality of their work, and the care and support they provided. For example, a team had points deducted because a person's keyworker was unable to answer a question about the person's care needs, which demonstrated they needed to get to know the person and their needs better. Additionally, the service had implemented an 'employee of the month' system in which people who used the service nominated staff for reward. These systems demonstrated that the provider took people's views into account, was aware of innovation and good practice within the service, and worked to ensure the service was improving.

Staff we spoke with told us they felt the service, and its culture, had improved. One unit manager told us, "It's been difficult. We have been through a really tough time but it's a lot better now. You can see the difference the changes have made to the staff, how we work together as a team, and the effect this has had on the care people receive". A care worker told us, "We get so much support now from the managers – they have great values and look after us very well". Another care worker said, "It has been really hard, but things are so much better now. We work together as a team to make sure we do our best and we get so much support."

We noted that the provider organisation had ensured the service received a lot of resources to facilitate the improvements made since our last visit in January 2014. Senior managers from the provider organisation had also worked closely with the local authority and the clinical

Good

Is the service well-led?

commissioning group to ensure changes were identified and acted upon. We discussed this with the senior staff member in charge of the service and the provider organisation's regional manager. They told us that the additional resources would remain as long as necessary to ensure the improvements made were sustainable.