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St Georges Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 August and 6 September 2017 and was unannounced. At the previous inspection in October 2014 we rated this service "requires improvement" but did not identify any breaches of legal requirements.

St George's Nursing Home provides accommodation and nursing care for up to 44 older people including people with dementia and substance abuse issues. At the time of our inspection there were 35 people using the service. Care is provided across several adjoined houses on St George's Square in Pimlico. Facilities included a day room, dining room, library, a single lift, a small patio and chapel, and services include a launderette and kitchen.

The service is not required to have a registered manager, but had a registered provider who was the business owner and matron, who was the registered person for the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people who used the service and their relatives were positive about the service they received, including the quality of care and management. People told us that they felt respected and their privacy and dignity was maintained.

People's privacy was not always respected, as CCTV cameras were operational in people's rooms and there was a lack of clear guidance of its use, which meant that these were left switched on when people received intimate personal care. We issued a warning notice with regards to this following the first two days of our inspection, and the provider had taken action to address this by the final day of our inspection. Care workers were not consistently caring and respectful towards people, and there was limited use of tools to enable people to express their views about their care. Care plans were not always person centred, but care workers and managers demonstrated a good understanding of people's needs and wishes. The provider obtained consent to care, but did not always assess people's capacity or assess whether measures such as bedrails were restricting people's liberty. There was not always consistent review of care plans, which were not always clear about people's wishes for the end of their lives and for after their deaths. People received good support to eat and drink and to maintain good health, and were able to have pets living with them.

Aspects of the premises were not safe. We found that fire escapes were blocked and some fire doors did not close properly. This had been noted in health and safety checks but not always followed up. Similarly, gas and electrical safety checks had raised concerns about the safety of these systems, but the provider had not taken steps to ensure the building remained safe. We issued a warning notice with regards to the safety of the premises, which the provider took suitable action to address. We visited with the London Fire Brigade to verify that the service met fire safety regulations. The premises were not always suitably laid out to meet the needs of people with dementia, particularly with regards to how people orientated themselves in the building, but people and their relatives praised the homely feel of the building. We have made a

recommendation about this.

There were good systems of communication and handover in place. Staff told us that they were well supported and received suitable training and supervision, and there was evidence that staff were able to develop in their roles. However, the provider lacked systems to record and audit staff training and supervision, and so could not demonstrate that this was up to date. The provider did not always obtain a detailed work history before people started work, but undertook checks to ensure that staff were suitable for their roles. The provider had risk management plans in place but these were not consistently reviewed. Medicines were safely managed and administered, but the provider did not check that these were stored at a safe temperature. Good infection control processes were not always followed, which included open bags of clinical waste being left in bathrooms.

Some key systems of audit were lacking, which included the auditing of staff recruitment, training and supervision and the checking of care plans. We found that turning charts were often incomplete and were not checked by senior staff. People were confident in making complaints, but we found that complaints were not always recorded in a way that ensured they were followed up and investigated. The provider did not notify the Care Quality Commission (CQC) of important events such as deaths of people using the service.

We have made recommendations about infection control and providing a more dementia friendly environment. We found breaches of regulations relating to safe care and treatment, storage of medicines, privacy and dignity, staff recruitment, training and supervision, notifications to CQC and good governance. We issued warning notices with regards to the safety of the premises and privacy and dignity. You can see what action we told the provider to take at the back 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?

Inadequate

The service was not safe.

The provider did not have adequate measures for ensuring fire safety and the safety of gas and electrical systems, but took action to address this after a warning notice was issued.

Risk assessments were in place to address risks to people who used the service, but sometimes lacked detail on how to meet people's needs and were not routinely checked or reviewed. There were considerable gaps in turning charts.

Staffing levels were appropriate to meet people's needs, but safer recruitment measures were not always followed.

Medicines were safely managed and administered, but temperatures of storage areas and fridges were not checked to ensure these were safe.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff told us they received suitable induction, training and supervision from senior staff. However, no records were kept of this, which meant the provider could not ensure that this was kept up to date.

The provider sought consent for some aspects of care and support, but did not routinely carry out mental capacity assessments or assess whether bedrails may restrict people's liberty. The building did not fully meet the needs of people with dementia, with a lack of signage or aids to orientation.

People received suitable support to eat and drink and to maintain good health.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

CCTV was present in people's rooms, without clear written

consents as to how this was used, and we saw that CCTV was left on when people received personal care. The provider took steps to address this. Some parts of the design of the building did not promote people's privacy.

People were not usually involved in reviews of their care. The majority of interactions were positive, but we saw some examples of less positive interactions.

Care plans were not always clear about people's wishes for the end of their lives and what would happen after their deaths.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were positive about the quality of care and how people's needs were met by nurses and care workers. Staff demonstrated a good understanding of people's needs and wishes, but this information was not always recorded on care plans. Reviews were not carried out consistently and there was no evidence that people were involved in these.

Complaints were recorded and often followed up, but the provider lacked systems for ensuring that complaints were always responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff and people who used the service were very positive about the management team, who had a strong presence in the service. Staff spoke of good communication, support and team work. There were good systems of handover and team meetings.

Managers lacked some key systems of audit, such as those relating to staff training, recruitment, supervision, and those of care plans, reviews and complaints. The provider did not notify the Care Quality Commission of significant events such as applications to deprive people of their liberty or of the deaths of people using the service.

St Georges Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 of August 2017 and was unannounced on the first day. On the second day the provider knew we would be returning to the service. We returned for a further unannounced visit on 6 September 2017 to check that the provider had complied with warning notices that we served following the first two days of inspection, which we carried out jointly with an inspector from the London Fire Brigade.

The inspection was carried out by two inspectors on the first two days and a single inspector on the final day. On the first day the inspection team included a specialist professional advisor who worked as a nurse, 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.

Prior to carrying out this inspection we reviewed information we held on the service, including notifications of significant events that the provider is required to tell us about, and other information we had received about the service including complaints and concerns. We asked the provider to complete a provider information return (PIR), which contains information about the service, however, this was not returned by the provider who informed us they did not receive this.

In carrying out this inspection we spoke with four people who used the service and six relatives. We carried out observations of care using the Short Observational Framework for Inspections (SOFI2). We spoke with the matron, the trainee manager, assistant matron, senior nurse, five nurses, seven healthcare assistants and the administrator. We looked at records of care relating to 10 people who used the service, including records of administration and management of medicines. We looked at four staff files and information relating to the management of the service, including rotas and checks of the safety of the building.

Inadequate

Is the service safe?

Our findings

We found that the provider had not taken adequate measures to ensure that the building was safe, especially with regards to fire safety. Following the first two days of the inspection we issued a warning notice requiring the provider to address this as soon as possible.

The provider told us that they had carried out a fire risk assessment within the last five years, but were unable to provide this, and the most recent risk assessment available for us to view was dated 2010. This had identified the need to ensure that batteries were not charged in corridors, that fire doors closed correctly and that fire exits were not blocked. However, we observed hoist batteries being charged in a corridor next to an oxygen cylinder, and that two fire exits were blocked with items such as hoists, furniture and rubbish. Fire safety checks had been carried out in February and May 2017 and identified that these fire exits were blocked, but no action had been taken to address this. Similarly, although the provider carried out regular checks of fire doors, action had not always been taken to address faults, and we found several fire doors did not close properly. The provider's evacuation procedure involved moving people so that there were at least two fire doors between people and a fire, and evacuating people where possible through fire exits, including those which were blocked. This meant that the provider may not have been able to safely evacuate the building in the event of a fire putting people at risk of harm.

We also had concerns about the safety of the gas and electrical systems in the building. Checks had been carried out in 2016 and 2017 on the safety of boilers, however five warning notices had been issued by the gas safety engineer stating that these appliances may be unsafe. The provider had not taken action to ensure that these appliances were safe. The provider had also arranged for yearly checks to be carried out of the wiring; however, the last two checks had identified a number of faults on the wiring which were identified as "C1", meaning danger was present. The provider was unable to provide further evidence that the wiring systems were safe. Therefore we could not be assured that the provider had taken appropriate action to mitigate risks to people using the service.

These issues represented a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Due to the serious nature of our concerns we issued a warning notice and reported these issues to the London Fire Brigade.

On the final day of our inspection we found that the provider had met the requirements of the warning notice. Hoist batteries were no longer charged in corridors and fire doors had been repaired to ensure they closed correctly. Fire exits were no longer blocked and the provider had introduced weekly checks of these. The provider had arranged for a satisfactory fire risk assessment, and we confirmed with the London Fire Brigade that they were satisfied with the provider's fire safety arrangements. The provider had also taken action to confirm that gas appliances were safe, and had arranged for a quote from an electrician to carry out work on the electrical systems, and we spoke with the provider's electrician who confirmed that the wiring was safe.

The provider had measures in place to protect people from the risk of pressure sores. Comments from staff

included "We take pressure sores seriously; sometimes people come with them but we work hard to heal them or to stop them from getting worse" and "We frequently monitor skin during personal hygiene and we look for any complications." This included carrying out a Waterlow score. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person. We found that there were risk management plans in place where a high risk of a pressure sore was recorded. This included the use of appropriate footwear and regular turning and equipment such as pressure relieving mattresses. However, we found that these assessments were not regularly reviewed. For example, one person had a pressure sore on their heel and one on their sacrum, but their assessment did not include information to show the grading of the pressure sores and had not been reviewed since November 2016. We saw the care plans of two people who were assessed as being of "very high risk", but these had not been reviewed since March 2017. One person's chart stated they were to be turned two hourly, however there was not a turning chart in place for them. We brought this to the attention of a senior member of staff who rectified this. Older positioning charts for this person showed gaps of up to 18 hours. For another person who required two hourly repositioning, we found gaps in their chart of up to 24 hours, but one chart had two days entirely omitted. We found that there was no explanation of these gaps and no record that turning charts were regularly checked by a senior member of staff. This meant that people were not protected from the risks of pressure sores.

The provider completed risk assessments for people where further action was required to help keep them safe. We found that staff reviewed these risk assessments in response to changes in people's needs, but there was not always a clear timescale for routinely reviewing risk management plans. In some cases risk management plans lacked detail. For example, one person's plan stated they were diagnosed with dementia, along with the type, but the plan stated that the person was to be supported "at all times" without further detail on how care workers were to do this and how the person's particular type of dementia may affect them. For another person, care workers were required to improve their posture before eating and drinking, however there was a lack of guidance for staff in the person's risk assessment on how to do this. This person also had a diagnosis of epilepsy, but their care plan was not clear on the precautions care workers needed to take and actions to be taken in the event of a seizure. For another person, their care plan stated that the person gets "easily lost in and out of the building", but there was no information on what action staff should take if this occurred. We found that risk assessments were not routinely checked by senior staff to make sure they still met people's needs.

This was also a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We received positive comments from people and their relatives about the safety of the service. These included "It's absolutely safe", "I have zero concerns about safety, it's clean and they hoover every day", "I've been here a long time and I feel safe" and "I think [my family member] is very safe here." The provider had a safeguarding policy, which included information for staff on how they could report concerns, including to an external body, but this did not mention that staff were able to report concerns to CQC. Staff we spoke with were able to describe their responsibilities to safeguard adults, including describing the types of abuse and the need to report suspected abuse. There was no evidence of complaints or incidents which may indicate possible abuse had taken place.

The provider had an emergency evacuation plan in place, which gave information on each person's mobility, communication needs and had a clear plan for how each person would be brought to safety. Staff had received a fire safety induction on joining the service and the provider carried out weekly checks of fire alarms, alarm points, emergency lighting and fire extinguishers. We saw that fire extinguishers were serviced appropriately. Additionally there were daily checks of tumble driers where these may pose a fire risk and

monthly checks of emergency lighting. We spoke to a staff member who was able to give a detailed overview of the fire safety procedures and what to do in an emergency, and that evacuation was covered as part of the induction for new staff. However, we did not see evidence that this was reviewed on a weekly basis and the London Fire Brigade recommended that staff physically practice evacuation procedures using equipment such as wheelchairs and beds.

The provider also carried out other health and safety checks such as weekly checks of first aid kits and checks of hoists and slings. The provider showed us two new hoists which had been purchased in order to replace those which had been identified as unsafe. Electrical equipment had been checked for safety. There was information for kitchen staff to check the temperatures of fridges and freezers, including guidelines on safe temperatures. These were taking place on a daily basis and showed that these were within safe temperatures. The kitchen team also maintained thorough records of the cooking, cooling and reheating of food and carried out monthly checks of labelling, storage, temperatures, worktops and rubbish disposal.

The provider kept records relating to incidents and accidents; these were divided between an incident and accident book without consistency as to which book was used. Most recorded incidents were related to falls. We found that incidents were recorded in a notebook without the use of a form, this meant that staff were not prompted to record the action they had taken in response to the incident. For example, one person had had three falls in six days. Care workers had recorded the immediate action they had taken to check whether the person was injured or in need of medical attention, but did not record any further follow up, so there was no evidence that this person's falls risk assessment had been updated in response. The provider told us these falls had occurred because the person was given a sedative which was too strong and that these had stopped once the medicine was discontinued, but this had not been recorded. There was no evidence that the provider regularly checked or audited these records to look at trends to identify that further action was needed.

Staffing levels were adequate to meet people's needs, and rotas showed that staffing was in line with what the provider told us. Typically there were between three and four nurses on duty with a further eight or nine healthcare assistants (HCAs). There was no evidence of staff shortages. There were call bells in people's rooms and in communal areas, and CCTV was installed throughout the building with a single full time member of staff monitoring the cameras.

We found that the provider obtained photographic identification for new staff but did not always obtain proof of address. However, we found that in some instances the provider did not follow safer recruitment measures. This was because in three files we looked at there were gaps in staff member's work histories, which had not been followed up by the provider. One member of staff did not have references at all, but did not have a prior history of working in health or social care, and so the provider was not obliged to obtain a reference although it would be good practice to do so. However, another staff member was a registered nurse, and the provider had obtained one reference, but did not have a reference from the their previous employer. Therefore we could not be assured that the provider's staff recruitment procedures were sufficiently robust to protect people from staff unsuitable to support them.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We found that prior to a staff member starting work, the provider obtained a check with the Disclosure and Barring Service (DBS). The DBS provides information about people's backgrounds, including convictions, to help providers make safer recruitment decisions. The provider told us that they reviewed these every three years, and this appeared to be taking place, although managers did not have an overall audit of this.

Similarly, we were able to verify that nursing staff had valid PINs. A PIN is a personal identification number which is used to verify that a nurse's registration with the Nursing and Midwifery Council (NMC) remains valid. However, measures to monitor this were not adequate, which meant there was a possibility that a member of staff could continue working although their PIN had expired.

We checked medicines records on all floors of the building, and found that medicines were managed and administered safely to ensure that people received their medicines as prescribed. Medicines were administered by staff with the appropriate training to do so, and we observed that this was carried out in a calm and unhurried manner. We saw that medicines administration records (MARs) were accurately and fully completed. Where people had been prescribed topical creams, these were also administered as required. There was guidance on MAR charts on how and when to administer medicines which were prescribed to be taken as needed.

We found that controlled drugs were safely stored and checked, and that medicines were kept in locked trolleys which were chained to the walls in communal areas. However, we found that there were no records of temperature checks of medicines fridges and medicines storage areas. We visited on a warm day and found some areas where trolleys were stored were very hot. This meant we couldn't be sure that medicines were stored at an appropriate temperature. Also, we noted that several bottles of medicated syrups were open but not dated, which meant that staff would not be aware of when to dispose of these to ensure they were not used past their expiry date.

This constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We also found some issues relating to infection control. For example, we saw some staff wearing gloves in communal areas after carrying out personal care, including pressing lift buttons and opening doors. We also saw that some yellow bags containing gloves, tissues and pads with faecal matter were left unsealed in bathrooms, which could be smelt from the corridors. We recommend the provider take advice from a reputable source on maintaining infection control measures.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they were confident in the skills of the care workers. One person told us "I think they are very experienced in dementia care and how to support my family member." However, we found that although all care workers told us they received adequate training and supervision, the provider did not keep records and therefore was unable to evidence what training staff had received.

Comments from staff about the training process included "I have had training in moving and handling and am aware that we cannot lift people as it is unsafe. The training is practical and I felt comfortable after doing it", "The trainer is really good at making us feel comfortable and it boosted my confidence" and "There are opportunities for training and I know there are some upcoming courses." Some staff told us that they had been supported to undertake recognised qualifications such as National Vocational Qualifications (NVQs) and there was a dedicated classroom in the building.

The provider showed us an extensive list of mandatory training for staff, but did not keep records to to show which staff had attended training and when this had been completed. There was no audit and checking of training, and we found that training certificates were not routinely kept on staff files. Some training certificates were displayed in the training room, but the majority of these were prior to the year 2000 and therefore we could not be assured that staff skills and knowledge were up to date to enable them to effectively meet people's needs.

Similarly, we received positive comments from staff about the induction process, but records were not kept of this. For example, one care worker told us they had an induction which lasted five days, including a tour of the building, fire safety procedures, a range of policies and procedures and an introduction to people who used the service. Another staff member told us "I had about 10 days of shadowing during my induction, and it was all day. It was really helpful and it covered moving and handling and we learnt safe techniques to use. Now, I help the new staff and they shadow me when they start." Another care worker said "I shadowed a more experienced carer, it helped me a lot and I got to know how to help the residents." However, there were few records kept of this or evidence that care workers had been signed off as competent to work independently.

The deputy manager told us that after initial training at induction, observations of competency and feedback from staff and residents would be taken, but not recorded. We found a limited number of records highlighting candidate performance with an evidence record, including their awareness of policies and procedures and competency with moving and handling, but this information was not available in any of the four staff files we reviewed. When dated these were from 2015 and some were not dated or signed, so we could not tell when they had taken place.

All staff we spoke with confirmed that they had mini supervision sessions, that weren't necessarily scheduled, but that senior staff were always available to discuss any issues or concerns at any time. Comments included "We have one to one meetings and can talk to nurses any time we have concerns. They always quickly fix the problem", "We have regular contact…I find them very supportive and they look into

any concern I bring up, no matter what it is" and "We get to discuss concerns. We also talk about training opportunities, these are always available."

However, we found that there were no records kept of these informal supervision sessions, and therefore we could not determine whether everyone received these or whether they took place regularly. A lack of documentation meant that there was no way of identifying what had been discussed and agreed at the last supervision or even verifying when or if this had taken place. Similarly, there was no oversight of supervision, which meant managers were not able to determine who may be due for a supervision session.

The provider told us they intended to introduce formal supervision and to compile an overview of care workers' training. They added there was upcoming training scheduled in safeguarding, dementia awareness, mental capacity and deprivation of liberty.

We looked through 14 appraisals which had taken place in 2016. They had all been dated around 12 August 2016, but only one had been signed. Appraisal forms gave the opportunity to record what care workers had enjoyed about the job, and what they found frustrating. There was a space for senior staff to comment and then give a summary of performance, however none of these records had been signed by the assessor and there were no comments from them or in the summary of the care worker's performance. Therefore we could not be assured that staff received sufficient support to enable them to meet people's needs effectively.

The above issues constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We found that the provider had obtained consent from people or their representatives to the use of bedrails and CCTV in the premises. However, we found in some cases care plans were not signed or the provider had not carried out an assessment of people's capacity in line with the Mental Capacity Act 2005 (MCA). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found only one situation whereby a person may be restricted from leaving the building, and in this case the provider had taken appropriate action to apply to the local authority to restrict this person's liberty, however they had not met their responsibility to notify the Care Quality Commission (CQC) of this. We found that bedrails were in widespread use, and although consent had been obtained for their use, the provider had not assessed people's ability to consent to this, or carried out an assessment on whether the bedrails were restricting people's liberty in a way which may require a DoLS assessment.

The above issues constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

When DNACPR (Do not attempt cardio-pulmonary resuscitation) forms were in place, although professionals and relatives had been appropriately consulted and signatures obtained, it was not clear whether the person's views had been obtained.

Comments about the support people received to eat and drink were positive. Comments included "The breakfast is good; I've not seen an alternative menu but they used to make [my family member] whatever [he/she] wanted and they offer something else if the food's not eaten" and "Most of the food is good, there are certain things that I can't eat and they offer something else if the food's not eaten."

We saw that people received support to eat, whether in their rooms or in the dining room, this was carried out promptly by care workers. The provider maintained appropriate records or people's nutritional intake, including the food and drink people had had and the amounts they had taken. We saw there was only one choice of drink made available which was orange juice, however people had their glasses filled at regular intervals and drinks were placed within people's reach. The provider told us that there were a variety of drinks in the kitchen that people could have whenever they chose. There was no information on the menu about alternatives, but the chef told us they were willing to prepare alternatives as needed. They told us that when new people came to the service, they met the person to discuss the foods they liked and disliked, and if the person had been assessed by a dietitian they followed the instructions. There was information displayed prominently in the kitchen about people's dietary needs. The provider told us "We keep a very close on their dietary requirements on a daily basis through the head chef and the nurses serving the meals to the patients."

Records showed that people received appropriate support from professionals such as dietitians and speech and language therapists, and when people were at risk of choking there were guidelines in place, including the use of thickeners. We noted that a container of straws in the dining room was labelled with the room numbers of people who could not safely use these due to swallowing difficulties. The kitchen had recently carried out a satisfaction in July 2017, although they received a relatively low number of responses these showed a high level of satisfaction about the food.

We saw that people received appropriate support to maintain good health. Everyone who used the service was under the care of a local medical centre, and a GP visited fortnightly or more often as needed. Comments from people and their relatives included, "The home was straight onto it, the GP came and visited and arranged tests", "My relative was losing weight and was seen by the GP and a dietitian and is now maintaining his/her weight" and "I had a bad case of [condition] once, the staff are wonderful. They made no fuss helping me and were so respectful. A carer escorted me to the hospital and she looked after me." Staff told us that people also received visits from an optician and dentist.

We found that the building did not meet best practice for meeting the needs of people with dementia. Areas of the building such as the basement were dark and quite cluttered, and the layout of the building was confusing, with many doors to open, confusingly laid out corridors and a lack of signage or visual aids which may enable people to orientate themselves. One person said "I don't know how someone who can't walk manages the lumps and bumps, the tight corners and narrow corridors in a wheelchair." However, the provider told us they sought to provide a homely environment, and that people did not want items such as signage which would make it look more like a nursing home. This was supported by comments from relatives who told us, "It might not be the most modern building but for [my family member] it could not be better suited for them and is why we chose here" and "It makes [him/her] feel at home, it is perfect for them."

We recommend that the provider take advice from a reputable source on how to promote a dementia friendly environment in a way which meets the preferences of people who use the service.

Requires Improvement

Is the service caring?

Our findings

We saw that most people were treated well by caring staff. However, there were some exceptions to this, and the provider did not maintain people's privacy and dignity due to the use of CCTV.

We saw that everyone using the service had CCTV installed in their rooms; this came through to two screens in the nurse's office. The provider told us that everyone had consented to this, and that it was switched off during personal care. However, the consent form which people, or their relatives had signed simply stated "I agree to the use of CCTV", without further explanation of how and where it may be used. The provider's policy on CCTV usage only stated that it was to be used to monitor entrances for security purposes and did not refer to its usage in people's rooms, and it was not mentioned at all in the service guide. On two consecutive days we saw examples of personal care being carried out on camera. This included staff giving people intimate care including bed washes.

This constituted a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Due to the serious nature of the breach, we issued a warning notice to the provider and returned on a third day to check this had been met.

We found that the provider had met the warning notice, as we did not see further personal care being carried out on camera on the third day of the inspection, although staff may have been aware that this was being monitored. The provider had updated their policy to cover their use of CCTV, however were yet to demonstrate training in and oversight of this to ensure that this poor practice was not repeated.

People we spoke with and their relatives told us that staff respected their privacy. Comments included, "They are really good on privacy and keeping [my family member's] dignity when [he/she] is being washed or in the toilet. The personal care is extremely good and [my family member] is respected by all the staff" and "I have lots of privacy. One of my rooms is an office and I can place my own times on visits and carers coming in."

We saw examples of notices on doors clearly expressing people's wishes about when and how they would receive visitors. We also saw examples of how staff had respected people's privacy and dignity when carrying out personal care, but we saw this as CCTV was in operation at the time. Some people's doors were left open, which was in line with people's preferences. However, aspects of the building design did not always promote people's privacy. For example, some rooms did not have curtains, and we saw that the majority of toilets in communal areas did not have locks. We noted that staff did not routinely wear name badges.

A relative told us "The staff are all kind and [my family member] has become very fond of them. [He/she] is treated with great kindness." "Another relative said "One of [his/her] carers is one of the nicest people I've ever met." We saw examples of caring interactions between staff and the people they were supporting. This included greeting people by their names and checking that they were happy with their meals, and care workers adjusting people's positions to ensure that they were comfortable. We saw staff members offering

people drinks and joining in singing with people over meals. The majority of interactions were positive, however we saw a small number of less positive interactions. This included a care worker adding thickener to a person's drink by taking a spoon out of their hand without asking, placing food in front of people without speaking with them and cutting up a person's food without asking for permission. We also saw one person who stated that they didn't want the pudding which was served to them; the care worker swapped their pudding with another person's without asking either person for permission.

The provider used surveys to assess whether people were happy with their care, however individuals we spoke with and their families were unaware of the content of their care plans, and there was no evidence that people were involved in the review of these. There was no system of one to one meetings documented with people in order to review care. Where people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders on their files, these were signed by an appropriate medical professional and were in date. There was evidence that families were aware of these decisions and these were taken with the involvement of multi-disciplinary teams. However, care plans lacked details about people's wishes for the end of their lives and for their wishes after death.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with and their relatives told us that they received good quality care which met their needs. One relative told us, "They have tremendous respect for [my family member] and really worked with [him/her] on washing and dressing. [My family member] had a serious problem with [an aspect of personal care] but was never smelly. It was very dignified. Compared to other places we've been to, they are so kind and caring." Another relative told us "They give [my family member] a certain amount of freedom and allow [him/her] to be independent. [My family member] doesn't like to be told where and when to go, but has decided to stay on here." Another relative said "I don't feel there's a problem with the care here."

Care plans for people included a brief medical history, an overview of the person's cultural and dietary needs and whether resuscitation was to be attempted. Care plans identified people's daily living needs and long term goals. There were individual care plans in place to meet people's medical needs, such as wound management, skin integrity and nutrition. Care plans also listed people's communication needs, information about what aids people required, including hearing aids and glasses and how diagnoses of long-term conditions such as dementia affected the person and their cognition.

We found that assessments were carried out when people were referred to the service. These documented people's hobbies and interests, information on their daily routines and people's likes and dislikes with regards to food. There was also information on people's life stories, family situations and former occupations. We found that this information was not always documented in people's care plans, which were not always person centred. However, staff we spoke with including the managers and owner had an extensive knowledge of people's care needs and their personal wishes. Some essential information, such as the need to use communication aids and carry out physiotherapy exercises were displayed in people's rooms.

People's rooms were decorated in a manner of their choosing, including paintings and furniture. Some people had second rooms which they used as lounges, offices or drawing rooms. Several people also had pets, including cats and dogs, which was managed well by staff, who told us that the pets were essential for people to be happy living in the service. The provider told us that people were able to bring in anything of their choice, but were required to have insurance to cover higher value items.

Individual plans were in place to cover people's needs, however these were not always reviewed consistently and there were no clear timescales to review plans. For example, skin integrity plans for people at high risk of pressure sores were in place, but some had not been reviewed for six months. There was no evidence that people were involved in the review process.

The provider had a library on the ground floor with access to newspapers and this was constantly in use. There was also a quiet room which was fitted out as a Catholic chapel, although the provider told us that this could be used by people of other denominations and religions. People and their relatives told us they were able to practice their religions, this included visits from representatives from nearby churches.

Activities in the service were led by care workers and the deputy manager, these took place in the day room or library and there was a timetable of weekly activities displayed. These included classical music, movement and exercises, discussions of current affairs, afternoon films and listening to recordings of opera.

People we spoke with told us that they knew how to make complaints and were confident that these would be resolved promptly. Comments included "I'd talk to [the owner] if I had worries" and "If I wasn't happy I'd speak to [the managers] or [the owner]. Wherever I've asked for anything, if it's safe, possible and appropriate it has happened. For example I asked for a small handrail in the bathroom and it appeared within days".

The provider maintained a complaints book, which was used to record complaints from people, their relatives and staff. However, this was written in a notebook without the use of any prompts, which meant that information about the complaint and its follow up was not always clearly recorded. In some cases people had complained about the conduct of a member of staff, who had been asked to record their side of the story and where necessary to apologise. In some cases, the provider had investigated complaints, including reviewing CCTV footage to respond to a relative. Other cases did not appear to have been followed up. For example, one person had complained that information about their family member's care had not been passed on, and had made specific requests for their family member's care on a particular day, but there was no further information recorded on whether this had been investigated or enacted. In another situation a relative had asked for more information about how their family member had fallen; a staff member had documented that the appropriate member of staff was not available and had asked the person to phone back on a different day, but there was no evidence of further contact.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider did not always understand their responsibilities with regards to their registration with the Care Quality Commission (CQC). For example, the provider told us that they compiled a monthly report to the local NHS which recorded information on when people using the service had died. However, they were not aware that this also needed to be notified to CQC. We last received a notification of a death in May 2016, however the provider's records showed that six deaths had occurred since this time. The provider had also applied to the local authority to deprive a person of their liberty but had not notified CQC of this.

This constituted a breach of regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider told us that they submitted notifications to CQC by post, which meant that they did not have a copy of a receipt of these, whereas they would receive a reference number if these were submitted electronically. The provider was also unaware of their responsibility to display ratings of the previous inspection, but resolved this by the final day of the inspection. The provider did not maintain a website, so were not required to display these electronically. The provider displayed their insurance and CQC registration appropriately in the main lobby, but also displayed their registration with the National Care Standards Commission, which had not been the regulator of social care since 31 March 2004. The provider had been asked by CQC to complete a provider information return (PIR) prior to this inspection; we confirmed that this had been sent, but the provider told us they had not received this and so this was not completed.

The provider carried out audits in certain areas such as catering, housekeeping, nursing, medicines and administration, which were effective but not always consistently carried out. We found that the provider lacked other key systems of audit, which had directly led to breaches of regulatory requirements. This included keeping records of staff training and supervision, auditing records of recruitment, Disclosure and Barring Service checks and nurse PINs, and ensuring health and safety checks such as those of fire escapes were carried out consistently and followed through in order to ensure the building was safe. We also found that systems were lacking or inadequate with regards to recording incidents, accidents, complaints, statutory notifications and reviews of care plans. The provider showed us a tool they were implementing for auditing individual care files, however at the time of the inspection they had only carried out an audit of a single file. The provider had an extensive folder of policies and procedures, however some of these dated back to 2005 and did not reflect current legislation and records.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People who used the service and their relatives told us that they liked the managers and appreciated the way the service was organised. Senior staff acknowledged the need to modernise the service and bring it in line with current regulations. A senior staff member told us "I must say, things are starting to happen." Senior staff members were supported to gain qualifications and to develop in their roles.

Care workers and nurses were also very positive about the way the service was run and the team worked together. Comments included "[The owner], she's wonderful, very understanding and very supportive.", "We work well as a staff team and there is good team work." "I'm very well supported and am listened to", "[The owner] is a wonderful and kind person, she gives us all opportunities and always encourages and supports us. She is a marvellous lady." We observed that the registered provider had a strong presence in the service and knew the needs of people who used the service well. We saw many examples of cards and compliments that the staff team and managers had received from families.

Team meetings were held on a monthly basis, and were used to discuss people's changing needs and to clarify expectations of staff and policies, including health and safety and rotas. We also noted that meetings were held in response to complaints and concerns, including a meeting of the catering team in response to concerns about the food. The staff team also maintained clear and effective systems of handover between shifts. We observed a handover between the two night nurses and morning nurses, including with one senior member of staff. This was used to provide a detailed overview of the needs of people using the service, which started with any concerns from the previous night, and then discussed how each person had slept, any changes in their health, nutritional needs, behaviour and any relevant observations or appointments for the day. These were recorded in the communication book so there was a record which all staff could refer to. A senior manager told us that five handovers took place during the day for all the staff present, which we confirmed by speaking to other staff members.

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 Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person did not notify the Commission of the death of a service user whilst services were being provided in the carrying on of a regulated activity 16(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission of a request to a supervisory body to deprive a person of their liberty made pursuant to Part 4 of Schedule A1 to the Mental Capacity Act (2005) 18(4A)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that care and treatment was provided with the consent of the relevant person as they did not act in accordance with the Mental Capacity Act (2005) 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users or do all that

was reasonably practicable to mitigate such risks, and did not provide for the proper and safe management of medicines with regards to storage 12(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not establish or operate effectively systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not establish and operate recruitment procedures to ensure that persons employed for the purposes of carrying on a regulated activity were of good character 19(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff received such appropriate training, supervision and appraisal as necessary to enable them to carry out their duties 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Accommodation for persons who require treatment for substance misuse	People were not treated with dignity and respect as the provider did not ensure the privacy of service users 10(1)(2)(a)

The enforcement action we took:

A warning notice was issued, and we returned to ensure the provider complied with this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
	The provider did not ensure that the premises were safe to use for their intended purpose 12(2)(d)

The enforcement action we took:

A warning notice was issued, and we returned to ensure the provider complied with this.