Mr & Mrs K Bhanji

Fernbank Nursing Home

Inspection report

Finchley Way
London
N3 1AB

Tel: 02083493426
Website: www.fernbanknursinghome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 7 December 2016 and 4 January 2017. Fernbank Nursing Home is registered to provide accommodation and personal care for up to 34 people and specialises in dementia care. The home is run by a private partnership. There were 23 people using the service at the time of this inspection.

At the last inspection on 1 May 2014, we asked the provider to take action to attend to maintenance matters around the building. The provider subsequently wrote to us to say what they would do in relation to this breach of legal requirements. At this visit, we found these matters to have been addressed.

The service had a registered manager, which is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives reported a caring service, which we saw to be the case. Along with the pleasant approach of staff, effort was made to understand how people communicated and to respond to them effectively. There was a broad range of activities that were adjusted to people's abilities, cultures and life histories. The service encouraged community relations and so there were frequent visitors, entertainers and religious services at the premises. The service promoted a positive culture that tried to enhance the lives of people using it.

People's medicines were safely managed, and there were enough staff working at the service. The service was kept clean and infection control procedures sufficiently protected people. There was a willingness to learn from quality auditing processes and concerns raised by anyone, so as to improve services to people.

However, we found some concerns about the safety and effectiveness of the service. Charts used to record the treatment of people at risk of pressure ulcers, malnutrition and dehydration were not consistently completed. There were no individual choking risk assessments. Referrals to community specialists for support with these matters were not always timely. This all failed to demonstrate safe care and treatment of some people using the service, and that some people's nutritional needs were consistently met.

There were overall two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Procedures to minimise the risks of people developing pressure ulcers were not consistently followed. Individual choking risk assessments had not been developed. Referrals to community specialists for support with these matters were not always timely.

People's medicines were safely managed, and there were enough staff working at the service. Procedures were in place to aim to prevent, and to deal with, accidents and allegations of abuse. The service was kept clean and infection control procedures sufficiently protected people.

Is the service effective?

Requires Improvement

The service was not consistently effective. There was overall insufficient evidence of ensuring people's nutritional needs were met.

Training and supervision generally enabled staff to have the skills and knowledge needed to carry out their roles and responsibilities.

The service was working towards fully embedding the principles of the Mental Capacity Act 2005 into its practice.

Is the service caring?

Good

The service was caring. People were treated respectfully and patiently supported. Their independence and autonomy was encouraged.

Staff knew of people's different communication abilities.

There were good visiting and contact arrangements for people's friends and relatives.

Is the service responsive?

Good

The service was responsive to people's individual needs and preferences, and helped them to have a good quality of life.

There was a broad range of activities that were adjusted to people's abilities, cultures and life histories. The service encouraged community relations and so had frequent visitors, entertainers and religious services.

Concerns were listened to and apologised for, and actions were taken to address matters.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The way the service was being managed was not always identifying risks to people's safety and welfare, particularly in relation to the concerns we identified.

There were regular audits of various aspects of the service quality, although these were not always effective. There was a willingness to learn from audits and concerns so as to improve services to people.

There was good feedback about the registered manager's approach and knowledge. The service encouraged good team-work amongst the staff and promoted a positive culture that tried to enhance the lives of people using it.

Fernbank 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 7 December 2016 and 4 January 2017. The first visit was unannounced when there were 23 people receiving a service. Whilst the service has a registration for up to 34 people, Mr Bhanji, one of the providers, told us there was a maximum practical occupancy of 25 as a number of rooms used to be double rooms.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider.

The inspection was carried out by one inspector and an Expert by Experience, a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with five people using the service, three people's relatives, five care staff, a nurse, four non-care staff, the registered manager, and Mr Bhanji. A community healthcare professional also provided feedback about the service outside of our visits.

During our visits, we looked at selected areas of the premises including some people's rooms and we observed care delivery in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records of five people using the service along with a number of people's medicines records. We checked records about the management of the service such as staff rotas, accident and incident

records, and audit records. We also requested further specific information about the management of the service from the registered manager outside of our visits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that the service was safe. One person said, "I feel safe. There's nobody falling over and I've not seen anyone badly treated." Another person told us of staff helping them to move around and that staff were "careful". A relative said, "I think it's safe for Mum. I've never seen anything to make me think otherwise." Another relative told us of their family member being admitted to hospital from another service for dehydration and unexplained bruises. They added that "there's been none of that since being here."

However, we identified concerns with the safe care and treatment of some people. A few people needed regular repositioning, to help them to avoid skin deterioration and pressure ulcers. Individual charts were kept in their rooms to help demonstrate that they were being moved to different positions in a timely manner. The registered manager told us that two people needed to be repositioned every four hours at night. However, at our first visit, these two people's charts across the previous eight days omitted night repositioning records on three and four occasions respectively. They also had entries across some days but not others. When we checked these people's care plans for pressure care management, the second person's care plans did not specify for filling out repositioning charts.

At our second visit, the registered manager told us of two people having developed grade three pressure ulcers, meaning full-thickness skin loss. One of these people was being treated in hospital for overall health deterioration. A referral for Tissue Viability Nurse input had been made for the other person, to help treat this ongoing healthcare concern. There was evidence of other actions having been taken to minimise the risk of developing the ulcer, including that the service had put in place charts to address physiotherapy guidance, and acquired other healthcare professional input.

We noted that whilst there were monthly reviews of risk assessments relating to each person's pressure care management, these were not sufficiently accurate as they stated the month but not the exact date. Some, including for the person above, had not been completed since November 2016 by the time of our second visit, so had not been kept under effective review between our visits. This was not safe care and treatment of people.

Staff and the registered manager told us of there being four people using the service who were at risk of choking whilst eating or drinking. One of these people, when being supported to eat, regurgitated liquid without warning, which confirmed an increased risk of choking. When we checked the person's care records, we found no record of speech and language therapist (SALT) input, the community healthcare professional with specialist choking knowledge. The service had not therefore acquired specialist advice in support of providing the person with safe care and treatment, which we drew to the registered manager's attention. At our second visit, we saw that a SALT referral had been made and a visit from them was imminent.

The above person's care file had no choking risk assessment in place. The registered manager confirmed that there were no specific risk assessments in place for anyone thought to be at risk of choking, which she would address. She added that training on choking was now being planned for.

We found that SALT guidance had not been incorporated into another person's care plan. Reviews of their nutritional support section of their care plan did not mention SALT visits or their recommendations. The reviewing process did not show, on the front of the nutritional plan, exactly what the SALT's advice was, so that staff could be easily guided by this. This included that the person's drinks were to be 'syrup' thick by the use of thickening powder. This failure to do all that was reasonably practicable to mitigate safety risks for the person was not safe care and treatment of them.

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

Both members of the inspection team, who arrived at different times on the first day of visiting, were able to enter the premises unnoticed via the unsecured front door before declaring their presence to staff. The registered manager and Mr Bhanji explained that there was an issue with the door not locking automatically, for which they showed a quote for a new door and frame to be imminently fitted. The new door was working fine at our second visit. However, security arrangements until then were of concern as staff were not ensuring the door was properly locked after use. There was additionally no guidance on display to remind them of this, despite there being a written risk assessment of the circumstances which identified that staff were to ensure the door was locked after use. Guidance was put in place during our first visit.

People's comments about staffing levels were generally positive, including, "There are enough staff but it changes quite often." No-one said they felt rushed when supported by staff. A relative said, "There's always plenty of staff." There were no concerns raised with how quickly staff responded to people's call-bells. Comments included, "In general they come on time" and "It's not too long, and they always listen." When we tested the call-bells, staff responded quickly.

The deputy manager told us that as well as a nurse working at all times, there were two care staff assigned to each of the two floors, who worked together to support each person. There were additionally non-care staff, to support with cooking and cleaning, and for activities, for example. The registered manager told us of there often being an additional member of care staff, which staffing rosters confirmed. Two care staff and a nurse worked at night.

Staff said they felt there were enough staff working. A staff member told us, "We have enough staff. We call people who are off duty to cover when someone's sick." The registered manager told us that one member of staff was employed by an agency on medium-term contract, which helped ensure their consistency. Records showed that there was low staff turnover overall, as most staff had been working at the service for at least two years.

People had no concerns about medicines support. One person said, "They help me with medicines and I get enough to keep the pain away." Medicines were securely stored and appropriately disposed of if no longer required. People's medicines records were fully completed and up-to-date. Our checks of administration records against remaining stock for a selection of people's medicines raised no concerns, which indicated that people received their medicines as prescribed. This included short-course medicines such as antibiotics, and medicines that the prescriber had instructed for weekly variance. Records of as-needed sedatives, prescribed for some people for behaviours that challenged the service, showed minimal and appropriate use.

The service kept records of accidents and incidents. One person we met had a minor facial injury. We checked how this occurred, and found an accident book entry the previous day that sufficiently accounted for it. Some matters had been notified to us as required by law. We checked investigation records and

outcomes, and were able to see that the required actions to mitigate risk had taken place. This included, for example, staff supervision and disciplinary processes.

The service had systems for protecting people from abuse. There was information on safeguarding people from abuse in the entrance hall that publicised the service's safeguarding policy. Staff told us of receiving training on abuse, and gave us examples of what can be seen as abuse, and knew what to do if they suspected or were told of abuse. For example, they said the registered manager was available by phone at all times if needed, and they showed awareness of external organisations that may need to be informed. A new staff member told us of safeguarding being covered in their induction process before providing care to people. Their interview record included questions about understanding safeguarding.

The service kept records of safeguarding alerts made, investigations undertaken, and action points arising from these. We noted that significant injuries were reported to the local authority's safeguarding team for their consideration, which showed good transparency.

Attention was paid to fire safety. There was evacuation information relating to people using the service by the front door. Fire doors were fitted with devices that allowed them to be propped open unless the fire alarm activated. We saw daily safety check records for various matters in people's rooms, and in respect of fire safety around the premises. There were regular checks of fire equipment and the fire alarm system, plus occasional fire drills. There was an up-to-date fire safety risk assessment in place. However, it was not written by a fire safety professional but by the registered manager who confirmed that she had not had specialist training on fire safety. This meant that some fire safety concerns may not have been identified through the current risk assessment.

There were risk assessments in place about various aspects of the environment and for ensuring safe systems of working. These were kept under review. However, the registered manager confirmed that there were no risk assessments relating to the specific hazards within people's rooms in relation to each person's capabilities. For example, there was no radiator cover in one person's room, and their wardrobe was not fixed against the wall. The registered manager told us this person had limited mobility and so would not be at risk of falling against the radiator or causing the wardrobe to topple onto themselves. A written risk assessment would document that these risks had been individually assessed and mitigated. However, we noted that there were records of regular checks of the rooms in order to identify hazards that could course harm.

We saw safe hoisting of people to occur. Correct slings were used, and two staff always worked together patiently and involved the person in the process. Staff we spoke with knew which colour slings applied to specific people, and there were records in people's files confirming this. There were records to show that equipment used in the service, such as hoists and slings, had recently been professionally checked as safe to use.

The premises was clean, warm, and well furbished. People confirmed that it was kept warm enough at all times. The floors were non-carpeted which contributed to good infection control, avoidance of infestation, and wheelchair and mobility-aid access. There was alcoholic hand-gel in the entrance hall for anyone to use on entering or leaving the building. We saw evidence of several temperature checks during preparation and serving of the lunch. The Food Standards Agency's most recent rating for the service was five-star, the highest available.

Requires Improvement

Is the service effective?

Our findings

People told us their healthcare needs were supported, and that a doctor was called if needed as well as through weekly visits. One person told us of some specific healthcare equipment that the service supported them to use. They said, "They look after it and I've never had any problems." Another person who had diabetes told us staff always attended if they felt they needed help, and that staff knew what to do. A community healthcare professional told us that the service engaged well with them, and put their recommendations in place to support people's specific health needs. Records on people's files confirmed this feedback and some ongoing monitoring of people's health needs.

People expressed general satisfaction with the food offered, but their comments indicated room for improvement. One person said, "I would like toast or something in the evening. It's always the same old sandwiches." Another person told us, "Instead of sandwiches at night I'd like soup, toast, or omelettes; something light." We found that the evening meal was ordinarily only a range of sandwiches made by the chef after lunch. Alternatives were not routinely offered, although these were available on request.

When we were talking with one person in their room during the afternoon, a piece of chocolate cake was laid on their table without the staff member checking with the person what they would like. When the staff member left, the person said that they did not much like chocolate and "you don't get much of a choice." We did not see alternatives on the trolley that was being taken around for the afternoon snack, although the registered manager told us that options from the trolley at breakfast were shown to people.

We checked records of people's food and fluid intake where that was being specifically monitored. Two people's records were missing entries for three of the previous eight days, and other days usually omitted what they ate for lunch. Their fluid intakes were not totalled, despite there being a clear statement of appropriate daily intake for one of them. This all indicated a failure to monitor their food and fluid intake effectively.

We found that one of these people had gained weight in recent months, but the other had lost almost 10% of their weight over the previous six months. This was of concern as the person was not recorded being on a planned weight-loss programme. Their nutritional risk assessment was being reviewed monthly, but the weight loss recorded since June 2016 should have resulted in weekly weight monitoring according to the assessment tool. There was no record of community dietitian support for the person during this period, despite dietitian referral being stated as an action within their nutritional care plan if weight loss occurred. Reviews of this plan since June 2016 did not mention weight loss despite recognising that the person's eating habits were sometimes "variable." This all failed to demonstrate that their nutritional needs were being met.

The above evidence demonstrates a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our second visit, the above person had been reviewed by a community dietitian. Their latest guidance

was clearly part of the person's nutritional care plan, which had been reviewed and updated in light of our concerns from our first visit.

There was some other good evidence of the service attending to people's nutritional needs. One person told us of having specific meals made for them daily based on their cultural background. The chef showed us a wide array of the ingredients used for this. There has been a recent changeover to a commercially-delivered frozen meal service, which helped ensure a varied diet. In particular, pureed food was well-presented. We saw records of staff feedback, on behalf of people using the service, about what was working well with the new system and what was not. The registered manager also told us that they had been checking with people and their relatives, and so specific alterations to the menu had been made based on the feedback. This indicated efforts to get food choices right for people.

There was good support provided for people who needed help to eat and drink. People were supported patiently and offered mouth-sized portions. Most were assisted with encouragement and social chat, which helped make the mealtime experience pleasant. Where one person did not eat much, different staff tried to support them at various times, and when the person responded better to one staff member, that staff member stayed with them.

People told us about receiving enough to drink. One person said, "The girls are as good as gold. They'll get me tea if I want it." A relative told us, "In the summer, when it was very hot, staff kept coming round with drinks, iced drinks and ice-cream. They replace liquids regularly and the water is always fresh." People had access to drinks throughout our visits. Staff knew signs of dehydration for people who may not be able to say, such as differences in their skin, and the volume of different-sized drinking containers so as to more accurately record how much people had drunk.

People and their representatives told us they felt staff had the right skills and abilities. One person said, "I feel the staff know what they are doing." A relative told us, "The staff know what they are doing. You tell them what you need and they'll do their best."

Staff told us of good training provision, and records confirmed this. This included practical sessions, for example, with moving and handling equipment, and tests at the end of the sessions to ensure they could demonstrate sufficient knowledge. A new staff member told us of induction processes, including being taken through each person's support needs. Their induction record covered a range of appropriate competencies, but lasted only one day and so was not in line with the recommended national Care Certificate standards.

Staff said they had regular supervision meetings with a member of the management team, at which they could raise matters for discussion and at which they were reminded of appropriate care practices. Supervision records we saw confirmed this, and included instances of the registered manager praising and thanking staff for specific work they had undertaken.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us there were no such conditions, and we did not see any amongst the DoLS authorisations in people's files. DoLS were in place, or applied for, for relevant people. The registered manager showed as a tracking matrix by which she made sure that authorisations were renewed where needed.

Staff were seen to gain consent from people where possible for care and treatment. They could explain appropriate ways to request consent where someone was refusing care but care duties indicated that care was needed. This included reporting to the nurse in charge, trying different staff, and giving the person a drink before asking again. Where care was not essential at that moment, for example, if someone was not ready to get up or go to bed, their decision was respected.

However, there were no assessments of people's capacity to consent to care decisions in the service such as for the use of bed-rails. This was not in line with the requirements and guidance of the MCA. This was because there were no records of attempting to assess the person's capacity to make the decision for themselves before recording a formal best-interests process if the person was assessed as unable to consent to the decision. The registered manager agreed to attend to this.

Good

Is the service caring?

Our findings

People told us the service was caring and they were treated respectfully. Comments included, "They don't just do the job; they consider you." and "The staff talk to me and we have a laugh." A relative said, "Mum loves it here and likes the banter." Another relative told us, "We moved here from another home and they were so welcoming and nice. The staff are amazing." We also noted many positive comments about the service's care within a compliments book in the visitors' room.

There were a number of ways in which the service sought to ensure people were treated respectfully. When hoisting people in communal areas, staff used a privacy screen. A relative said, "I like the dignity part of hoisting with the screens indoors and outdoors. It's nice for the residents to have dignity." We heard people being talked with throughout the hoisting process, which helped to involve and reassure them.

We saw staff knocking on people's doors before gaining permission to enter, which people using the service confirmed as common practice. One person who told us they were visually-impaired, said that staff "always announce themselves." Staff told us of aiming at same-gender care but also recognising people's preferences.

People told us they were supported patiently and in an unhurried manner. Comments included, "The staff are very good and never rush me when washing and dressing." We saw staff noticing people and responding to them. One person found their dinner plate to be a little hot, for which the staff member checked with them about whether it was manageable. Another person was not eating much at lunch. The staff member helping them asked if they wanted something else, and went off to arrange for an alternative.

Staff told us of ways in which different people communicated, and of efforts to understand them better. We saw people's communications being understood when not verbal. Staff knew of people's different communication abilities, such as how someone whose speech was affected post-stroke conveyed things. A new staff member told us of the importance of learning to understand the specific way people communicated.

People told us their independence and autonomy was encouraged. One person said, "I feel well looked after. I go to bed when I want and I get up when I want. I like the area and I can come and go as I please." Other comments included, "My balance is dodgy but I get out in the garden as long as someone is with me" and "I have my own fridge to put my stuff in." Staff told us about encouraging choice, for example, offering people different items of clothing when helping them to get dressed. One staff member told us of recognising someone's loss of independence causing frustration and aggression, which we saw as good empathy that helped with caring approaches.

People had mixed views on how involved they were with planning their care and how much they were interested in this. Comments included, "There were a lot of questions when I came in" and "I don't have much to talk about with my care plan." However, relatives felt that their views were sought and acted upon, for example, "We were involved in his care plan and planning his routine."

We noted that staff meeting minutes paid good attention to conveying people's views as understood by staff. This helped to review and improve on people's experiences such as at mealtimes by ensuring people were not kept waiting and risking having cold meals. This helped to show a caring ethos at the service.

People and their representatives had no concerns about visiting and contact arrangements. People's comments included, "I can have visitors anytime, even nine at night", "My sons can come and go as they like" and "My visitors sit in my room and I make them tea if they want it." We saw people being warmly welcomed into the premises, that there was information for visitors in the entrance hall, and that the service had a separate private room for visitors and meetings if needed. We were shown how the service had set up arrangements for people to talk to others via video links. People also confirmed that they could make and receive phone calls.

Good

Is the service responsive?

Our findings

People were happy with activities at the service. Some people told us of the daily sessions at the service. Others did not wish to take part in the daily advertised activities, telling us, "I'm pleased with what I've got. I watch the sport on the telly and read books" and "I like my puzzle books and read my books."

We saw engaging group activities taking place using equipment bought into and made at the service, for example, ball exercises. At our first visit, people were also given activity equipment to occupy themselves with in the morning, and a dog-petting service attended in the afternoon. The activities coordinator told us this was the first time having the dog visit, but more sessions were planned. They told us about visits a fortnightly musician's visit, occasional children's choirs, and regular mobile library visits.

At our first visit, we were shown many photos of people at the service enjoying the activity resources. There were a number of Christmas decorations that had been made in the previous few days by people at the service with support. It was encouraging that the Christmas period was being well-planned for, with many decorations already up and a festive party being held imminently. Mr Bhanji told us of quarterly parties and attempting to create a sense of community in and out of the service, for example through visitors from a local church and inviting relatives of people who used to use the service to still come along. This all helped to provide people using the service with a greater sense of well-being.

The activities coordinator told us of using the internet to find songs that reflected people's specific cultures and life histories. Life history records were being developed to help find out people's interests and to empathise with how they used to live. This helped to stimulate people including those who preferred to stay in their rooms and those who tended not to participate. Mr Bhanji told us of one such person now willing to read sermons at Catholic services that took place in the premises every fortnight. We saw that activities had been designed to help one person with partial limb paralysis to be very much involved.

The activities coordinator said that they had been attending activities workshops hosted by the local authority, and that the service was involved with a college that was researching dementia care. They had developed many of the activity ideas through these resources. For example, we saw quite dependant people being provided with materials and objects of differing colours and textures which they interacted with purposefully. Where one person was visually impaired, 'Living Paintings' had been acquired which could be explored by hand to build the picture up. Mr Bhanji told us that this had also helped care staff to be more comfortable with being involved in supporting people with activities and recognising that this was part of their role. We saw staff being very involved in activity sessions and generally talking with people where possible. This all helped demonstrate a service that was responsive to people's individual needs and preferences, and helped them to live as full a life as possible.

One person had moved into the service the day before our first visit. All the staff we spoke with that day knew of the person's basic needs, whist those that had worked with them already had more detailed knowledge. One staff member said that along with being provided information about their specific needs at the staff handover before starting work, they talked with the person to find out how they liked to be

supported, for example, in brushing their teeth and being positioned in bed.

We observed an afternoon staff handover and heard a brief discussion on each person's current needs and how they were across the previous shift. It conveyed information accurately, for example, that someone had only eaten half their lunch, and what some people preferred to eat. The process was therefore responsive to people's needs.

People told us of being responded to well. One person said, "If I want a cup of tea I wait for one of the girls to pass and they will get it for me." We saw staff listening to people and responding to their requests.

A community healthcare professional told us that people's care records were always up-to-date and organised. This helped with joint working so as to provide a more responsive service to people.

People's care files showed that the service assessed people's needs and preferences before they were offered the opportunity to use the service. Further assessments took place once the person had moved into the service. Care plans were set up based on these processes, and from feedback from the person, their representatives, and staff who had initially worked with the person. The assessments and care plan were kept under review.

There was a guide to the service and information on making a complaint within a folder in each person's room and in the entrance hall. The information included options for raising concerns with independent bodies if felt necessary, which helped to demonstrate a transparent complaints process.

People told us they had no cause for complaint but they would talk directly to staff or the registered manager if were unhappy with an aspect of the service. Their comments included, "There's a matron in charge…if I had a complaint I'd see her or one of the staff." A relative said, "If I had any concerns I'd speak to the manager on duty. There's always someone in charge and I am confident there's someone to talk to." Another relative explained a recent concern but that it was dealt with immediately.

There was one formal complaint about the service within the last year which had been appropriately resolved. Provider audit records considered complaints and concerns, which helped to ensure appropriate processes were followed.

The registered manager told us of resident and relatives meetings taking place periodically, but that they were not well-attended. Records confirmed this. However, concerns were listened to, apologised for, and actions set to address matters. For example, individual laundry baskets had been set-up to stop people receiving others' clothes, which was subsequently confirmed as working better. We also noted that matters from those meetings were discussed at staff meetings, to help ensure an effective response. We tracked one relative's request at these meetings for an adjustment to their family member's care, and found that the desired health outcome was being achieved. This all demonstrated that the meetings were used to improve on the care that people received.

Requires Improvement

Is the service well-led?

Our findings

People fed-back that the registered manager, often referred to as 'matron', was well known and talked to people and their visitors frequently. One person said, "Matron's in charge and she's always going around." Relatives told us the registered manager had good knowledge of their family members. Their feedback indicated that the registered manager was well-respected.

Staff told us that the registered manager was approachable and knowledgeable. One staff member said that the registered manager is "a wonderful manager. She comes to see me about my work. We are treated equally." Another told us, "The managers appreciate what I'm doing. If I make a mistake they will tell me but they make me feel OK." The tone of the quarterly staff meeting minutes and the handover we saw reflected this. Staff were asked their opinions at these meetings, and feedback included the reflection of the preferences of individuals using the service. Staff were also told of good practice at the staff meetings, including by new publications from external bodies. Meeting minutes included an update, a few days later, on actions already taken.

Staff were happy with support from the provider. For example, we were told of equipment requests, for improving services to people, being quickly arranged. Staff had been surveyed about their views of their employment. Results showed good return rates and very positive feedback. For example, everyone stated they knew very well what was expected of their role.

Staff also spoke highly of the service and were proud of how they tried to enhance the lives of people using it. One staff member told us that the smaller number of people using the service helped ensure better quality of living, for example, through more individualised care. They described the service as "like a home." We saw good team-work taking place, for example, to support people to eat, and we were told of staff helping each other out. This all helped to demonstrate the positive, open and person-centred culture at the service.

There were regular audits of various aspects of the service quality such as for staff recruitment checks, infection control, and checks of night care. The provider also undertook an overall audit every four months. These helped make improvements in the quality of the service. For example, the registered manager's recent audit of medicines in the service had identified some concerns which had been communicated to nursing staff. Our checks of medicines showed that the concerns had been effectively addressed.

However, some aspects of quality auditing were not comprehensive. There were audit records in respect of people's care files. However, they were not designed to check the accuracy of records, and so did not pick up on the breached regulations that we found. We noted that audits had not picked up on some out-of-date items in a first aid box in the dining area, albeit another such box in the treatment room was appropriately stocked. We also noted that there was no summary kept of accidents, incidents and safeguarding alerts, by which to further scrutinise these matters as whole. We found, therefore, that the way the service was being managed was not always identifying risks to people's safety and welfare.

At our second visit, the registered manager told us of a number of actions taken to address our concerns from the first visit. There were records of a group supervision by which to discuss with staff how to ensure matters such as care charts were kept up-to-date at all times. The registered manager told us this was an ongoing process by which to work out what resulted in the best outcomes for people using the service whilst providing staff with processes that were easy to use. This helped to demonstrate a transparent approach to the service and a willingness to learn from concerns so as to improve the service to people.

At our first visit, the staff handover took place in the dining area, in easy hearing distance of both people using the service and any visitors. It was not therefore confidential. We drew this to the attention of the registered manager. At our second visit, the registered manager told us the location of handovers had now been changed to a private room with one staff member remaining with people using the service so as to respond to them if needed.

During our second visit, we found that there was no hot water coming from taps in both the laundry area and some people's bedrooms. Mr Bhanji and the registered manager told us that a boiler pump had failed. It had already been fixed that day, but there was likely an after-effect such as air in the pipes preventing effective water flow. Mr Bhanji said an engineer had therefore been called via the heating service contract, and he emailed us later that evening to inform us the matter had been rectified.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that care and treatment is provided in a safe way to service users, including: • through doing all that is reasonably practicable to mitigate risks to the health and safety of service users of receiving the care and treatment, and • by ensuring that timely care planning takes place to ensure service users' health, safety and welfare where responsibility for their care and treatment is shared with community professionals. Regulation 12(1)(2)(b)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons failed to ensure that nutritional and hydration needs of service users are met, including ensuring the receipt by service users of suitable and nutritious food and hydration which is adequate to sustain life and good health. Regulation 14(1)(4)(a)