Life Style Care plc

The Grange Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 30, 31 August and 4 September 2017 and the first day of the inspection was unannounced. During the last comprehensive inspection in June 2015 we found the service was meeting our regulations.

The Grange Care Centre provides accommodation for people requiring nursing or personal care for up to 160 people. The service has eight units, each with single en suite bedrooms, dining and sitting rooms and bath and shower facilities. At the time of inspection there were 156 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service since August 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified some shortfalls in medicines management which could place people at risk of not receiving their medicines safely. We discussed this with the management team and they said they would address our concerns promptly.

Care records were not always personalised so did not reflect people's individual care needs. Where people's needs were not always being fully met, the reasons for this had not been explained in the care records.

Although the service had comprehensive auditing and monitoring processes in place, further work was needed to ensure medicines management and personalisation of care records were kept up to date.

Activities staff were available and activities programmes were in place and being followed. Work was ongoing to meet people's diverse hobbies and interests and the need to keep the activities provision under review was understood by the registered manager.

Staff received safeguarding training and knew to report concerns. Staff recruitment processes were being followed so that only suitable people worked at the service. There were enough staff to meet people's needs and staffing levels were kept under review.

Risks to individuals had been assessed and action plans were in place to minimise them. Risk assessments for equipment and safe working practices were in place to mitigate risks to people visiting and working at the service.

Infection control procedures were being followed to protect people from the risk of infection and keep the environment clean.

Staff received training to provide them with the skills and knowledge to care for people effectively. The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

People's dietary needs were being identified and overall they were being met, Feedback about the food was mixed and work was ongoing to ensure people were aware of the variety of food options available to them. People received the input from healthcare professionals, according to their needs and staff implemented any changes in care and treatment.

Staff treated people in a caring and gentle manner. They found out about people's care needs and preferences and respected these. Staff treated people with dignity and respect.

The complaints procedure was available and people, relatives and staff were encouraged to express any concerns so they could be addressed.

The management team were receptive and worked hard to maintain a good standard of care provision at the service. Staff said the management team were approachable and supportive.

We found three breaches of regulations at this inspection. These were in regards to person centred care, safe care and treatment and good governance. You can see what action we have asked the provider to make at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not always safe.

We identified some shortfalls in medicines management which could place people at risk of not receiving their medicines safely.

Staff received safeguarding training and knew to report concerns.

Staff recruitment processes were being followed so that only suitable people worked at the service. There were enough staff to meet people's needs and staffing levels were kept under review.

Risks to individuals had been assessed and action plans were in place to minimise them. Risk assessments for equipment and safe working practices were in place to mitigate risks to people visiting and working at the service.

Infection control procedures were being followed to protect people from the risk of infection and keep the environment clean.

Is the service effective?

Good

The service was effective.

Staff received training to provide them with the skills and knowledge to care for people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

People's dietary needs were being identified and overall they were being met., Feedback about the food was mixed and work was ongoing to ensure people were aware of the variety of food options available to them.

People received the input from healthcare professionals, according to their needs and staff implemented any changes in care and treatment.

Is the service caring?

Good

The service was caring.

Staff treated people in a caring and gentle manner. They found out about people's care needs and preferences and respected these. Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care records were not always personalised and did not reflect people's individual care needs. Where people's needs were not always being fully met, the reasons for this had not been explained in the care records.

Activities staff were available and activities programmes were in place and being followed. Work was ongoing to meet people's hobbies and interests according to their diverse needs and the need to keep the activities provision under review was understood by the registered manager.

The complaints procedure was on display and people were encouraged to express any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Although the service had comprehensive auditing and monitoring processes in place, further work was needed to ensure medicines management and personalisation of care records were kept up to date.

The management team were receptive and worked hard to maintain a good standard of care provision at the service. Staff said the management team were approachable and supportive to them and addressed issues raised.

The Grange Care Centre

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 checked 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 30, 31 August and 4 September 2017 and the inspection was unannounced. Before the inspection we reviewed the information we held about the service.

The inspection was carried out by three inspectors including a pharmacist inspector, a specialist advisor in occupational therapy 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. The expert by experience had experience with care services for older people and of accessing services for people with physical disabilities.

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. Before the inspection we also reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

During the inspection we viewed a variety of records including the care records for 18 people, some in detail and some looking at specific areas, the medicine administration record charts for 82 people and carried out medicine stock checks for 17 people. We also looked at six staff files, risk assessments for individuals and for the premises, systems and equipment, servicing and maintenance records for equipment and the premises, audit reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) at lunchtime on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the interaction between people using the service and staff on all units as we carried out the inspection.

We spoke with the registered manager, the quality director, the clinical services manager and the three

deputy managers, the training and development lead, five registered nurses, one team leader, one senior healthcare assistant, 15 healthcare assistants, the rehabilitation assistant, three activities coordinators, the laundry supervisor, two domestic staff and the chef. We also spoke with 20 people using the service, 11 relatives and two visiting health care professionals, those being a GP and a physiotherapist, and the hairdresser. Following the inspection we sought feedback from two other healthcare professionals and received this from one of them. We have referred to the provider's managers and deputy managers as 'the management team' in this report.

Requires Improvement

Is the service safe?

Our findings

The service was not consistently safe with regards to managing people's medicines. There were processes in place for the storage, recording and administration of medicines including controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring), as outlined in the providers own medicines policy. However we saw evidence that this was not always followed. We saw a discrepancy in one of the CD registers that showed a mismatch between the stock balance in the CD register and actual physical stock in the CD cupboard. We discovered that this was because the previous evening dose given to the person was not documented in the register, even though the daily stock check had been carried out and signed by two nurses on the morning of the inspection without identifying the error.

We noted that some care plans did not identify the risks associated with certain medicines, such as the risk of falls when people were prescribed sedating medicines and any special instructions or monitoring needed such as when people were prescribed certain medicines. This was previously highlighted at our last inspection in June 2015, and we noted that the provider has not addressed this issue. We found two expired boxes of prescribed medicines for one person in one medicines fridge; we advised staff to obtain an alternative supply from their pharmacy immediately. We checked the medicines disposal records and found that these were not always documented before disposal as recommended by the Royal Pharmaceutical Society guidance, 'The handling of medicines in social care'; therefore we were not assured that all medicines could be properly accounted for.

Review of medicines administration records showed that people were given their medicines as prescribed, although administration was not always in a timely manner. For example, one person was prescribed a time sensitive medicine, and we saw evidence that these were not always administered in a timely manner. We brought this to the attention of the registered manager who took immediate action to ensure accurate administration of all medicines including time sensitive ones.

We noted that one person prescribed emergency medicines for the control of seizure did not have 'as required' protocol in their file. We brought this to the registered manager's attention and were informed that the protocol was available but had mistakenly been filed away. This was found for the second day of the inspection. We did not see any documented pain assessments carried out for people on 'as required' pain relieving medicines.

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

Medicines received from the pharmacy were recorded on the Medicines Administration Records (MAR charts) and the remaining quantity in stock could be reconciled with the MAR. Where people were having their medicines administered covertly, there were appropriate mental capacity assessments, documenting the reason for doing this, and that this was in their best interests. Staff told us how they assessed people's pain by asking those able to verbalise, as well as observing any changes in behaviours. We saw on MAR charts evidence that 'as required' pain relieving medicines were regularly offered to people.

Medicines were stored securely including controlled drugs and appropriate temperature monitoring was carried out to ensure that medicines remain suitable for use. There was evidence that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed. People with high risk medical conditions such as raised blood pressure and diabetes were also appropriately monitored to check that their medicines were effective. Staff told us that the GP visits weekly and people's medicines were reviewed regularly, and we saw some evidence of medicines reviews carried out by people's GP. Records showed that staff responsible for administering medicines had undergone relevant training. Following the inspection the registered manager submitted an action plan which stated what they were doing to address our findings and this included repeating medicines competency assessments for all staff involved with the administration of medicines.

Staff we asked knew the action to take if someone was unwell, including contacting the emergency services. One relative told us, "There have been emergency situations - life threatening when they called an ambulance- they always call me." A person using the service said, "When I needed to get into hospital they did immediately."

People and relatives confirmed they felt people were safe at the service. Comments included, "I sleep at night now I'm assured she's the best she can be", "I feel safe here. The staff are very nice", "I am happy with the care my [relative] receives, she is safe here and settled. The home is supportive of me" and "I have no concerns about my [relative's] safety." Staff confirmed that they had regular training in safeguarding and we saw that there had been several training sessions in 2017. Staff knew to report any concerns they had or incidents they might witness to a nurse or member of the management team so they could be addressed. We discussed whistle blowing with staff and whilst the majority of them were clear about the process to follow including reporting concerns to the local authority and the CQC, there were some staff who struggled to articulate this. The registered manager said this would be discussed to ensure the understanding of all staff with regards to whistle blowing.

Staff confirmed there was a poster about whistle blowing in the staff room and we saw flow charts for the identifying and reporting of any suspicions of abuse were displayed on each unit and in the reception area. We saw that any events with a possible safeguarding element had been reported to the management team who in turn had informed the local authority safeguarding team, so they could take the necessary action and advise the service. At the time of inspection there was one safeguarding concern open and the registered manager was in contact with the local authority and awaiting the outcome of the referral.

Risks to people were assessed and documented within their care records. Each care file contained a range of assessments at admission and included details on physical risks, medical conditions and risks, communication abilities and mental cognition. With the exception of medicines, there was information on how to manage or mitigate each identified risk, such as enhanced supervision for those who were at risk of absconding. There was a section in care files for risks associated with care including pressure sore development risk, moving and handling and falls risk and nutritional risks. Each assessment generated a score which identified the level of risk which had been updated monthly. All records we viewed were up to date. Risk assessments for equipment and safe working practices were in place and had been reviewed in 2017 to keep the information current. The fire risk assessment had last been reviewed in September 2016 and areas identified for action had been addressed.

Equipment in use was serviced at the required intervals and checks were carried out, for example daily checks of the pressure relieving mattresses to confirm they were set and working correctly. We saw that there had been significant swings in some people's weight records between two months and this was due to a set of scales not weighing accurately, so they had been repaired and people then reweighed to get an

accurate reading. Call bells were available and the majority of people and relatives confirmed call bells were answered in a timely way. The registered manager said she monitored the call bells and would check if a bell was ringing for an extended time. Although the majority of call bells were answered promptly, we heard some bells ringing for about 10 minutes before staff went to people to address their needs. We also received mixed feedback that sometimes there were delays in answering call bells because staff were busy with other people and two people stated delays had been significant and caused them discomfort. The registered manager said she checked the print-outs for call bell monitoring if concerns about delays in answering call bells were received and spoke with staff regarding any delays identified. The registered manager said she would remind staff about answering call bells in a timely way.

We found that recruitment procedures were in place and being followed to ensure only suitable staff were employed at the service. Application forms with work histories had been completed and any gaps in employment had been explored and the reasons recorded. Two references including the applicants last employer had been taken up and disclosure and barring service checks had been carried out. Proof of identity including a photograph was available and people's right to work in the UK had been ascertained. Health questionnaires had also been completed to show that he applicants were physically and mentally fit to work with people using the service.

The majority of people and staff we spoke with felt there were enough staff scheduled to work on the various shifts and acknowledged that the service was quick to organise agency staff to cover short notice sickness. Staff told us that if the agency staff were 'regulars' they got to know the people's routines, however they felt it sometimes slowed down the processes and a permanent staff work team was the ideal, which the service did strive to achieve.

The registered manager said that when looking at the ratio of staff to people using the service they took into account people's dependencies and individual care needs, as these could vary widely. We saw this in practice, when the provider/manager reviewed the staffing levels on one unit due to the needs of someone who had been admitted to the service just before our inspection. On the first two days of inspection the rehabilitation assistant for people with physical disabilities was on leave and we noted that the activities coordinators assisted and encouraged people from these units to attend various activities. On the third day of inspection we met with the rehabilitation assistant and they were focussed on the needs of younger people with physical disabilities and the activities provision was increased on these units. With the increase in the number of younger people at the service there had come higher demand for a wider range of activities and outings to meet individual needs. We spoke with the registered manager about reviewing the number of activities coordinators the service had to meet this increase in demand, which they acknowledged and said they would discuss with the provider.

The home was clean and smelled fresh throughout. One person told us, "The place is fine, lovely and clean and well kept." The service had recently been refurbished to a good standard. We saw domestic staff using colour coded cleaning equipment and one domestic assistant was able to clearly explain recommended guidance for this. Bathrooms were suitable to the needs of people using the service and toilets were well equipped with hand washing liquids and paper towels. Personal protective equipment such as gloves and aprons was available and in use when required, such as when delivering personal care.

We viewed the kitchen and it was well equipped, clean, uncluttered and well organised. Fridge and freezer temperature checks were carried out every day and the kitchen cleaning tasks and daily checks had been completed and all records were up to date. The laundry facilities were clean and the washing machines had appropriate settings including for washing soiled items so items were cleaned thoroughly.

Good

Is the service effective?

Our findings

People were cared for and supported by staff who had regular training so their skills and competencies were kept up to date. The majority of staff considered that the amount of training provided was adequate and were able to give examples of recent training such as fire safety, health and safety and safeguarding. Where specialist needs were identified staff had attended for training, for example, two nurses had attended training specific to a person's complex needs prior to them being admitted to the service.

Whilst most staff were happy with the training they received, some said they had not received dedicated training in first aid. The Health and Safety training listed that the training included 'first aid' and 'response in an emergency'. The learning and development lead said they would review this so that staff were clear about the training and also to see if additional training in this area was needed. The learning and development lead was based at the service and was responsible for identifying training needs and arranging for training to be given.

Staff confirmed they received one to one supervision sessions and a supervision record was maintained for all supervisions carried out, which was done every two to three months. New care staff undertook the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care service. The training matrix also evidenced staff who were in the process or had completed recognised training qualifications in health and social care. The learning and development lead said the programme of training was ongoing and blended online and face to face training to keep staffs' knowledge and skills up to date.

Some staff did not have a good command of spoken English and found it difficult to understand some of the questions we asked. Some senior staff commented that this was a problem at times and we also received comments from people and relatives regarding instances of poor spoken English. The registered manager and the training and development lead took on board our comments and said they had an English tutor who had previously provided English classes for staff. They said they would arrange further English classes for staff identified as needing help in this area. The home provided a service to a multicultural group of people and we observed several staff who communicated effectively with people using the service and with relatives in their first language, which was a benefit for those whose first language was not English.

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 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 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.

Staff had received training in mental capacity and some were able to explain the key principles of the MCA. Staff were aware of people's rights to make choices about the care and support they received. Mental capacity assessment forms were seen in the people's care plans and had been completed correctly and were signed and dated. The registered manager had a file for the DoLS documentation for people on each unit and the index identified those who had DoLS authorisations in place and also the stages DoLS applications and assessments were at for others. The lists were also seen in the nursing offices on each unit so staff were aware of who had a DoLS authorisation in place and this was on the electronic care records also. The registered manager said that at the time of inspection none of the DoLS authorisations had conditions in place and we sampled the records and saw this was the case in those viewed.

Where there was a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place this was shown clearly in red on the cover page of the electronic care recording system. Some DNACPR forms had been scanned into the care records and there was a file on each unit containing the original documents so they were easily available for staff and healthcare professionals to view if necessary. These were appropriately completed by the GP following discussion and agreement with the person or their legal representative and senior staff.

We received mixed feedback regarding people's involvement with their care plans. Whilst some people and relatives had seen them and been involved in regular discussions regarding the care, others could not remember or said they had not seen their care plans. Consent to the care records were not seen and the registered manager said the written consent forms had been archived. They told us the management team were aware of the need to evidence consent on the electronic system and intended to scan in the documents and also use the system to evidence consents electronically.

Care plans were in place to address people's nutrition and detailed specific needs such as swallowing difficulties, consistency of food required and any aids in use such as adapted cutlery. People were weighed monthly and the nutritional risk assessment was updated with automatic alerts to the system if there was significant weight loss. When the scales had been reading inaccurately staff had still added the weights to the records, so there had been several alerts for weight loss when people had not actually lost weight. The clinical manager said this had been addressed and checks done to ensure people's weight records were now accurate. Drinks were available throughout the day and night and fluid and food intake was recorded in real time and was easy to monitor if any concerns were identified.

We had mixed feedback about the food. One person said, "Same food every week, it's boring, I can't stand stews or casseroles. I want a different choice." Another said, "Reasonable, could be cooked better." A relative told us, "Food is always appropriate for my [relative]. My [relative] really likes the food here and eats like a horse." Several younger people commented on their dislike of stews and casseroles, whilst older people seemed to enjoy these in the main. There was an alternative menu with burgers, pizza, bhajis or fishcake, served with chips. People were offered choices of food at breakfast, lunch and supper. Vegetarian options were available and we saw evidence of some special requests on menu forms, such as salads or sandwiches rather than a cooked meal, and halal meals to meet cultural needs. People selected their choices of menu the preceding day and this was recorded and sent to the kitchen. Any special dietary needs, such as pureed food were recorded on the forms for kitchen staff. There was a list of people's birthdays in the kitchen and the chef said that cakes were prepared for these occasions.

The chef said he visited units twice a day to get feedback from people and staff on the food served. In addition there were 'Mealtime Experience' questionnaires which were available for people to complete, although we only saw four completed ones in the kitchen for the month of August 2017. The chef also attended the 'residents and relatives' meetings to get feedback on the food and discuss ideas or suggestions

for menus. We discussed the feedback we received with the registered manager as although options were available people did not always seem to be aware of these. The registered manager took our comments on board and said they would discuss them with the catering staff to see what improvements could be made to communicate the varied options available to people and better meet individual preferences.

People were referred for input from healthcare professionals and any changes were recorded and implemented. One health care professional told us, "People are referred appropriately and they are excellent at following through instructions." Visits from health care professionals were recorded in a professional visits log in each care record. These had been completed consistently and there was good evidence of visits from GPs, opticians, chiropodists, the tissue viability nurse, physiotherapist, dietician and other professionals. People attended hospital appointments and where required staff escorts were arranged. One relative told us, "[Relative] is always accompanied to appointments and treated with compassion." Another said, "If the Dr is needed it is done promptly. If [relative] has a UTI they ring me up to tell me." During the daily flash meetings held with the senior staff and management team, healthcare input was discussed and staff present at the meetings demonstrated that they were knowledgeable about people's individual healthcare needs.

On the first day of our inspection, some of the dining rooms seemed very crowded with furniture which had very recently been delivered. Any tables and chairs that were surplus to requirements had been removed by the second day of inspection and there was more room for staff to manoeuvre people's wheelchairs and seat people comfortably and appropriately at the tables. All rooms had en-suite facilities with toilet and washbasin and some also had showers. Bath and shower facilities were available on each unit. We were told there had been issues with shower rooms being out of order and they had now been refurbished. During the inspection one of the showers was out of order and this was addressed by the maintenance staff.

Although the service had just been redecorated and refurbished, there was a lack of signage for communal areas such as dining rooms and lounges. There were long corridors within the units and signage could help people to find the communal areas. The quality director said that the design had been done by dementia specialists and that they had used a colour scheme identified as appropriate for people living with dementia. By the second day of inspection notices to identify the different units had been put back up and we acknowledged that the redecoration had very recently finished. There were accurate clocks in the lounges and dining rooms to help people keep orientated in time and the pictures on the walls of each unit prompted reminiscence, for example the royal family, places of interest and actors from yesteryear.

Good

Is the service caring?

Our findings

People and relatives were happy with the care provided by the staff and felt the staff were caring. Comments included, "Staff listen to me. Most of the staff are very nice and understanding", "Good living here, staff are good, quick to answer call bell, Halal food is ok", "Staff are kind and caring", "Anything I ask for, it is done. They have been wonderful with everything" and "It's quite pleasant here. Service is good, the whole place is lovely. The staff are nice." People confirmed they had been assessed to identify their needs before coming to the service. One person said, "Before I came here someone came round to see me from here for a chat" and a relative confirmed their family member had been assessed by one of the deputy managers before coming to the service, so their needs had been identified.

We asked staff their thoughts about caring for people and comments included, "I think of my parents when I care", "It's all about what they [people] want. I question myself with everything I do, would I be happy for a relative of mine to have this care?" and "Safety, privacy, diligence, dignity and to give the person choices." Staff confirmed they would be happy to have a loved one cared for at the service. Staff were attentive and caring to people and spoke appropriately and gently with people, providing care and support without rushing them. Staff were familiar with people's needs and progress and were able to explain the support individuals required.

On one unit we observed two staff being very caring and they had a good bond with the people they were looking after. They understood what people with communication difficulties were saying and were able to help us to speak with them. During our observations of the lunchtime experience on one of the dementia care units we saw that staff offered two small plates of food to people and also explained what the choices were, and people were able to choose at the time of the meal. Staff explained that due to their diagnosis, choosing their meals the previous day was not appropriate for the people on the unit, as they were unlikely to remember.

Staff were available to assist people and did so in a gentle manner, being attentive and offering drinks and food alternatives when people did not want their first choice. On another unit someone did not like the meal they had and they were offered another option. We saw a lady sitting in one of the lounges looking out of the window and having her breakfast. She was happy and told us she could get up when she wanted to and that 'the service is wonderful here." Staff were gentle and reassuring when people were distressed and this had a positive and calming effect. People were dressed to reflect individuality and looked well cared for. Many of the bedrooms were individualised and homely and people were encouraged to bring in personal items.

There were staff who were able to translate for us with people who did not speak English. The service had several staff who spoke other languages, which helped people for whom English was not their first language to have their wishes understood. One member of staff said, "We all work together" and told us if someone whose first language was trying to communicate they would go and get a member of staff who spoke their language so they could translate. Staff were happy to translate and understood the importance of effective communication, and we observed this on occasions during the inspection.

People's preferences and routines were documented in care plans, such as daily sleeping and waking routines and personal care preferences. One relative told us, "[Relative] does have a choice when she goes to bed. Often she will go early because she is tired. [Relative] doesn't mind if she has male or female carers - she prefers some more than others." Another said, "Staff are knowledgeable and always ask permission before giving [relative] care." Staff said they were aware of people's individual needs and wishes and we observed that people received personalised care and support. There were people whose conditions had improved significantly since being admitted to the service and they expressed their wish to move and live more independently. The management team were very aware of this and were in regular contact with the social care professionals responsible for assisting people to move on.

We observed that people's privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care. One person said of the care, "The best of care, they are very good here." Relatives expressed satisfaction with the way their family member was cared for. Comments included, "It's very good, not perfect but very good", "Staff are excellent. My [relative] couldn't have been treated better", "The staff are fantastic, they all do what they can for [relative]" and "Staff treat me with so much respect and are lovely to me." One person told us, "Very nice here, I feel safe, food is good, I don't have much activity, most of the time I don't want to do them. My room is comfortable. I don't need to ring the call bell. Staff are very fair."

Requires Improvement

Is the service responsive?

Our findings

The service had introduced an electronic system of care records. Each person had an individual electronic file. The system was comprehensive and could be navigated to provide details on all assessments, care plans, risk assessments and up to the minute records of care delivery and monitoring such as food /fluid intake, regular observations and activities as well as personal profiles, records of access to health care professionals and reviews. The front cover page of each person's file contained a photo and key details such as a brief summary of main care needs and risks, medical history overview, any particular issues to be aware of and contact details for GPs, family members and other professionals. Documents such Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and correspondence could be scanned into the system for easy reference.

Each care plan outlined the care needs, outcome or objective and care actions required. However many lacked sufficient individual detail and were generic, for example, 'encourage to eat a good diet' or 'needs to take more than four different types of medication.' Therefore the care plans did not reflect people's specific nutritional needs or personalised information regarding the medicines they were taking. We also saw that information recorded in one area of the system was not always reflected in other relevant records. For example, the DNAR status was not always reflected in the care plan for end of life wishes.

Wounds had been recorded and there were dates with information about the wound and the initial input from the tissue viability nurse specialist (TVN). However, we found information was not always up to date as entries had been repeated month on month, rather than recording the progress. For example, one person had been treated with an antibiotic and this information was repeated on each entry, even though the course of antibiotics had been completed. When we queried this we were told that this information was historical, so the record did not accurately reflect the current treatment. Dressing change records were not always in line with the frequency stated in the care plan. When this was queried we were shown additional records for one person's dressing changes that had been recorded on the hand held devices or from the handover session and these were more frequently recorded but had not fed into the main wound care records so had not been possible to audit. The registered manager identified the necessary steps to be taken by staff to transfer entries into the daily records. Dressings and wound care were discussed by the nursing and management staff at the daily flash meetings and they were aware of the dressing regimes and progress of each wound but the documenting needed to be improved.

Personal care records did not always reflect that the wishes of the individual had been carried out. Care plans recorded people's preferences with regard to if/how often they liked a shower, bath or wash. We checked daily records and charts of personal care against preferences in the care plans. We saw that people who had documented preferences for a shower every day or every alternate day had not always had these fulfilled, for example, one person had not had a shower for a month. When questioned staff said that some showers had been out of order for a period of time and offers of showers on other units had been declined. This had not been reflected in the care records and also needed to be clearly explained to people so they understood what their choices were in such an eventuality.

Care staff were positive about the record system, which they felt was time saving and efficient. All said they had received training and were becoming more adept as using the hand held devices. However, few said they accessed care plans to understand people's needs or routines and tended to rely on information from nursing or other staff, or just 'picked up' what to do for each person by getting to know them. This meant that they were potentially at risk of missing important information about people's needs and well-being.

Care plans and risk assessments were reviewed monthly, using a 'Resident of the Day' system. All care records viewed had been reviewed within the last month, although there was little commentary to support reviews which tended to simply record the date of review and the date of the next review rather than document any changes or progress. There was no documented evidence of people or, where appropriate, their representatives, having had any input or involvement into the development or review of the care plans or being invited to do so.

We received mixed feedback regarding involvement of people and representatives with the care plans, with some having been consulted and involved and others who had not seen the care plan. The clinical manager had carried out audits of care records and had completed action plans where improvements were needed and given timescales for these to be addressed, however the timescales had not always been met. When we discussed the issues we found about care planning with the management team, they were clear that work was needed on the care records to make them person-centred and reflect accurately the progress of the care and treatment being provided.

The paragraphs above are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were care plans for each aspect of care that a person received such as communication, personal care, daily life, mobility, mental capacity, end of life wishes, medical care/medication, skin integrity and nutrition. The system provided automatic alerts on the front of each person's file to show any change in risk that needed to be addressed, such as significant weight loss or change in risk scores, as well as flagging dates for the next review. There were body maps to indicate wounds and these had been recorded in all the records we checked. The staff entries on the hand held devices meant they could update the records in real time, for example, food and fluid intake and care given. Observation rounds were recorded and each person had a bar code by their door or in their room so when staff carried out a check they could scan this with the hand held device and this was recorded.

There were three activities coordinators who worked across all the units, plus a rehabilitation assistant who worked with people on the young physically disabled (YPD) units. There were weekly activities programmes, one for the YPD units and one for the rest of the service, which all were welcome to join in with. The rehabilitation assistant told us, "I put myself in their situation. Motivating people is paramount." They provided activities to assist with building physical strength such as upper body exercises and equipment was available for this.

There was a games room, plus activities for people to enjoy, for example, the gardening club. The activities coordinators were trying to arrange more outings to match with people's interests. They were also aware of people's individual needs and worked to meet these, for example, taking someone out each day to get fresh air and enjoy one to one time in the garden. One person said, "I enjoy the karaoke, quiz and going out. I go out on my own to the shops. And play pool on the table here." A relative said about activities, "They always ask but [relative] is not interested. They do keep asking though and do not just assume it's no." We saw staff playing 'catch' with soft balls and balloons with people on two units and people responded well and joined in. We also heard care staff chatting with people about various topics and there was a good atmosphere.

Some people felt there were few opportunities to leave the home to go on individual outings, for example to the shops or the park, as there were not enough care or activities staff to accompany them. Staff felt there was not enough time to conduct one to one sessions for all the people who were unable or unwilling to leave their rooms or who did not wish to engage in group activities. We discussed these points with the activities coordinators and they explained they did as much one to one activity as they had time for. They also said they could take people out locally and did this when they could, however they needed to book community transport for larger outings and this was very oversubscribed, especially in the holiday times, so there had not been a group outing in recent months. We spoke with the registered manager with regards to the hours available for activities coordination and transport facilities and she said she would discuss this with the provider to see what could be done to improve the provision.

The service had a well-equipped multi-sensory room and we saw this being used on the second day of inspection for hand massages and relaxation. The massage therapist attended three times a week and people enjoyed this and it helped them to relax. The service had a cafeteria area on the first floor and people were encouraged to attend to meet others and join in the activities that took place here. We saw people taking part in a game of bingo on the first day and then there was a music activity on the second day. One person who had previously been restless was calm and enjoying the music. People were encouraged to dance to the music and the musician interacted individually with everyone who attended, with some singing along, others moving their hands to the music and all were engaged and enjoying themselves. One relative said, "[Relative] loves the music and is so happy dancing."

An arts and crafts session took place during the inspection and an activities coordinator who was working with two people was gentle and enthusiastic. They told us, 'We see what people can still do' and encouraged participation. The hairdressing room was next to the cafeteria. The hairdresser said that staff were kind and helpful and ensured people attended for their appointments.

The service had a 'magic table' game, which was a series of interactive light games specifically designed for people with mid to late stage dementia. On the first day of inspection we saw people were engaged with the activity and played a flower game, touching them to make them bigger and smaller. The activity then changed to a ball game people could touch and make move on the table and we saw more people engage and interact with this game. In the lounges there were 'rummage baskets' containing a variety of items with different textures and types, which staff gave to people and prompted conversation. The baskets had been provided as part of the refurbishment of the service in line with dementia research to stimulate thought and discussion. The service had a well maintained garden with appropriate furniture for people to sit out in the garden if they so wished.

The registered manager told us of the religious input the service received, with visits and services carried out by representatives from various religious denominations including Roman Catholic, Methodist, Pentecostal and Muslim. There was a monthly Church of England service and visits to the Temple for people who were Sikh. This meant that the service recognised and took action to meet the religious and cultural needs of people living at the service.

The service had a complaints procedure and this was displayed in the reception and there were also individual copies next to the signing in book that people could take away with them. People and relatives said they would raise any issues. Comments included, "If I think something could be improved I'll say and they do it", "I have not got any problems here. If I have, I air them straight away" and "I know how to make a complaint. There is information by the signing in book." We viewed the complaints file and saw complaints had been recorded and responded to and action taken to address the concerns raised.

Requires Improvement

Is the service well-led?

Our findings

The provider had a series of audits carried out both internally and also by external auditors. We saw an external audit carried out in July 2017 and there had been some issues highlighted with medicines management and with the food provision at the service, with recommendations made for improvements. However, during our inspection, more than a month later, we also identified some issues with medicines management that the provider's systems had not picked up. When we gave feedback about our findings and concerns, the management team took action promptly following our inspection to draw up an action plan to address the shortfalls identified with medicines management.

In regards to our findings that care records were not written in a person centred way, the management team were aware of the improvements needed with the care records and had set timescales for improvements which had not been met. Following the inspection the registered manager said this would be addressed with the involvement from the managers and the deputy managers within a two month timescale.

The paragraphs above are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out other types of audits to check other aspects of the service. Weekly kitchen audits were carried out and the service had last been awarded a Food Standards Agency 'level 4 good' score by the local authority environmental health department. Maintenance checks were carried out in-house for systems and equipment including fire safety and equipment, water temperatures, window restrictors, bedrails and call bells to ensure they were safe and equipment was maintained in good working order.

Staff confirmed they felt supported by the management. They said that managers were visible and approachable. They considered that there was an open and transparent system of management at the service and several deputy managers so that there was always a senior member of staff available if needed. One told us, "It's a great place and they [management] stick to their word", "I'm quite happy, I feel very comfortable here. I can ask anything. The clinical manager and deputy managers are very supportive, always, and any problems I can ask. Every morning the manager comes around and is very supportive." A relative told us, "Management are all really good and if I ask for anything there is always a positive outcome. It's faultless, I'd score it ten out of ten." Another said, "I am not 100% sure who the manager is. I have seen the director around. I talk to the nurses - they are lovely. I have never needed to speak to the manager. I have been invited to relatives meetings." A healthcare professional said, "It's a great team. They are incredibly supportive of each other. They see me as part of the team."

The registered manager visited each unit every morning to get an update and check on any issues. The management team had a good knowledge of the people using the service and their needs and strived to ensure these were being met. There was a member of the management team on duty over the weekends so people, visitors and staff always had access to them if they needed to discuss any matters. Any issues that we identified as part of our inspection were discussed with the quality director and the registered manager and they responded promptly to take appropriate action to address them.

There were daily 'flash meetings' held at 11am and we attended these on two days of inspection. The nurse/team leader from each unit attended along with the management team. Each unit was discussed and this covered staffing, appointments, resident of the day, planned visits from health or social care professionals and advocates, safeguarding, wound care, complaints, antibiotic therapy, maintenance, hospital admissions and admissions to the service. The meetings were informative and evidenced good communication between the senior staff, who were able to action any issues that were highlighted at the meetings. Staff attending demonstrated a good knowledge of the people living at the service and what their care needs were. The registered manager said the flash meetings also took place at night and a night time audit report evidenced this also. There were daily handover meetings on each unit and weekly senior management meetings. There were general staff meetings held also and staff had annual appraisals. Relatives meetings were held to keep people informed of what was happening at the service and encourage them to share any points they wanted to raise so they could be addressed.

The service had recently appointed a deputy manager with responsibility for the young physically disabled (YPD) unit and they were working on determining the focus of the unit, looking at rehabilitation alongside maintaining people's abilities. The service had worked with people on their rehabilitation and it was clear that for several people the service was no longer an appropriate place for them to live, as they were capable of living more independently. The provider was liaising with the local authority in this regard.

The provider carried out annual satisfaction surveys and these had been completed in February 2017 and the outcomes were good. The service displayed 'what you said, what we did' information to tell people the action taken to address points raised. There had been some concerns regarding laundry and action had been taken to provide individual bags for use when washing laundry along with clear marking of all items. The service had received 13 reviews on the carehome.co.uk public website and scored an overall 8.8 out of a maximum 10 points. 11 out of the 13 reviewers were likely or extremely likely to recommend the service to others. Staff we asked said they would recommend the service to people needing care and some had done so.

The service had worked in partnership with Pan London Clinical Commissioning Group and West London University on the I-Hydrate project and the registered manager said this had enhanced the staff knowledge and skills regarding hydration. Notifications were sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required to monitor the service. Policies and procedures were in place and included reference to current legislation and good practice guidance. They were updated when any changes were required and the index reflected when each document had last been updated.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always design care and treatment with a view to achieving service user's preferences and wishes and to make sure people's needs were met. Regulation 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was always provided in a safe way because their arrangements to manage medicines safely were not always effective. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems to monitor the quality of the service and to ensure that any findings following audits were addressed promptly to provide people with safer care and treatment. Regulation 17(1)(2)(a)