Fraser Residential Limited

St Heliers Hotel

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

This inspection took place on 31 March and 1 April 2016 and was unannounced.

St Heliers Hotel is a care home providing care and support for up to 30 older people. There were 19 people living at the service at the time of our inspection. People cared for were all older people; some of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs, including diabetes. Some people needed support with all of their personal care, and some with eating, drinking and their mobility needs. Other people were more independent and needed less support from staff.

St Heliers Hotel is a large proportioned terrace house. Accommodation is provided over four floors, with passenger lifts allowing stair free access. There are communal sitting and dining rooms together with a sun lounge and bar. Large enclosed gardens are accessed at the rear of the property.

The service had two registered managers in post. The provider had taken this step so there was a manager present at the service every day. A registered manager is a person who is 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.

St Heliers Hotel was last inspected on 11 September 2014, when concerns were identified about the management of medicines and some aspects of staff recruitment processes. The provider sent us an action plan telling us how they had addressed these shortfalls.

At this inspection we found required improvement had been made in some areas. However, we identified other shortfalls where some regulations were not being met.

Risk assessments were not in place for a person who had initially come to the service for short term care, this placed them at risk of injury and unsafe care because steps were not taken to identify or reduce any risks.

Management of water within the service was not safe; hot water from some taps exceeded maximum permitted temperatures, hot surfaces such as radiators were unguarded with no risk assessments in place and suitable measures were not in place to safeguard against the risks of Legionella.

An oxygen cylinder was not stored in line with requirements, representing a fire and safety hazard.

Recruitment checks were incomplete because some mandatory checks had not taken place to ensure all staff employed were suitable to work at the service.

Elements of some care plans were not tailored to individual preferences and clear links were not always made between some conditions and other associated care needs. This did not provide staff with the best and earliest opportunity to be responsive to changes in people's needs.

Auditing carried out for the purpose of identifying shortfalls in the quality and safety of the service provided had not been wholly effective.

Medicines were safely stored and administered; the service was clean and appropriate fire safety checks had taken place.

People were supported by enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Staff were caring and responsive to people's needs and interactions between staff and people were warm, friendly and respectful.

Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and applied these principles correctly.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately addressed.

People commented positively about the openness of the management structure and were complimentary of the staff.

We found a number of 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 always safe.

Risk assessments were not always in place when needed.

Hot water and hot surfaces were not adequately monitored; effective measures were not taken to ensure they did not present a risk of scalding and burns; water management processes were not in place to safeguard against the risks of Legionella and an oxygen cylinder was not safely stored.

Recruitment processes did not ensure mandatory checks were completed for all staff.

Medicines were managed safely and the service was clean and hygienic throughout.

Is the service effective?

Good

The service was effective.

The service was meeting the requirement of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Staff received appropriate instruction and training when they first started work; on-going training ensured staff had the skills and knowledge to support the people they cared for.

Staff were provided with opportunities to meet the managers and provider to discuss their work performance, training and development.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

Is the service caring?

Good

The service was caring.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Individual support preferences had not always been established and some information was not detailed enough to guide staff how to support people consistently.

Care planning did not always establish links between some conditions and other associated care needs.

A complaints procedure was in place, people and visitors told us they had not needed to complain.

People enjoyed a range of activities and were supported to stay in touch with friends and family.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and quality assessments were not wholly effective in identifying shortfalls within the service.

Staff felt supported. They were aware of the service's values and behaviours and these were followed through into their practice.

People, their relatives and staff thought the service was well run and spoke positively about the leadership of the registered managers and provider.

There was an open and transparent culture; people and staff felt encouraged to speak up with suggestions and concerns.

St Heliers Hotel

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 in response to concerns raised with us, and 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.

We undertook an unannounced inspection of this service on 31 March and 1 April 2016. The inspection was undertaken by one inspector.

We focused on speaking with people who lived in the service, speaking with staff and observing how people were cared for and interacted with staff; including the lunchtime meal, administration of some medicines and the activities taking place. We looked in detail at care plans and examined records which related to the running of the service. We looked at six care plans and four staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the service was managed such as audits, policies and risk assessments. We also pathway tracked some people; this is when we look at care documentation in depth and obtain people's views on their day to day lives at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the service including some bedrooms, bathrooms, the lounge and dining areas as well as the kitchen and laundry area. During our inspection we met and spoke with nine people who live at the service, five visitors, a visiting health care professional, three care staff, the chef, both of the registered managers as well as the service provider.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and were happy living at the service. Comments included, "I find it very pleasant here", "I feel well looked after" and "I haven't any criticism, I am very happy to be here". A visitor we spoke with felt they were kept up to date with the care and support their relative received and told us, "I have every confidence in the home, the staff, the safety of my relative and the care provided".

Our last inspection on 11 September 2014 identified some shortfalls concerning the safe management of medicines and aspects of staff recruitment processes. In October 2014, the provider sent us an action plan explaining how these shortfalls had been met. During this inspection, we found our previous concerns had been addressed; however, we identified other areas of concern which meant that the service was not safe.

People were at risk of unsafe care and treatment because risk assessments were not always in place. For example, although basic admission assessments took place for people coming to stay at the service for respite (short term) care, they were not expanded upon to include a full needs assessment or assessment of risks. This meant staff were not aware of support requirements a person may need in relation to their mobility, moving and handling or falls prevention. Additionally, where a person self-administered medicine a risk assessment was not in place ensure they were able to do this safely. Records showed one person, initially admitted to the service for respite care, had stayed at the service in excess of two months. A full needs assessment had not been completed in this time and consequently no risk assessments were in place. This placed the person at risk of receiving care and treatment that was not safe and at risk of injury because no steps had been taken to identify, assess or mitigate any risks. For example, in relation to the person's mobility because of a condition affecting their legs.

Some people may need help and assistance to leave the service in the event of an emergency evacuation. Individual plans should establish people's needs and staff should be aware of these support needs. Discussion with the registered managers found they had identified the need to complete personal emergency evacuation plans for people, however, although planned, none were in place. Staff may not be aware of the support people needed in the event of an emergency or people's understanding of what they were supposed to do, this placed people at risk of inconsistent and unsafe support.

Providers are required to ensure the premises and any equipment used there are safe. Thermostatic water mixer valves, intended to deliver water at a safe temperature, were fitted throughout the service. Although water temperature checks took place, these were limited checks to ensure mixed hot and cold water was at the right temperature when supporting people to wash and bathe. The service did not measure individual hot water outlet temperatures to ensure they did not present a risk of scalding. Our check found the hot water from a wash hand basin tap exceeded the maximum permitted safe temperature set out in the service's policy. This presented a risk of scalding to people and staff.

The service's hot water and surfaces policy establishes that radiators and any exposed hot water pipes should be guarded to prevent the risks of burning; or risk assessments should be in place setting out why the unguarded hot surfaces do not present a risk to people. Most radiators, including those in people's

bedrooms, were unguarded and no risk assessments were in place. This presented a risk of significant burns should a person be in contact with a hot surface for too long, for example, if they were unresponsive or lacked the mobility or cognitive capacity to move away from hot surfaces.

Proper arrangements were not in place to safeguard against the risks of Legionella, a waterborne bacterium. We found that a Legionella survey had not been completed and no preventative measures or practices were in place. This meant that people were not protected against the risks associated with Legionella because no detection or control measures were in place.

An emergency use medical oxygen cylinder stored in a bedroom was not secured to prevent it being accidently knocked over or removed and statutory British Standard signage, to alert the emergency fire service to the storage of oxygen, was not displayed. This presented a safety and a fire risk.

The provider had failed to assess the risks to the health and safety of service users or do all that was reasonably possible to mitigate risks. Risk assessments and evacuation plans were not in place where needed. The provider had not ensured the service was safe; water temperatures were not safely regulated; arrangements were not in place to safeguard against the risks of Legionella; hot surfaces were not protected where needed and oxygen was not safely stored. This was a breach of Regulation 12 (1)(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as far as practicably possible by a safe recruitment system. Disclosure and Barring Service (DBS) checks had not been undertaken for two people working at the service. DBS checks are required for unsupervised volunteers and staff aged 16 and above who have direct access to, or work directly with adults at risk. This is to establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Staff should not work unsupervised before DBS check results are known.

Processes were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable procedures were in place for the ordering, receipt, storage, administration, recording and disposal of medicines. Medicines held by the service were securely stored and people were supported to take the medicines they had been prescribed. We looked at people's Medicine Administration Records (MAR) and found that all medicines had been signed to indicate that they had been given. Staff who administered medicines to people had attended appropriate training and were regularly assessed as being competent to manage medicines. People we spoke with told us they received their medicine when they were supposed to.

There were sufficient staff to meet people's needs. Staffing numbers were established based upon people's needs and risk assessments. Two registered managers provided support and oversight for the service seven days a week as well as 'hands on' assisting with some delivery of care and support. Care staffing comprised of three carers per day shift, always including a senior carer. Two waking staff provided night support. Other staff undertook other duties such as housekeeping and maintenance duties. A chef provided meals supported by kitchen and servery assistants. Agency staff were not used as any shortfalls were met through use of existing staff. This helped to ensure consistency of care.

Any concerns about people's safety or wellbeing were taken seriously. Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them what to do. The service were familiar with locally agreed safeguarding

protocols. Staff said in the first instance they would alert any concerns they might have to the registered managers, but understood about and could name the relevant agencies that could be contacted if their concerns were not acted upon.

Incidents and accidents were reviewed and audited by the registered mangers, with a running monthly analysis displayed for staff. The service looked for any patterns or trends to inform learning and care plan reviews. For example, following falls some people were referred to falls clinics and provided with personal alarms and if appropriate floor pressure mats, door alarms and bed sensors. This helped to alert staff if people were mobilising and helped to keep people safe by minimising the risks of injury and of incidents happening again.

Records showed equipment was checked regularly to help keep people safe. Checks included the electrical installation, gas safety, portable electrical appliances, fire alarm and fire fighting equipment. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Service contracts ensured equipment to support people with their mobility such as the service's lifts were safe and fit for purpose.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "The staff are very good, they certainly look after me", "Staff are hardworking and efficient" and "All of the staff are very capable and pleasant". People and their relatives said that staff communicated well with them. A visitor commented, "Staff are always welcoming, and are good at keeping me updated about how my relative is". Other visitor's comments included, "I feel confident and reassured by the staff" and "I can come any time of the day and night, I am always welcome, it makes me feel there is nothing to hide". We spoke with a visiting health care professional. They felt communication was good at the service; told us staff took on board their comments and instructions and were proactive in ensuring people received the care and support they needed.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS), which form part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for seven people who lacked capacity to consent to receive care and treatment at the service. Receipt of the applications had been acknowledged and the service maintained regular contact with the local authorities pending their decision making processes.

Staff understood the basis of the MCA and how to support people who did not have the capacity to make a specific decision. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Staff gained people's consent to give them care and support and carried this out in line with their wishes. People were involved in their day to day choices about the food they ate, the clothes they wore and the activities they preferred. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service had been used.

Induction training for new staff had previously been based on common induction standards for staff working with older people. Common induction standards were competency based and in line with the recognised government training standards (Skills for Care). The registered manager had enrolled all staff, new and existing, to undertake the new training for the Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life. Other training for new staff included some class room based sessions, shadowing experienced staff, written assessment workbooks and observational

assessments of competency. This helped to ensure staff had understood what they had been taught and could apply their training in practice. Staff said that induction could be extended or they could be asked to repeat units if necessary. This helped to ensure staff had the right basic level of knowledge and skills to support people effectively and safely. Discussion with staff confirmed they understood their roles and responsibilities.

Staff were positive about the training received. Training certificates were displayed in the service; they confirmed training undertaken and were displayed to celebrate learning and achievement and also to inspire confidence in people about the staff who supported them. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Training was obtained from external sources as well as in-house so as to gain the maximum benefit from training available. Staff training included other courses relevant to the needs of people supported by the service such as dementia awareness. Care staff were encouraged to carry out formal training in health and social care, such as vocational qualification training or diplomas to levels 2 or 3. These are work based awards that are achieved through assessment and training, and show staff have the ability to carry out their job to the required standard. Most care staff had undertaken this. A visiting health care professional told us they did not have any concerns about the training of staff.

Supervision of staff had lapsed for parts of 2015, however, records showed and staff confirmed the service had since addressed this issue; a current schedule was in place and supervision took place when planned. Staff supervision was a one to one meeting with the registered managers or service provider. Staff told us supervisions now took place every six to eight weeks, but said they also had informal discussions to keep up to date with any changes. Supervisions included discussions about best practice and setting of personal objectives and development plans. Staff said they welcomed the opportunity to think about their development and received support to achieve their goals. The supervision and appraisal process enabled the registered managers to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This helped to ensure clear communication and expectations between managers and staff. Supervision processes linked to disciplinary procedures where needed to address any areas of poor practice, performance or attendance.

Staff told us they felt valued and proud of where they worked. They described the service as clean, friendly and a homely place for people to live. All staff said they would recommend the service to others, one commented "I would be happy for any of my family to live here". Staff told us people's choices were respected, the service was not institutionalised and that if someone did not want something at one point, like personal care or food, then it was "Important to give them time and to come back later to see if that was still their decision". We observed some of a staff handover during the change of shift. This was structured and informative, giving a summary of people in terms of their wellbeing and any needs as yet unmet.

People's care records showed evidence of regular health appointments and contacts with health professionals, for example, the mental health team, community, diabetic and warfarin nurses, dentist, chiropodist, dietician and speech and language therapist. Health and social care professionals were contacted to give treatment as needed. Staff were familiar with advice about how to support people and advice received was effectively put into practice. Where people's behaviour had changed or become challenging, comprehensive efforts were made to understand why and provide any support. People's weight was recorded when they moved to the service and then again monthly. Any significant weight gains or losses were reported to the registered managers and GP referrals made. This helped to ensure people's overall health and wellbeing was maintained.

People received a wide variety of homemade meals, fresh fruit and vegetables were available every day.

Home baked cakes, biscuits and desserts were frequently made, they were popular and people told us they appreciated the efforts of the chef and kitchen staff. People were provided with menu choices and said the food was very good. Some comments included, "The food is great, plenty to choose from and I always find something I like", and "The food is first class, it's well cooked and well made." A visitor commented "There is a good choice of food, I've eaten here and it's very nice". A menu planner showed lunch and supper time meals and choices of desserts. There was a selection of breakfast choices, including a cooked breakfast and snacks were available at any time. Mid-morning and mid-afternoon drinks were served often with a choice of home-made biscuits or cakes. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day. Where people required soften or low sugar meals, these were provided. Staff supported people to eat and encouraged them to drink where needed. The chef was familiar with people's different diets, and regularly discussed the meals and the food with people. This helped to ensure they were aware of people's preferences and received direct feedback about the food they provided. The kitchen had recently been assessed by the Environmental Health Authority and had achieved a five star rating, this being the highest standard.

The provider had refurbished and improved the service over a period of time in terms of its design and adaptation for its client group. A wheelchair lift, also suitable for mobility scooters, provided access to the service from the pavement for people with limited mobility. Passenger lifts within the service provided stair free access to all floors.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. They felt valued and respected as individuals and said they were happy and content in the service. One person said, "The staff are just so kind and caring." Another person told us "Staff are wonderful; it's surprising how kind the staff are. I didn't think people could be so caring". A relative commented about their mother, saying, "They take great care of her and it is so lovely to see her looking so well; some of her visitors have told me they would happily come and live here." People told us staff listened to them and acted on what they said; this was evident from our observations during the inspection together with their enthusiastic and engaged service delivery. Some people, visitors and staff commented the service had a unique 'feel' to it, describing it as an enabling environment because, as named, the service had the atmosphere of a hotel rather than a residential home. Facilities included a resident's bar which people told us added to the feeling of a hotel. People were content living at the service and reassured by the support provided by the staff and owner and their genuine nature.

Staff were clear about how to treat people with dignity, kindness and respect. All of our observations were positive, staff used effective communication skills which demonstrated knowledge of people and showed them they were thought of as individual. For example, if people were seated staff crouched down, often touched the person's hand or arm and spoke with people at the same level. They made eye contact and listened to what people were saying and responded according to people's wishes and choices. This approach helped people not to feel intimidated, gave people the sense that staff sincere in giving time to deal with them and helped to orientate people to the responses staff gave. Staff were courteous and polite when speaking to people behind closed doors. For example, we heard a staff member supporting a person in their room. They gave the person time to respond and spoke in a way that was friendly and encouraged conversation.

A visitor commented staff had always helped their relative to look their best. They told us "She asked staff to help match her clothes so things were coordinated and went together well. Her nails were painted and her hair was always nicely brushed. They take that extra bit of care and it makes all the difference".

Staff knew people well and demonstrated a high regard for each person as an individual. Staff spoke with affection about the people they cared for. They were able to tell us about specific individual needs and provide a good background about people's lives prior to living at the service; including what was important to people. We saw people were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, when one person finished their meal they became agitated wanting to leave the table and return to their room. Staff spoke calmly and slowly with the person and supported them to back to their bedroom. They chatted with the person while doing this which helped to calm them down.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a discreet and dignified manner. One person we spoke with said, "I have incontinence pads and need help washing myself, it was something I was worried about because it's private and personal and something I would prefer not to have to need help with. But the staff are good they

help me when I need it, maybe I'm used to it, but it doesn't worry me now". Care records were stored securely and information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this.

Throughout the day staff spent time with people, chatting often with appropriate and shared humour and laughter. Some people shared experiences with each other as they chatted with staff, reflecting on past times and encouraging each other to reminisce. Staff encouraged conversations and activities which they knew people enjoyed. Some people enjoyed games whilst other people received their daily newspaper and spent time quietly reading or listening to music. Staff actively encouraged people to remain independent and participate in activities of their choice, for example, supporting people to use the well-kept gardens and when playing, listening to music in a nearby bandstand. The service kept a supply of pre-owned books people could buy for token amounts and a selection of large print books, audio books, DVD's and cassettes provided by the local library were kept at the service for people to use.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff supported them and responded to their needs, they said they were asked about their interests and preferences and were offered choice in all parts of their care. One person told us, "I get offered choices and can decide my own routine." Another person commented, "I like to stay in my room, although they ask, you're not made to do this and that, it suits me, most of the time I'm happy in my own company, the staff understand that." Throughout our inspection people were cared for and supported in line with their individual wishes. However, some elements of care plans were not tailored to individual preferences; clear links were not always made between some conditions and other associated care needs and people's weights, although recorded, were not set against established care sector tools intended to identify pathways to address changes in people's condition. Without individual preferences and needs identified and supported, the service could not be responsive to people's needs.

Pre-admission assessments completed from the outset intended to ensure the service could meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after they moved to the service. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. However, we found that some aspects of care planning were not sufficiently developed or adequately detailed to be individually meaningful. For example, continence support plans were not personalised specifically for the people they were intended to support; they did not indicate people's daily routines, their preferences for support or the extent to which people may wish to manage their continence themselves. There was no guidance for staff about how people may wish their continence to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider any other support required.

Similarly, where people had behaviours that could challenge other people or staff, although the service recognised changes in people's behaviour could indicate changes in their mental or physical health and timely referrals were made; care planning lacked guidance for staff about how a person should be supported and strategies or techniques which may help when behavioural incidents had occurred. Circumstances before behaviour occurring were not always recorded nor was the support provided, or a review of how effectively the support may have worked. This lack of information made it difficult for staff to develop behavioural management strategies to ensure potential causes of behaviours were understood. This would have helped to ensure that people were consistently supported in ways that suited them the best.

Care plans were reviewed and updated regularly and changes in health or social needs were responded to. However, although decreases in people's weight were recorded and referrals made to GP's or dieticians, weight records were not linked to tools available within the care sector designed to promote treatment and signpost intervention pathways. For example, MUST is a 'Malnutrition Universal Screening Tool' containing a five-step approach to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. Similarly in the event of reduced weight

or mobility and incontinence, other tools such as the Waterlow score give a point value for people's build/weight for height, skin type/visual risk areas, sex and age. An estimated risk for the development of a pressure sore can then be calculated. These systems provide information which is individual and specific to a person. They are more meaningful than recording only weight and offer an early indication of potential risk and an indicator of changes in a person's condition. In turn, this allows for greater notice to plan for and respond to changes because they can be recognised earlier.

Individual needs and preferences had not been established. The provider had not ensured that the care and treatment was person centred to meet with people's needs and reflect their preferences. This was in breach of Regulation 9 (1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to stay in touch with family and friends. The service organised outdoor summer events held in the adjoining private grounds of Clifton Gardens. People were encouraged to have visitors to stay for meals. Inclusive broadband access allowed people to stay directly in touch using services such as email and Skype. Staff told us how they had escorted one person to attend a family wedding. Care staff provided most activities. People told us, "There is usually something happening" and told us about visitors calling to facilitate bingo and armchair exercise. People also spoke fondly about Ruby, the visiting PAT dog and Zoo Lab who visited the service to show people animals such as snakes, lizards and some large spiders. People told us how they enjoyed summer open days and BBQ's put on by the staff as well activities like art, craft making, quizzes, card games and hangman.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts, but also encouraged people to raise any concerns or complaints with staff, the registered managers or service provider. A registered manager was available seven days a week. There was an 'open door' policy and the managers made themselves available to people and their relatives, this was evident during our inspection and commented upon positively by visitors we spoke with. There was a system for people to write down any concerns and staff told us how they would support people doing this. Documentation showed that all concerns and complaints were taken seriously, investigated, and responded to in a timely way. People were confident they could raise any concerns with the staff or the registered managers and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints.

Requires Improvement

Is the service well-led?

Our findings

Two registered managers were in post, providing continuous management access for people, staff and visitors. People and visitors were supportive and complementary about the registered managers and staff, commenting positively about how approachable they were. People told us they felt staff made time for them. Visitors told us they were made to feel welcome. The service provider was regularly on site, people told us the provider knew them by name, they found him friendly and committed to ensuring people had the best experience possible while staying at St Heliers Hotel. People felt any issues raised with the registered managers or provider were resolved quickly and efficiently.

The registered managers undertook regular checks of the service to make sure it was safe and met people's needs. These included areas such as infection control, medicine management and care plan quality. In addition a programme of audits completed by the provider helped to support governance processes and reviewed operational processes, the quality of life for people, the environment they lived in, care and the leadership of the service. Where checks identified concerns, action plans, timescales and accountable staff ensured they were addressed. However, the concerns identified during this inspection illustrated that the quality assurance measures in place were not fully effective. This was because they had not recognised or put measures in place to resolve areas where regulations were breached. These include ensuring risk assessment and personal emergency evacuation plans were in place for each person, excessive hot water temperatures, unguarded hot radiator surfaces, no water management plan to safeguard against the risk of Legionella, incorrect storage of oxygen cylinders and incomplete staff recruitment processes. Therefore, systems had not ensured continuous oversight of all aspects of the service.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives and staff. The service had developed close working relationships with visiting health and social care professionals, which was reflected in the positive comments received. Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. Where people and staff made suggestions, these were well received and acted upon. For example, one person wasn't eating well, staff suggested supporting them to eat in the privacy of their bedroom; their appetite had improved and the person preferred this. Other examples included people's suggestions being acted upon for choices of decoration, favourite meals and some activities.

There was a clear staffing structure. Staff understood lines of accountability and their individual roles and responsibilities. People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interactions with each other showed that staff felt comfortable with other staff of all levels and there was a good supportive relationship between them, working together to achieve good outcomes for people. For example, discussing activities, or the health of a person who was unwell and suggested actions.

Staff told us that they attended regular staff meetings and felt the culture within the service was supportive and enabled them to feel able to raise issues and comment about the service or work practices. They said they felt confident about raising any issues of concern around other staff members practice and using the whistleblowing process to do so if the need arose; they felt their confidentiality would be maintained and protected by the registered managers.

The care philosophy for the service set out the principles of providing quality care. The registered managers and provider told us that the values and commitment of the service were embedded in the expected behaviours of staff. Staff recognised and understood the values of the service and could see how their behaviour and engagement with people affected their experiences. We saw examples of staff displaying these values during our inspection, particularly in their enthusiasm toward the people they supported.

During our inspection, the registered managers and provider were responsive to our concerns about the breaches of regulations identified and, once pointed out, put in place immediate measures to reduce some of the risks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Individual needs and preferences had not been established. The provider had not ensured that the care and treatment was person centred to meet with people's needs and reflect their preferences. This was in breach of Regulation 9 (1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of service users or do all that was reasonably possible to mitigate risks. The provider had not ensured the premises used were safe for their intended purpose. This was a breach of Regulation 12 (1)(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services. This was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Recruitment procedures were not established and operated effectively to ensure that persons employed met the requirements for the purposes of carrying on a regulated activity. This was a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.