

Mr C and Mrs LA Gopaul

Kenilworth Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 11,12 and 13 April 2016 and was unannounced.

The last inspection took place on 19 and 20 May 2015, when we identified breaches of two regulations relating to safe care and treatment and the need for consent and good governance. Additionally we made two recommendations around the design of the environment and meaningful activities as directed by The National Institute of Care Excellence (NICE) guidance.

The provider sent us an action plan indicating how they would address the issues raised at the inspection. Improvements had been made, but areas such as those indicated by the recommendations required further improvement.

Kenilworth Nursing Home is a nursing home registered to provide accommodation, personal and nursing care for up to 40 people, some of whom are living with the experience of dementia, mental health conditions and people that are being cared for under the Mental Health Act 1983. At the time of our inspection there were 28 people living at the service.

There was a registered manager in post. 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 found that some practices around the handling of medicines were not safe and this presented a risk.

The provider had not always assessed people's capacity to consent to care and treatment, specifically around sharing bedrooms and the covert administration of medicines.

The service had improved the environment since the last inspection on 20 May 2015 but needed to continue the programme of redecoration in line with The National Institute of Care Excellence (NICE) guidance about environments for people with dementia.

The provider had daily activities in place but these were not suitable for all the people who used the service. We recommended the service develop the activities programme in line with The National Institute of Clinical Excellence (NICE) Guidance for leisure activities and choice.

We saw the majority of the medicines were administered and dispensed safely.

Staff were supported through regular supervisions and yearly appraisals. Staff were sufficiently deployed and appropriately trained to meet the needs of the people using the service.

The service had a safeguarding policy and procedures in place.

The environment had improved since the previous inspection and was clean and well maintained.

Health needs were being met through assessments, monitoring and support from the relevant professionals.

Staff were kind and caring. They knew the people who used the service well and were able to meet their needs.

People had person-centred care plans and we saw evidence that staff followed them to meet people's needs.

People who used the service, staff and relatives told us the managers were approachable and they could raise concerns with them.

We found breaches in 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?

Not all aspects of the service were safe.

We found that some practices around the handling of medicines were not as safe as they could be and this presented a risk.

We found that the cleanliness of the environment had improved significantly since the last inspection on 20 May 2015. Cleaning schedules were in place and monitored. On 25 May 2015 Environmental Health confirmed improvements had been made to the cleanliness of Kenilworth Nursing Home.

People had their own slings and a laundry schedule was in place.

A call bell audit had been put in place. Additionally people who used the service were checked on hourly, so if there was a problem with a call bell, people would still have regular staff contact.

Care plans we looked at were appropriately completed with relevant risk assessments.

Staff were able to demonstrate an understanding of safeguarding and what action to take if required.

The provider carried out pre-employment checks to make sure staff were suitable to work with people using the service.

Staff were adequately deployed to meet the needs of people using the service.

Requires Improvement ●

Is the service effective?

Not all aspects of the service were effective.

We found that the provider had not always assessed people's capacity to consent to care and treatment, specifically around sharing bedrooms and the administration of medicines covertly.

However we did observe on a day to day basis, people were asked about preferences.

Requires Improvement ●

The service had improved the environment since the last inspection but needed to continue the programme of redecoration in line with The National Institute of Care Excellence (NICE) guidance about environments for people with dementia.

The provider was making DoLS applications appropriately and had a system for following them up.

Staff were supported to maintain good practice through supervision, appraisals, training and team meetings.

People's nutritional needs were met.

We saw people were supported to access appropriate health care services to maintain their mental and physical health.

Is the service caring?

Good ●

The service was caring.

People, their relatives and professionals told us the service was caring.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement ●

Not all aspects of the service were responsive.

The provider had daily activities in place but these were not suitable for all the people who used the service. We recommended the service develop the activities programme in line with The National Institute of Clinical Excellence (NICE) Guidance for leisure activities and choice.

The service had made improvements to their record keeping since the last inspection on 20 May 2015 and had implemented new monitoring forms including a care plan audit and multi-disciplinary logs.

People who used the service had individual care plans that addressed their needs. People's individual preferences were noted and respected.

Is the service well-led?

Requires Improvement ●

Not all aspects of the service were well-led.

We found the service had revised and improved their quality assurance systems including infection control and care plan audits.

People who used the service and their relatives told us they liked the service.

The management team were open and available. People and staff said they were approachable.

There was a complaints procedure.

The service had good relationships with external professionals and networks.

Kenilworth Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 11, 12 and 13 April 2016 and was unannounced.

The full inspection team for three days included two inspectors, a pharmacist 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 on this inspection had personal experience of supporting someone who was living with dementia and used care services. On 11 April 2016 the inspection team consisted of an inspector and an expert-by-experience. On 12 April 2016 the inspection was carried out by two inspectors and on 13 April 2016 an inspector and a pharmacist undertook the inspection.

Prior to the inspection we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team.

During the inspection we spoke with 13 people who used the service, five relatives and two visiting professionals. We observed staff interaction with the people who used the service. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We interviewed eight staff including the registered manager, two nurses, care staff and kitchen staff.

We looked at the care plans for seven people who used the service. We saw files for staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. We also looked at records including maintenance and servicing checks and audits.

After the inspection we spoke with professionals from the Clinical Commissioning Group, the local authority Safeguarding Team and the local Mental Health Trust to gather information on their experience of the service.

Is the service safe?

Our findings

At the inspection on 20 May 2015, we found that people were at risk because of practices that were not safe. For example, people were not protected from the risk of infection due to the level of cleanliness of the environment and an issue with pest control. Additionally people shared slings for which there was no evidence of a cleaning schedule.

At the inspection on 13 April 2016, the premises were clean and we saw an up to date cleaning schedule implemented. Furthermore we saw that the manager or a nurse checked a random sample of seven rooms each day to ensure a good level of cleanliness throughout the home. People's bedrooms and communal areas were clean. One relative who visited daily told us, "I see it (Kenilworth) at all times. The place is always clean and there is always staff about." In addition to the cleaning schedule, a programme of redecoration in both communal rooms and bedrooms had begun which had improved the environment in general.

Ealing Environmental Health inspected Kenilworth on 25 May 2015 and made recommendations. Environmental Health returned on 28 May 2015 and wrote, "(The) kitchen has evidentially improved from the inspection on 25 May 2015", indicating the service had responded to improving the home's cleanliness. The kitchen had a weekly cleaning schedule which we saw was completed daily. The infection control policy was last reviewed on 17 January 2016.

To address the issue of pests, Kenilworth had a contract with Rentokil who visited three monthly. The last visit was 6 April 2016 and there were no major concerns.

From 8 August 2015, all the people who used the service had their own individual slings and a laundry schedule was completed to ensure each sling was laundered weekly.

The provider had a contract with an external company for the maintenance of bath and hoist equipment. Equipment was last serviced 24 March 2016.

At the inspection on 20 May 2015, we found that people were at risk because they were without access to a call bell. At the inspection on 13 April 2016, all the care plans we looked at had risk assessments for call bells and bed rails. People had access to a call bell in all the bedrooms and there were instructions on how to use the bell. Call bells were checked monthly for all people. For people who were known to disable the bells, a weekly check was in place to identify and repair any call bells, so people always had a working call bell.

Additionally all the people who used the service were checked by staff hourly. There was a record to show that checks had been made.

Medicines were administered and recorded as prescribed. However, some of the practices the staff followed meant that there was a risk of errors and therefore a risk to people's safety and wellbeing.

The staff did not always follow the provider's procedures for recording medicines. For example, in two

instances the staff had handwritten information on medicine administration records but had not recorded all the prescription details and instructions. This meant that there was a risk that people would not receive these medicines correctly.

Some people had been prescribed as required (PRN) medicines. There were protocols in place to explain why these were required and when they should be administered. The staff had recorded when they had administered these medicines. However, we noted that two people had received PRN medicines daily as a regular dose for a prolonged period. The staff confirmed that they had considered these medicines as required all the time. However, there was no evidence of discussion with the prescribing doctor to ensure that this was the right decision for the person or whether there was an alternative to this.

The staff told us that people leaving the home for long periods of social leave would have short courses of medicines requested from the pharmacist and that the service completed transfer forms. However, one person had their medicines transferred from their original container into a dossett box when they were visiting relatives. There was a risk associated with this type of "secondary" dispensing by staff and the practice is not in line with Nursing and Midwifery Council (NMC) guidance regarding the administration of medicines.

Medicines were administered by qualified nursing staff who had received annual medicines training from an external provider. However, the provider did not have evidence that they had assessed the competency of the staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at the MAR charts for the 28 people in service. Each person had a medicine profile alongside their MAR charts. Three people had allergies which were documented on their profile and MAR chart. Two people's allergies were documented on their care plan but one was not. All MAR charts were completed with administration details.

The provider had received support from the local Clinical Commissioning Group (CCG) pharmacist who had offered guidance in relation to their medicines policy. The home was visited regularly by a supporting GP practice. People who used the service had their medicine reviews documented on their MAR charts and these were facilitated by the supporting GP practice.

The provider, supplying pharmacist and local CCG had carried out audits of medicines management at the service. There was evidence the provider had acted on areas of need which had been identified.

At the inspection on 20 May 2015, we found that people were at risk because risk assessments were not comprehensively completed and not all documents were dated.

At the inspection on 13 April 2016, we saw that templates had been updated to reflect more fully people's needs such as indicating if the person who used the service could be verbally or physically challenging. The revised templates also included a name, signature, the date the form was completed and a review date.

We reviewed the care plans for eight people who used the service. The care records included risk assessments for pressure care, nutrition, use of bed rails at night and falls. Staff reviewed the assessments monthly and they included clear guidance for staff on how to support the person to minimise risks.

For example, the staff asked one person how often they wanted to be checked during the night and the

person had requested hourly checks. The care notes staff completed confirmed they carried out the checks. The record also included a smoking risk assessment. There was evidence the person was involved in agreeing the support they needed and they had agreed to keep their own cigarettes and to ask staff when they needed a lighter. We spoke to the person about this and they said they were happy with this arrangement.

One person told us, "I feel safe living here. It's a good home. It's OK." A relative told us "(My relative) is safe here. Staff are very attentive."

People were protected from the risk of abuse because the provider had an appropriate procedure designed to ensure they acted swiftly when people were identified as at risk of abuse. The staff had undertaken training on safeguarding adults. They understood the provider's safeguarding procedures and told us they would use these to keep people safe. Their comments included, "Abuse is not tolerated, I would speak to the manager if I saw anything happening" and "I have done safeguarding training, we must tell someone straight away if we are worried."

Staff told us they were aware of the whistleblowing policy which was last reviewed on 20 January 2016, and they knew how to contact other agencies regarding complaints.

The service had an up to date policy on safeguarding and used Pan London Safeguarding Adults Alert forms. A log was kept of incidents and the appropriate notifications were made to the safeguarding authority, Care Quality Commission, next of kin and other relevant persons.

The provider kept an incident and accident book where they recorded incidents, the action to be taken and the outcome/ resolution. Each form was dated and signed by the manager.

People lived in an environment which was safely maintained. The fire alarms were tested weekly and there was a monthly fire drill. The provider undertook a monthly fire audit that including checking the alarms, lighting, doors and fire extinguishers. The bedroom doors of the people who used the service were colour coded to indicate if they required assistance to evacuate the building. Meetings for people who lived at the service and the staff included discussion around fire safety.

The provider carried out pre-employment checks to make sure staff were suitable to work with people using the service. Each of the staff files we reviewed included an application form, interview notes, a photograph, proof of identity, references and a criminal records check. Where necessary, the provider had checked evidence of the staff member's leave to remain and work in the UK. When the provider employed nurses to work in the service we saw evidence they checked the nurse's registration with the Nursing and Midwifery Council.

We observed that there were enough staff to meet people's needs and that there was always more than one member of staff in the lounges. When a person became agitated, the staff were quick to respond and offered support to the person. Staff we spoke to, and observed, had a clear understanding of the needs of people who used the service.

We saw four weeks of staff rotas which indicated there was a stable staff team. The service employed 63 people altogether. When additional staffing was required the provider employed their own bank staff who were familiar with the people who used the service.

The staff told us there was "enough staff on shift." One relative told us their relative had been sedated in a

previous home because the staff could not manage their needs. However they told us that at Kenilworth Nursing Home, "They are very good. I have seen the way they handle people with aggression. He (the manager) is very experienced and hands on. There is always adequate staff."

Is the service effective?

Our findings

At the inspection on 20 May 2015, we found that the provider had not always assessed people's capacity to consent to care and treatment, specifically around people who shared bedrooms.

At the inspection on 13 April 2016, we found eight people continued to share four bedrooms. In some cases there was evidence that the decision had been discussed with relatives and social services, for example for one person who shared a room we saw a social work placement review on 3 March 2016. However, there had not been a discussion with the person themselves and there was no record of their consent to this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us the decision for people to share a room was made prior to the person being placed at Kenilworth and was discussed with the Commissioning team and the families. The service was now in the process of reducing double bedrooms and as double rooms became vacant, they were changing them into en suite bedrooms which we saw evidence of on the ground floor.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The provider had a procedure for the administration of covert (without the person's knowledge) medicines. We saw that the staff had recorded individual protocols for the administration of these medicines. However, in some cases the protocols had not been agreed by the prescribing doctor, person's next of kin or dispensing pharmacist. The staff told us this method of administration had been discussed with the relevant parties, however, in some cases, there was no evidence of this. There were no recorded mental capacity assessments or best interest meetings in respect of this decision. In addition there was no recorded review date for these decisions. Therefore the provider had not acted within the legal requirements of the MCA and restrictions were placed on people without their knowledge which may not have been in their best interests.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider was following the correct procedures where applications for DoLS had been made.

There was a system in place for reapplying for DoLS when required. The provider monitored conditions attached to the DoLS authorisations. One person's conditions were around access to the community and the person had a separate activities book which recorded outings. Another person had conditions around their diabetes.

At the inspection on 20 May 2015, we recommended the provider review the design and decoration of the premises in line with guidance from the Alzheimer's Society.

At the inspection on 13 April 2016, we saw that improvements had been made. The home had an ongoing programme of redecoration and refurbishment. We saw some bathrooms had been refurbished and evidence that quotes had been sought for a planned June 2016 refurbishment of a ground floor bathroom. Redecoration included both communal areas and bedrooms. We observed people's names on their bedroom doors with a picture of something that characterised them, such as their country's flag, however these were quite small and high up.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, "Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety." The guidance also refers to the use of "tactile way finding cues." The government guidance on creating "Dementia friendly health and social care environments" recommends providers "enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do."

A number of people who used the service smoked and the garden had a large, easily accessible covered area with lights provided as a designated smoking area. It was well used, although some people did need to be encouraged to move away from the doors and smoke in the designated area.

People were cared for by staff who had the support and training they needed. The staff induction provided training and the opportunity to shadow experienced staff. Records showed staff had completed training the provider considered mandatory, including infection control, health and safety, safeguarding adults, food hygiene, dementia awareness and moving and handling. Staff also attended training the local authority organised, including risk assessments, challenging behaviours and person-centred support. The service had an in house trainer who worked part time as a trainer and the rest of the time they were on the floor meaning they were able to monitor how training was being implemented and what areas required more training.

Staff were supported to develop good practice. Staff told us they were able to access the training they needed to work with people using the service. One member of staff said, "If there's training you need to help you work with one person, (the manager) will arrange it."

The provider had planned group and individual supervision sessions for all staff throughout 2016. Records of group supervision sessions in November 2015, January and March 2016 showed the provider gave staff information and the opportunity to discuss a range of issues.

Individual supervision records showed staff met with a senior staff member to discuss performance, care practices, policies and procedures, punctuality and their training needs. Training, supervisions and appraisals provided staff with the knowledge and skills to provide effective care to the people who used the service.

Stakeholders we spoke with including people who used the service, relatives, staff and other professionals said that the service was able to communicate effectively. One relative told us "They're good with communication and notify me if there is anything. Everyone is very co-operative." A health professional said, "Communicating is important, they tell me the patient's history." Staff told us, "Management will let us know about changes and will ask what staff think."

We observed that staff had the right skills to support the range of people who used the service. Senior staff were visible on the floor talking with both people who used the service and staff. Staff said they felt supported by the senior management and could talk to them if they had any concerns or needed support.

Staff worked well as a team to provide support and we observed that they were able to effectively manage the needs of people who used the service. The manager told us the staff regularly discussed how to meet people's needs, including supporting people when they became agitated, during team meetings.

One relative told us that they thought staff were adept and showed flexibility when supporting their relative. They said, "Sometimes one staff, or at other times three staff, help (relative) to shower if they're hitting. If (relative) is aggressive, staff will often take them for a walk." A professional told us that a specific person who used the service was "quite complex in needs and the home has learned to manage them. (The person) can be quite aggressive and hostile and they manage to deescalate things."

Meals were cooked freshly each day and served to people by the kitchen staff. We saw pictorial menus. People generally said the meals were fine. A relative told us, "The food is very good." Another relative told us, "The meals are brilliant. (Their relative) is eating again now and they (offer) them sandwiches and things outside of mealtimes." We observed several people having sandwiches as and when they requested them throughout the day. Juice was also always available on the tables in the lounges.

People's nutritional needs were assessed and recorded in their care plans. Where required, people had weekly or monthly weight monitoring charts. If staff were concerned about a person's weight they spoke to the nurses, who made a multi-disciplinary referral. The dietician visited every six months to discuss concerns with the nurses and provided individual meal plans as required.

The kitchen had a daily request food form which recorded people's individual dietary needs. We discussed the benefits of having a permanent list of people's detailed dietary requirements in the kitchen so that this information was always accessible for the kitchen staff. The staff asked people what they would like to eat at mealtimes and completed the form daily for the kitchen staff. Individual preferences were catered for, for example one person sometimes liked to have a glass of wine with their meal. The meetings for people who lived at the service had menu requests as a standing item.

There was a policy around protected mealtimes so staff were not disturbed and could be on the floor to support people during mealtimes. Managers completed monthly mealtime assessments so they knew what was working and where improvements needed to be made. There were enough staff to support people who needed help with eating and people were obviously enjoying their meal.

People were supported to maintain good health and had access to various healthcare professionals including diabetic nurses, social workers, the chiropodist, dietician, mental health professionals and physiotherapists. We saw evidence of referrals being made and followed up. The GP visited the service weekly. A health professional told us, "They take on board all the advice (the professional gives them)."

One person told us "I have physiotherapy once or twice a week. They did not give me physiotherapy at the

hospital but I get it here. My goal is to get my leg to strengthen again and walk, maybe with a frame." One relative told us their relative had seen the GP recently and was getting appropriate medical attention. Another relative said the staff "get the doctor in very quickly if there's any problem," and as soon as this person has to go to hospital, staff contact their relative, the nurse accompanies the person to the hospital and will wait until their relative arrives at the hospital. The relative said, "They don't just leave. It makes a difference."

We recommend that the provider continue to make improvements to the environment in line with the NICE guidelines.

Is the service caring?

Our findings

People who used the service and relatives told us the service was caring. People commented, "They are taking very good care of me for now and I hope it continues.", "They're alright, yeah.", "I can do a lot for myself and the staff are here to help me, they are good.", "There's always staff to take me out. I go shopping, to the bank and to have a meal.", "It's OK here, there's not a lot of people to talk to but the staff are very kind" and "I like the staff, they talk to me." One person told us they had recently moved to a different bedroom. They told us they did not have all of their personal possessions with them and this made them anxious. We discussed this with the deputy manager who told us they would arrange with the person and their relative for their belongings to be moved to the new room.

Relatives told us, "They do everything that is possible to make (person) happy and comfortable. We talk in depth with (staff) about (person's) care...(person) has perfect care; there is nothing they could do better.", "The care is really excellent. I have no complaints.", "They're all cheerful. It's good that it's a house – it feels like a family home." and "It's wonderful when we're here. Never had any problem. Staff are wonderfully kind."

A professional told us, "I think they are quite person centred. For (person) they look at (person's) needs and (person's) needs change day to day. They adjust staff levels and adjust to meet (person's) needs."

Staff were friendly and welcoming and throughout the inspection and we saw many positive interactions with people using the service. We observed that staff knew the people who used the service well and were able to respond proactively to their needs. We witnessed some people becoming agitated and communicating this by spitting and swearing at staff. The staff always remained calm and supported the person to feel calmer.

When the manager was in the room, people were keen to speak with them and they responded to people individually, and in some cases in the person's native language. The interactions indicated an understanding of who the people were and their interests.

Staff spoke to people in a kind and caring manner and asked them what they would like. One member of staff told us they asked people what they liked and what they did when they were younger. The staff member tried to get an idea of the person and their culture and maintain it. Another member of staff told us, "I always give them time to make decisions. I always ask them before I do anything." We saw staff responded to what people asked them for, for example a sandwich or we saw one person say they wanted to go out and this was arranged for them. When someone asked for the tv channel to be changed, it was. We saw people could choose to have their bedroom doors opened or closed.

The deputy manager was a Dignity in Care Champion and we saw people were treated with dignity and respect. For example, staff knocked on doors before entering rooms. All the staff we spoke with talked about the importance of privacy and explaining what they were doing when they provided personal care. One staff member said, "With everything we do, we have to let people know all our movements." Where

people had shared rooms we saw screens provided for privacy.

Staff were aware of people's needs and routines. At the end of the shift, staff wrote up the notes for the people who they worked with that day in their care file which meant that staff were familiar with the details in the care plans.

We saw minutes from monthly meetings for people who lived at the service. Their involvement was evident. Agenda items included health and safety, menus and activities.

Information on advocacy services was displayed and we saw evidence in people's files that some people had an advocate.

Relatives were able to visit when they chose to. All relatives said that the staff always made visitors feel welcome and were responsive and helpful. We also saw that one person was supported to go to visit their family and the journey was arranged by the service.

Is the service responsive?

Our findings

At the inspection on 20 May 2015, we could not be assured that people were protected from the risk of unsafe or inappropriate care because the provider did not maintain accurate records.

At the inspection on 13 April 2016, we found that the provider had discussed the need for improved record keeping with other stakeholders such as the Clinical Commissioning Group (CCG) and had improved their record keeping. The service had a newly created Care Plan Evaluation Record, which each file was being audited against on a six monthly basis.

In response to the last inspection the service had implemented multi-disciplinary logs and referral follow ups in each person's file which recorded all contact with professionals and outcomes.

We looked at eight care plans for people who used the service. We saw that pre-admission assessments were undertaken by the manager and information from other sources such as social services and families were obtained. The records included a local authority care needs assessment and the provider's own assessment of the person's needs and risk factors.

The care plans were well organised and included people's individual profiles and preferences. Care plans contained an appropriate level of detail with evidence of preferences, routines and any relevant risk factors which addressed physical, medical and psycho-social needs. For example one care plan stated "Staff to approach (person) gently and allow them to talk about their feelings and fears, likes and dislikes, choices and preferences."

Another person's care plan included information about the person's health and personal care needs and how staff would meet these in the service. There was evidence staff had met with the person and recorded their preferences with regards to the gender of staff that supported them, their dietary needs and morning and night time routines. Four weeks after the person moved into the home, the provider arranged a review of their care and this included consideration of their cultural, religious and dietary care needs. This included arrangements for offering the opportunity to visit a place of worship and the provision of culturally appropriate foods the person chose.

The care plan included personal care, mobility, mental health and activities and the care records we saw showed care and support were delivered in line with the plan. For example, staff had supported the person to visit a local college to make enquiries about courses, had supported them to have meals in local restaurants and to have a haircut.

Not everyone was aware of care plans and we observed that not all care plans were signed by the person who used the service, or if appropriate, a person with the legal authority to sign on their behalf. One relative said they were not specifically aware of a care plan but their relative's likes, dislikes and specific needs had been discussed with them. Another relative told us they were involved in the care plan and review. A professional commented that if they made suggestions around assessments or care plans, the service

followed through with what was asked of them.

Care plans were updated by the nurses and we saw evidence in files of yearly placement reviews with social services.

The service had an activities co-ordinator to arrange activities and staff supported with the activities. We saw a programme of daily activities posted on a board in the lounge. We also saw a calendar of cultural celebrations and people told us days relevant to people who used the service were celebrated. For example they had recently celebrated St Patrick's Day. On Valentine's Day an external organisation had brought all the people who used the service a wooden rose. A theatre group provided entertainment at Christmas. People were also able to receive holy communion once a week and there was a weekly prayer group.

Activities tended to be group based and we did not see arrangements for specific one to one activities. We saw people being encouraged to take part in chair exercises, arts and crafts (there was evidence of facemasks made the previous week on display) and board games. However without one to one encouragement not everyone was able to engage in the activities. During one morning of the inspection, a singer with a guitar ran a session which 13 people attended. People enjoyed the activity.

Although there were not specific one to one activities we did see evidence of people requesting to go out, being supported to do so. One person told us they were going out for lunch with staff as it was their birthday. The person seemed happy and appreciative that their birthday was being celebrated in this way. Additionally every one sang Happy Birthday to them during the entertainment session.

Another person told us they were going out after lunch by taxi to withdraw money and do some shopping. We later heard staff asking for the person's taxi card so they could order a cab for them.

A third person told us, "I'm not happy here (because) there's never anyone to take me out." However during lunch we saw staff arranging for someone to accompany the person out at 2pm. The person told us they wanted to go at 1:30pm to do some shopping and visit a club which closed at 4pm. We also saw from this person's activity book, they went out several times a week.

Overall we observed that while there were some meaningful activities available to those more able to engage, there was not enough options for people who were less able to engage. We discussed with the activities co-ordinator.

The National Institute of Clinical Excellence (NICE) Guidance for leisure activities and choice states "It is important that people with dementia can take part in leisure activities during their day that are meaningful to them. People have different interests and preferences about how they wish to spend their time. People with dementia are no exception but increasingly need the support of others to participate. Understanding this and how to enable people with dementia to take part in leisure activities can help maintain and improve quality of life."

The service had a complaints procedure which was clearly visible and translated into several languages. Staff told us they knew how to make a complaint but would generally speak to one of the managers. People's bedrooms had an information page of Comments, Concerns and Complaints which included contact details for the local authority, the local ombudsman and the Care Quality Commission.

We recommend that the provider review activity provision in line with the NICE guidelines.

Is the service well-led?

Our findings

At the inspection on 20 May 2015, we found that the quality assurance system was not always effective.

At the inspection on 13 April 2016, we found the service had revised and improved their quality assurance systems including infection control and care plan audits.

We saw various weekly and monthly audits that were completed by the managers. These included: a monthly checklist for food safety and hygiene regulations, a weekly kitchen cleaning schedule completed daily, a weekly thermometer calibration log, a monthly Electroset insect killer record, a weekly call bell maintenance check for people who damaged call bells and monthly call bell audits for all people who used the service, monthly internal and external maintenance schedules, a monthly fire audit, daily fridge / freezer temperatures and cooking / serving temperature records.

After the 20 May 2015 inspection, the service completed an action plan to address the issues identified in the inspection. Additionally they spoke to other professionals about how to improve their systems and practice.

However, people living at the service were at risk of having care which did not meet their needs or reflect their choices. For example, the provider had not always consulted people about their care and treatment or evidenced that decisions were made in their best interests and they did not always receive their medicines in a safe way.

We observed people who used the service and the manager engaged well. One person told us, "He is a nice man." A relative told us the deputy manager "reassured me when (their relative) was being challenging and that they are there to support." Another relative told us that they can speak to the staff. They said when they asked about a chiropodist for their relative it was dealt with straight away. "If anything concerns me they are so approachable." Another relative said, "We have a very good relationship. Right from the beginning we could talk to management."

Staff told us, "I can come to (deputy manager) any time.", "Any concerns you have, you can come to any of them (managers). They listen.", "Management is good. If I have any trouble I can have a word with them, they always help."

The managers were on the floor daily and had an open door policy. Everyone we spoke with said the management team was accessible and open. The manager told us that the last inspection had provided a focus for the service to improve. The managers were transparent about needing to improve and were proactive in talking to other professionals about making changes. "We're not afraid to ask for help." Professionals commented that the managers were not defensive and could take on advice.

The service was a family run business and the staff turnover was low. Staff felt supported by the management and there was a clear sense of teamwork which contributed to a positive atmosphere and

stability for both people who used the service and the staff.

We saw the service had sent out a satisfaction survey to people who used the service and professionals to get feedback on how people felt their care and support was delivered. A staff survey was also completed in February 2016. The service had collated the results of the surveys and we saw most people were satisfied with the service they received.

The service worked with various professionals including a diabetic nurse, the GP who visited weekly, social workers, dentist, chiropodist, mental health services and a psychiatrist. There was clear evidence of contact with professionals logged in each care plan indicating people were receiving the support they needed to maintain good mental and physical health. Professionals confirmed to us that communication with the home was good.

The management team attend provider group meetings organised by the local authority where new legislation, guidance and best practice were discussed. The local authority was starting a group for registered managers only from May 2016 and the provider planned to attend. Human resources was outsourced to an external company and they provide the service with relevant information such as changes in the national living wage. The managers also liaised with colleagues in other nursing homes and at Ealing Hospital. Interaction with other providers kept the managers up to date with legislation changes and current best practice.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	The registered person did not ensure that the care and treatment of service users was provided with their consent.
Treatment of disease, disorder or injury	Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The registered person did not ensure that care and treatment were provided in a safe way for service users because there was not always proper and safe management of medicines .
Treatment of disease, disorder or injury	Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Diagnostic and screening procedures	The registered person did not always ensure that service users were protected from improper treatment because restrictions were placed on their liberty through the administration of medicines without their knowledge.
Treatment of disease, disorder or injury	Regulation 13 (7) (b)

