Optivo

Sycamore Lodge

Inspection report

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16 March 2018

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 14 and 16 March 2018 and was unannounced. Sycamore Lodge has been re-registered under the provider, Optivo since 26 October 2017. Optivo is a housing association and a registered society which also operates three other care homes in London. This was the first inspection of Sycamore Lodge under their ownership.

Sycamore Lodge is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide personal care and nursing care for up to 77 people. There were 73 people living at the service at the time of our inspection.

The care home is purpose built and has three floors with lift access. Each person has their own bedroom with en suite facilities. The rooms are arranged into three 'streets' of 15 and two 'streets' of 16. Each 'street' has its own dining room, lounge and kitchen area along with an activities room. The service employed nursing staff on the first and second floor where people were living with the experience of dementia and required nursing care.

There was a registered manager in post at the time of our inspection who had worked at the service since May 2017 under both the previous owner and current owner. 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.

The provider did not have effective arrangements to protect people against the risks associated with the management of medicines.

The provider's systems for ensuring that only suitable staff were recruited were not always effective. Some personnel files were missing significant information to demonstrate that a robust recruitment process was in place. Some of the missing information was received after the inspection.

There were systems in place to assess and monitor the quality of the service, but these had not always been effective and had not identified the issues we found during our inspection.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe care and treatment, Fit and proper persons employed and Good governance. You can see what action we have told the provider to take at the back of the full version of this report.

There were systems and processes in place to protect people from the risk of harm. There were enough staff on duty to meet people's needs and there were contingency plans in the event of staff absence.

Care plans and risk assessments were reviewed and updated whenever people's needs changed. People and relatives told us they were involved in the planning and reviewing of their care and support and felt valued.

The risks to people's safety and wellbeing were assessed and regularly reviewed. People were protected whilst supported to remain as independent as they could be. The provider had processes for the recording and investigation of incidents and accidents.

The provider was acting in accordance with the Mental Capacity Act 2005. People's mental capacity was assessed when their care was planned. People had been asked to consent to their care and treatment and the staff understood their responsibilities under the Act. Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully.

People were protected by the provider's arrangements in relation to the prevention and control of infection. The environment was clean and free of hazards. The provider had a procedure regarding infection control and the staff had specific training in this area.

People's individual needs were met by the adaptation, design and decoration of the premises, and the provider was planning to further develop this.

People's health and nutritional needs had been assessed, recorded and were being monitored. People had access to healthcare professionals as they needed, and their visits were recorded in people's care plans.

People were supported by staff who were sufficiently trained, supervised and appraised. The service liaised with other services to share ideas and good practice.

People's care plans were comprehensive and detailed people's identified individual needs. They were personalised to reflect people's wishes and what was important to them.

Staff had received training in end of life care and advanced care plans were put in place when a person was identified as needing end of life care.

A wide range of activities were arranged that met people's individual interests and people were consulted about what they wanted to do.

Staff were caring and treated people with dignity, compassion and respect. Care plans were clear and comprehensive and included people's individual needs, detailed what was important to them and how they wanted their care to be provided.

Throughout the inspection, we observed staff supporting people in a way that took into account their diversity, values and human rights.
People's complaints and concerns were listened to and the provider responded appropriately to these.

There was a clear management structure at the service, and people and staff told us that the management team were supportive and approachable. There was a transparent and open culture within the service and people and staff were supported to raise concerns and make suggestions about where improvements could be made.

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.

Medicines were not always being managed safely.

Staff recruitment files did not always contain the required information about employment checks, to show that only suitable staff had been recruited to work at the service. However the provider obtained some missing information after the inspection.

The provider had systems in place to manage incidents and accidents and took appropriate action where required to minimise the risk of reoccurrence.

There were systems designed to protect people by the prevention and control of infection.

Is the service effective?

Good

The service was effective.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and these were regularly reviewed.

Consent to care and treatment was sought in line with legislation and guidance.

People were supported by staff who were well trained, supervised and appraised.

People's health and nutritional needs had been assessed, recorded and were being monitored. People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Feedback from people and relatives was positive about both the staff and the management team.

People and relatives said the care workers were kind, caring and respectful.

People and their relatives were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

Care plans contained enough detail for staff to know how to meet peoples' needs.

There was a wide range of activities available that met people's needs and preferences and people were encouraged to join in.

There was a complaints policy and procedures in place. People's concerns were addressed appropriately.

People's needs were met when they reached the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not always identified risks to the safety and well-being of people. They took action to mitigate these risks following our inspection visit.

There were systems in place to assess and monitor the quality of the service, but these had not always been effective and had not identified the issues we found during our inspection.

People and their relatives found the management team to be approachable and supportive.

The provider encouraged good communication with staff and people who used the service, which promoted a culture of openness and trust within the service.

Sycamore Lodge

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 14 and 16 March 2018 and was unannounced.

The inspection was carried out by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. 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.

During the inspection, we observed support being delivered to people to help us understand people's experiences of using the service. Our observations included using the Short Observational Framework for 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 also looked at records, including 11 people's care plans, five staff records, medicines administration records and records relating to the management of the service. We spoke with ten people who used the service, three relatives, one visiting friend, the head of care, the registered manager, the deputy manager, two nurses, a senior care worker, a care worker, the chef and the administrator. We spoke with a healthcare professional who was visiting on the day of our inspection. We also received feedback from three other healthcare professionals by email.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with indicated they felt safe in their environment and trusted the staff who supported them. Their comments included, "Yeah, I am safe", "Very much so [feeling safe]. Everything is all right. The treatment is good and everyone is friendly", "I've only used my call bell once and they came in two seconds and were kind", "Yes they supervise people here", "They have enough staff", "They do everything for us", "The staff are very good. They talk and listen to me. I'm friendly with them all", "I have a call bell and when I ring, they come", "Yes the staff are good. Plus I've got a call bell in my room", "It's nice and clean and you can't fault the food" and "They give me my medication at the right time." Relatives agreed and stated, "Yes [they] are [safe]. My [family member] is always comfortable and peaceful. [They are] in the right place", "I am aware of staff being mindful of moving and handling [my relative] when washing and dressing [them], I am very happy with the staff" and "Yes, [my relative] is very safe here."

Medicines were not always being managed safely. On the day of our inspection, we saw that all of one person's morning medicines due to be given the following day were not in their blister packs. This meant the person was missing some of their medicines including the possibility that the person may have been given two sets of medicines. We discussed this with the nurse in charge but they were unable to offer an explanation.

We checked all the medicines administration record (MAR) charts on both floors and saw that most of these were completed appropriately. However we saw that two medicines had been administered but the MAR charts had not been signed.

On the first day of the inspection we saw that one person's had a medicine which was prescribed to be taken each morning specifically at 11am, as instructed by a medical specialist, but by 12pm, this still had not been given. On the second day of our inspection, whilst we were carrying out a check of this medicine, we witnessed the nurse in charge administering this medicine at 11.30am. This meant that the person was not receiving the medicine as prescribed.

One person was prescribed a liquid medicine to be given four times a day. We saw that this had not been given since the start of the cycle three days prior to our check. On 13 March, staff had recorded the letter 'F' on the MAR, meaning 'other'. However, there was no explanation to state what 'other' meant. The nurse in charge told us the person had not needed this medicine, but admitted that a clear explanation should have been recorded.

Another person was prescribed three medicines that had not been given to them since the start of the cycle. We raised this with the nurse in charge who told us that this was because people had not needed these. However, none of these medicines were prescribed to be given 'as required' (PRN), and there was no explanation or codes to indicate why these had not been administered as prescribed.

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

The staff files we viewed were missing information to demonstrate that the provider operated robust recruitment processes. The provider's application form did not require the applicant to provide a full employment history, together with a satisfactory explanation of any gaps in employment. Therefore the provider was not aware if the applicant had a full employment history or gaps in employment and reasons for leaving their previous employment. As a result these matters were not explored at interview and it was not always clear why an applicant was shortlisted and/or interviewed based on the information supplied on an application form. We raised this with the registered manager, who could not provide an explanation for this.

We looked at the records of five of the most recently appointed staff. All files viewed were organised and accessible. Contents of files were consistent and included photographic ID, reference checks, a criminal record check and evidence of the right to work in the UK. However, we saw that there were other discrepancies on some of the files. For example, one staff member's application form stated a reason for leaving their previous employment which was different to the reason given in the employment reference from that employer. There was no evidence that this had been verified. Another two staff members' files only showed one employment reference each. We discussed this with the registered manager who said they would liaise with the provider's human resources (HR) department to obtain the missing information.

Following our inspection, the registered manager was able to obtain some of the missing information from their HR department and we received this evidence by email. However, we could not be sure that this information was available for the registered manager at the time of the recruitment of the individual member of staff and was still lacking in content. As a result, there was a risk people could be receiving care and support from unsuitable staff.

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

We discussed the concerns we identified about the management of medicines with the registered manager. They took immediate action regarding the incident where a person may have been given an extra dose of medicines, which included, seeking advice from the GP and pharmacist, informing the relatives and the local authority's safeguarding team, and conducting an internal investigation. We were reassured that the person using the service had been under close observations and had shown no adverse effects. Following the inspection, the registered manager introduced systems for monitoring how medicines were being managed, including more frequent medicines audits.

There were protocols in place for the use of PRN (as required) medicines, for example, pain relief medicines. Boxed medicines were counted at each administration by staff to ensure they were correctly administered and at the right time. These checks were recorded and kept up to date.

People told us they received their medicines as prescribed. One person said, "I get given my medicines twice a day in the morning and evening. If I need painkillers, they give me paracetamol during the day if I need it" and another stated, "The staff always do my meds and yeah, I get pain relief for my [health condition]." Medicines, including controlled drugs (CD)were stored appropriately in locked cupboards and administered by registered nurses or senior staff who had received appropriate training. Records showed that CD medicines were also being managed appropriately.

There were policies and procedures for the management of medicines and staff were aware of these. Staff received medicines training and had their competencies checked regularly, to ensure they were able to administer medicines safely. The senior staff undertook weekly medicines audits and the supplying

pharmacist also carried out audits to check medicines were being appropriately managed.. MAR charts were personalised with recent photographs of each person. These contained information about each prescribed medicine including possible side effects, and information about how the person wished to have their medicines administered.

The registered manager told us that staffing levels varied for each unit. They explained that although the provider had a dependency tool this was not used to determine staffing levels. Staffing levels were flexible to support appointments and any new challenges, such as people requiring supervision and support during their settling in period or changes in their needs.

People told us they were happy with the staffing levels, and we saw that there were enough staff on duty on the day of our inspection. The registered manager told us they used the provider's own bank staff to cover staff absence, and staff from the provider's other services (which were located nearby) were available to cover at short notice. They also occasionally employed the services of agency staff, however records showed that the use of agency staff had significantly reduced in recent months. We viewed a random sample of staff rotas including December 2017 and February 2018 (for all five units). These showed that there were sufficient staff on duty at any one time. We noted that there were a number of occasions where there was only one night nurse scheduled to cover two units. However when this happened, we saw that additional care staff were on duty to ensure people's needs were being met.

The provider had taken steps to protect people from the risk of abuse. Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. A healthcare professional stated that people were safe at the service and said, "Are people safe here? Yes I believe they are. I would say it is the best it has been in five years." The service had a safeguarding policy and procedure in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy. At the time of our inspection, we had received whistleblowing information and we were able to check on the concerns raised. These included health and safety concerns and staffing issues which we used in planning our inspection.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. These were reviewed yearly or more often if necessary and included risks to general health, mental health and the person's ability to complete tasks related to everyday living such as nutrition, personal care and mobility. Each risk included a score for the likelihood and impact and these scores were multiplied to indicate the level of risk. Based on the level of risk, appropriate control measures were in place. For example, where a person had been identified at risk of malnutrition due to poor dentition, we saw instructions to staff included, "Staff to give [Person] soft and chewable food."

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required. There were staff on duty 24 hours a day and they knew who to call in case of emergency.

Incidents and accidents were recorded and analysed by the registered manager to identify any issues or trends. We saw evidence that incidents and accidents were responded to appropriately. For example, where a person had fallen, they had been referred to a relevant professional and were under close observations. Another person had developed bruising as a result of their health condition. We saw evidence that the person had been referred to an occupational therapist to seek advice about appropriate measures to be taken to reduce the risk of further bruising.

The registered manager told us they ensured that lessons were learned when things went wrong, or when accidents and incidents occurred. They said, "We look at the issues, we get statements. If it involves staff, we address issues and concerns in supervision, staff meetings, handovers. Then we look at, what is the way forward? It could be training, involving the pharmacist if it is a medication error. We investigate and record everything. We put in a plan of action, and cascade information to staff." Records we viewed confirmed this.

The provider had a health and safety policy in place, and staff told us they were aware of this. This helped to ensure the safety of people, staff and visitors. Regular health and safety audits were completed by the staff. Areas inspected included electrical and gas safety, water, manual handling equipment, fire safety and trip hazards. Any concerns were recorded and the level of risk rated as low, medium or high. Records we viewed showed that where an issue was identified, prompt action was carried out to rectify this.

A full time maintenance person was employed to ensure that repairs were carried out without delay. For example, where a staff member had reported a faulty bed rail, we saw that this had been repaired straight away. Other maintenance records were up to date and included items of equipment such as hoists and slings, first aid kits, blood pressure monitors and profiling beds.

The provider had taken steps to protect people in the event of a fire, and an up to date fire risk assessment was in place. We saw that where issues had been identified, action had been taken to rectify these. People's records contained individual fire risk assessments and personal emergency evacuation plans (PEEPS). These included a summary of people's circumstances and needs, and appropriate action to be taken in the event of fire. Senior staff carried out weekly alarm testing and monthly fire checks which included means of escape, emergency lighting and fire extinguishers.

People were protected from the risk of infection. Staff were provided with personal protective equipment such as gloves, aprons, hand washing facilities and sanitisation gels to ensure infection was prevented and controlled. The environment was clean, free of hazard and odour free. We saw that there was a cleaning schedule which was followed by domestic staff. Toilets were cleaned several times a day to ensure they remained fresh.

Good

Is the service effective?

Our findings

People's care and support had been assessed before they started using the service. People who used the service had been referred by the local authority. The registered manager told us they assessed people before they moved into the service, to ensure the service could meet their needs. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any associated risks in supporting them to meet their needs. The head of care told us, "We have to be careful to match people to our resources so we can meet their needs" and the registered manager added, "Yes it is when we do our pre-admission assessment that we have to be careful." People and relatives told us that they were consulted before they moved in and they had felt listened to. The healthcare professionals reported that the staff team provided a service which met people's individual needs and they had no concerns.

People's records included guidance for staff about the circumstances in which they should contact relevant health care services if a person was unwell. We found evidence to show people who used the service were effectively supported to access appropriate health care services. Records we read confirmed there were effective systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained appropriate information. Staff implemented the recommendations made by healthcare professionals to promote people's health and wellbeing.

Staff we spoke with were able to describe the actions they had taken when they had concerns about people's health. For example, we saw how people who had been identified as losing weight were monitored and referred to dieticians and speech and language therapists (SALT) when appropriate. A healthcare professional told us, "From my clinical input to Sycamore, I feel that patients are safe and SALT advice is followed. Referrals are made appropriately." We also noted the provider had organised for the local GP to visit the service twice every week. People were accompanied by staff when necessary when they visited dentists and chiropodists.

People's appointments with healthcare professionals were booked, recorded and followed up by staff to ensure people attended and had effective care which followed the guidance of these professionals. We also noted the provider had liaised effectively with professionals concerned with issues relating to mental capacity such as the memory clinic and best interests assessors.

People were supported by staff who had the appropriate skills and experience. All staff we spoke with had an induction that included shadowing more experienced staff members and a probation period after which they were assessed before becoming permanent. New staff were supported to complete the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

Staff received training the provider had identified as mandatory. This included moving and handling, medicines administration, health and safety, infection control, food hygiene, safeguarding and Mental Capacity Act 2005 (MCA). They also undertook training specific to the needs of the people who used the

service which included dementia, equality and diversity and end of life care. Records showed that staff training was up to date and refreshed yearly. Staff told us they received regular training and refreshers and felt well trained. The provider's training matrix we looked at confirmed this. This meant that staff employed by the service were sufficiently trained and qualified to support people appropriately.

People were supported by staff who were regularly supervised. Staff we spoke with told us they felt supported and were provided with an opportunity to address any issues and discuss any areas for improvement. We saw evidence that issues about staff's conduct and ability to carry out their duties were addressed during supervision sessions.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found from observations, care records and discussions with staff, that people's rights to make their own decisions were respected.

The provider had a separate file used exclusively for DoLS applications to the local authority. We saw that all people who could not make decisions and had been assessed as lacking capacity in certain areas, had been referred effectively and contemporaneously. There was also evidence that the provider had chased applications, where the outcomes were delayed.

We saw in one application that a person who lacked capacity to consent to care had begun to refuse their medicines. Whilst an application for authorisation under DoLS was being made, we saw the provider had involved the GP, the local authority and the person's family in making a best interests decision for the person which included giving the provider permission to place the person's medicines in their food, without their knowledge (covertly). This meant the provider had made an appropriate decision following the best interests process to keep the person safe.

The provider recognised the importance of food, nutrition and a healthy diet for people's wellbeing, as an important aspect of their daily life. People told us they enjoyed the food. Their comments included, "The food? I'm not fussy. I like it. You get a vegetarian option and I prefer that", "We need to have more vegetables. I am going to talk to them about it. They ran out of veg on Sunday! I am on the food committee with [two other people]", "The food is quite good. You get a plate of food and you can eat whatever you want from it", "The food is very good and I can choose whatever I want to eat", "The food is marvellous and I can have a snack whenever I want" and "You get fed well." A relative agreed and said, "They cater for world cuisines" and "Yes she does get enough to eat and drink."

There was a calm atmosphere during lunch and people were not rushed/. Dining tables were set with linen cloths, placemats and artificial flowers. Condiments were available on tables and a choice of water or two juices were served. Staff handling food were seen to wash their hands and wear a disposable apron and gloves. Food arrived on a hot trolley and staff took the temperature of food prior to serving. Staff were aware of the minimum temperature they were testing for. People were given a choice of meal and we noted that

most people finished their meal.

People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plans. Each person using the service had a nutritional needs assessment which included a risk assessment tool that had been completed by a nurse. In addition to the service's assessment professional advice from dieticians and speech and language therapists had also been obtained. The chef was aware that some people required specialist diets and others required fortified food. People's weight was monitored on a regular basis and food and fluid intake was documented. This helped staff to ensure that they were not at risk of malnutrition and dehydration.

We spoke with the chef who showed us information on special diets such as pureed food or culturally prepared food. Menus were created daily with instructions taken either from the person or from the relatives, where people did not have capacity and from speech and language therapists or dieticians. People who wished for different food were catered for. This ensured people's preferences were met. People's diverse and cultural dietary needs were met. The registered manager chaired regular diversity and food committees involving staff, people who used the service and the chef. They told us, "We had a diversity week in February. Everyone took part. We have meals from different countries once a week." The menus we viewed confirmed this. On the day of our inspection, people were enjoying a Caribbean meal. All food was correctly stored and fridge temperatures checked twice every day.

Care plans we viewed indicated that the provider had liaised effectively with relevant professionals, the person and family members to ensure each person received nutritious food which they liked and which was appropriate with regard to their medical and cultural needs.

The home was a large building and this could make it difficult for people to orient themselves. Therefore the provider had taken steps to improve this by creating 'streets' which were painted in contrasting colours. The registered manager told us they were planning to add other features such as memory boxes, tactile and sensory equipment and attractive features throughout the communal areas and corridors. Each floor had a different themed room such as a reminiscence room, a library and a sensory room with tactile objects. The corridors were wide and included hand rails.

The communal rooms were fairly large and light, however seating arrangements mainly consisted of armchairs arranged around the rooms and did not include individual seating arrangement to enable people to socialise in groups or have privacy. People had personalised their bedrooms with their own belongings. There was a hairdressing salon and a hairdresser visited the service regularly to provide this service to people. The garden was fairly large with paths and lawn areas. There were raised flower beds. The registered manager told us that they were planning with a relative to introduce a range of sensory plants and people who used the service would be involved in the choice of these.

There were notice boards throughout the service which included information for people and their visitors, information about making complaints, details about activities and information about health and safety.

Good

Is the service caring?

Our findings

Most people were complimentary about the care and support they received and said that staff treated them with kindness and respected their human rights. Two people told us, "Some are kind and caring" and "Most of them are kind and caring but not all of them. They don't know what they are doing but some are better than others." We discussed these comments with the registered manager who said they would speak with people and address any issues they may have. Other comments included, "There's always a knock on the door and they wait till you say 'come in'", "The staff are very respectful", "They knock and wait before coming in. I get up when I want to", "They treat me very well", "They do talk about my care with me" and "They're very good." One person was less complimentary and told us, Most of them are kind and caring but not all of them. They don't know what they are doing but some are better than others." We discussed this with the registered manager who told us they would speak with people and relatives and take necessary action where concerns are raised. "Relatives' comments included, "I would say they go the extra mile for her", "I can visit any time" and "We have always had a good rapport. There are very special people here." A healthcare professional echoed this and said, "Staff are very caring."

People's cultural and spiritual needs were respected. The service manager told us that cultural diversity was taken into consideration with themed activities to celebrate various festivities or to recognise specific times of the year such as Black History Month and Eid. One person told us, "The priest comes in monthly for mass and the nun gives communion every week" and another said, "I am a Catholic and the Sister comes every week to give me communion." The registered manager told us that they used the pre-admission assessments to identify and ask people who used the service if they required anything in particular with regards to their faith and cultural beliefs. Records we viewed confirmed this.

We saw staff approached and addressed people in a kind, caring and respectful way. Staff we spoke with were aware of the needs of each person who lived at the service and we saw that the culture of the service was based on providing care and support that met each person's unique needs.

People told us that their privacy was respected. We saw that staff spoke discretely about people's needs and offered support in a sensitive manner. They knocked on people's doors and asked permission to come in. Staff stopped and spoke with people throughout the day and there was a calm and happy atmosphere in the service. We saw that people's needs were met in a timely manner and nobody had to wait when they required assistance.

Relatives told us they felt welcome and able to visit their family members anytime they wanted. There was a visitor' room available if their family member was unwell and they needed to stay overnight.

We viewed a range of compliments the provider had received from people and relatives. Comments included, "I am very happy with the care my [family member] is getting", "[Person] is very happy with the home" and "I am happy with the service provided for my [family member]."

Good

Is the service responsive?

Our findings

People and their representatives were involved in the development and review of their care plans and records we viewed confirmed this. One person told us, "The care plan? Yes. And they involve my son too." People's care plans were being transferred to an electronic system so we were able to view both electronic and hard copies of these records. All the care plans we looked at were comprehensive, detailed and personalised. They were designed in a way to support people whilst maintaining their independence. Care plans also provided staff with clear guidance on how to meet each person's specific care needs. Each person's care plan included details of their preferences in relation to how their care and support should be provided. They were developed from information provided by people and family members, as well as healthcare and social care professionals involved in people's care. This information was combined with details of people's specific needs identified during initial assessments.

Care plans were regularly reviewed and updated to help ensure they provided staff with sufficient detailed information to enable them to meet people's individual needs. Each care plan included details of the people's background, past occupation and family, likes and interests as well as information about their medical history so staff had all the necessary information about the person to understand the person's needs and how they liked to be cared for.

People and relatives told us staff were responsive to their needs and they felt valued and listened to. Our observations of staff interactions and support throughout the inspection demonstrated staff were responsive to people's needs and showed a caring an enabling approach. Staff worked as a team and were heard requesting support from each other. We saw staff operating hoists safely whilst giving people reassurance throughout the process. We observed call bell response times and saw these were timely.

People told us they enjoyed the activities on offer at the service. Their comments included, "I join in everything. They don't force you but they encourage you to do things", "I like colouring in", "I like listening to classical music on the radio" and "I love drawing and doing my jigsaw puzzles in my room. I love reading."

The provider employed an activities coordinator who provided and facilitated a range of activities at the service. An activity plan was created following discussions with people and this was displayed in communal areas. Activities were held in the communal areas or in the themed activity rooms on each floor. Activities on offer included pampering sessions, musical quiz, origami group, chair aerobics, karaoke and table games, besides various specific celebrations from time to time such as Valentine's Day, Mother's Day or Christmas. During our inspection, we saw that preparations were underway to celebrate St Patrick's day, which included purchasing Guinness and preparing Irish food.

The activities coordinator stated they aimed to provide a program which reflected the wide range of individual needs, abilities and preferences. This involved activities which promote physical fitness, reduce isolation, provide mental and social stimulation as well as fun and play. They said, "We have one resident whose preference is to stay in their room. As an activities coordinator, it is my duty to make sure that they are receiving the right care. I read the care plan, likes and dislikes, and through that I encourage them to do

knitting which is what they want."

There was a 'garden room' which was used for indoor planting so that people could engage in gardening when it was too cold to use the garden. However the activities coordinator told us that they took people out in the garden, weather permitted, to do some gardening and relax. There was also a 'cinema room' which was used once a week to show a film chosen by people who used the service.

Food and cooking was included in planned activities. For example, twice a month, a 'reminiscence fish and chips' meal was organised. The activities coordinator told us, "We serve this in a newspaper just like the old days." We were told this was a very popular meal. There were also monthly baking sessions which the activities coordinator told us people "really enjoyed" and added, "This month, we baked cookies and they were really pleased."

The service had a policy and procedures for dealing with any concerns or complaints. Details of the service's complaints processes were available to people who used the service displayed in communal areas. People told us they understood how to report any concerns or complaints about the service. Their comments included, "I complained once or twice one or two years ago. I don't remember what it was about but they did put most of it right" and "If I had to complain, I would." A relative stated, "Yes I would be confident about speaking up if there was anything I was concerned about."

We saw evidence that complaints were taken seriously and issues were resolved in a timely manner. For example, where a complaint was made about continence management at the home, the registered manager conducted an investigation and provided a full response to the complainant.

During the inspection we were able to speak with the nurse on duty with regard to end of life care (EOL). The nurse explained the care home currently had one person who had been assessed as requiring end of life care. We saw in the person's care plan how the decision was reached for the person to receive end of life care after the staff had discussed the person's symptoms with the GP.

The staff had then created an EOL care plan with assistance from health and social care professionals. We also saw in copies of e-mails how the lead nurse had organised a meeting with the person's family to ensure the person's wishes and preferences were addressed in the EOL care plan.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were complimentary about the management team, thought the service was well run and felt that the registered manager was approachable and they could speak with them at any time. People's comments included, "The manager is pretty good and you can talk to him. He comes up every morning to chat. Yes there is a good relationship between the staff and management. I am sure that his door is always open to them", "People are friendly and responsive, definitely", "If you think something is wrong, they explain or do something about it", "I would definitely recommend this place. I'm very, very happy here and give it 10 out of 10", "It's quite well run. [Registered manager] is very hard working. He comes in on a Saturday and starts at 6.30am. He arranged the Food Committee", "Yes I would recommend them. They do everything well" and "I am satisfied and I'd give it an eight out of 10. I'd never give a 10 for anything." Relatives echoed these comments and said, "Yes I would recommend this place. They are caring better for [family member] than I ever could", "The new manager is responsive and excellent. Yes he is approachable" and "Yes I would recommend this place and I'd give it a 10+ out of 10. I want to write down that all the staff on [name of unit] deserve a salary increase."

Notwithstanding the above comments, our findings during the inspection showed that the provider's systems for identifying and mitigating risks were not always effective. We found that the arrangements to manage medicines were not always effective to protect people against risks associated with medicines. In addition, the provider's quality assurance systems had not identified that they were not always operating effective processes when recruiting staff to make sure they had all the necessary checks to determine their suitability for the roles they had applied for, before they were offered employment at the service.

This was a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post at the time of our inspection. They were supported by a head of care, a deputy manager and an established senior team. The registered manager had experience working in care homes and was a qualified general and mental health nurse. They also held a qualification in dementia studies. They told us that they had organised a week of dementia awareness where they invited staff, relatives and members of the public and this had been successful and well received by everyone. As a result they were organising another event to take place this year, and planned to invite other care homes. The purpose of this was to raise awareness and improve the care delivered to people living with dementia.

Staff thought the management team was approachable and they felt well supported by them. One staff member told us, "Managers visit the units every morning. They meet with senior care assistants to talk through any problems. [Head of care] visits once a month and talks to service users and staff." Of the registered manager, they said, "We've had seven managers in three years. [Registered manager] has made improvements since becoming the manager. Staff's attitude has changed. Staff are now arriving on time for their shift. He offers updates, interacts with service users and staff. We feel we can raise concerns. He offers lots of positive reinforcement. We are getting there."

A senior staff member echoed this and said, "I feel supported in my role by [Registered manager] who is very knowledgeable. The home has been unstable for a number of years. Now it's a happy home, good leadership is in place, health and safety prioritised, auditing, safety checks and follow through happen. Daily handovers have developed into constructive auditing and proactive learning."

The registered manager recognised the importance to keep themselves abreast of changes within the social care sector by attending managers' meetings, conferences and workshops. From these meetings, relevant information was cascaded to the staff team during meetings to improve knowledge and share information. They also attended managers' forums in other boroughs where they discussed social care changes and updates and liaised with other managers. They also consulted the Care Quality Commission (CQC) website and provider's handbook to keep abreast of developments within the regulatory framework of care services.

The senior management undertook monitoring visits, based on the CQC's key questions, and we saw these were regular and thorough. Audits included checks of people's files, medicines, staff's files, training, incidents and accidents and complaints. We saw evidence that where issues were identified, and action plan was drawn. We viewed a range of audits and saw that where issues had been identified as needing improvement, these had been addressed without delay.

There were systems in place to monitor the standards of care provided and identify any areas in which the service could improve. These included regular meetings with people who used the service and relatives. The provider carried out surveys of people and relatives. The results of these were analysed and any areas for improvements were discussed and used to improve the service. Comments from people indicated they were happy with the service. The registered manager chaired regular health and safety committee meetings. These included discussions about the environment, maintenance issues and repairs. There were also regular food committee meetings to which people who used the service were invited. We viewed the minutes of these and saw that people were able to make suggestions and bring ideas to the meeting. The chef confirmed they were involved in the meetings and used people's suggestions to improve the menus.

The service manager told us "Everyone has to embrace the core values of the organisation. We learn and improve by adapting to what's topical, listening to service users, we have relatives' meetings, we have a suggestion box and a complaints policy."

Records showed there were regular staff meetings. Issues discussed included communication, report writing, incident reports and training. These meetings gave staff an opportunity to raise issues and be involved in the development of the service. There were also monthly managers' meetings where any relevant operational matters were discussed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not made suitable arrangements to ensure that medicines were managed safely. Regulation 12 (1) and (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always have effective arrangements to assess, monitor and improve the quality of the service. Regulation 17 (1) and (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider's recruitment procedures were not established and operated effectively. Regulation 19 (2)