Beaumont Court Care Home Limited

Beaumont Court Care Home

Inspection report

Peter Shore Court
Beaumont Square
London
E1 4NA

Tel: 03333843884

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16 October 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 9,10 and 16 October 2018 and was unannounced.
This was the first inspection since the provider took over the service from Gateway Housing Association and registered it with the Care Quality Commission (CQC) on 29 April 2018. The service was previously called Peter Shore Court and at the previous comprehensive inspection in November 2016 the service was rated as 'Requires Improvement'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Peter Shore Court' on our website at www.cqc.org.uk'.

Beaumont Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beaumont Court accommodates 42 people in one building across two floors, with each person having their own bedroom and en-suite bathroom. There were also communal living and dining rooms, a main kitchen and access to a secure garden. At the time of the inspection the care home was supporting 41 people with physical health conditions and those living with dementia.

There was a manager in post at the time of our inspection and they had submitted their application to be a registered manager on 16 October 2018. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the time of the inspection the service was in a period of transition. A new manager was in post who was trying to create a settled environment. The provider was aware of the mixed feelings and differences in the morale of the staff team who were getting used to changes and new ways of working. The majority of staff feedback received was positive about the takeover and the direction the service was going in.

The provider had quality assurance processes in place to monitor the service. The provider acknowledged there were areas that needed improvement and the service was still a work in progress since they had taken over.

The provider did not meet the CQC registration requirements regarding the submission of notifications about serious incidents, for which they have a legal obligation to do so.

Risk assessments were in place to identify and manage areas of risk to people. However, information was not consistent throughout people's care records as some assessments had not been updated. Risk assessments did not always provide staff with guidance on how to minimise risk.

Safeguarding investigations that had been carried out were not always recorded accurately or were clear about the response to the concerns and what the outcome was. Supporting documents relevant to the

investigation were not always available or stored within the safeguarding log.

Although the provider used a dependency tool to assess staffing levels, we received mixed feedback about the staffing structure across the service with the changes that had been made since the takeover. Although more people were present in communal areas on the ground floor for the staff team to monitor throughout the day, we did observe times when staff were less visible on the first floor.

The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service.

People received their medicines safely from staff who had completed refresher training with a new pharmacy and had their competency assessed. Medicines records were completed and checked by staff on a regular basis to minimise medicines errors. However, some poor practice was observed in relation to medicines administration and recording.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Best interests meetings were held in relation to decisions where people did not have the capacity to consent to their care.

People were supported to have a balanced diet, which took into account their preferences as well as any medical, cultural and nutritional needs.

Staff had completed the provider's mandatory training programme and received regular supervision to support them in their role.

People had regular access to healthcare services and other health and social care professionals, with weekly visits from the GP or practice nurse. Staff worked closely with district nurses if they had any concerns about the change in people's health.

The provider had recruited an activities coordinator since the takeover and we received positive feedback about the impact this had on reducing social isolation. We saw that people were encouraged to take part in a range of daily activities and regular events and the activities coordinator was passionate about their job.

Care records were still in the process of being reviewed and updated at the time of the inspection. The provider acknowledged the inconsistencies we found and an action plan was in place to ensure monthly evaluations were completed and information reflected the care and support people received.

People and their relatives we spoke with knew who to speak to if they wanted to make a complaint. The provider gave people and their relatives the opportunity to give feedback about the care and treatment they received. However, any minor issues or concerns that were raised were not formally recorded. We were made aware after the inspection of a previous complaint that had been made by a relative, but there was no record of this and the provider had not told us about it during the inspection.

People and their relatives told us staff were kind and caring. We observed positive interactions throughout the inspection and staff were patient and understanding and provided emotional support to people when needed.

We found two breaches of the regulations in relation to safe care and treatment and notifiable incidents. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place to identify and manage areas of risk to people, however the level of detail and guidance for staff was not consistent throughout the records we reviewed.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm. However, safeguarding investigations were not always clearly documented about what actions had been taken and what the outcome was.

Dependency assessments were completed to determine staffing levels. We received mixed comments from people and staff about staffing levels since the takeover. With people being encouraged to spend more time in communal areas on the ground floor, there were times staff were less visible on the first floor.

The provider had recently started using a new pharmacy to support the staff team in managing people's medicines. Medicines were administered and recorded by staff who had received refresher training and had completed competency assessments.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and staff were suitable to work with people.

Is the service effective?

Good

The service was effective.

People had regular access to a GP and other health and social care professionals, such as district nurses. People's health needs and any concerns were discussed daily during a morning handover.

Staff completed a programme of mandatory training and had regular supervision to support them in their role.

Staff were aware of their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).

A DoLS log was in place to monitor the status of people's applications and when they were due to expire.

People were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs. Kitchen staff were aware of people's preferences.

Is the service caring?

Good

The service was caring.

People told us staff were kind and compassionate. We saw positive interactions between people and staff throughout the inspection. People were supported to celebrate their own and other people's birthdays.

We saw that staff treated people with respect and kindness. Staff were patient and understanding and provided emotional support to people when needed.

People who used the service and their relatives told us they felt they were involved in care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were in the process of being reviewed and updated. The provider acknowledged the shortfalls we found in relation to the level of detail and monthly evaluations not always being completed.

People and their relatives we spoke with knew who to speak to if they wanted to make a complaint. The provider gave people and their relatives the opportunity to give feedback about the care and treatment they received. However, we found that a complaint had not been recorded.

People were supported to take part and be involved in a range of activities and events. The provider had highlighted this as an area of improvement and had been proactive and recruited an activities coordinator. We received positive feedback about the impact this had on the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider failed to meet their legal requirements to inform the

Care Quality Commission of notifiable incidents.

The provider acknowledged there were areas that needed improvement and had found this through their own quality monitoring checks. The provider had introduced new systems to monitor the service that were being implemented at the time of the inspection.

The provider had recently appointed a new manager, who had just applied to become registered with the Care Quality Commission at the time of the inspection. They were aware of the effect that the takeover had had on some members of staff and new ways of working. They were working to provide stable management and develop teamwork.

People and their relatives we spoke with were positive about the service. The majority of staff spoke positively about the support they received during the takeover and the vision the provider had for the service.

Beaumont Court Care 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.

Why we inspected - This was a routine inspection as the service had been taken over by a new provider in April 2018. We were scheduled to carry out a return inspection at Peter Shore Court in February 2018 but had to postpone it due to the takeover.

The inspection took place on 9,10 and 16 October 2018 and the first day was unannounced. We told the manager we would be returning for the following days of the inspection.

The inspection team consisted of three inspectors, a specialist professional advisor in the nursing care of older people living with dementia 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 service.

Before the inspection we reviewed the information the CQC held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report when it was managed by the previous provider. We also contacted the local authority commissioning and safeguarding team to support the planning of the inspection. In addition to this we reviewed the 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.

During the inspection we spoke with eight people using the service, three relatives and 19 staff members. This included the manager, two directors, an area manager, three team leaders, four key workers, four care assistants, the activities coordinator, the chef, the administrator and one domestic assistant. We also spoke

with two health and social care professionals who were visiting the service at the time of the inspection. We looked at 11 people's care plans, seven staff recruitment files, staff training and supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed the care and support provided to people in the communal areas across different parts of the day, including during mealtimes.

Following the inspection we spoke with four health and social care professionals who had worked with people using the service for their views.

Requires Improvement

Is the service safe?

Our findings

People we spoke with confirmed that they liked living in the home and felt safe. One person said, "I like it here, it isn't bad and yes, I do feel safe." Another person said, "Yes I feel safe. They aren't a bad lot." Relatives we spoke with had no concerns about the safety of their family members. One relative said, "From our point of view my [family member] is safe and we are pleased with the care they get." One person told us that another person had walked into their room at times so they had used a wheelchair as a barrier to stop them coming in. We saw the manager spoke with this person and explained what measures could be put in place to prevent this from happening again.

Initial assessments were carried out before people moved into the service which identified any potential risks to providing their care and support. A range of assessments covered people's communication, medicines, mobility, health conditions, skin integrity, nutrition and well-being. However, there were inconsistencies across the risk assessments we reviewed. Not all records had sufficient information in place or guidance for staff to follow to support people safely.

One person had risk assessments for their mobility, nutrition, bed rails and a gate across their door to prevent other people from walking into their room. They were detailed and clearly documented how staff were to support them. However, for another person, mobility and nutritional risks were identified but lacked detail. Their diabetes care plan did not identify the type and stated, 'they can get into hypoglycaemia'. There was no further information about the signs or symptoms for staff to know what to look out for or if they were at risk. Their mobility assessment said they had a habit of walking into people's rooms but there was no clear management plan to mitigate this risk. We also observed another person walking into people's rooms on the first day of the inspection. We saw this person had been involved in a recent incident where they hit another person. There was no information about this in their care records or that their behaviour could be a risk to others by going into their rooms. Although it recorded that staff should monitor the person, there was no fixed plan in place for how this would be achieved.

We also saw a skin integrity assessment was in place for one person but it had not been updated to reflect that the person was refusing to sleep in their bed and was sleeping in an armchair. This person had previously had pressure sores and was at a higher risk of skin breakdown. There was no further information about how this was being managed or if any further advice had been sought about how to manage the risks associated with the person sleeping in a chair. We spoke to the manager about this and the inconsistencies we viewed across people's files. They acknowledged this and said they were aware that more information was needed and were working on getting all records reviewed and updated.

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

We looked at the systems in place for managing people's medicines. The provider had recently made some changes and were now using a new pharmacy that they already used with another one of their care homes. They were just completing the first medicines cycle and the pharmacy had provided training for staff

responsible for administering medicines. The manager told us that with the previous provider, after carrying out an initial medicines audit, they felt too many staff were responsible for administering medicines which had led to an increase in errors. Team leaders were now responsible for the administration of medicines and were supported by key workers. Staff also completed competency assessments before supporting people with their medicines and we saw these in the staff files for those responsible for administering people's medicines. One member of staff said, "It is a much more personalised service and the training was really good."

Medicines were stored securely in locked medicine trolleys. We reviewed a sample of medicines administration records (MARs) and saw they were completed accurately and demonstrated that people received their medicines as prescribed. We saw daily handover records checked that people's medicines had been administered and signed for. A detailed medicines audit had been completed in May 2018 and the area manager was carrying out a quarterly audit on the third day of the inspection. The manager sent a copy to us after the inspection which highlighted the action that needed to be taken after their findings.

We did observe two examples of poor practice during our observations on the first day of the inspection. We saw a team leader dispense two different medicines and sign a person's MAR chart before administering the medicines. We also observed a key worker attempting to support a person with their inhaler during lunchtime when they had a full mouth of food. We discussed this with the manager who acknowledged it was not best practice and said she would speak with the staff involved.

One person told us that they managed their own medicines and they were kept in their room. The medicines section for their assessment had not been completed and there was no risk assessment to ensure the person was able to manage their own medicines safely. The manager told us they would update this right away.

The staffing structure showed that there were six staff on during the day which included a team leader, a key worker, who supported the team leader, and four care workers. At night there were four staff on duty consisting of a team leader and three care workers. We looked at staff rotas for the week of the inspection and the three weeks prior to the inspection and saw this was in line with what the manager had told us. There was a shift allocation sheet completed each day that detailed who was responsible for key tasks such as supporting people's personal care, support with meals and staff break times. This also included domestic and laundry staff. The provider told us that a dependency tool was used to work out staffing levels but that this was just used as a guide. We saw a copy of the dependency tool and how this was used to work out people's needs and the level of staffing required to meet these.

We received mixed views about current staffing levels at the service and if they were sufficient to meet people's needs. People we spoke with felt there were enough staff to support them. One relative told us at times they felt there were not enough staff. Since the takeover in April 2018 the provider had encouraged people to spend time out of their rooms and downstairs in the communal areas. They felt this helped to reduce social isolation and increased the levels of engagement people could have with each other and the staff team. One member of staff said, "Giving people the opportunity to spend time in the main lounge and dining room has been an amazing change which has had a positive effect on people. We can see people more regularly and what is going on." We did observe that due to the drive for people to be downstairs staff were not always available on the first floor which meant that people could be at risk of not being attended to. For example, we saw one person walking into other people's rooms but there were no members of staff available to monitor this. We found a domestic staff member to make them aware of this and they went to support the person.

We did receive comments from three members of staff who told us that additional staff were not always provided to support people to appointments, which meant that staffing levels were reduced when a person was escorted to an appointment. We discussed this with the manager who said they were aware of the concerns and were looking at ways for the staff team to try to ensure that only one appointment was scheduled per day. They had also recently written to relatives to ask them if they were able to support their family members to healthcare appointments. The manager added that if this was not possible they were able to use agency staff to provide suitable cover.

The provider had a clear recruitment process in place and new starters had a checklist form to ensure all necessary documentation had been received before they started working at the service. There was evidence of photographic proof of identity, proof of address and right to work records, along with two verified references. Staff files contained details of applicant's employment history, however, it was not always recorded if gaps in employment had been explored with staff. All staff had a Disclosure and Barring Service (DBS) check in place. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. We did note that some DBS records had been authorised in early 2015 and had not been reviewed after three years. The manager told us that they were in the process of renewing checks to ensure that staff remained suitable to work with people and we will follow this up at our next inspection.

Staff had received training in safeguarding and were able to explain how to keep people safe from the risk of abuse. Staff understood how to recognise the signs of abuse and told us they would speak to the manager or a senior member of staff if they had concerns about a person's safety or welfare. The provider had recently introduced a new initiative to help staff stay up to date with important policies. A 'policy of the month' was discussed with the staff team and a copy was left in the office for staff to refresh their knowledge and sign to confirm they had read it. For the last two months we saw the safeguarding and whistleblowing policies had been covered. The whistleblowing policy encouraged the reporting of all serious concerns to management and that staff could do so without the fear of reprisals.

Staff we spoke with were confident that any concerns reported would be dealt with immediately. However, we found that the safeguarding investigation log did not always record what action had been taken and what the outcome was. Supporting documents related to investigations, such as statements, meeting minutes and email correspondence were not always readily available when reviewing the records. We spoke to the manager about this who told us the incidents had happened before they became the manager and had not had the opportunity for a handover with the previous registered manager. Due to this, they were not aware of the status or the outcomes of all the investigations we reviewed.

Infection control procedures were also observed to have been followed as we saw staff wearing personal protective equipment such as disposable gloves and aprons during mealtimes and when preparing to support people with personal care. Responses from satisfaction surveys sent out in August 2018 showed people and their relatives were happy with the general cleanliness of the service. All the people and their relatives we spoke with confirmed this. One person said, "It is clean, they keep it pristine." Throughout the duration of the inspection, we found a sluice door on the ground floor left open, unattended and wedged open on three separate occasions, despite signs saying it must be locked at all times. We brought this to the attention of the manager on the first day and the third day of the inspection. They acknowledged this as an issue and said they would speak with the staff team. Daily cleaning schedules were in place and newly introduced bedroom audits picked up any areas that needed improvement. For example, we saw one check found a bedroom had not been cleaned and this had been discussed with the domestic staff about completing the allocated shift plans.

Good

Is the service effective?

Our findings

People's rights were protected as staff understood the main principles of the Mental Capacity Act 2005 (MCA). The 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 make 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). The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS.

We discussed the requirements of the MCA with the manager and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. Mental capacity assessment forms had been completed and best interests meetings had taken place regarding consent to care and treatment. There was sufficient detail to evidence where people did not have the capacity to make decisions in relation to their care and support needs. A DoLS log was in place which included applications for people who were under constant supervision and not free to leave the building for their own safety. There was correspondence with the authorising body to follow up any pending applications. The provider was aware when people's authorisations were due to expire and had made the necessary renewal applications before the current authorisation had expired. For one person, we saw that specific conditions of their DoLS authorisation were being met. Training records showed that staff had completed mandatory training in the MCA and DoLS.

The service assessed people's needs and choices so that care and support was delivered in line with current legislation to achieve effective outcomes. The provider had guidance in place for managing authorities to ensure best practice when identifying any possible deprivation of liberty. There had been contact with the Association of Directors of Adult Social Services (ADASS) with guidance about DoLS applications. A screening tool guide highlighted priority applications and examples of scenarios and behaviours that met the level of criteria.

The provider had developed an induction booklet in line with the Care Certificate standards but did not provide the Care Certificate training. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Staff were expected to commit to completing the induction within 12 weeks. It covered areas such as communication, safeguarding, dementia, nutrition and hygiene, person centred support, health and safety, infection control, fire safety and the MCA. There were questions for staff to answer to check their understanding on the areas covered.

Staff had completed a mandatory training programme with modules that included customer care, infection control, health and safety, food hygiene and nutrition, pressure ulcer awareness and fire safety awareness. Certificates were also in place for staff that had completed theory and practical learning in moving and handling. Although this was a good range of topics for care staff, we did note that this was completed over

one training day and was a lot of information to take in. However, staff we spoke with were positive about the training they received. One staff member said, "We had further training when they took over. I was happy with it and feel that I've learnt more and benefitted from it."

There was a training matrix in place that showed that the majority of staff had completed their mandatory training. Where there were gaps we could see this was a result of staff sickness or leave and the manager told us that training was being organised to ensure that all staff had their training up to date. First aid training had been scheduled for next month and the area manager also told us that they were looking to carry out some further training in dementia and how to support people with behaviour that challenged the service, as staff were currently supporting people with such needs. We saw records that showed staff had regular supervision at least every two months, which was in line with the provider's policy. We saw that records highlighted staff performance issues and training and development needs. Staff appraisals had not taken place since the new provider had taken over but forms were being sent out to staff so they could prepare for appraisal meetings that were scheduled to take place from December 2018 and onwards.

Staff told us that they worked closely with a range of health and social care professionals to ensure people received effective care and support. We saw people were supported to attend a range of healthcare appointments. People's physical health needs were generally attended to in a timely manner. A GP or practice nurse visited on a weekly basis and there was a system in place to ensure those who needed to be reviewed had their names on the list. We observed a morning handover on the second day of the inspection and saw the night shift team leader went through each person and gave an overview about their night and if there were any health concerns that needed to be followed up. For one person, we saw staff had liaised with a district nurse when they had concerns about their skin. A health and social care professional we spoke with told us that they felt the new management team were aware of people's healthcare needs and made the necessary referrals if they had any concerns. They felt care staff were able to follow their guidelines for managing people's health conditions. The manager had also just recently introduced a referrals diary to have a better oversight of people's health conditions. We did see for one person that a health and social care professional had advised staff to encourage fluids as the person was not drinking enough. However, there were no records to demonstrate this was happening. The manager told us that staff had not previously been encouraged to complete food and fluid charts and it was something that was being addressed.

The home had been awarded a five star food hygiene rating at its last environmental health inspection in February 2018, when it was managed by the previous provider. The top rating of five means that the home was found to have 'very good' hygiene standards. People gave us positive feedback about the food. Comments included, "The food is good, you can also ask for tea and coffee and they bring me one" and "If there is something I don't like I can get something different." One relative said, "[Family member] likes the food and seems to enjoy it. They look so much better and healthier since they lived here."

We spoke to the chef who was aware of people's nutritional and cultural needs and specific diets, which included halal, vegetarian, diabetic and those on a soft diet. There were lists of food items available which had been discussed with people, including people with any food allergies. One person said, "I only eat brown bread, they remember this and listen to what I want." We did observe one person, who was a vegetarian, receive the wrong dish on the first day of the inspection. However, the kitchen staff acknowledged it was a mix up and their preferred meal was served right away.

Since the takeover the provider had introduced monthly Malnutrition Universal Screening Tool (MUST) assessments. This assessment helps identify people who are at risk of malnutrition. We saw monthly assessments were in place and the provider had identified 18 people who required their foods to be fortified. There was NHS guidance in place about fortified diet plans and dietary changes that could be introduced to

prevent weight loss. The importance of this and for MUST assessments to be checked had been discussed at a recent meeting for kitchen staff.

We observed lunch in the main dining room during our inspection. Staff encouraged people to eat in the main dining room on the ground floor and the dining room on the first floor was no longer in use. People still had the choice to eat in their rooms or in the lounges and we saw this during the inspection. One person still wanted to eat their meals on the first floor, and whilst they were encouraged to go downstairs, their choice was respected. We saw that people were given a choice where they wanted to sit and space was made for people with wheelchairs to get into a comfortable position. Staff displayed warm and gentle manners and were proactive to ensure people had everything they needed and were supported to sit comfortably.

Good

Is the service caring?

Our findings

People we spoke with told us they were generally happy with the care they received and spoke positively about the staff who supported them. Comments from people included, "They do care. I don't think you could get a better group of staff, they are friendly and chat to me", "Yes, they are kind and I can talk with all of them" and "They aren't bad." One relative told us that their family member was happy and that staff would check on them to make sure they were OK.

Throughout the inspection the majority of observations were positive interactions between people using the service and staff. Staff were observed to be interested in people, polite and engaged with them when they were providing support. Whilst observing some activities people who had joined in were laughing and smiling and the activities coordinator walked around the room and encouraged people to get involved. During one activity, achievements were celebrated and people's comments were valued and not disregarded if their responses had already been mentioned. We saw the staff team supported people to celebrate their birthday. The activities coordinator had a birthday schedule in their activity folder and we saw that seven parties were scheduled for October 2018. We observed one person's birthday party on the second day of the inspection and saw people were invited to celebrate it and the chef had baked a cake for them.

Throughout each day of the inspection, we observed one person who displayed behaviour that challenged the service regarding the frequency of when they could smoke. At times they became quite frustrated and agitated if their demands could not be met. We saw that staff were aware of the behaviour and had a range of techniques to manage this. All staff observed were patient, responded calmly and spoke respectfully to the person at all times. One positive example of this was when a member of staff, the manager and the area manager all engaged with the person which resulted in them playing a piano and singing along to songs they had suggested, distracting the person from their previous behaviour. Staff we spoke with recognised the achievements that had been made in helping this person to cut down on smoking.

People we spoke with told us that people respected their privacy and dignity. We observed staff knocking on people's doors and announcing their presence throughout the inspection. During a morning handover we observed that staff spoke about people in a respectful and dignified manner, especially when they were talking about sensitive issues or health matters. One staff member said, "It is important to respect people, ask people how they want things done and give them a choice." Where one person had food stains on their clothes after lunch, we saw a member of staff talk with the person about this and encouraged and supported them to change into a clean jumper. We did observe two examples of poor practice regarding people's privacy and dignity on the first day of the inspection. There were no protected mealtimes in place as medicines were being administered in the dining room during lunchtime. The member of staff responsible for medicines did not always respect people's privacy as they were speaking loudly to other staff across the room about people and their medicines, rather than going closer to the person and talking in a calmer manner. We also saw one person was supported with an ointment whilst in the dining room. We spoke to the manager about this who acknowledged the staff should have taken the person back to their room to ensure their privacy.

People's care plans had information about their likes, preferences, interests and best approaches for staff to make them feel calm and positive. Where this was not in place the provider acknowledged that people's records were still in the process of being updated and changed over to their own template format. Staff we spoke with told us they had opportunities to review people's files when assessments were carried out to get to know how they liked to be supported. One member of staff said, "With the agency staff that we use, they do use regular staff who have worked here before and know the residents and work closely with the staff team. I'm confident in the job they are able to do."

Although people were not always able to tell us if they were involved in decisions about their care, staff told us that people were supported to express their views about the care they received. One person said, "The manager came to speak to me and asked what time I wanted to get up. One relative told us that their family member had provided information about how they wanted to be supported. We saw one person's relative had been involved and invited to a meeting to discuss their family member's care needs with a health and social care professional. The manager told us that relatives were always invited to any scheduled meetings.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved in and we saw pre-assessment plans had been completed. The provider also accepted people on a respite basis, for short periods of time, with the possibility the placement would become permanent. The manager told us that they made sure people and their relatives were involved and we heard arrangements being made for an initial assessment during the inspection.

Care records included people's personal information and covered a wide range of areas which included personal care, breathing, health conditions, continence, communication, nutrition, mobility and behaviour. However, there were inconsistencies across the care plans we reviewed. Not all records had sufficient information in place to ensure people received personalised care and monthly evaluations had not always been completed. The provider acknowledged this and was aware of the areas where improvements needed to be made. The area manager said, "We know it is a work in progress and we are addressing the issues we find. We need to get into the mindset about what work needs to be done and we are getting there."

For example, one person's dignity care plan stated that staff should ensure their preferences were met but it was not documented what their preferences were. Their physical health check records were blank and their monthly care plan evaluations had not been updated. We spoke to a team leader about this person who was able to provide updated information about their care and support. It included pain relief creams had been introduced, the person was prone to urinary tract infections and now needed the support of two staff for transfers, but not all of this had been recorded in their care plan. We saw that concerns with another person's care and support had been addressed and referrals had been made regarding foot hygiene and catheter care. However, this had not been highlighted or updated in their care plan.

We spoke to a health and social care professional on the third day of the inspection who was carrying out an assessment on a person. They told us that they had been unable to carry out the assessment as the person did not have any hearing aids. Their care plan had also not been updated. We spoke to the manager about this who told us that they had not been made aware of any hearing issues and would make the relevant referral to an audiologist.

We saw that daily notes had not always been completed, with gaps in recording of the care and support people received. Where people needed to be monitored at specific time intervals this was not always being recorded. We discussed this with the manager who told us that this had not been common practice with the previous provider. We saw that this issue had been discussed at a recent staff meeting where it was highlighted about the importance of evidencing the care that has been provided. A health and social care professional also told us after the inspection that they had concerns about the lack of information that was recorded by staff to evaluate any trends or changes in people's health and support.

There was evidence that the provider listened to people's preferences about how they wanted staff to support them with their cultural or religious needs, with information that staff needed to be aware of. For one person, there were some simple phrases in their native language to help support staff when they were

carrying out personal care. Another person had information for staff to ensure they had food that met their cultural requirements three times a week. We saw a third person was supported to watch Irish news channels on an iPad. A health and social care professional told us after the inspection that they felt one person's cultural needs were not being met. We saw a copy of meeting minutes dated 18 October 2018 that stated a visual aid would be put on the person's wall with phrases in their native language to help staff encourage the person to engage in personal care.

Since the provider had taken over the service, they had recruited an activities coordinator. They had created an activities folder where each person had a profile which recorded their preferences and interests. It was reviewed monthly and recorded what people had been involved in and what they had been encouraged to take part in. The activities coordinator said, "I always try and spend time to find out what it is that people like. [Management team] have been really supportive of my ideas and given me full authority to do what I can and organise events and activities people are interested in."

Activities available were scheduled monthly and included a range of interactive card, board and word association games, gentle exercise routines, a plant pot painting project, current affairs and a book and film club. One relative had highlighted about cooking and we saw photos of a baking activity and another one had been scheduled for later in the week. We observed two people having a manicure and hand massages. Records showed that one person was supported to watch horse racing on an iPad. One person said, "I had a good laugh yesterday playing snakes and ladders." Another person told us that they had been supported to attend a football match. They added, "I went to the Arsenal match. I lost my voice as I shouted so much, so did the carer that came with me." We heard this person continue to reminisce about this experience on the third day of the inspection.

Apart from day to day activities, the activities coordinator had organised events throughout the summer and saw people were encouraged to get involved. We saw an activity diary had photos of a Royal Wedding party, a tea party, an Eid party with live music, a fashion show during London Fashion Week, trips to a memory café and the local city farm. One relative said, "[Family member] seems to join in with everything. They were all screaming with laughter when they did a fashion show with hats." One member of staff said, "The decision to recruit an activities coordinator has been great and has made a positive difference to people."

The activities coordinator had also introduced monthly residents meetings since July 2018 as a way to listen to people's experiences about their home. We saw minutes of previous meetings which showed areas discussed included entertainment, food choices, the building and any concerns with equipment. The meeting in July provided feedback for the chef with any questions about food. We saw that despite some people's abilities to contribute, people were encouraged to attend and get involved.

People using the service and their relatives said they knew who to talk to if they had any concerns or complaints about the service. One person said, "I know how to, but I've not needed to." There was a complaints procedure in place which looked to deal with any formal complaints within 28 days. The manager told us that if they received any minor issues or concerns they would deal with them immediately, but there were no formal records kept of what the concern was or what action was taken. We were told that there had only been one formal complaint about staff conduct that had been received during the inspection and was in the initial stage of being investigated. However, a health and social care professional told us after the inspection that a relative had made more than one complaint about the care their family member received, which had resulted in a healthcare visit on 1 October 2018. The concerns that were found during their visit were shared with the manager the following day and requested a full internal investigation into why the person's needs had not been met. We were not told about this during the inspection and it had not been recorded. We spoke with a director after the inspection who acknowledged that this had been missed.

We received correspondence from a health and social care professional that the provider had been proactive since being informed of the concerns and their response had been positive. They were happy with the actions that had been taken and were working towards positive outcomes for the person.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in post. The previous registered manager had left in July 2018. The current manager had submitted their application to be a registered manager during the inspection. She was present on each day and assisted with the inspection, along with the two directors.

The registered provider is required by law to promptly notify the CQC of important events which occur within the service. We found that not all safeguarding incidents had been notified to us. We found three safeguarding incidents had been raised in July 2018 which had not been notified to us. The provider said this had been the responsibility of the previous registered manager however acknowledged them as an oversight. We saw an incident of physical abuse had occurred in August 2018 where one person had physically attacked another person but had not been notified to us. The manager acknowledged that the incident had not been notified and told us they would make sure they notified us with any future similar incidents. We spoke with two health and social care professionals after the inspection who told us about a safeguarding concern that we had not been notified about. The local authority shared correspondence with us where the provider was made aware of the concerns on 2 October and a safeguarding meeting was held on 18 October 2018. We had not been notified about the incident at the time of writing the report and a director acknowledged this as an oversight.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the time of the inspection, the service was in a period of transition. The provider had taken over management of the service and a new manager was in post. We received mixed feedback about the management of the service and some of the changes that had been implemented which had led to a feeling of low morale amongst some of the staff team.

The majority of feedback was positive and comments included, "I'm confident that we are going in the right direction and that this will be a great place for both the residents and the staff team and we are working hard to fulfil people's needs", "They are very approachable and if there have ever been any problems they have always helped me", "The directors have a hands-on approach and deal with any issues. I find them very open and they regularly visit to check on everything" and "The change has been good. The directors are very involved and have knowledge and experience in this sector. They have plans for the future and I think the end result will be great." The negative feedback we received related to some staff feeling they were not listened to, staff well-being was not addressed and that they did not feel they could approach management with their concerns. One member of staff said, "There are some morale issues, the new company works differently to how we had previously worked. But, there is more monitoring in place which I feel is more robust." The management team was aware of these issues and explained that some staff were adapting to the changes but they were looking at ways to improve the current atmosphere. Another staff member added, "The manager is good and we are learning the importance that teamwork and having a good team helps to run the ship smoothly, and she is doing that."

We received positive feedback about how the provider had supported staff during the takeover and kept

them updated with any changes. Comments included, "It took a while to settle in with the changes, but I was supported during this time and feel we are now fully settled and work well as a team", "There have been periods of consultation and we have been updated about the changes in the structure of the company and discussed it in meetings" and "I feel the takeover was handled very well. My role was made very clear and we had meetings to discuss the handover and get any reassurances."

People we spoke with told us they knew who the manager was and felt comfortable talking to them. One person said, "The manager has been very helpful and approachable." One relative said, "Yes, I think it is well managed." Another relative said, "I know the manager yes, she's lovely." One health and social care professional told us that they felt the service responded well when they highlighted some issues and understood their responsibilities. Where we followed up a safeguarding concern for one person, another health and social care professional told us that the response from the provider had been positive and outcomes seemed to be improving.

The provider had started to put a number of internal auditing and monitoring processes in place since the takeover and acknowledged that the service was still a work in progress. The area manager had carried out a quality assurance visit at the beginning of the takeover in April 2018 and returned on 20 and 21 August 2018 for a follow up visit to check the action plan was being implemented. They were also carrying out a visit during the inspection. Areas covered included safeguarding incidents, care records, medicines, staffing, health and safety, training and supervision, activities and people's finances. The August 2018 visit showed that some improvements had been made since the first visit in April 2018. For example, the first visit highlighted there was no activities coordinator in post, little evidence of any activities occurring and the environment lacked stimulation for people living with dementia. We saw action had been taken and saw the positive impact this had made on the service. The area manager said, "We are still working on creating a more dementia friendly environment as there was nothing previously in place when we took over."

The August visit highlighted that some progress had been made and was ongoing, with actions to be completed being carried over to the next visit. The areas of concern highlighted were consistent with our findings during the inspection. For example, the audit highlighted care plans were still in the process of being transferred over to the new provider templates and lacked regular monthly evaluations. We saw that the lack of paperwork being completed and the importance of getting records updated had been discussed at a staff meeting in September 2018. Performance issues had also been picked up during staff supervision. The manager told us they were aware of this and were working towards addressing the findings from their internal audit.

We saw records that showed the manager had a range of daily, weekly, monthly and annual checks in place to monitor the service. People's financial transaction records were completed and signed by two members of staff and audited quarterly. Monthly bedroom audits had been implemented to check for safety and maintenance issues. There were a range of health and safety checks which included weekly door guard checks, bedrails checks, water temperature tests and mobility equipment, including hoists. Where we found some gaps in recording between August and September 2018, the manager acknowledged this and explained that their maintenance person had left without giving notice. They were currently recruiting for this position but were being supported by the maintenance person from one of the provider's other homes that was located approximately 20 miles away. They were present on the first day of the inspection. The fire risk assessment had been updated in July 2018 following a visit from the London Fire Brigade. Weekly fire alarm tests were carried out and we saw that seven fire drills had been completed between 5 September and 8 October 2018, all at different times to ensure all staff were involved.

The provider had sent out a survey to people who used the service and their relatives in August 2018 to

obtain their views about how satisfied they were with the home and the care and support they received. Questions covered areas including the appearance and cleanliness of the home, the food, attitude of staff, communication with staff and the care received. There was also an opportunity to highlight activities that people would like to see offered. Nine responses were received, with only one survey highlighting a negative response. Positive comments included, 'I'm happy living in this place, it is good', 'When I visit they always seem to enjoy what they do' and 'I cannot find any faults. My [family member] has settled in really well.'

We saw that the provider had worked closely with charities and organisations to build relationships in the local community. They had created links with the Alzheimers Society and people had been supported to be involved with a local memory café. The provider had encouraged people to complete their survey forms by offering to donate £1 to the Alzheimers Society for every form returned. They had also held a tea party during Dementia Action Week. The activities coordinator told us that they were involved in an activity coordinator forum, which was held at the local hospital. They said it gave them the opportunity to have regular meetings with other coordinators in the local area to discuss any problems with the role and share ideas and 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (ii) (iii) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that risks to the health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b)