Sanctuary Care Limited

Hawthorn Green Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted a comprehensive inspection of this service on 30, 31 October and 1 November 2017. The inspection was unannounced and we told the provider we would be returning the following two days. During this inspection we also followed up on information of concern that was received before the inspection in relation to a death.

The last focused inspection took place on the 4 and 11 October 2016 where we made two recommendations about the staffing levels and person centred care. The service was rated requires improvement.

During the focused inspection on 11 and 12 November 2015 we found two breaches of legal requirements in relation to staffing and complaints. The service was rated requires improvement.

Hawthorn Green Residential and Nursing Home is registered to provide residential and nursing care for up to 90 people. The home is organised into six units. The ground floor has two residential units, the first floor has two nursing units and the second floor has two nursing units specialising in care for people living with dementia. Each unit has 15 rooms with en-suite facilities and spacious communal facilities.

The home is located in Stepney and provides convenient access to local shops and transport links. At the time of the inspection there were 84 people living in the home.

The service had a registered manager in post who was present during the three days we inspected the home. 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.

Sufficient guidance was in place about the actions staff needed to take to make sure risks were safely managed; however these were not always followed. People received their medicines when this was needed and audits were undertaken, however aspects of the management of medicines were not always safe.

Not all staff had received regular supervision and appraisals. Training was available for staff to ensure they had the skills and knowledge to provide effective care for people; however not all staff training was up to date. A review of training had been undertaken to ensure staff completed the required mandatory training.

Feedback about the deployment of staff in the service was varied. Staffing levels were consistently monitored to manage this. The provider was in the process of recruiting new staff.

People gave us mixed feedback about the quality of the food. They were provided with sufficient food and drink and a dietician checked people's nutritional requirements, however staff did not always ensure that people's meal times were a good experience.

Routine visits were carried out by health practitioners to offer advice and treatment for people to meet their healthcare needs.

People and their relatives told us staff were kind and caring and their privacy was respected, however aspects of their personal care were not always fully met in a timely way. Advocacy and befriending services were accessible to ensure people had their views heard.

Systems were in place to monitor complaints and the information was accessible to ensure people understood how to raise any concerns.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was meeting these requirements.

People were supported to maintain positive relationships with their relatives and friends. They were provided with opportunities to participate in a programme of activities. People's cultural and spiritual needs were met and their care plans were person centred but some information need to be recorded more accurately.

People's feedback was sought about the quality of care. Checks were carried out and audits undertaken but these had not identified the issues we found. Staff spoke positively about the management of the home. The provider worked with external stakeholders to deliver integrated care.

We made one recommendation about the safe storage of medicines. We found three breaches of regulation in relation to safe care and treatment, staff supervision and good governance. You can see what action we asked the provider to take at the back 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

Aspects of the service were not always safe.

Risk's associated with people's healthcare needs were not consistently managed to ensure people were protected from harm.

People received their medicines when this was needed however medicines were not always managed safely.

Safeguarding procedures were in place for staff to follow. CQC had been notified of incidents required by law, but in one instance we found the provider's procedure in relation to safeguarding referrals had not been followed.

The deployment of staffing levels in the home was assessed to ensure there was enough staff to meet people's needs.

Recruitment checks were carried out on staff to assess their suitability for their roles.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

Supervision and appraisals for some staff were not regularly carried out.

Training was available for staff; however not all staff training was up to date. This was under review.

People's capacity had been assessed and best interests meetings held to ensure that people's rights were protected in relation to consent.

People had enough food and drink. However people had mixed views about the food and the menus did not always accurately reflect what was served.

Guidance and advice was given by healthcare practitioners when people needed support to meet their healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Aspects of some people's personal appearance required more care and attention to uphold their dignity.

People and their relatives told us staff were kind and caring and we saw examples of this.

Advocacy was available for people to access to ensure their views were heard.

Is the service responsive?

Good

The service was responsive.

Care plans showed the personalised care people required but some records did not contain enough detail.

A planned programme of activities was on offer to give people the opportunity to socialise with others in the home.

Complaints processes were available in accessible formats so people could understand how to raise any concerns.

Is the service well-led?

Requires Improvement

Aspects of the service were not always well led.

Systems to assess, monitor and improve the service were in place. However, these did not always effectively identify and address shortfalls.

People's views were sought about the quality and delivery of the service.

Staff spoke favourably about the registered manager of the home.

The provider was committed to working with external agencies to provide integrated care that met people's individual needs.

Hawthorn Green Residential and Nursing Home

Detailed findings

Background to this inspection

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

We conducted a comprehensive inspection of the service on 30 October 2017 which was unannounced. We told the provider that we would be returning to complete the inspection on 31 October and 1 November 2017. The inspection team consisted of one inspector and two experts by experience on the first day and a specialist advisor nurse and one inspector on all three days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), previous inspection reports and notifications sent to us about the service. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any serious incidents reported by the provider.

We contacted a representative of the Clinical Commissioning Group (CCG) to obtain further feedback about the service and obtained a copy of their site visit report.

During the inspection we spoke with 22 people and four relatives and spent time observing the care people received in all six units. We reviewed eight people's care records and 10 people's medicines records. We spoke with three activity coordinators, eight care workers, the assistant chef, head chef, two laundry assistants, the maintenance man, the regional manager and the registered manager. We checked four staff recruitment files, training records, rotas, minutes of meetings, quality assurance audits, staff rotas and some

of the provider's policies and procedures.

Additionally we spoke with four health and social care professionals visiting the service.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's health care needs were not always accurately identified and managed to ensure that people were protected from harm. Before our inspection we received information of concern about pressure sore care. We checked how people's pressure area care was being managed. There were wound treatment plans in place following input from a TVN and care plans were drawn up based on these to provide guidance for staff about how to minimise the risk of skin breakdown. However this guidance was not always consistently followed. For example, for one person we found a TVN's advice was not fully documented in their care records in relation to the person's turning regime and aids and equipment to be used. We checked the pressure mattress and found this was set correctly for the person's weight and staff documented daily the care carried out. A referral was made to the GP who advised the TVN should visit on a regular basis. The nurse explained they had visited however we could not find any records to show they had visited during this time. After the inspection the provider sent us information to show the district nurse had visited the person. Information in the person's turning chart showed they were to be turned two hourly, however on three separate dates in October 2017 there were large gaps in these records during the night shifts. For one date there was no recording on the charts for 14 hours. For a second date there was no recording on the chart for 12 hours, and for a third date there was recording on the chart for 14 hours. The care plan advised that weekly photographs must be taken and the wound measured however this was not consistently carried out in line with the provider's policy on wound management and pressure area care.

Another person had a history of reoccurring pressures ulcers before moving into the home and we saw a period where these had healed. Repositioning charts were checked over a period of one week and these were filled in correctly and the pressure mattress was set correctly. They had frequent hospital admissions and we saw that body maps were completed during admission and discharge however these were not done on every occasion. Following one hospital discharge we saw there were changes to the person's skin integrity, however there were no records to evidence these changes over a period of nine days. Records showed after this period and in line with their own procedures a referral was made to the TVN and the appropriate plans reviewed. The care records advised that photographs were to be taken every week; however we found that this was not done consistently. There was a pressure ulcer audit form in place however this was not completed accurately.

We checked people's mobility care plans. We found that risks associated with one person's mobility were not being reviewed each month as required in line with the provider's procedures. A nurse told us another person was not able to bear weight. Their mobility plan was up to date however this was inaccurate and read the person was weight bearing and could stand with the support of a mobility aid. We pointed this out to the nurse who told us this was completed by the night staff who might be unaware of the person's mobility.

This meant in these instances the provider had not done all that was possible to mitigate risks to people's safety. The above paragraphs constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

We checked how people were supported to manage their diabetes. One person's records showed their diabetes was insulin controlled and their care plan stated that staff should check their blood sugar twice a week. The records we viewed demonstrated this was being followed. For a second person we found their diabetes was diet controlled. Records showed the person's appetite was poor and that they were visited by the dietician in September 2017 who reported the person had lost weight, which would require close monitoring. The diabetic care plan noted the person's blood sugar was to be monitored by staff monthly; however there was only one blood sugar reading recorded which was high. There was no evidence that subsequent checks had been carried out. We spoke with nurse who agreed that the blood sugar monitoring should be carried out more frequently, with the readings reported to the GP. This meant we could not be assured that this person's diabetes was being safely managed. After the inspection the provider sent us information to show that this person's blood sugar readings were being monitored monthly.

People told us they received their medicines on time and when this was needed. Their comments included, "It arrives after every meal" and "I can ask any of the staff, sometimes if I am in pain they tell me what I could have but I know really. I can only have so many paracetamol a day, but it does not help that much. But they did listen because I have a patch now which is a bit better, they all help me." However one person told us they had to wait longer for their medicines if agency staff worked during the night.

Medicines were stored in a locked trolley within a locked room when not in use. The nurse held the keys to the trolley and only relevant people were handed the keys. The temperature of the treatment room and fridge showed readings which evidenced they were in the recommended safe storage limits. There was evidence of daily readings documented for this. Medicines in the fridge were suitably stored and spot checks showed these to be within their expiry date, however for one person we found their topical creams Diprobase and Cavilon were stored in their room once they had been opened and were not locked away. The nurse told us no one on the floor was independently mobile, except for one person who would not enter any room other than their own. These creams should be safely and securely stored due to the risks associated with emollient creams. We recommend the provider seeks advice about current best practice for safe storage of medicines and update their practice accordingly.

We checked the management of medicines. For two people we saw their medicines were administered covertly. There were clear protocols in place for this, following best interests meetings with health practitioners and their relatives, and these decisions were reviewed annually. However one person required their medicines to be given in crushed form, but there was no information to show that a pharmacist or GP had authorised this. We pointed this out to the registered manager who agreed to act on this.

Controlled drugs (CDs) were securely stored within a locked cabinet. There was a bound CD book and the remaining balances were checked at each administration and also during each shift by two nurses. Medicines for return and disposal were stored in plastic tamper-proof containers in a secure room along with a crushed doom kit. Disposal records were completed and signed, with two signatures noted for CD returns. There was signatory proof that nurses had read the provider's medicines policy manual which was stored in the treatment room, however there was no signatory proof that other staff members responsible for supporting people with their medicines had read the policies.

After the inspection the provider sent us information to show the person's record had now been signed by the pharmacist and details to show staff had signed records to demonstrate they had read the policies.

People received their medicines as prescribed. We observed a medicines round in a nursing unit. The nurse cross-referenced information between the medicines administration records (MARs) and the blister packs and checked the identification of each person. They took time with each person supporting them to take the

medicine before the MAR was signed. PRN protocols for staff to follow were clearly documented within the MARs. PRN medicines are those that need to be taken 'as and when required.' The trolley was not left unattended at any time. MARs noted people's details, including photographic identification, any known allergies and their preferred method of taking medicines. There was omission codes recorded for any medicines not given. The MARs we checked demonstrated staff had signed these to evidence that people's medicines had been administered. Systems were in place for staff to record any noted unsigned MARs, on a gap monitoring form and no incidents had been recorded. There was a system in place for the registered manager, GP and relatives to be informed if people did not receive their medicines as prescribed, and people involved would be closely monitored for any adverse signs and symptoms. The incident would be clearly documented and staff responsible for the error would be supported with further training and supervision if this was required.

Prescriptions were reviewed by the GP every month or as requested by staff. The nurse was clear about the need to regularly review whether medicines were necessary and effective and commented, "Our doctors are very good; they listen." They told us that new nurses received medicines training to ensure their competency in administering people's medicines.

There were checks in place to show that pressure relieving mattresses were appropriately set and in working order. For one person regular checks were carried and records were ticked and initialled every day to evidence these were in working order. However the mattress pump unit had calibration markers showing, but no indication as to how to match these to the person's weight. We pointed this out to the nurse to check how they indicated the mattress was correctly set, but they were unable to tell us. There was no manual in the person's room to use as guidance for staff to ensure the mattress pressure settings were appropriate for the person's weight. We pointed out our findings to the registered manager who was responsive to this. She photocopied the page from the manual and had it laminated, in order that the staff could check it was suitably set. She expressed the view that the mattress was not of a standard she felt was acceptable and told us she would purchase a more up to date model. She also checked all of the mattresses in the home, and found one other model like this one and explained it would also be replaced.

Before this inspection we received information of concern about staffing levels. We asked people if there were enough staff to support them when needed. Their comments included, "Yes generally speaking" , "I think so, but I would like to see more", "Yes, there is enough", "No; they seem to shout all the time "and "Sometimes there is, sometimes not. Sometimes they rely on agency staff. There is no continuity but sometimes you can make a rapport." A relative told us, "Daytimes yes, night time when someone goes to the hospital it can be ok. At the weekends plenty of staff around. In the year [my family member] has been here, never seen a shortage."

The majority of staff we spoke with told us there was enough staff but said it was a "balancing act" trying to cover unplanned leave and difficult at times to find agency staff. Three staff in one unit explained there was not enough staff on their floor to support people. One staff member gave us an example of how they remained on duty after their shift had ended as the team leader on night duty had called in sick. Therefore they had stayed on duty for an extra hour to assist people with their medicines until an agency staff member could be sourced. The registered manager explained the nurse from another unit could also support people if needed.

At our last inspection we made a recommendation for the provider to assess the deployment of staff to ensure people's needs were met in a timely way. During this inspection we found the provider did have staff vacancies in the home and sourced bank and agency staff to cover any additional shifts and the registered manager told us there was less reliance on agency workers. A process of recruitment was in place for five

care assistant vacancies and domestic assistants. The registered manager was supported by a deputy manager who was on leave during our inspection. At the time of the inspection there was no clinical lead in post. A new candidate had been recruited and was due to take up the position by the end of the November 2017. The registered manager told us they monitored staff's absence regularly, and felt there were enough staff in the home. Rotas were drafted a month in advance and the registered manager explained staff were able to swap shifts when this was required. The provider determined the level of staff required based on the occupancy of each unit.

At the last inspection we were told the call bell system was to be upgraded to provide data to show how long it took for staff to respond to call bells. During this inspection we were told the system had not yet been upgraded so we could not check this information.

We observed that calls bell were in reach of people to ring for assistance when this was needed and people told us staff responded to these but said at times staff were busy. They commented, "I press my button here, they come to me, they come quickly sometimes but they are busy" ,"They come maybe up to 15 minutes, depends how busy they are", "They listen and come when I press my bell" and "The call bell is not working at the moment, hasn't been working for two months. They said it is being looked into and it is complicated. The manager bought me a hand bell. I don't like using it as it makes me feel we are in Upstairs /Downstairs." The maintenance staff explained they were waiting for repairs to be carried out to the system but this had been delayed as parts for the system were difficult to source due to the call bell system being an older model.

The provider had installed new technology that determined the number and length of times a person required support in their rooms. Staff were required to swipe the room doors when entering and leaving people's rooms. The data collected could be used as a dependency tool to assess the staff support required to meet people's individual needs during the night. However we could not check this information as the system required repairs and we were told by the registered manager this was being followed up

Pre-employment checks were carried out to assess staff's safety and suitability before being employed by the provider to work in the service. There was a robust procedure in place, two references were verified and criminal records checks were undertaken. Letters were sent to staff as a reminder to bring in official documents when these had expired, such as proof of their right to work in the UK. Nurses were registered with the Nursing and Midwifery Council and their PIN numbers were checked and were up to date.

People we spoke with described the service as being safe and said, "I feel safe, but I don't know why. Maybe it's the care of the staff and the regular food", "I do feel safe they always look after you nothing is too much trouble, the nurses are the ones who know what is going on" and "There is always someone around. I don't see strangers walking around." A relative commented, "I think [my family member] is safe. All the family are happy [they] are being well looked after and are safe." Another relative told us, "I come in every day, [my family member] always has clean clothes on I have never seen any marks and if there are any problems this is usually brought to my attention by the nurse."

There were systems in place to reduce the risks of harm or potential abuse. Staff we spoke with told us the actions they would take if they suspected that people were at the risk of harm. The provider had notified us of any incidents that occurred in the service as required by law. Where safeguarding alerts had been raised they had worked with the local authority to implement a plan of action. There was one on going safeguarding in relation to a death in the home. We noted that although the provider had notified us of a grade three pressure sore as a serious injury and the appropriate referrals were made to healthcare professionals, these injuries were not raised as a safeguarding alert in line with the providers wound

management procedure. We discussed this with the regional manager and the registered manager who acknowledged this.

Staff knew how to report workplace concerns if they suspected wrongdoing and were able to explain what type of things they would report and who they would report this to.

People told us their rooms were regularly cleaned. They commented, "The room is good", "Definitely always spotless" and "Every day the place is vacuumed out." Despite this positive feedback some areas of the home required more general cleaning and up keep. We saw there was a domestic assistant on duty tidying people's rooms but in one area of the home the floor coverings were worn and in communal areas, the visitors bathroom required cleaning, hand gel wash had ran out in one unit and there were scuff marks in communal hallways. The laundry room was tidy and people's clothing was placed in separate laundry baskets labelled and coded with people's names. We spoke with the laundry assistants who told us they had completed Control of Substances Hazardous to Health (COSHH) training and there was always two staff on duty to help with laundry duties. They explained how they washed bedding items at high temperatures to reduce the risk of contamination and maintain safe infection control.

Checks were carried out in the home to minimise the risk to people's safety. External contractors were on site to carry out routine maintenance on the exterior of the building requested by the provider. The maintenance man told us that routine checks were carried out on equipment such as bed safety checklists every quarter and fire safety equipment and the records we checked confirmed this. In this way the provider had taken appropriate action to ensure people's safety. People had individual personal emergency evacuation plans (PEEPS) in place, however we found that one person's required a review.

Requires Improvement

Is the service effective?

Our findings

People we spoke with gave us mixed feedback about staff being sufficiently trained to carry out their roles. Their comments included, "Absolutely yes", "The full-time staff are trained", "I think so, they do what is necessary", and "Not sufficiently" and "Some of them are and some are not, those that do are good." A relative told us, "They all seem to know what they are doing."

Staff training was tailored to reflect the needs of people who used the service and the requirements of the role. New employees described the induction and mandatory training they received when they began working for the provider. Information showed the provider had engaged with external organisations to deliver face to face training for staff. We saw that dementia awareness training was booked for November 2017 every week for three hours to be facilitated by a trainer at the local hospital. Records evidenced a nurse had received training from a hospice in palliative care to provide dignified end of life care for people. There was information about a nurse engagement forum for nurses to keep in touch and share knowledge, information and discuss any concerns. Records showed the provider was 100% compliant with train the trainer in moving and handling people and two staff we spoke with confirmed they had completed this training. One staff member told us about expectations in relation to moving and handling, they said, "We have to use the hoist and have two people assist, the provider is very strict around this, it will be straight to disciplinary procedure if you attempted that by yourself."

Records showed that compliance rates for some staff training was low. The compliance rates for moving and handling was recorded as 78%, medicines 70% safeguarding 67%, the Mental Capacity Act (2005) 65%, fire wardens training 25% and engaging people with dementia 17%. Records demonstrated a review of staff training was carried out on October 2017. This noted that the training matrix had been updated, and the provider was to increase compliance for these subjects. Further schedule training dates were to be scheduled and possible reminder letters to be sent to the staff to ensure they completed and attended the refresher training. We will check this at our next inspection.

The majority of staff we spoke with told us they had received regular supervisions to discuss their practice and performance. However, two members of staff told us they had not received regular one to one meetings or an annual appraisal. We checked staff files and found two out of the four showed staff did not have regular one to one meetings and there was no staff annual appraisal on file for these two members of staff. This was not in adherence with the providers procedures.
Training, supervision and appraisals are essential to enable staff to carry out their duties effectively to ensure people's needs support needs are met.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the food served in the home varied. Their comments included, "I am looking forward to my lunch they have a good choice here, every day something different. I have lots of drinks and I like the cakes and biscuits they are always bringing something round for us and my family bring me chocolate and

sweets", "They try their best, some lunch is better than others, I like the cornflakes", "The food is ok, pretty good no reason to complain", "I don't like the dinner it looks the same every day" and "Now there is a bugbear. I am a vegetarian and the choices are not very varied." A relative commented they made a complaint about the food and said, "The food, it's rubbish. It didn't match what was on the menu versus the plate. This was about six weeks ago. They used to have menus on the table but they have now gone."

We observed the lunchtime meals and saw people were served their meals on time; however we saw that the menu did not match what was being served. We spoke with the assistant chef and staff about this who told us there was a mix up with the delivery of food. In order to inform the units of any changes they posted a memo to all staff which we saw on the kitchen noticeboards, however the incorrect menus were still displayed on the dining tables.

We sampled the food and found this to be tasty and of good quality. The portions were of a good size, several people were given second helpings when offered and people finished what was on their plates. A relative commented, "[My family member] put on a good 10kg in the year [they] have been here." Drinks were offered before, during and after lunch. We saw staff asking people if they would like drinks frequently and noted tea, blackcurrant and orange juice and water being offered. On all the days of our inspection we saw that hot and cold drinks were placed in reach of people in their rooms and when people were seated in the communal areas of the home.

We observed interactions between staff and people during their meals. On one unit support was not task led and there were good interactions and frequent conversations between people and staff. Two people were asleep in their rooms and we noted staff checking on them. On a second unit we noted a person exhibited behaviour that challenged as a symptom of their dementia and we saw this did not deter staff from using deflection techniques to give full support to them with their meals, which was managed skilfully. However, on the third unit we noted the tablecloths, coverings and napkins appeared dirty and there was no feeling of a mealtime occasion. During lunch we observed the bin bag being changed beside a person when they were eating. There was little effort to interact with people although we saw a member of staff after lunch explaining carefully what a person could do and asking them where they wanted to go.

We checked the kitchen where foods items were prepared and stored. The white board held details of people's requests and specific dietary needs, such as halal foods and vegetarian options. The assistant chef explained they followed the dietary notifications and any advice following the dietician's assessment of people's nutritional requirements. People's birthdays were listed and the chef explained this was a reminder so they could prepare them a birthday cake of their choice to mark their special occasion. There were separate preparation areas for foods, such as fruit, vegetables and meats. Regular temperature checks were recorded and foods items were stored appropriately. The service had been rated a '5 star' food hygiene rating which is the highest rating. The top rating of five means that the home was found to have 'very good' hygiene standards.

The provider followed the legal requirements 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some people were able to make decisions for themselves and told us that staff sought their consent before doing things for them. Their comments included, "I do make decisions, they ask me about my pain or food and they listen to me and I get my family to help" , "They are committed to asking" and "They ask me first if

they can wash me." Where people were unable to make specific decisions for themselves we found the principles of the Act were applied and followed. In these cases, assessments had been carried out and best interests meetings were held, for example, for people to be cared for and accommodated in a safe environment. Records evidenced that people's decisions were listened to, for example, we saw notes where one person was offered support from a dementia care team but had refused this support.

Staff understood they could only provide care and support with people's consent. We observed nurses obtaining people's consent prior to administering their medicines and heard staff explaining what they were going to do clearly before they supported people, for example, during their mealtimes.

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 the Deprivation of Liberty Safeguards. DoLS applications were sent to the placing authority as required and authorised where appropriate.

People told us they were visited in the home by healthcare professionals. Their comments included, "They come all the time. My dentist I used to know before I came here, we really laughed when she came in as I have known her for years. They are always checking if I need to see someone" and "The doctor comes every Tuesday and Thursday I just tell the carer who sorts out the appointment."

We saw a number of health and social care professional visits take place during the inspection including a dietician, GP, an occupational therapist and a registered mental health nurse. Records evidenced the frequency of these visits when requested by staff along with routine checks and the actions they advised staff to take. We spoke with a GP who explained there were four allocated GPs on the rota who provided treatment and advice for people and guidance for staff to follow in the home. They spoke positively about the service provided including the clear communication with the nurses on site. The home worked as part of an integrated care team and records of professional health visits included the chiropodist, social workers and the dentist. A psychiatrist was available to carry out assessments and reviews for people diagnosed with a mental health condition.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and kind. Their comments included, " I do not worry they are kind", "They always give me drinks, they smile", "The staff care so much, all of them we are always doing different things and they cannot do enough for you" and "The staff really do care, all the time they rush around and then they sit and talk. Some people here sleep a lot or they come into the lounge and are awake for a while then they fall asleep, but the staff smile and stroke them or help them when they wake up. They all look after me, I am very lucky." A relative told us, "The standard overall is good but there are those that do the basics and those that go the extra mile."

People had washing and dressing care plans which outlined the personal care they required support with. One relative told us that their family member was living with dementia and they could not verbally communicate, so would not be able to communicate if there were any concerns. They saw that staff took good care of their family member and explained why, "I can tell by [my family member's] appearance." However in one unit we saw that more attention and care was required for aspects of some people's personal appearance and their environment. For one person, their hair appeared unwashed and their records showed their hair required washing with a prescribed product, to manage a specific health condition. It was noted daily this personal care need was to be carried out by the night staff, but records gave a general description stating the person was washed and dressed but did not document that this specific care need was carried out. There was also no care plan in place for this person regarding their nail care and no reference made to how this need would be met. Their bedding also looked crumpled and unwashed. We pointed this out to staff and the nurse explained they would amend the care plan to include this. The following day we checked on this person again and found that one aspect of their personal care had improved and their room had been cleaned. For a second person we observed their nails required care but saw no reference to this specific aspect of their care in their personal hygiene care plan.

There was a welcoming and calm atmosphere in one unit and the majority of the staff explained they had worked in the home for a number of years most notably, one staff member for 17 years. They explained they enjoyed working in the home because of the good staff. When we spoke with them about people's needs it was apparent they were knowledgeable about people's backgrounds, lifestyle choices and health conditions. A relative told us, "This unit is managed excellently. I think [my family member] is in a safe place. There was one occasion where [my family member] refused personal care. I saw the way [staff name] managed this. The way they spoke with [my family member] to make [them] change, they managed this excellently and just knew what to do."

At our last inspection we found that staff did not take the time to sit and interact with people frequently. At this inspection we asked people if staff took the time to talk with them throughout the day. Their comments included, "Occasionally only because they are too busy", "Yes but not as much as I would like it", "No not really" and "Some do some don't." A relative told us, "Yes definitely I have seen them."

Located at the rear of the home was a large outdoor garden with neatly manicured lawns and seating areas. People and staff talked about the garden and the outside space being used frequently. One person told us,

"We go out to the garden, I love the barbeque and sitting in the garden, we won't be able to go so much in the winter because it is too cold but we go every week in the summer, sometimes I think I go every day."

In the communal areas the views from the windows, the wide corridors and large rooms gave the home a feeling of space, and we saw some people walking about or sat in areas of the home relaxing peacefully. Visual aids such as memory boxes were placed outside some people's rooms to help them recognise their room and people told us their family and friends visited the home frequently. One person commented, "My sister comes and a good friend comes too, as well as the priest. I am still on the church committee." Relatives explained they visited their family members when they wished and were always welcomed by staff on arrival.

All of the people we spoke with told us their privacy was respected and said they were able to choose how they wanted to spend their day. On person told us, "I get up about 8am. It is my choice someone comes in to get me up." Another person said, "I am not a good sleeper. Never sleep all the way through. I would make a fuss if they woke me up so they leave me alone." Staff knocked on people's doors and called their names before entering their rooms. They told us they closed doors and curtains to ensure personal care was carried out in the least intrusive way. One person commented, "They are professional, some are very caring and do treat me with respect. They use my name and tell me what they are going to do, very considerate staff."

People had expressed their end of life wishes and these were documented in people's files. We spoke with a visiting health and social care professional from a local hospice who described how the staff and the GPs worked in liaison with the hospice to support people who receive dignified palliative care. We saw information to show there was a befriending and advocacy service available for people who were terminally ill and those reaching the end of their life. The registered manager explained they were keen to use the befriending service that offered friendship and advocacy to people to meet most specifically their cultural and spiritual needs.

Good

Is the service responsive?

Our findings

At our last inspection we found some people's records were not updated to reflect peoples' nutrition and fluid intake. During this inspection we checked the food and fluid balance charts for people and found they were completed consistently, but we noted for two people their Malnutrition Universal Screening Tool (MUST) had been calculated incorrectly. These people were a healthy weight but the tool is set to highlight potential risk so that measures can be taken to minimise malnutrition before it happens. We spoke with staff who stated this was a typing error and agreed to update these changes. We saw the dietician during our inspection who was reviewing people's nutritional needs along with the nurse, who was helpful in assisting them.

Records showed the provider carried out a 'pre move in assessment' of people's needs to determine whether or not the service could provide people with the required support. We found some of these contained limited information and needed to be completed in more depth to fully capture an overall assessment of people's needs. However, we found that care plans covered all aspects of people's individual needs.

Care plans were in place to give staff guidance on how to support people, such as what was important to each person, a personal history and account of their lives, how to keep people safe and healthy and their expressed preferences. A relative told us, "The care plan is done by the nurse here and we see people get out of their chairs, they have full support. They encourage [my family member] to get up and walk on [their] own. She/he is eating well."

Transitional placements were available for people based on their changing needs. One staff member told us they were involved in the initial assessment of people's needs along with health practitioners which was a beneficial approach so everyone had a shared understanding of people's overall care and support needs. They further added because people and their relatives knew staff well in the unit they were more reassured about the transition from the residential units into the nursing units. We spoke with a representative from the continuing health care team who was conducting an assessment of two people's health needs in the residential units to see if they met the requirements to be moved into the general nursing units. They gave us examples of the referrals that were made to their team and how the overall outcomes of the assessments were decided based on people's healthcare needs.

People told us about the activities they enjoyed in the home. Their comments included, "I love the music on Fridays we all go down and listen to the piano and have a really good sing song like all the war songs, well it might just be two or three of us because everyone else is asleep. Sometimes we make things there is always something going on here. I really like the bingo, everyone is laughing and calling out, such good fun the carers join in with us.", "I stay in my room but sometimes they come and talk to me", "There is music which is nice and there is a lovely garden" and "Always something to do, I like these cards they show us what to do."

We spoke with three enthusiastic activity coordinators during our visit and observed the different activities taking place. The activities were held in different units each day. We saw people being supported to attend

the other units, which allowed other people to meet and socialise. We noted that two activities did not take place as scheduled but there was a concerted effort by staff to organise alternatives which included live music, quiz games and a Halloween themed party which involved people making arts and crafts in preparation for the event. One person told us, "Sometimes I am bored but then I try and make myself get unbored because there is always something to do then the boredom wears off. I might look at my magazine, books or I watch a film I like 'Annie' or something else is happening."

There was a programme of activities on the notice boards with information about upcoming events, such as visits from the hairdressers, pet therapy sessions and a church service. One staff member told us a member of their team met the spiritual needs of the Bangladeshi community and took people to the local mosque to pray. Sanctuary Care had developed their own volunteer scheme so that people in the local community could contribute to different activities with people to encourage social inclusion. The registered manager told us this would be rolled out by the end of November 2017. There was an intergenerational project with local schools and a person commented, "A young lass come from the community and came to talk with me. I liked that very much."

Refurbishments in areas of the home had taken place. There was a bright and welcoming Namaste room used to provide therapeutic and calming space for people living with advanced dementia. A room on the first floor had been refurbished into a spacious rock and roll themed café area for people and their relatives to sit and relax with each other. Newsletters documented the activities that took place in the home and we saw people had been involved in birthday celebrations, Silver Sunday and an Easter egg hunt during dementia awareness week. Records showed that a staff member accompanied their family member to a special celebration when requested and a relative told us people went on a coach trip to Southend. There were photographs of the trips and outings people had attended and an attendance list showed details of people who participated. In response to the activity programme taking place the GP had provided written feedback complimenting the 'creative and inventive activities that showed pride on what was offered'.

People told us who they would speak with if they were dissatisfied with the service. Their comments included, "Firstly the staff, then the manager in the reception area", "I would talk to the nurses I would ask them" and "I could ask anyone they would help me and I can ask my family they would know what to do." Comments from relatives included, "Well [my family members would be the one to ask the questions but I think you could talk to any of the staff here and [family member] does know who the senior nurse is" and "I am confident in their ability to resolve a complaint. The manager is very forthright, she would sort it out."

There was a system to manage complaints about the service and the complaints procedure was displayed in areas of the home. The registered manager told us there had been no complaints since the last inspection. The procedure gave information about external organisations that people could take their complaint to if they were not satisfied with provider's response. To ensure people could understand the information the service had produced an easy read version of how to make a complaint and a compliment. The information was also available in Bengali to meet the needs of people using the service.

Requires Improvement

Is the service well-led?

Our findings

Regular audits had been carried out to check on the quality of care. These identified actions that needed to be taken to improve the quality of care. These included staff training, DoLS, the environment and people's medicines, for example, these picked up gaps with MARs compliance, such as failure to follow coding instructions. However these did not pick up the issues we found with people's medicines, staff supervision, dignity and care and records required a more thorough approach to assessing risk.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

External agencies had carried out checks on the service and implemented a plan of action for the provider to follow, most notably for staff compliance with training to be met, recording accurate information in care records regarding people's nutrition, storage of topical medicines and cleanliness in areas of the home.

People and their relatives told us they knew the registered manager of the home and expressed their views about how the service was run. Their comments included, "Relaxed, friendly and congenial", "It is everything you need it to be if you need to be here", "Knowing how it is, I wouldn't go anywhere else" and "Better than the other place." Comments from relatives included, "Just maybe some reservation with regards to staffing levels and food requirements" and "There is not a lot of selection of care homes in this area for people with dementia and challenging behaviour and they manage this well."

Staff described the registered manager as supportive and treated them as a valued member of the team. They explained, "I do think it's well managed. [She] is always someone you can go to and approach, she praises her staff when they have done well", "The manager is good and understanding. She is lovely and acts professionally" and "She is very good and really helps to sort out any problems."

During all three days of the inspection the registered manager was visible, approachable and was seen frequently speaking with people and staff in all of the units. They were very knowledgeable about people's interests, health needs and preferences and told us their door was always open for relatives to speak with them about any suggestions or concerns they had.

Staff were given the opportunity to lead and manage the residential units each day. They were allocated as the team leader on different shift patterns along with the responsibility of allocating the team, medicines and general discharge of duties. A staff member explained this was good practice and enabled them to progress their skills and practice in this role.

We did not see consistent records of staff meetings and were only able to check the records up to May 2017, and it was noted a potential nurse's meeting was to be also held in May 2017. The registered manager told us the minutes of subsequent meetings had not yet been typed up.

People and their relatives told us their views were sought about the quality of the service. The resident's

survey for 2017 was sent to us after the inspection. This showed that 75% of people were satisfied with the food, 92% were happy with their care and support, 100 % said they were happy with the activities and the services overall.

The provider benefitted from the support of an integrated care team in Tower Hamlets, for example, the occupational therapist from the local hospital carried out a falls assessment for everyone in the home which led to individual fall care plans being produced. We saw information about the initiatives to prevent social isolation in care home's and the provider's involvement with this.

The provider worked with other agencies as a part of an integrated approach to care in order to share knowledge and information. The service had signed up to work in collaboration with the vanguards which enabled them to trial new initiatives that were taking place in the borough. Vanguards work with new models of care to deliver real change for people and staff. The provider was part of the Tower Hamlets 'Red Bag' scheme. The red bag holds all the key documents and items for people if they need to attend the hospital such as information about people's medical condition, clothes and personal belongings on admission to hospital. Items such as hospital notes and newly prescribed medicines are placed in the red bag by the hospital staff when the person is discharged. This ensures all the key information for people is easily accessible to ambulance and hospital staff and improves the sharing of information when people transfer between two healthcare facilities.

The registered manager explained there were future plans to refurbish a room on the ground floor with views of the garden to provide a family room with additional facilities for visiting relatives and their children.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate risks Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation17 (1)(2) (a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Staff did not receive regular appraisals of their performance to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a)