

M D Homes

Frithwood Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 3 August 2017 and was unannounced. The service was last inspected on 1 March 2016 when we found four breaches of Regulation because the provider had not ensured that the care and treatment of people who used the service met their needs and reflected their preferences, people were not treated with dignity and respect, care and treatment was not provided in a safe way and there were no systems to assess, monitor and mitigate risks to people using the service. At this inspection we found the provider had made some improvements. However, we found two repeated breaches of Regulation.

There was a registered manager at the service at the time of our inspection. 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.

Frithwood Nursing Home is a nursing home for up to 26 older people, some of whom were living with the experience of dementia. There were 22 people in residence at the time of our inspection. There was one room which was shared by two people. The service was managed by MD Homes, a private organisation which managed five nursing homes in North West London.

Staff did not always follow the procedure for recording and the safe administration of medicines. This meant that people were at risk of not receiving their medicines safely.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, medicines audits had failed to identify the issues we found.

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the management of medicines and governance. You can see what actions we told the provider to take at the back of the full version of this report.

Staff received training identified by the provider as mandatory. However some of the courses were delivered by the registered manager who was not qualified to deliver this training. Training specific to the needs of the people who used the service was delivered by external certified trainers. This equipped staff with the skills to provide appropriate and effective care for people using the service.

There were organised activities at the service and we saw people being involved in these on the day of our inspection. However, there was a lack of person centred activities.

The environment was not designed in a way to support people who were living with the experience of dementia.

People's capacity to make decisions about their care and treatment had been assessed. Processes had been

followed to ensure that, when necessary, people were deprived of their liberty lawfully.

People told us they felt safe at the home and trusted the staff. They told us staff treated them with dignity and respect when providing care. Relatives and professionals we spoke with confirmed this.

We saw people being cared for in a calm and patient manner.

People gave positive feedback about the food and told us they were offered choice. People had nutritional assessments in place. People had access to healthcare professionals as they needed, and the visits were recorded in their care plans.

People, relatives and professionals we spoke with thought the home was well-led and the staff and management team were approachable and worked well as a team.

The care plans we looked at were signed by relatives or representatives. We saw evidence of best interests assessments where people lacked the capacity to make decisions about their care and support.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Care plans were reviewed and updated monthly and included instructions for staff to follow to ensure people's needs were met. Care plans contained information about people's daily routines and preferences.

The provider had processes in place for the recording and investigation of incidents and accidents. Risks to people's safety were identified and managed appropriately.

There were enough staff on duty to meet people's needs in a timely manner.

People felt safe when staff were providing support. Staff had received training in safeguarding adults and demonstrated a good knowledge of this and what they would do if they thought someone was being abused.

Staff received regular supervision and an annual appraisal, and told us they felt supported by their manager. There were regular staff meetings and meetings with relatives.

Recruitment records were thorough and complete and the provider had ensured that staff had appropriate checks prior to starting work.

There was a complaints process in place and most people and relatives told us they knew who to complain to if they had a problem. Relatives were sent questionnaires to gain their feedback on the quality of the care provided.

We made recommendations in relation to the environment and consent.

We are proposing to take further action against the provider for the breach of regulation in regards to safe care and treatment. We will add full information about CQC's regulatory response at the back of the full version of the report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe.

Staff did not always follow the procedure for the recording and safe administration of medicines. This meant that people were at risk of not receiving their medicines safely.

People felt safe when staff were providing support. Staff had received training and demonstrated a good knowledge of safeguarding adults.

The provider had processes in place for the recording and investigation of incidents and accidents. Risk to people's safety were identified and managed appropriately. Staff were aware of the risks to people's safety and supported them to manage those risks.

There were enough staff on duty to meet people's needs in a timely manner. Checks were carried out during the recruitment process to ensure only suitable staff were being employed.

Requires Improvement 

Is the service effective?

The service was not always effective.

The environment was not designed in a way to support people who were living with the experience of dementia.

Some of the staff training was delivered by the registered manager although they were not qualified to do so. This meant that the training might not have been validated. Other training specific to the needs of people who used the service was delivered by certified external trainers.

Staff were suitably supervised and appraised by their line manager.

Most people had consented to their care and support. The service had policies and procedures in place to assess people's capacity, in line with the Mental Capacity Act (2005).

People were protected from the risks of inadequate nutrition and

Requires Improvement 

hydration. People had a choice of food and drink for every meal, and throughout the day.

Staff supported people to access healthcare services and liaised closely with healthcare professionals so people's needs were met.

Is the service caring?

Good 

The service was caring.

Staff interacted with people in a friendly and caring way. People said they felt well cared for and had good and caring relationships with all the staff. Relatives and professionals told us people using the service were well cared for.

Care plans contained people's background and their likes and dislikes. People were supported with their individual needs in a way that valued their diversity, values and human rights.

Is the service responsive?

Good 

The service was responsive.

There were organised activities. However there was a lack of person centred activities.

People's individual needs were identified when their care and support was being assessed, planned and delivered.

People and their relatives were encouraged to express any concerns and complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement 

Some aspects of the service were not well-led.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, audits and other checks carried out by the provider had failed to identify the issues we found.

At the time of our inspection, the service employed a registered manager. Staff told us they felt supported by their manager.

People, relatives and professionals we spoke with thought the home was well-led and the staff and management team were

approachable and worked well as a team.

Frithwood 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.

This inspection took place on 3 August 2017 and was unannounced.

The inspection was carried out by one inspector, a pharmacist specialist advisor, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spent some time observing care and support being delivered to help us understand people's experiences of using the service. We also looked at records, including the care plans for seven people who used the service, four staff records and records relating to the management of the service. We spoke with ten people who used the service, nine staff, including the director, the registered manager, four care staff, the chef and a nurse. We also spoke with two sets of relatives who were visiting people at the time of our inspection.

Following our visit, we contacted six healthcare and social care professionals who were regularly involved in the care of people using the service to gather their views about the service and obtained feedback from three.

Is the service safe?

Our findings

We checked medicines storage and medicines records for all the people who used the service. All prescribed medicines were available. Medicines were stored in a locked medicines trolley in a designated locked room. There was a medicines fridge and we saw a temperature chart was in place and temperatures recorded were within safe limits.

Most people and their relatives were happy with the way they received their medicines. Their comments included, "Yes, that's always done by the nurse", "I am also happy that [my relative's] medication is given at the right time" and "Everything is ok with medication."

Whilst it was evident that most people received their medicines as prescribed, some did not and we saw evidence of this in the medicines administration record (MAR) charts we looked at. For example, a person had been prescribed a course of antibiotics at night when the on call doctor visited. The person had also been prescribed a regular prophylactic course of antibiotics while awaiting for the prescribed course of antibiotics to be delivered from the chemist and which was to be stopped when this was received. However, the MAR chart showed that both medicines had been given and signed for on two days. Another person was prescribed an inhaler to be taken twice a day and this was clearly stated on the MAR chart, however, as only the 6pm dose had been highlighted on the MAR chart, staff had followed this and only administered and signed for one dose for the whole of the month of June. We asked the registered manager to report this to their local authority's safeguarding department without delay and we received confirmation that they had done this the next day.

Two people were prescribed a liquid medicine to be given twice a day after food and at bedtime. We saw that one person's MAR chart was highlighted for the medicine to be given daily at 6pm, and this was the only dose signed as given for the whole of the cycle. The other person's MAR chart was highlighted to be given daily at 7am and 6pm. For both people, the times of administration did not reflect the instructions of 'after food and at bedtime'.

Another person was prescribed a five day course of antibiotics to be given three times a day. Their MAR chart clearly stated this. However we saw that the medicine was signed as given for four days plus one dose then marked as 'course complete'. The nurse in charge could not provide us with an explanation for this. The same person was also prescribed a medicine where the MAR chart stated 'one or two tablets to be given'. However on two occasions it was not recorded if one or two tablets had been given. A different person was prescribed 20 tablets but 22 doses had been signed for as administered. Someone else was prescribed a cream to be applied for seven days. However, we saw that this had been signed for eight days.

The Insulin record stored with a person's MAR chart had a hand written dose of 10 iu and 6 iu. In 2010 the National Patient Safety Agency (NPSA) recommended that 'The term 'units' is used in all contexts and abbreviations, such as 'u' or 'iu', should not be used. This was aimed at reducing the number of wrong dose incidents involving insulin'.

We saw a hand written medicine name and instructions on a MAR chart documenting that the next dose was due on 11 August 2017. However the MAR chart had been marked by highlighting the box for the next administration to take place on 8 August 2017. This lack of consistent information might lead to ambiguity and risks that the person might not receive their medicine as prescribed.

A person on respite care brought their own medicines to the home. We saw that the labels on some of the boxes of medicines were faded and it was impossible to read the names of the medicines, date or instructions. Pain relief and eye drops had been dispensed in June but it was unclear if these were still in date. When asked what they would do if the person needed access to pain controlling medicines, the nurse in charge stated their practice was to use homely remedies in stock. However, the provider's medicines policy stated that 'Homely remedy stocks must be signed by each person's GP who agrees to their use'. This showed that the provider had not acted in line with their own policy because the GP of the person's on respite care, had not signed the homely remedy stocks.

Several people who used the service had their medicines administered covertly. When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the person. It was not clear from the records maintained at the service whether this process was being safely managed. The provider had a range of documents, some had been transferred from a previous service the person had used and included previous pharmacists' recommendations. However we could not establish if the decision to administer medicines covertly was current and had been taken in line with legislation and best practice.

There were protocols used for the administration of medicines that were taken 'as required' (PRN). Whilst some people were able to request PRN medicines, others were not. The nurse in charge told us they were able to establish whether people needed their 'as required' medicines by assessing their symptoms. However, we did not see any evidence that nurses were using recognised pain assessment tools and were therefore relying on their judgment rather than evidence. This meant that some people may not receive medicines such as pain relief when they might have needed them.

Controlled drugs no longer required were recorded as denatured, (A process by which drugs are made harmless), prior to collection by a registered waste contractor. The home had a supply of DOOM Kits available. These kits are an effective and appropriate means of destroying drugs. We found that kits awaiting collection had not been activated correctly and tablets, ampoules and patches remained in a liquid layer above the activated gel. DOOM kits are for single use although the nurse in charge confirmed that they had been used for multiple destructions. The registered manager also confirmed that the kits had not been activated correctly.

A community pharmacist conducted a medicines audit in June 2017 and we saw in their report that they had identified a discrepancy and had requested for the home to investigate. We discussed this with the registered manager who confirmed that this had not been undertaken.

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

Controlled drugs (CD) were stored in a locked CD cabinet. Random checks of several CDs were carried out during this inspection. The quantity of CDs in stock matched the quantity recorded in the CD registers. This indicated that people were getting these medicines as prescribed.

The stocks of homely remedies were in date and there was a record of the homely remedies used.

At the inspection of 01 March 2016, we found a breach of legal requirement because people were at risk because cleaning products containing dangerous chemicals were not always stored securely and had not been correctly labelled. We also found that electrical cables in the sluice room had been damaged and presented a risk for people accessing this room. At the inspection of 03 August 2017, we found that improvements had been made.

All areas of the home were clean and tidy and free of any hazards and all cleaning products were safely locked away. Overall the rooms were satisfactory and people had personalised their own rooms with photographs and objects of their choice.

People told us they felt safe at Frithwood Nursing Home. Some of their comments included, "It's very good", "Yes, very safe", "It's alright. It's very nice. The people are very nice to me", "The hoist is done ok and I am comfortable", "I love it" and "Staff are gorgeous."

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. Staff were aware about individual risks to people. Guidance for staff ensured that people were kept safe. For example the staff were aware that a person living with diabetes required to have their blood sugar tested twice daily. They also knew that they should give the person food rich in sugar to prevent their blood sugar level from getting low. One staff told us, "When I give [person] a bath, I look out for any sign of injuries and report it to the senior staff because this is a source of infection and if not treated immediately can be aggravated."

Staff undertook regular checks during the day and night to ensure that people were safe. For example they ensured that the air mattresses were at the right pressure to be working effectively. Records showed that this was done and recorded consistently.

People who were at risk of falls from their beds had bedrails fitted. There were bedrails risks assessments in place. However we noticed that there were two beds without bumpers. This placed people at risk of entrapment. The staff told us that one of them had been taken for washing and had not yet been replaced. In the other case the staff had been checking on the person every 15 minutes because of their deteriorating health condition and we were reassured that any concerns would be identified without delay.

People were protected through the provider's safeguarding procedures. The manager raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of allegations of abuse. The manager worked with the local authority's safeguarding team to carry out the necessary investigations and management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. A social care professional, and the records we viewed, confirmed this.

Staff told us they had access to the safeguarding policy and procedures and were aware of the whistleblowing policy. Some of their comments included, "The home is safe. I would know if someone's behaviour had changed. We would check for bruises. We also talk to people and they would feel confident to tell us" and "Abuse can be physical. If I saw something I would report it to the nurse or the manager."

Accidents and incidents were clearly recorded and included details such as time and place, action taken, outcomes and steps taken to prevent re-occurrence. Each record was analysed and included an action plan. For example, we saw that a person had fallen out of bed when their bedrails had been down and described as broken. We checked the maintenance records and saw that this had been reported immediately and the

bedrails had been repaired without delay.

The provider had a health and safety policy in place, and staff were aware of this. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers.

The service had taken steps to protect people in the event of a fire. There was an up to date risk assessment which included information about individual people's needs. Windows were fitted with approved window restrictors to prevent them from opening wide and these were regularly checked.

There were enough staff on duty to keep people safe and meet their needs. People and relatives told us they were happy with the staffing levels, and we saw that there were enough staff on duty on the day of our inspection to meet people's needs. We looked at the staff rota for the months of June and July 2017. These showed there was at least one qualified nurse on duty at all times, sometimes two if it was particularly busy. During the day there was a minimum of six care staff in the morning and five in the afternoon, plus staff in the laundry and kitchen, and a cleaner. Staff we spoke with thought that the number of staff was sufficient for them to do their job effectively. One staff member told us, "People are safe at the service because there are enough staff for us in order to care for the people."

We did not see people waiting for support and staff responded in a very caring way when people needed assistance. Staff were attentive and offered people a choice of tea, coffee, squash or water throughout the day. The atmosphere was relaxed and staff chatted and joked with people while they supported them. We viewed a record of the call bells for the last week and saw that all were responded to promptly.

Recruitment practices ensured staff were suitable to support people. We looked at four staff files, one for a nurse and three care workers. These included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working for the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) check was completed. The nurse's file included confirmation of their qualification and Nursing and Midwifery Council (NMC) pin number.

Is the service effective?

Our findings

The environment was not designed in a way to support people who had dementia. The colour schemes, lighting and additional features did not reflect good practice guidance for environments for people who were living with the experience of dementia. There was insufficient signage to help people find their way to bathrooms or toilets. Principles 5 and 6 (pages 29 and 30) of The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, "Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety." The guidance also refers to the use of "Tactile wayfinding cues." The Department of Health guidance on creating "Dementia friendly health and social care environments" explains what these are and recommends providers "enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do."

We recommend that the provider seek relevant guidance in relation to improving the environment to meet the needs of people living with the experience of dementia.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider understood the principles of the MCA and had followed its requirements. The manager had identified people for which restrictions had to be put in place and had taken appropriate action to make sure these were in people's best interests and were authorised by the local authority as the Supervisory Body. This included an authorisation for a person for whom bedrails were being used.

During the inspection, we saw that people were consulted and consent to their care and treatment was obtained verbally. Staff employed at the service told us they had received training in the MCA and some were able to provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interests if they lacked capacity. However, other staff we spoke with did not fully understand their roles or had no understanding of these in relation to the principles of the Act. We saw that MCA training had been provided by the registered manager although they did not hold a trainer's qualification in this.

We recommend that the provider seek relevant guidance and training to ensure they comply with the legal requirement of the MCA.

People and relatives told us they were supported by staff who had appropriate skills and experience. Their comments included, "Yes, [family member] is kept clean and always looks very presentable. She is not upset. They're very efficient" and "Things are done with care and she would tell if things weren't right and tell us about the staff too." Staff told us they had received an induction when they started to work for the service. This included training and working alongside other staff members. Staff told us they were able to access the training they needed to care for people using the service. Their comments included, "We have a lot of training like dementia, pressure sores" and "I have had training like moving and handling, safeguarding, health and safety and infection control."

We viewed the training matrix where the registered manager recorded all training delivered to staff. This indicated that staff had received regular training in subjects the registered manager identified as mandatory, such as moving and handling, health and safety, safeguarding, food hygiene and infection control. The registered manager told us they were qualified to deliver all these courses. However when we checked their records, we found that their 'train the trainer' certificate did not include any of the mandatory subjects and was three years out of date. However they did hold a valid 'train the trainer' qualification in moving and handling, and we observed staff to be competent in this subject. We discussed our concerns with the registered manager who told us they were currently in discussions with senior managers to appoint a recognised training provider.

The local pharmacist delivered regular training to staff and other external professionals delivered training specific to the needs of the people who used the service, such as dementia, tissue viability and diabetes.

The qualified nurses received regular training and had their competencies assessed in subjects such as venepuncture and catheterization.

People were cared for by staff who were well supported. During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us they received regular supervision meetings with their line manager. The registered manager told us that this provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and their line manager to reflect on their performance and to identify any training needs or career aspirations.

People's nutritional needs were met. The provider recognised the importance of food, nutrition and a healthy diet for people's wellbeing generally, and as an important aspect of their daily life. There were risk assessments in place for people who had swallowing difficulties and who required assistance to eat and drink. Food and fluids were monitored for some people at risk of malnutrition and samples seen were well completed and up to date. Malnutrition Universal Screening Tool (MUST) scores were recorded and updated monthly to show nutritional risks and had been completed consistently. Records showed that people with a high score and above were referred to the dietician. A person who had been referred to the dietician was prescribed food supplements and their food fortified. At lunchtime, we saw that the food was fortified and they were also given snacks in addition to food supplements. Records showed that this intervention had led to an improvement in their condition. This was evidenced by the weight charts we viewed.

People and relatives were positive about the food. Their comments included, "From what you can see, she eats well", "I like the food", "If she wanted something special, they'd do it. They'd cook it fresh", "The food is good. It's ok" and "It's all right. I take it as it comes. You don't get a choice, the food is pretty good. I'm not a

fussy person really."

There were pictorial menus available to make it easier for people to make a choice. We viewed all menus for the week and saw that they changed daily and were rotated across the month. The food served was hot, nutritious and looked appealing. The meals on the day of our inspection were cooked using fresh ingredients. People had adequate amounts to drink. A drinks trolley was placed in the lounge and people could have refreshments at any time they wanted.

At lunchtime people who wanted to eat in the dining room were supported to come to the dining room. The table was nicely laid and there were mats with coloured photographs of the day's menu. People were well dressed and there were social chit chats and smiles which showed that people enjoyed the occasion. There was a variety of drinks and food available to people from ordinary texture, mashed and puréed food, thickened fluids and fortified food. The chef was supplied with accurate information about people's dietary needs, including any allergies. We saw that meals had been prepared according to the recommendations of the dietician and the speech and language therapist (SALT). There were enough staff available to support people with their meals. We observed staff sitting comfortably next to the people they were supporting. They supported them in an unhurried manner and engaged in social interaction. People we spoke with said that they enjoyed their meals.

There was written guidance on how to prepare thickened food and we observed staff using this guidance to prepare drinks for people at risk of choking.

We saw written evidence that the healthcare professionals attended regularly to check on progress of people who were referred to them. For example the dietician recommended that the person who had a high MUST score was weighed weekly and prescribed fortified food, food supplements, and snacks. Once the weight had improved the monitoring of the person's weight was changed from weekly to monthly by the dietician. The weight charts we viewed confirmed this. We also saw that staff received clinical supervision from the relevant professional regarding that aspect of people's care.

People were given the support they needed to stay healthy. The provider was responsive to people's health needs. Staff told us that external health care professionals provided guidance for them on how to support people with various conditions. We saw evidence of referrals to the GP, dietician, tissue viability nurse, diabetic nurse, palliative care nurse, SALT, physiotherapist and dentist. Records of external professionals' visits were made and included the reason for the visit and actions taken. For example, we saw that a person using the service was sent for a chest X-ray following a persistent cough.

Is the service caring?

Our findings

At the inspection of 1 March 2016, we found that people's privacy and dignity were not always respected. The staff did not always show people respect, offer them choices or think about the care they were providing from the person's perspective. At the inspection of 3 August 2017, we saw that improvements had been made.

People were supported by staff who were kind and caring and treated them with dignity. People and relatives were complimentary about the care and support they received. Their comments included, "Yes they are [caring]. They are very respectful", "Yeah, they are kind and caring. They cover me with a towel when I have a wash" and "Yes they are [caring] and I can get up and go to bed at the time I like. [Pointing to a staff member] He is very good, he'll do anything."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. One staff member told us, "I close the curtains; I knock on the door, introduce myself and say good morning." Staff we spoke with knew people well and were able to tell us their likes and dislikes.

All staff we observed displayed a gentle and patient approach throughout the day when caring for people in the home. They communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people including offering reassurance and praise. We heard comments such as, "Don't worry, I will help you", "That's it. Well done" and "You are fine. You are doing well." They were attentive when people needed assistance and understood how best to talk with different people according to their communication needs.

Staff were able to engage well with people. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day, not only when they were performing physical care tasks. Staff were seen to knock on closed doors before entering and said they always respected privacy and dignity by ensuring that people's choices were respected and closing doors when delivering personal care.

People's end of life wishes were discussed and recorded in their care plan. We saw that people who were at the end of their lives received input from the palliative nurse and were regularly reviewed by the GP. The recorded daily care for people included support with their personal care including oral hygiene, keeping a person's lips moist when they were no longer able to take in food and fluid, continence management and regular re-positioning to prevent discomfort and skin deterioration.

The provider kept a record of cards and compliments received from people and relatives. We viewed a sample of these. Comments included, 'I would like to thank the management and staff for all their care and consideration', 'Thank you for your kind attention, help and care' and 'Every time we left our mum, we knew she was in safe hands and the family could relax'.

Is the service responsive?

Our findings

At the last inspection of 1 March 2016, we found that people's individual needs and preferences were not always being met. At the inspection of 3 August 2017, we found that improvements had been made.

People told us they were happy with the care they received and their choices were respected. People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people and their relatives had been involved in discussions about their care, support and any risks that were involved in managing the person's needs. People and their relatives told us they had been involved in the initial assessment of their needs. Where people had been referred from the local authority, the provider had obtained relevant information from them. This included background information for most people which helped understand each person and their individual needs. The registered manager told us that people's individual needs, such as the time they wished to go to bed and get up and if they preferred a bath or shower was discussed with them before their admission and regularly reviewed. They said, "The resident is always asked before bedtime if they wish to stay longer or if they like to go to bed at that time. Residents' wishes are always respected."

Care plans were comprehensive and contained sufficient information to know what the care needs were for each person and how to meet them. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences and included health and wellbeing, eating and drinking, communication, mobility, washing and dressing and lifestyle. For example, 'Two staff to transfer [person] using the standing hoist' and 'Give clear and concise instructions during the procedure'. We observed these instructions to be followed in line with the care plan on the day of our inspection.

People's care records included their hobbies and likes and dislikes. The registered manager told us that activities were discussed with people and their relatives. However, there was a lack of person centred activities organised at the home and people's individual needs were not always discussed with them. For example, one person told us, "I can't read anymore. My concentration is bad. I used to read four books a week." We asked if the person had ever considered 'talking books'. They told us they had not but thought it was a good idea. This was fed back to the registered manager during the inspection.

The service did not employ an activities coordinator and all activities were delivered by the staff on duty. Three staff members had received activities training. We spent time in the lounge where the activities were taken place and saw that everyone was sitting around the room with an over chair table in front of them. There was a large board in the lounge displaying various activities. These included exercises, games, arts and crafts, music, movie time and memory album.

On the day of our inspection, there was soft music playing throughout the morning. The registered manager told us that people liked this kind of music in the morning as it was calming. They added that the more varied activities took place after lunch when people were more alert. In the afternoon, we saw a member of staff sitting for a few minutes with each individual playing with large cards or encouraging people with a game of solitaire. In the afternoon, two members of staff were playing a ball game with people, who

appeared to enjoy this.

We asked people's opinion about the activities offered at the home. One person told us, "Playing ball, cards, everything. I don't join in but I try" and another said, "I like the ones with [staff member]. He's gorgeous."

People's complaints and concerns were investigated and acted upon. The service had a complaints procedure in place and this was available to people who used the service, staff and relatives. Some people told us they knew how to make a complaint although others were unsure. One person told us, "I've got no complaints. No, I wouldn't know (who to complain to). Talk to the nurse?" and another said, "I've got no complaints. I don't know but I would talk to someone I get on with." A relative told us they had previously made a complaint and said, "We are satisfied because something did change."

A record was kept of all the complaints received and we saw evidence that these were taken seriously. Each record included the date, nature of the complaint, action taken and outcome. Where complaints had been received, we saw that these had been investigated and the complainants responded to in accordance with the complaints procedure. This included a complaint from a relative about missing property. We saw that the registered manager addressed these concerns immediately.

People and relatives were supported to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. We saw that the results showed an overall satisfaction. Some comments included, "Nothing is too much trouble. Staff are always willing, mum is always clean" and "Staff are very good, residents are happy, rooms are nice." We saw that the provider analysed the quality questionnaires and where concerns were raised, put an action plan in place to make the necessary improvements. For example, where a relative had expressed a concern about the provision of activities, we saw that an action plan had identified the need to improve this and some staff had been provided with activities training.

Is the service well-led?

Our findings

There were systems to monitor the quality of the service and make improvements. The registered manager had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks and health and safety checks. Audits were evaluated and when necessary, action plans were put in place to make improvements in the service. In addition, the provider commissioned an external quality assurance audit which took place in March 2017. We saw that this audit had followed the Care Quality Commission's (CQC) key lines of enquiries and had found the service to be rated Good. However, these audits and checks had not been always effective because they had not identified the shortfalls we found during our inspection so the provider could address these. For example the recent medicines audit had not picked up the discrepancies and shortfalls we found during our inspection in regards to medicines management. The provider had also not identified the shortfalls in regards to staff training and improving the environment to better suit the needs of people with dementia.

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

At our last inspection of 1 March 2016, we found that there was no contingency plan for when the registered manager was absent and people living at the service had been placed at risk of poor practice. At the inspection of 3 August 2017, we found that improvements had been made.

The registered manager told us that when they were absent, they ensured that two nurses were on duty. One would take responsibility for the managing and supervising of the staff, and the other would take responsibility for the nursing interventions, administration of medicines and any medical emergencies that may occur. The director told us that they were also available anytime to provide support.

The registered manager had been in post for two years and was a qualified nurse. They kept abreast of developments in social care by attending the provider forums organised by Hillingdon. They also attended twice yearly conferences. In addition, they organised regular workshops at the home, such as wound care management workshops for all staff to attend.

Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were regular.

The registered manager was expected to submit a weekly report to the provider. This included incidents and accidents, occupancy, staff hours, complaints and safeguarding concerns.

The provider carried out six monthly audits of the service. These included checking the building and environment and speaking to a sample of people who used the service to find out if they were happy with the care they received. They also checked documentation such as staff records and care plans.

We saw that the managing director and another senior manager carried out an unannounced night time

visit in February 2017. They found everything to be in order except for an air mattress that was bleeping. Records showed that this was addressed the following day.

People and relatives we spoke with were mostly complimentary about the staff and the registered manager. People thought that the home was well managed and the staff worked well as a team. Their comments included, "She's very good. We've spoken to her and she's very welcoming" and "They're all too nice. They like me and I like them. We're alright."

Staff commented that they felt supported by senior staff and were confident that they could raise concerns or queries at any time. All staff we spoke with were positive about their jobs and all said the registered manager was supportive. Their comments included, "This job is very rewarding. We have a good team and a good manager. We work well together. The manager is a person you can talk to easily. She listens", "[Manager] is a good leader. She knows what she is doing and is clinically very good", "The manager is the best manager I have had. She is good with the staff and residents" and "The manager is good, very nice. She tries to do her best for the staff. She's always in handover every morning."

Staff told us they had regular meetings and records confirmed this. The items discussed included safeguarding, health and safety and issues concerning people who used the service. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. The registered manager had started to organise meetings for the nurses and we saw that one had taken place in July 2017. We also saw evidence of regular meetings for relatives of the people who used the service. Some of the subjects discussed included nutrition, dignity and care and activities.

There was a board in the entrance hall which displayed information about CQC, the last inspection rating, health and safety information and the complaints procedure. This meant that people, staff and visitors were provided with relevant information about the service.

There was a business plan in place which included what was planned in terms of refurbishment and areas of improvement. We saw that environmental improvements had been made, such as a large, bright and airy room with comfortable furniture for meetings, and for people and relatives to spend time in privacy if they wished to. However, as stated previously there was scope for the environment to be more suitable for people living with dementia.

Service user guides were issued to all people living at the service. They included a statement of purpose, a service agreement and information about the service and the organisation, its aims, objectives and values.

The service worked closely with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The registered person did not have systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from carrying on the regulated activity.</p> <p>Regulation 17 (2) (b)</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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

The enforcement action we took:

Warning notice