The Fremantle Trust

Apthorp Care Centre

Inspection report

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Date of inspection visit:
06 July 2016
12 July 2016

Date of publication:
15 August 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 July and 12 July 2016 and was unannounced.

Apthorp Care Centre is part of The Fremantle Trust. It is a three-storey purpose built residential care home that is registered to provide accommodation for up to 108 persons who require personal care. It is divided into ten units called 'flats'. All bedrooms are single rooms with en-suite facilities. At the time of our inspection there were 93 people living at the service who were older people, who were living with dementia or were people who have learning disabilities or who have autistic spectrum disorder.

There was not a registered manager in post as they had resigned from their post in June 2016. There was an acting manager and the provider was in the process of recruiting a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous inspection on 22 July 2015 the service had been found to be Good overall. However in the inspection prior to this in October 2014 the service was found to be Inadequate overall.

People told us they felt safe at the service however we found a number of concerns that put people were at risk of harm. People told us they received their medicines in a timely manner and that staff asked if they needed pain relief. We found no errors in people's medicines administration records but medicines were not being stored in a safe manner in some of the units and we had to ask the service to take urgent action to make sure medicine was being stored safely.

We found that although most people had risk assessments, some risk assessments had not been updated after a change in circumstances, for instance when people had serious falls that had affected their mobility the falls risk assessments were not updated. Also one person did not have a robust risk assessment in place to protect them from other people who had behaviours that were difficult to manage. We found two people did not have risk assessments in their records in addition to lacking most of their care and support plans even though they had been living in the service since January and May 2016. This meant the service did not have systems in place to keep people safe.

Falls and injuries were not being adequately recorded and were not investigated in a robust manner and there was no falls matrix to identify if a person was falling for a specific reason or if there were trends in the service that was contributing to falls.

The provider undertook robust recruitment practices to ensure staff were safe to work with vulnerable adults.

We found that some staff had not received supervision for several years. In addition although some core training had taken place, training records were not well kept and it was not possible to identify what training staff had received or when they were due for refresher training. This meant that staff were not being supported to undertake their caring role.

Health assessments such as Malnutrition Universal Screening Tool (MUST) and the Waterlow Assessment (for good skin integrity) were not completed and reviewed on a regular basis. Therefore the service was not ensuring people's nutritional needs were being met and did not consistently record people's weight to ensure their nutritional intake was adequate.

We observed people being supported to eat tastefully prepared pureed meals in an appropriate manner however it was not consistently recorded why people required a pureed diet and one person's records were not completed to show staff had supported them appropriately to eat.

Staff were able to tell us how they got people's consent before offering care and support. The service had undertaken mental capacity assessments and made Deprivation of Liberty Safeguards (DoLS) applications appropriately to ensure they were working under the Mental Capacity Act (2005) to ensure people's legal rights were being upheld.

People said that most staff were very good and caring although relatives had mixed views about staffing numbers and staff's manner towards people. We saw mostly positive and sometimes sensitive interactions by staff.

The service did not facilitate people or their visitors to complain as there was no information displayed telling them how to complain. There had been very few complaints recorded and these were all with the exception of one complaint not investigated thoroughly.

There were some varied group activities and special events but only some people could attend. There was not varied individual activities or meaningful activities within each unit.

The service was not well led. Policies and procedures were not up to date and were not accessible to staff. Audits had taken place but these had failed to identify the number of ineffective systems in the service.

The provider had started to reorganise the management structure in the service to include floor managers that have a responsibility for the units on a specific floor.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider. We will report further on this when it is completed.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not being stored in an appropriate manner to ensure their effectiveness.

Risk assessments were not always updated on a regular basis or in response to a change in people's circumstances. Some people had not had risk assessments undertaken in a timely manner.

There was no falls matrix to establish the reasons why people had fallen or to identify the trends that might be contributing to people falling in the service.

Staff told us how they would recognise and report safeguarding adult concerns. However there was no information displayed to remind staff of their responsibilities or to inform people and their relatives how to report any safeguarding adult concerns they might have.

There were robust recruitment processes in place to ensure that staff were safe to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective as staff did not always undertake all the appropriate assessments to ensure people's health needs were being met and did not consistently record people's weight.

Staff had not received supervision in line with the service supervision policy. Some staff had not received supervision for a number of years. There had been no appraisals completed for the last year.

The training matrix system did not support senior staff to identify which staff had received training and which staff required refresher training.

Management had made some recent Deprivation of Liberty applications appropriately and were working towards applying for others. The service was undertaking mental capacity assessments and staff asked consent before giving care to people.

Is the service caring?

Requires Improvement

The service was caring. We saw staff were kind and professional in their interactions with people.

Staff were respectful of people's privacy and knocked before entering people's bedrooms. People's personal information was kept in a private manner.

Staff were aware of people's diversity support needs and gave some us examples of where they met these support needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Most people had person centred plans but some people had not received person centred plans and the associated documents in a timely manner.

There were group activities taking place that people said they enjoyed however the space for group activities was limited. Activities for people who remained in the units was limited.

Complaints were not addressed in an appropriate manner by the service and there was no information displayed to tell people and their relatives how they could complain.

Is the service well-led?

Inadequate

The service is not well-led. There were auditing systems in place however these had failed to identify and address the concerns identified in this report.

The recording systems in the service were not effective at capturing information and important information was not being recorded in an agreed format by staff.

Paper copies of policies and procedures were not kept where they were available to staff and had not been updated. Computer copies of policies and procedures were not accessible to staff and difficult for managers to locate.

Apthorp Care Centre

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 the 6 July and 12 July 2016 and was unannounced.

On day one the inspection team consisted of three inspectors, an inspection manager and two experts- 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. In this instance the experts by experience had knowledge about caring for older people and people living with dementia.

On the second day the inspection team consisted of an inspector and an inspection manager.

Prior to the inspection we reviewed the information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection visits we talked with sixteen people who lived in the service and five relatives visiting their family members.

We reviewed ten people's care records including their care plans, support plans and risk assessments. We also reviewed eleven medicines administration records and observed the administration of medicines. We checked the storage of medicines in the service. We looked at four staff personnel recruitment records and ten staff supervision and appraisal records.

We spoke with eight staff, the maintenance worker, the Head of Services for Older People, the acting manager, the care practice manager and the deputy manager. We observed staff interaction with people using the service throughout both inspection days.

Following the inspection we spoke with two relatives of people living at the service. We spoke with a health and social care professional and the commissioning body.

Inadequate

Is the service safe?

Our findings

People told us they received their medicines when they needed them. Medicines administration records were completed without any gaps or errors. We asked staff administering medicines what the medicines were used for and some staff knew what the medicines treated. However one staff member could not tell us about some of the medicines they were administering and another was not sure of some medicines but appropriately referred to a guide for commonly prescribed medicines available for staff to refer to.

We observed people receiving PRN medicines, that is 'as and when needed' medicines. Staff asked people if they were in pain and would they like some medicine. People told us staff asked them if they needed pain relief. "They always ask me how much pain I'm in and yes they do increase my medication." However we found there was not clear PRN medicines guidance to tell staff when the PRN should be given. This meant that people's PRN medicines might not be administered appropriately.

The storage of medicines was not safe. In one unit we found a large amount of single-injection insulin pens being stored in a medicines fridge that was displaying a temperature of 11 degrees Celsius. This is too high a temperature for the safe storage of these medicines. The medicines fridge did not feel cold enough to suggest the display was simply in need of recalibration. We found temperature records for the medicines fridge ceased in July 2015. Staff were not able to say if the medicines fridge was previously displaying a concerning temperature, but the maintenance worker said a new medicines fridge was on order. The maintenance book showed that concerns about the medicines fridge were raised at the end of May 2016. We raised this as a concern that needed urgent action by the provider. The provider took immediate action as requested and a new fridge was installed before the second day of our visit with a replacement stock of insulin.

In addition we found a medicines trolley where there was no temperature records recorded for three months. Records stated that temperatures were not recorded because there was no thermometer provided to take the recordings. This meant staff could not be sure medicines were being stored at a safe temperature to ensure the effectiveness of the medicines.

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

People told us "oh yes I feel safe, I don't feel unsafe and have no reason to feel unsafe" and a family member said "I do feel my mother is safe here she can leave her bedroom door open and her possessions are safe." Staff we spoke with said they had received safeguarding adults training and could tell us how they would recognise signs of abuse. However we saw that there were no posters displayed to remind staff of their responsibilities to report abuse or to inform people and their visitors how to report any safeguarding adult concerns.

Although the service undertook risk assessments to ensure the safety of the people these were not always completed for each person and were not always reviewed and updated to reflect changes in people's circumstances. For example one person had been admitted into hospital in March 2016 following a fall at

Apthorp Care Centre. They were found to have a fractured hip. They had been discharged from the hospital in April 2016. However the falls risk assessment in the person's care records was dated from January 2016. This had not been reviewed following the fall and there was no mobility care plan. This means that the person's risk assessment was out of date and the risks to their health had not been properly assessed and measures had not been put in place to tell staff how to support them.

We found examples of people sustaining injuries that were only recorded by a body map with an x marking the site of the injury. We met a person with a dressing on their arm and we asked staff why there was a dressing as there was only a body map in the person's care records. They told us the person had had a skin tear and district nurses had dressed the injury. The person had very fragile skin and it is probable their skin would tear very easily. However there was no record in their daily notes to say how the tear had occurred or how it had first been noticed or how the injury was treated. There was no record of an incident in the incident record book and no record of the dressing in the district nursing file. After some searching a senior staff member found an entry in a senior staff communication book where a staff member had raised the skin tear and the senior said they would request a dressing. There had been no investigation of the cause of the injury and no instruction to staff to minimise the risk to the person.

We found that there were not robust systems in place to investigate incidents such as falls and unexplained injuries to ensure no abuse or neglect had taken place. The system for recording falls and incidents was muddled with incidents being recorded in two different files without a comprehensive filing system. There was no falls matrix to record falls and injuries and identify trends for the individual or for the service. We showed the records to the Head of Services for Older People who agreed staff had in error been recording incidents in two different files and confirmed there was no system for analysing falls and injuries for the individual or for identifying trends within the service.

The service had made safeguarding notifications to the CQC and local authority. However because of the poor recording systems we could not be sure falls and injuries were being investigated appropriately and this could mean safeguarding adult issues might be missed.

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

We found incidents of injuries which had not been investigated or reported appropriately. One person's records showed they had suffered fractured fingers in March 2016. A hospital record indicated that the person had been hit on the hand by a walking stick. The injury was caused by another person using the service. The service had not raised the injury as a safeguarding alert until a social worker identified an issue. We observed that the person alleged to have caused the injury was being verbally aggressive towards the person who had sustained fractured fingers on the day of our visit. Staff told us they monitored their interaction and we observed staff taking this action. However there was no risk assessment to state how this risk would be managed and it was not an effective measure, as staff had duties that meant they could not monitor people's interaction at all times. We informed the local authority we had concerns with regard to the on-going safety of the person.

In addition one person's care record included a body chart that recorded "right arm and elbow bruise" in May 2016. It was in the records that the bruise started at the mid-forearm and continued almost to the shoulder. The bruising was not investigated The CQC has raised this as a safeguarding concern.

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

People told us that they received help from staff when they needed it. One person was critical of the staffing

levels and in particular the lack of continuity of staff. People told us "I think the staff here are excellent but I think they are understaffed" and another person told us "You get more assistance in the night than during the day." Relatives had differing views about their experience of staffing levels telling us "Yes I do think there's enough staff here, I can see and I'm here most of the time" another regular visitor told us "there really seems to be a lack of staff, two staff but that can be down to one and one floats between flats".

During our inspection we checked the staffing rota and noted that it accurately reflected the number of staff who were working at that time.. Management had asked some staff to work in other units in the service to cover staff absence. We found that one unit had one staff member supporting eight people in the afternoon when there would usually be two staff on duty. We brought this to the attention of the management who explained the other designated staff member was supporting someone to their medical appointment. Explaining that management would usually go and support the remaining staff member and they were ready to go and assist if needed, however due to our inspection they were assisting us. We observed people's care and support throughout both days of inspection and did not see people waiting a long time for staff assistance. We monitored call bells and observed all except one call bell answered speedily. We checked why the one call bell had rung for over 5 minutes and found there was adequate staff available in the unit but they had not realised the call was from their unit so we brought this to their attention. We asked management how they covered staff absence they told us staff are asked if they would like to work extra shifts. Explaining if there were no staff available they would request agency staff. We noted there were some agency staff on duty during our inspection to ensure there was adequate staffing cover. We concluded that the management were taking steps to cover staff absence by offering overtime or providing agency staff.

People told us "yes my room is always clean and it's cleaned every day" and "two days ago they come in and shampooed my carpet but it's always kept clean, even the carers come in and hoover and put toilet paper in the toilets." On the two days of inspection the service was clean with no mal odour. We noted that bathrooms and toilets had toilet paper, paper towels and hand wash available. We saw staff would re stock if needed. Staff used protective disposable equipment such as gloves and aprons when providing personal care to prevent cross infection. Training records showed some staff had received infection control training.

We noted that there was a 5 star food hygiene rating awarded to the home in February 2016. Food in the individual kitchenettes was stored appropriately. The service had systems in place to prevent and control infection.

Inadequate

Is the service effective?

Our findings

The provider was not supporting staff in their role by providing them with regular supervision and appraisals. One staff member told us they did not feel supported by the service for their role. They said they had not had a supervision meeting or an appraisal for two years. We found when looking at staff records that supervision was erratic with some taking place in 2016 but some staff had not received supervision since 2013. Yearly appraisals had not been undertaken. The provider's supervision policy stated supervision should take place for each staff member six times a year and this was not taking place.

Staff told us there had been recent refresher training in core topics. However some staff said that there was no opportunity for professional development describing a lack of training opportunities such as dementia care when they were working with people who have dementia. We looked at the training matrix and found there were recordings of some training in core topics such as safeguarding adults, moving and handling, food safety and fire safety training. However the training matrix had two spread sheets one for staff who had attended training and one for staff who had training requirements. The spread sheets had been completed in such a way that it was not clear which staff had received training and which staff were due for training. This meant we could not be sure if staff had received appropriate training to enable them to undertake their role. We spoke to the acting manager and their response revealed that there was no way to evidence that all the staff had been appropriately trained as the records had been entered incorrectly.

Staff were not appropriately supported in terms of supervision or training to ensure they were equipped to undertake their role.

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

People told us "if I need to see the doctor, they arrange this" and "the GP comes every Tuesday. If you need the doctor at another time they arrange it." Staff were able to tell us about people's health support needs. People were supported by staff to attend medical appointments and people's records recorded the GP and district nurse visits. We saw evidence of appointments with consultant clinics such as urology. Health and social care professionals such as physiotherapists had attended to people. We noted one record where the person had no GP visits recorded since November 2015 although their family talked of good health support and GP visits.
Staff were not undertaking regular health monitoring checks in particular weight and Waterlow (skin integrity) assessments. For example in one person's record we noted that the moving and handling assessment had been updated in June 2016 to reflect that the person was no longer mobile and required two staff to hoist them. However their Waterlow assessment was not updated from April 2016 to reflect the person was no longer mobile and therefore had an increased risk of pressure ulcers. In addition their weight was not recorded since April 2016 even though their weight had decreased from 57.6kg in October 2015 to 54.4kg in April 2016. This was concerning as the person's health had deteriorated and they should have been carefully monitored to ensure there was no further weight loss and to maintain good skin integrity.

In addition one person's records showed a weight loss from 54.1kg in September 2015 to 50.5kg at the next recorded entry in June 2016. However, the Malnutrition Universal Screening Tool (MUST) assessment had not been completed since 5 July 2015. The Waterlow pressure ulcer risk assessment dated in October 2015 stated there was a 'high risk' requiring weekly review according to the Waterlow documentation. However, there were no reviews recorded to ensure their skin integrity was being maintained.

Most people spoke positively about the food offered but some felt there was not enough choice. People told us "food is very good, I get what I ask for and I get a good choice and if there's something I don't like they will make something for me." One person's care plan stated they disliked fish we noted they were served an omelette instead of fish pie for lunch. Some people did not like the food served and said they cannot eat the food as it is too greasy, they had complained to the kitchen and management and some measures had been put in place to provide food they found acceptable.

We saw staff supporting people to eat pureed diets. Food was served in an appetising manner to encourage people to eat and staff took time to support people with care. However we observed one person supported to eat a pureed diet, staff described the person preferred this diet as they have some swallowing difficulties. We found that no preference for a pureed diet recorded in their care plan. There was no risk assessment with regard to eating and swallowing and no speech and language therapist assessment in their care records.

We found one person's risk assessments and care plans had not been reviewed since October 2015, except for a two-line entry about needing support with eating as they "refused to eat when no-one is around" in April 2016. Their nutritional plan in October 2015 stated dysphasia and a pureed diet were recorded under "swallowing difficulties" and under "Assistance required with eating", the plan stated "needs guidance to enable [X] to eat safely. This is due to them suffering from dysphasia. Therefore one staff member to be present when eating." However the latter entry in April 2016 that they "refused to eat when no-one is around" indicates that they were unsupported sometimes or that the reason why they required support was not understood by the person making the entry.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were able to explain how they got people's consent and one staff member explained how they asked people for their consent for care and support saying that "you can't push them" but to respect refusals. They understood to try different approaches if they felt the person needed care.
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 Apthorp Care Centre as the managing authority had applied for DoLS from the statutory body appropriately, having taken into account the mental capacity of people at the service to consent to their care and treatment. There was evidence that mental capacity assessments and best interest meetings had enabled decisions to be taken on behalf of people who lacked capacity Staff explained they used the least restrictive options to keep people safe.

The service was purpose built with wide corridors to accommodate wheelchairs and bedrooms with en-suite bathrooms. There was a communal lounge and dining area in each unit with room for each person to sit. There was a balcony to allow people to go outside on the middle floor and an accessible garden on the ground floor. People in the one dementia unit each had different pictures by their bedroom door, these were sometimes of family members or their name or a flower to orientate and remind which was their room.

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the staff and told us for instance "yes I like it here there are no better places, the staff are very good to me" and "on a 1 to 10, it's a 10, the staff are very good" Visitors we spoke with had mixed views about some staff interaction, most were positive saying for example ""yes they always treat her with kindness and respect and they always knock on her door before they go into her room" however another relative told us "I've seen lots of staff shouting at the residents." One relative told us "very good with [X] lots of affection from staff…it has been better recently, staff answer questions, they are better informed" On the day of inspection we observed staff interaction with people and found them to be caring and professional in their manner.

Staff respected people's privacy for example they knocked on doors and waited to be asked in before entering. People told us "they always knock on my door before they come in and they always make sure the door is closed when they're doing anything for me" One staff member told us one person had had "a rough night" so they were going to support them with personal care explaining usually they did not require as much support. The staff member waited outside the person's bedroom door and told us "I am giving them some privacy." The staff member monitored that the person was managing in a discreet manner by calling out to them rather than going in. This was a sensitive response that demonstrated respect for the person's privacy and dignity.

People's care plans stated their diversity needs. We saw plans that stated people's religion and what support with observances they required. For example one care plan stated that a person was a member of the Church of England but did not wish to attend a service, however liked to watch Songs of Praise on the television. Holy Communion was observed once a month in a communal area and people were supported to attend. People's care plans contained their dietary requirements for example we saw records stated "no pork or beef eaten" or that people ate a vegetarian diet. Staff could tell us of the cultural backgrounds of the people in the flat they worked in and were familiar with their likes and dislikes. Some people told us staff went out for them and brought culturally specific food for them. Staff told us how they went out to purchase food for people who liked specific foods and the kitchen cooked the food.

Some relatives told us they had been involved in their relative's care planning prior to their admission and one relative said they had read through a review of their relatives care plan. Some but not all records had been reviewed and signed by people or relatives as read and agreed.

There were end of life plans in some people's records that detailed what they wished to happen and who should be contacted. Some people's records had "Do not attempt resuscitation" (DNAR) forms signed by people or their GP with consultation with family members. However we noted in one record the DNAR was situated in the middle of the record when it should be at the front of the record for emergency access and in another person record the form was not in their care record but in a DNAR file in the administration office not near to the unit. The DNAR when requested by the inspector took staff some time to locate. The DNAR should be accessible in the event of emergency.

Requires Improvement

Is the service responsive?

Our findings

People told us "I complained to the manager about a staff member's attitude. The manager had a word with them". Other people told us "I never complain, complaints never go anywhere."

The service did not record and address complaints appropriately. Although Apthorp Care Centre had 93 people living in their service at the time of inspection there had been only four complaints recorded in a one year period up to June 2016. Three of these complaints recorded were not investigated fully as indicated by the records. Some people's relatives who had complained to the service told us they had not had a response to the concerns they had raised. Prior to inspection we knew that people's relatives had complained about a number of issues. For example one concern was that staff did not wear name badges and therefore relatives did not always know who they were talking to and said they could not identify staff if they wished to raise a concern. During the two days visit we saw only two staff and one manager wearing identification so we had to ask each staff member who they were. We had raised this concern with the previous registered manager earlier this year however the issue had still not been addressed at the time of inspection in July 2016. The acting manager told us this issue was now being addressed.

In addition there were no posters or leaflets visible to inform people or their relatives how to complain and although staff told us there had been a suggestions box there was not one at the time of inspection. The provider was not telling people how they could make a complaint and was not recording, investigating and addressing complaints appropriately.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16.

Most people had person centred plans that specified their support needs that told staff how they wished and needed to be supported. Some people's records had "My Story" that contained their history with a request that asked people to read it. The histories were detailed and gave a good sense of the person. People's care plans detailed in some instances. However two care records we looked at did not contain care plans, support plans and associated documents. The two people had been admitted to the service in January 2016 and May 2016. This meant that staff did not have guidelines about how people should be supported for a number of months. We brought this to the attention of the management who addressed this by the second day of our visit.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9.

Some people's plans stated what activities the person might enjoy such as listening to the radio or going to the hairdresser. There was an activity schedule with activities advertised throughout the week such as exercises in the bar lounge, music time and general knowledge quiz. We saw activities facilitated by the activities co-ordinators singing and a group from the local community came in to entertain people. In addition a relative played the piano for people and had started a choir. There were specific events such as the care home open day, an outing to Paradise Park and a best balcony completion between the Fremantle

Trust Homes. Apthorp Care Centre was hosting and some people had made art work for the event and planted flowers. We noted one unit had put attractive scarves, pictures and objects for people with dementia to hold and look at whilst they walked along the corridors. Staff told us "it is very good, it brings back memories" we thought this was a good initiative that could be utilised in other units.

However the space for group activities was limited to approximately twenty people. This meant there were a lot of people that remained in their units and could not be supported to join in an activity. We saw activity trolleys in each unit on the days of our visit but these were not offered to people. One person told us ""I don't do any of the activities I'm too tired to do any but I would like to go upstairs and sing and do some colouring". Relatives described that their family members usually sat in the same place in the unit and did not join in activities and that family members used to like activities that no longer take place. We raised this with the acting manager who explained that they had plans to change how activities were offered to people as they were aware of the limitations of the current space. A variety of meaningful activities needed to be available to all people living at the service.

Inadequate

Is the service well-led?

Our findings

People told us "yes the manager is ace she knows the industry backwards" and "the manager does a good job and I can talk to her." People told us there were residents meetings "we have a residents meeting once a month which I do go to."

There was not a registered manager in post as they had recently finished working for The Fremantle Trust. The provider had taken steps to ensure there was an acting manager covering the role whilst they recruited a person into the registered manager role. In addition there was a deputy manager who was familiar with the service and an experienced care practice manager. The acting manager and head of service told us they were in the process of altering the management structure of the service in recognition of the large size of the service by having a floor manager on each floor. The floor manager would be responsible for overseeing the daily running of the units on each floor to give more leadership to staff and clearer accountability.

Some staff told us they thought that management had spoken rudely to staff and relatives at times. Staff meeting minutes showed that regular staff meetings took place, however we noted the tone of previous minutes was at times not supportive of staff. For instance instead of exploring the reasons why the staff might not be able to attend at the time stated the staff were strongly criticised. We raised this with the acting manager who told us they had recognised the need to be accommodating around staff meetings so staff with commitments such as child care could attend. As such they were rotating the day of each meeting this allowed staff a chance to attend on their working day. We saw this was so as staff meetings were being advertised during our visit that covered a range of days to accommodate staff.

Management had difficulty locating the policies and procedures. Paper copies were not in an accessible place for staff or managers to refer to and were out of date. Polices were dated 2012 and should have been reviewed by September 2015 at the latest. New copies of Policies and procedures were available on the computer system but once again these took time for management to find and were not easily accessible for staff.

We were told auditing took place. Management described daily checks of the environment and any maintenance concerns were put into the maintenance worker's book to be addressed. We saw that repairs were undertaken by the maintenance worker. We saw there were monthly audits including medicines audits however management told us they were aware medicine audits had not been completed recently. The pharmacist undertook a yearly review of medicines administration. There were also monthly reviews of safeguarding, accident and incidents and health and safety the findings were collated and sent to the head of service by the previous registered manager. The service had themed audits undertaken by the head of service who visited each month. In addition there were visits by external agencies such as Healthwatch Barnet in February 2016.

However the audits had not identified and addressed the numerous and serious issues we found during our inspection. This included that recording of falls and accidents and injuries was not fit for purpose and there was not investigation into how injuries occurred. There was no falls matrix to track and analyse the trends

for individuals or across the service. We found unexplained bruising that should have been reported as a safeguarding concern. Medicine storage was not safe and had not been addressed for a lengthy period of time. People's care records were not updated in a timely manner and two people from the sample of records looked at did not have the fundamental documents required to give care and support. Important information such as DNAR forms were not readily available to staff in emergency. The service had not facilitated, investigated or addressed complaints. Some staff had not had supervision for several years and training records were not effective in tracking and identifying staff training needs. Audits undertaken had failed to identify and address these concerns.

The service had received a "Good" rating in July 2015 but in the inspection prior to that in October 2014 had received an "Inadequate" rating. We saw that the work undertaken to achieve the "Good" rating in 2015 had not been sustained by the provider as evidenced by the findings in this inspection report.

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

The provider told us of initiatives they are implementing to ensure the future quality of the service. This included a new integrated audit tool and workbook to strengthen the management oversight of the service. In addition they are now going to have two people in post as Head of Services for Older People.

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 Regulation 12 was breached in a number of ways: The unsafe storage of medicines No risk assessments in some people's records The lack of updating of risk assessments in response to changing circumstance. The lack of medical health checks and assessments to monitor the health of people using the service

The enforcement action we took:

Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13: Systems were not in place to identify and report possible abuse.

The enforcement action we took:

Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 was breached a the service did not support people to complain and did not record, investigate and address complaints.

The enforcement action we took:

Positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 was breached as there was not

	robust and effective systems of auditing to identify and address systems failures.

The enforcement action we took:

Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 was breached as staff were not given supervision and training was not identified to ensure staff were equipped to undertake their role.

The enforcement action we took:

Positive Conditions