Lifestyle Care Management Ltd

St Johns Wood Care Centre

Inspection report

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London
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Website: www.lifestylecare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

St Johns Wood Care Centre is a 100 bed nursing home which provides nursing and/or personal care for up to 100 predominantly older people and young people with physical disabilities. Each person has their own bedroom and there are communal lounges and dining areas on each of the four floors of the home.

This inspection took place on 15.16 and 19 August 2016 and was unannounced. At our previous inspection of this service on 21, 23 and 29 December 2015, we found five breaches of regulations, namely Regulation's 9 (Person centred care), Regulation 12) (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs) and Regulation 18 (Staffing). The provider sent us an action plan after the inspection detailing how they would address these breaches. At this inspection we found that significant progress had been made although some improvement was still required.

At the time of our inspection a registered manager was employed at the service. 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 staff of the service had access to the organisational policy and procedure for protection of adults from abuse. They also had the contact details of the London Borough of Camden which is the authority in which the service is located and other authorities who also placed people at the service. Staff said that they had training about protecting people from abuse and this training had been updated, which we verified on training records. We found there were the designated numbers of staff on each floor during our visits. Staff were regularly present in communal areas to identify and respond to immediate assistance that people required.

We saw that risks assessments concerning falls and those associated with people's day to day risks were much improved. Measures to minimise emerging risks, and in particular those associated with falls, were now being speedily identified. This improved the response to safety concerns that arose for people living at the home.

We saw there were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make some decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home twice each week, but would also attend if needed outside of these times. Healthcare needs were responded to well and we saw that staff supported people to address their medical needs.

The care plans we looked at were based on people's personal needs and wishes in some cases, were now much more clear in areas such as nutrition and hydration and contained better information about people's care needs, but could still be improved upon in terms of the consistency with which information was recorded. People's personal, cultural, religious and lifestyle pretences were not given sufficient attention in care planning.

People's views were respected and we found much improved communication and interaction between staff and people using the service. Feedback from people using the service showed that the view was of a caring staff group and we saw that staff were respecting people's dignity and right to make free choices.

The service had undergone a long period of uncertainty last year about its ownership and operation. We found that the provider who had taken over the service had implemented detailed oversight systems for monitoring of the performance of the service.

As a result of this inspection we found one breach of regulation in respect of staff adhering to completing mandatory training updates. 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?

Good

The service was safe. People's safety and any risks that were identified were reviewed quickly and there was a far greater degree of consistency among the staff team about how to respond to all potential risks.

At the time of our inspection there were sufficient staffing resources available to meet people's needs, although this was being reviewed.

Medicines were being handled and administered safely and appropriately.

Is the service effective?

Requires Improvement

The service was not always effective. Staff received training, although compliance with the expected level of mandatory staff training required improvement. Staff supervision was now occurring consistently across the whole staff team.

There was clear knowledge about how to assess and monitor people's capacity to make decisions about their own care and support, and we found that people's care records were held securely.

People were provided with a varied nutritious diet and had the opportunity to make choices about what they would like to eat and drink.

People's healthcare needs were being identified and were responded to appropriately in liaison with other healthcare professional's involvement as required.

Is the service caring?

Good

The service was caring. Staff were seen speaking and interacting to people in a respectful and dignified way.

Personal attention was being given a high degree of priority and staff were respectful of people as unique individuals.

Staff undertook care tasks in a compassionate and unhurried

way. They explained what they were doing and re-assured people whenever they were providing care.

Is the service responsive?

Good

The service was responsive. We found that people's care planning records were not always completed in a consistent way across each floor of the home, although the care plan profiles were still a fairly new system. We discussed this with the manager who had tasked the newly appointed clinical lead nurse to support staff around the home to familiarise themselves with this system to ensure it was applied consistently. Care planning had, however, improved markedly since our previous inspection.

Activities were provided but we noted that activities at weekends and the opportunity for people to go out of the home were areas people thought could be improved upon.

People were able to complain if they wished to. People who were able to tell us about their views told us they felt confident to raise anything of concern.

Is the service well-led?

Good

The service was well led. We were informed that the provider had a system for monitoring the quality of care, and we confirmed that systems were in place.

Staff felt supported and able to raise matters with the management team at the home, who they believed would listen to their views.

Visiting professionals told us that there had been marked improvements to the home after a long period of uncertainty

St Johns Wood 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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Monday 15, Tuesday 16 and Friday 19 August 2016. The inspection team comprised of four inspectors.

Before the inspection, we looked at notifications that we had received and communications with other professionals, such as the local authority safeguarding and commissioning teams. We received written feedback from two visiting social workers, spoke with a visiting GP and two social workers.

During our inspection we also spoke with thirteen people using the service, a GP and two social workers who were visiting, fourteen members of staff (nine care staff and five nurses), an activity coordinator, the assistant chef, the registered manager, the deputy manager and the area manager for the provider.

As part of this inspection we reviewed 24 people's care plans. We looked at the training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, audit information, maintenance, safety and fire safety records.

We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people was having a positive effect on their wellbeing.

Good

Is the service safe?

Our findings

Almost everyone using the service was very frail and unable to give us their detailed views. However, about feeling safe, people told us "I like this place very much", "They look after us very well" and "I think this is the best place for an old person."

At our previous inspection we had found that people's risk assessments were not always updated in a timely way. At this inspection we found this had improved significantly. Care plans showed that where people were at risk of falls each person had a risk assessment in place detailing what action should be taken to minimise their risk of falling. The Registered Manager said he carried out a monthly audit of accidents, incidents and safeguarding issues and he reported a reduction in the number of falls during the past three months. Three members of nursing staff told us that they knew how to respond if there was an accident or incident and said they would complete a report for submission to the manager and monitor the person following the incident. Three registered nurses said they had completed risk assessments for people who were at risk of falling and we saw five examples of these including what action should be taken in their care plans.

People's personal risk assessments contained details of how risks were managed and examples of risk assessments seen included nutrition, pressure care, moving and handling, use of bed safety rails and falls. People who were at risk of developing pressure ulcers had these risks assessed. Pressure relieving equipment such as cushions and mattresses were used and the person's care plan included guidance for staff related to the settings and the checks which should be carried out by staff. Three registered nurses told us that they would contact the tissue viability nurse and GP when required and we saw evidence of this and records of mattress checks.

The service had access to the organisational policy and procedure for the protection of adults from abuse. They also had the contact details of the London Borough of Camden which is the authority in which the service is located and it was mostly this authority placing people at the service.

We were told that it was the policy of the service provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. We reviewed the induction records for three of the five staff who had been recruited since our previous inspection, which confirmed that safeguarding people was included in their induction.

At the time of our previous inspection the staff who we met had a variable, and some a limited understanding, of what constituted abuse and the action they must take, namely they must report it. This was not the case at this inspection and the staff we spoke with were all very clear about the action they should take if they were concerned that anyone had come to harm. The home had cooperated effectively with the local authority to any concerns that had been raised.

Staff feedback on whether there were enough staff available, was variable. Some felt there was sufficient staff, whilst others said it can be stretched at times. We spoke with the registered manager and area operations manager about this. Both were able to show that a business case had been presented to the

provider to recruit additional care staff for two of the floors where staffing levels were recognised as being stretched at times. They told us that they expected this request would be approved. The staff rota for the last three months showed that the designated number of staff for each floor were on duty for most shifts each week. On only a small number of occasions was a floor short of the number of care staff required to be on duty and this was usually due to staff sickness.

The registered manager told us that five new members of staff had been recruited since the beginning of 2016. We viewed the recruitment records of three newly appointed members of staff. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were permitted to work in the UK.

Medicines administration records (MAR) were clear and administration was accurately recorded. Medicines received from the pharmacy were recorded in the MAR charts and the quantity could be reconciled with the administration record. Medicines were stored securely including controlled drugs. Room and fridge temperature was monitored daily.

There was evidence of best interest meetings for people whose medicines were administered covertly, as well as appropriate instructions for medicines administered to people via feeding tubes. Nursing staff told us how they rotated the sites used for administering medicines supplied in patch form. There were plans for staff to follow for medicines administered only when needed. We also observed that nursing staff who administered the lunch time medicines offered people medicines prescribed as 'when needed' such as analgesia and would only administer these medicines if the person required them.

We saw that gloves and aprons were used by staff and that there were ample supplies of these available. We spoke with staff about infection control and they were aware of the precautions that needed to be taken. A member of the domestic staff team was able to tell us about what precautions to take when we asked about infection control. Domestic staff were seen to use mops and buckets correctly, hand sanitizers were available, with soap and towels available in bedrooms that we looked at. Hoists and slings used to support people with transfers were regularly checked and these checks were up to date to support people's safety.

The most recent infection control audit carried out at the home in June 2016 showed a compliance rating of 98.39 % with only a minor area requiring action.

At our previous inspection we found that although the home had a working call bell system in place, there was no monitoring of response times. The registered manager told us that the call bell system was being refitted and we saw an engineer working on this during our inspection. We will look at whether response time monitoring has improved at our next inspection as the system was undergoing improvements during this inspection.

We were shown records of health and safety checks of the building and the appropriate certificates and records were in place for electrical and fire systems. A fire safety officer inspection visit earlier in 2016 had identified some areas of improvement and all but one of these improvements had been achieved. The remaining improvement was in respect to glazing on some windows which we were told would be completed in the next few weeks, at which point the fire officer will return to confirm.

The provider had emergency contingency plans for the service to implement should the need arise.

At our previous inspection we had seen that a large collection of wheelchairs and walking aids were stored

in the external area of the lower ground floor directly outside bedroom windows. These had been removed and the exterior of the home had been improved significantly.

A mice infestation issue that had arisen earlier in 2016, as too had a bedbug infestation on one of the floors and these issues had now been addressed. To ensure this did not re-emerge the home were being visited by a pest control contractor to monitor the situation. The communal areas of the service were all clean and the current programme of redecoration and refurbishment was having a beneficial impact on the overall environment of the home.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection staff told us that they received supervision with the management, although the frequency of the supervision was variable. This had improved markedly by the time of this inspection. Staff told us they received regular supervision and training which was evidenced from reviewing staff files. We saw that, during a supervision session, their supervisor chose different topics to focus their discussions on, such as safeguarding, whistleblowing, medicines management, confidentiality or maintaining people's dignity and privacy.

Staff told us they received regular training which enabled them to carry out their role. Staff training consisted of both classroom based training carried out by a designated trainer employed at the home and online learning which staff completed in their own time. Staff training records confirmed that staff had completed training in areas such as Dementia Awareness, Fire safety, MCA/DoLS, safe administration of medicines and infection control. However staff training records also highlighted areas where staff compliance with training was low. Records showed that the service was 33 percent compliant with fire safety training for managers and zero percent compliant with health and safety for managers. Records also showed that some nursing competencies had also not been completed, for example, personal hygiene and prevention and management of pain. We raised this with the manager who said that an action plan to address these shortfalls would be implemented.

Staff compliance with mandatory areas of training did not achieve the level of compliance required. This is in breach of Regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager confirmed that since commencing in post in April 2016, he had not yet completed any staff appraisals. The provider had taken over this service less than a year before this inspection but was aware that appraisals need to take place. The registered manager, and area manager, informed us that a programme of appraisals was being developed to ensure completion within the next two to three months.

Two registered nurses we spoke with said that they were provided with information regarding potential admissions. This was in order to assess specific needs such as equipment and ensure that the correct level and skill mix of staff were available.

Three members of staff told us that care plans were reviewed on a monthly basis and eleven of these evaluations were seen and were up to date. The care plan provided information for staff regarding the care and support required by the person. Staff told us they were provided with an update of each person's condition during handover at the beginning of each shift.

The care plans contained a lot of information in respect of eating and drinking assessments, care plans, weights and the malnutrition universal screening tool (MUST) scores. Most people were on food and fluid charts, although mostly completed we did find a couple of occasions for one person where it had not been recorded for two days. We mentioned this to the registered manager who immediately asked a nurse to

check this. The overall standard of recording and updating of this information had much improved since our previous inspection.

At our previous inspection we found that there was a lack of directional aids and signage on the first floor, where people with dementia were living. In addition there was a lack of domestic style orientation aids such as clocks, calendars, daily newspapers all of which are good aids to orientation. Some rooms that had clocks, displayed incorrect times. Although signage had yet to be put back due to the on-going decoration work we were told that these would be as soon as the work was completed with improved signage to aid people's orientation. We saw that all clocks had the right time and the manager told us that this was checked by the maintenance person each morning.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked 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 procedure is 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.

Staff we spoke with were able to demonstrate a good understanding of the issues around consent and were aware of the meaning of capacity, and told us that they encouraged people to make choices as much as they could. We observed staff taking time with people to maximise their understanding of what choices were being offered and seeking their views about their wishes.

Where Deprivation of Liberty Safeguards decisions had been approved, these were usually made for the use of bedrails for people who were at risk of falling or climbing out of bed and who were unable to provide informed consent. The service had notified CQC accordingly and were re applying annually for re-assessment of these restrictions.

People who were able to give us their views about the food on offer told us "The food is good", "its ok" and "I enjoy the food".

We observed lunch on each day of our inspection on all floors. Food arrived in a heated trolley and was plated by staff in the dining room. Most people ate in their rooms. Staff were seen wearing plastic aprons and placed clothing protectors on people before serving food or supporting people to eat. We noted these were removed once lunch was over.

Copies of menus were displayed on the tables in the dining room and jugs of water and juice were available on each table. The tables were laid with colourful table mats and serviettes. We observed staff assisting people at lunchtime and treating them in a relaxed and dignified manner and also saw they were at eye level with people who were seated. People were offered choice, for example one person was offered a choice of fish or meat. Another person was offered a choice of potatoes or rice. People were proactive in requesting items such as yoghurts and fruit. On the dementia unit, one person thought it was breakfast and said they only wanted a cup of tea. A member of staff reminded them it was lunch time so the person was happy to have something to eat as well. Staff were offering choices with regard to where people wanted their lunch

and what they wanted to eat. Staff responded when people changed their mind and respected their choice of meal that they then provided.

On the second floor on the first day of our inspection staff served people in their rooms also, however, over half an hour after people in the dining room had been served two people in their own rooms had not been served. Most people in their rooms ate independently; however, we reminded staff that people should be served at the same time as soon as practicable unless they had specifically requested their lunch later. It was a period of very warm weather at the time of our inspection and we saw that people were being assisted to eat lunch outside on the balcony if they preferred to eat there, which was shaded from the sun. The interactions observed and choices being offered to people was much improved on what we had found at our previous inspection.

People were supported to maintain positive health and had access to health care support. Where there were concerns we saw that people were referred to appropriate healthcare professionals. A registered nurse told us a GP visited the home twice each week, and we met the GP who was visiting on the first day of our inspection. This GP told us that there had been a lot of changes at the home recently and thought that nursing staff had the necessary skills and abilities to respond to people's healthcare needs. A visiting social worker told us that the recently appointed clinical lead was "brilliant and a great resource." They went on to say that this person "had their finger on the pulse" of what people needed and was very knowledgeable and helpful.

Monthly multi-disciplinary team (MDT) visits and meetings to review people's conditions and needs took place. People also had access to a range of visiting health care professionals such as dentists, physiotherapists, opticians and podiatrists. We saw records on the multi-disciplinary sheets referring to visits made by MDT members. Registered nurses told us that as people's health needs changed there would be a referral made to the relevant professional for advice and guidance. These included community nurses, physiotherapists, opticians, tissue viability nurses, dentists and oral hygienists. The care plans contained the outcomes of visits and records of advice which had been provided by a range of healthcare professionals including GPs, occupational therapists, podiatrists, tissue viability nurses and dieticians.

Pain assessments and pain care plans were in place detailing the pain experienced by each person, and what medicine should be provided. End of life care was recorded throughout the care plans we viewed.

There was a lot of equipment in use including specialist beds and mattresses, which were checked daily to ensure they were fully functioning. In addition there were stand aid hoists, full body hoists specialist bathing equipment, walking frames and two lifts to access all parts of the home which were also being checked by a maintenance contractor at least annually.

Good

Is the service caring?

Our findings

Visiting times at the home were open and relatives were made welcome at any reasonable time of the day. A small number of relatives visited during the course of our inspection visits although none wished to speak with us on this occasion.

People using the service told us "Everybody is nice. They are glad to see you," "They (staff) are very nice. They show respect" and "I am happy, I am satisfied here."

At our previous inspection we had found that not all staff were demonstrating the appropriate degree of respect and dignity towards people. The atmosphere and engagement between staff and people using the service was much improved at the time of this inspection.

Where people were non-verbal or repeating words or sounds, staff stayed with the person and maintained eye contact which helped in reassuring the person. Staff were also maintaining some physical contact such as hand holding or stroking someone's cheek where this was appropriate and calming for the person.

The general atmosphere in the dementia unit lounge was lively and people were clearly enjoying the activities either in groups or on their own. Staff were chatting and joking with people and this was having a positive effect on their well-being. Staff told us they enjoyed working with the people on the first floor and we could see that positive relationships had developed between staff and people using the service.

Registered nurses told us that a care plan was agreed following initial assessment and this was updated on an on-going basis and reviewed monthly. We were told there was "a care plan co-ordinator and key worker" system in place which meant that each person had a dedicated registered nurse and carer.

Staff we spoke with were knowledgeable about the care and support people required and care plans contained information of what people were able to do for themselves. They also knew about what support each person required for using equipment such as walking frames to support their independence.

We observed staff talking with people in the lounges and other parts of the home. Staff were attentive and respectful in their approach and manner. Conversations were friendly and relaxed and demonstrated that care staff were on good terms with the people they were caring for.

The bedrooms are single occupancy with en-suite facilities. Some bedrooms were personalised with people's own possessions, furniture, photographs and personal items where they had chosen to bring these possessions with them.

We observed staff transferring people using a hoist. This was done very sensitively and professionally. Staff were maintaining physical contact with the person and reassuring them throughout the transfer. Staff were also working and communicating well together.

There were a number of people who were very poorly and could not go to the lounges but instead stayed in bed most of the time. Throughout the time we visited we saw staff popping in and checking on people and staying with them for a while when they couldn't leave their room. Activities co-ordinators also spent individual time with people on each floor when they were unable to become involved in group activities.

Two registered nurses told us that the home was working with Marie Curie Palliative Care Research Unit and University College London Hospital using the Compassion Care Model for the Care of Memory problems in Advanced stages. The team included medical staff and researchers who visited the home and involved the people living there, family members and staff.

Care plans included advanced care plans which detailed the person's wishes at the end of their life. This included pain management and how the individual expressed pain if they were not able to do so verbally.

Staff we spoke with were enthusiastic about their work and said they wanted to provide a high quality service for people who were living at the home.

Good

Is the service responsive?

Our findings

People who were able to give us their views about the service told us "I'm not worried about raising concerns", "I've no complaints at all" and "I've got no complaints, I can do what I want to do."

At our previous inspection we found that, prior to the admission of people to the service, a care needs assessment had been carried out, although these were in some cases incomplete. This had much improved by the time of this inspection. Three registered nurses we spoke with told us that a pre-admission assessment was carried out by the registered manager and/or the deputy manager. People's care records throughout the five floors that we viewed all contained a completed pre-admission assessment. The pre-admission assessment included personal details, next of kin, GP, past medical history, current medicines taken, any known drug allergies/sensitivities, personal care and physical well-being. The assessments also contained information about weight and dietary preferences, sight, hearing and communication. oral health, foot care, mobility and dexterity, history of falls, continence, mental state and cognition, current referrals to other healthcare professionals, and overview of life history and personal safety and risk.

Three members of staff told us that the "Resident Care Profile" documentation was commenced on admission to the centre and a "Snap Shot Care Plan" was also completed to provide guidance for staff to follow in order to meet people's needs. The "Snap Shot Care Plan" was located in the person's room and available to all staff. It included details of the person's needs including pictorial representation in twelve sections. These were Medical History, Communication, Elimination, Work and Leisure, Emotional and Psychological needs, Breathing, Washing and dressing, Self-Expression, Eating and Drinking, Maintaining a safe environment, Mobility and Sleeping and waking. Three members of staff told us this was a useful reference document and eleven examples of "Snap Shot Care Plans" were seen and were completed in the most part.

Three registered nurses told us that the Care Profile folders should be completed within one week of admission to the home, Once completed these provided guidance for staff to follow in order to meet people's needs. In addition staff completed a daily communication record which was retained in people's rooms and discussed during staff handover at each shift. At our previous inspection we had concerns about consistency of care planning although improvements had been made since then. However, we found that the quality of information and updating of care plans varied widely on each floor of the home. Staff did not appear to be using the same interpretation on each floor of how much details should be put into care plan profiles or regularity of updates. It is acknowledged that the care plan profiles are still a fairly new system and that the recently appointed clinical lead nurse has been tasked to review these around the home. We suggested that the date of admission of the person, the date of completion of the plan and the name and designation of the member of staff is included.

The activities co-ordinator told us a timetable of group and one to one activities was in place from Monday to Friday and records were seen of people's participation/involvement in activities. The majority of activities were based in the home with little opportunity for engagement with the local community. An activities co-ordinator and the registered manager both said that trying to arrange suitable transport to enable people to

take trips out had been very difficult but they were continuing their efforts to make this happen. Activities involved reminiscence, music and movement, films, arts and crafts and individual activities with one to one time being spent with people who could not leave their room. We spoke with the activities coordinator who had a good understanding about how and why people living with dementia should be kept occupied and engaged. They interacted well with people and made sure they were being supported to take part in activities in order to maintain their well-being.

People's like, dislikes and care preferences were recorded. There was not always a lot of detail in people's social history but this was because people either did not have a next of kin or they were too poorly to be asked. Staff did know about people's history, told us that as new information came to light they included this and people's preferences when we asked them.

People's care plans included information about their culture and religious observance and how these needs should be respected and upheld. As there was not a lot of information in people's care plans when they first arrived at the home, staff used a "Snap shot" care plan summary which was in each person's room.

We asked people we spoke with about whether or not they knew how to complain and if they felt confident that they would be listened to. People felt confident they could complain to staff if necessary. There had been no complaints made since the new provider began operating the service in September 2015. The provider had a clear complaints and comments system and this was on display around the home.

Good

Is the service well-led?

Our findings

None of the people using the service made specific comments to us about the registered manager or other senior staff.

The provider of the service had taken over from the previous provider in September 2015. It was evident, given the concerns that had arisen as the result of our inspection in December 2015 that improvements had since been made at the home.

There was a clear internal management structure in place and staff were aware of their roles and responsibilities. Staff told us that although the work was challenging at times the registered manager was firm but fair and was clear about the expectations placed upon staff.

The service has a registered manager who had been in post since April 2016 and was supported by a deputy manager and a clinical lead nurse. Staff told us the registered manager and deputy manager, were supportive and the recently appointed clinical lead had a high profile around the home.

The registered manager said that registered nurses had begun preparation for revalidation with the Nursing and Midwifery Council. The provider had a structure in place which included group supervision, appraisal and support with individual staff training portfolio management.

Staff meetings had begun to take place since the recently appointed registered manager came into post. Staff were asked to raise issues which they were doing and the minutes of the meeting held so far showed that staff felt able to raise matters. Management staff had discussed the provider's proposals regarding staff incentives, extra staff recruitment, pay and performance monitoring of staff.

Staff told us they felt they worked as a team, changes were continuing to be made but none felt these had any other purpose but to improve the service people experienced at the home.

We observed that staff felt able and comfortable to approach the registered manager and senior staff. We also observed how visitors to the home were not hesitant about speaking with the manager, knew who this person was, and the manager was engaging openly with any person who spoke with him.

We were informed that the provider had a system for monitoring the quality of care, and looked at these systems. Regular reporting to the provider was required and covered a wide range of areas, from direct care, staffing, budgetary performance and maintenance among other areas. Audits were carried out of clinical practice, medicines, care plans (we were informed that auditing of the newly introduced care planning system was about to be implemented as the system had only recently been established) as well as day to day operation around the home, for example catering and housekeeping. The provider had a business continuity plan in place that outlined what action should be taken in the event of any serious event which may affect the safe operation of the service. Such events would include outbreaks of infectious disease, fire or flood and loss of heating and power supply. The provider had effective communication systems with

other health and social care professionals whose input was well established with the home.

There had yet to be a satisfaction survey of people using the service, relatives or other stakeholders. We were, however, shown examples of communication that had been entered into with people using the service (where that had been possible), relatives and other interested parties about the change of ownership of the service last year. A survey process had just been commenced a few days before the start of this inspection and this was advertised in the home with feedback forms for people, whether they be visitors or others, being readily available.

The manager informed us that the provider was securing an advocacy service to undertake work on obtaining feedback from people using the service, particularly those who found it more difficult to express their view. We will review this feedback at such time as the resulting quality assurance survey assessment and report have been completed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Mandatory training was not being completed by some staff as required by the provider.