Shaw Healthcare (Group) Limited

Wellesley Road Care Home

Inspection report

1 Wellesley Road
London
NW5 4PN

Tel: 02072844460
Website: www.shaw.co.uk

Date of inspection visit:
25 May 2016
26 May 2016
31 May 2016

Date of publication:
20 September 2016

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

This inspection took place over three days on 25, 26 and 31 May 2016 and was unannounced. At our last inspection on 28 and 29 July 2015 we found that the provider was not meeting two of the regulations that we inspected against. We found breaches in regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not adequate and did not contain enough information to enable staff to care for people appropriately. At this inspection we found that the provider had addressed this issue. The home was not adequately auditing people's medicines to ensure the safe management of medicines. At this inspection we found that this issue had not been adequately addressed.

Wellesley Road is registered to provide accommodation, nursing and personal care for a maximum of 60 older people, most of whom have dementia. On the day of inspection there were 56 people using the service.

The home had a registered manager who is also registered for another 60 bedded care home which is located nearby and run by the same provider. The registered manager spends most of her time at the other care home. The provider had employed a manager, as of February 2016, who is working full time at Wellesley Road and has applied to be registered for this home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home completed some audits of people's medicines. However, there were not enough people's medicines checked to ensure a robust auditing system and identify medicines errors.

Stock control of medicines was not always checked or documented. Some people received covert medicines; there was no documented Mental Capacity Act (MCA) assessment for people around providing covert medicines.

Staff did not always receive regular documented supervision and support. The home did not provide adequate support and guidance for staff or identify individuals learning and development needs.

The home was compliant with applications for the Deprivation of Liberty Safeguards (DoLS). However, management failed to notify the Care Quality commission (CQC) when an application had been granted.

There were concerns raised by staff and relatives around the amount of agency staff that were being used in the home. The home completed 48 hour diaries, documenting the amount of care required, when a person's needs changed. This was discussed with the local authority and staffing allocated according to identified need.

Food looked and smelt appetising. People told us that the food provided by the home was good. People were asked what they would like to eat the day before so that the kitchen could prepare the meals. This included alternative meals. However, on the day, people were not consulted as to whether this was still the meal that they wanted and an alternative was not offered. Some people were unable to remember what they had chosen the day before.

People told us that they felt safe within the home and were well supported by staff. Relatives also said that they felt their family members were safe within the home. We saw positive and friendly interactions between staff and people.

Staff understood people's individual needs in relation to their care. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report abuse to if people were at risk of harm.

Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people were not able to have input in to making decisions affecting their care, there were records of MCA assessments and best interests meetings. □

Care plans were person centred and reflected individual's preferences. Care plans had been signed by people. Where people were unable to sign, they had been signed by relatives.

People were supported to maintain a healthy lifestyle and had healthcare appointments that met their needs. There was good joint working with healthcare professionals and we received positive comments from the healthcare professional the home worked with.

There was a dedicated activities coordinator and a weekly activities schedule that showed activities were provided seven days a week. We observed people engaging with activities and smiling and laughing.

Staff training was updated regularly and monitored by the manager.

People were supported to have enough to eat and drink. Where people had specialist diets, they had been assessed by Speech and Language therapists (SALT). Staff understood individual needs around food and hydration.

There was a complaints procedure as well as an accident and incident reporting. Where the need for improvements was identified, the manager used this as an opportunity for learning and to improve care practices where necessary.

There were regular health and safety audits. These allowed the provider to ensure that issues were identified and addressed. A recent service user survey had been completed and the service was in the process of collating these results.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

There was an improved and open atmosphere within the home. The management encouraged a culture of

learning and staff development.

Overall, we found breaches in regulations, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We identified breaches of regulations relating to medicines, supervision, medicines auditing and notifications. You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Systems to ensure that medicines were handled and administered safely were not effective.

There were concerns around the amount of agency staff that were being used and the impact of this on people's care.

The risks to people who use the service were identified and managed appropriately.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

Safe moving and handling practices were used.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive regular supervisions and support from management.

People were consulted on their choice of food. However, there were no menu plans displayed in the home. People were not always offered alternative meals.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DOLS).

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs, likes and dislikes.

People were treated with respect and staff maintained privacy and dignity. Interactions between staff and people were generally positive .

People were encouraged to be as independent as possible.

Relatives were able to visit whenever they wanted.

Is the service responsive?

Good

The service was responsive. People's care plans were written in a way that was person centred and tailored to meet individuals' needs and preferences.

People, where possible, and relatives were involved in creating people's care plans.

There was an activities coordinator employed by the home. There was a full activities timetable consisting of internal and external activities. Activities took place seven days a week.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well led. The service did not notify The Care Quality Commission about Deprivation of Liberty Safeguards (DoLS) that had been authorised.

Auditing systems were in place for health and safety, kitchen audits and care plans. However, auditing of medicines was not adequate and the manager did have oversight of this.

There was an improved, open culture within the home and staff felt that management was more inclusive and open to listening to them.

There was good joint working with healthcare professionals and healthcare professionals were positive about their communication and relationship with the home.

Wellesley Road Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 25, 26 and 31 May 2016 and was undertaken by two inspectors, a specialist advisor with particular knowledge, qualifications and experience of nursing in dementia care and a pharmacist that looked at people's medicines. An Expert by Experience also attended the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we had about the provider, including notifications of any safeguarding concerns or incidents affecting the safety and well-being of people.

During the inspection, we spoke with 18 people that used the service, five staff and four relatives. We spoke with three healthcare professionals that were visiting the home at the time of our inspection, two doctors and a Speech and language therapist (SALT). We also spoke with a priest that provided faith services and pastoral care to people living at Wellesley Road.

We looked at nine people's care plans and risk assessments, 13 staff files, including supervisions and appraisals and other records that the home held, such as health and safety, audits of systems and policies and procedures.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us 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 well-being.

Following the inspection, we spoke with six relatives and the Camden Advocacy service. Camden Advocacy service worked with seven people living at Wellesley Road that had no next of kin and acted on their behalf,

where necessary, to ensure their wellbeing. We spoke with a further seven staff.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "Oh yes, I feel safe here." Another person said, "Of course dear, I'm well looked after." Relatives said, "Safe? Yeah, I think so. Whenever I see my mum she seems happy with the people" and "I feel she is safe and she is well looked after." Another relative commented, "Every time I go there, I feel safe leaving her when certain staff are on. She's safe there but it could be better." The relative said that they felt that the home used a lot of agency staff that did not know his relative well and were not always familiar with the person's needs.

Medicines were provided by the local pharmacy. Medicines were kept in individual boxes and containers and clearly labelled with the name of the person and date dispensed.

We checked the Medicine Administration Records (MAR) charts for 21 people for May 2016. There were no omissions in signing the MAR charts, which indicated that people had received their medicines. However, when checking the stock of medicines against the MAR charts we found that for nine people, there were 19 medicines errors where there were either too many or too few tablets left in stock when cross checked with the MAR chart. One person had had 28 medicines delivered for digestion. Twenty-one had been signed for which should have left seven in stock. However, there were two tablets left. Another person's pain relief medicines had been documented as 28 received, 23 signed for but six left in stock. The person had not received some of their dose of pain relief medicine. This had not been documented. The senior member of staff that was present when medicines were being checked was unable to explain what had happened to the tablets.

Medicines audits had been carried out. However, the audits in May 2016 did not include a big enough sample size for the manager to be assured that medicines errors were being identified. No medicines errors were identified in these audits. The manager confirmed that no medicines errors had been reported in this period.

One person had recently suffered a lower leg fracture and was on strong pain relief. However, the MAR chart had notes on the back stating that the pharmacy was out of stock of the prescribed pain relief. Whilst this had been documented, it had not been adequately followed up. The person did not receive their pain relief for seven days. This potentially left the person in pain. The type of pain relief that had been prescribed can potentially cause constipation and the person had been prescribed a laxative. When the person stopped receiving their pain relief, staff continued to administer the laxative. The person then developed loose bowels. This was documented by staff and the laxative stopped three days later. The person was incontinent and wore pads. This could lead to a breakdown of skin integrity. We immediately raised this with the manager who was unaware of the issue. Following our inspection we spoke with the manager who said that the person had been reviewed by the GP and pain relief was being given on an as needed basis.

On two occasions, staff within the home had converted a prescribed daily medicine to an as needed medicine on the MAR chart. One was a medicine to help the person sleep and the other was pain relief. There was no documentation to show that staff had sought the permission or had agreement from the

prescribing GP to do this. Staff were also unable to explain why this decision had been taken.

One person's MAR chart noted that they had no allergies. However, on their care plan it was noted that they had an allergy to penicillin and seafood. This put the person at risk of harm as the pharmacy and the prescribing GP were unaware of the person's allergies.

The same person was receiving covert medicines. Covert medicines are where the home administers medicines without the persons consent. Two medicines were noted to be given covertly. However, the person had also been prescribed a high-risk medicine that was to be given once a week. There were specific guidelines around the administration of this medicine. The person needed to have the medicine 30 minutes before eating in the morning and must be in an upright position for 30 minutes after taking it. There was no information on the person's care plan how this medicine was given and risk assessment or guidance for staff on how to safely administer this medicine. Following the inspection, we sought assurance from the manager that this medicine was being administered appropriately and safely. The manager informed us that he had spoken to staff and staff understood how to administer the person's medicine safely.

There were two people receiving covert medicines. These medicines were crushed and mixed with food or fluid. There was no documentation of a Mental Capacity Act (MCA) assessment and covert medicine forms had not been signed by the pharmacist. The medicines policy stated, 'Medication should only be crushed with permission and written directions of the GP and pharmacist.' The policy also noted that if a person does not have capacity, a MCA assessment must be completed before covert medicines were considered.

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

The home had six units with capacity for ten people on each unit. Each unit had two care assistants. Team leaders covered either one or two units. In the nursing unit and several of the residential units, people often required two staff to deliver care. We observed that staff sometimes found it difficult to provide one to one support for individuals with dementia.

Some staff and relatives that we spoke with expressed concern around the amount of agency staff that were being used within the home. One staff member said, "There's still a lot of agency [staff] we are often a staff member down on at least one of the units." Another staff member said, "We don't always have time to spend with residents on one to one basis. In general staff are really hard working but there are so many agency that don't know people, I spend more time trying to sort them out." One relative said, "To be honest, care is very bitty. It's a lovely equipped home. Some carers I wouldn't give you two bit for. Others really take their time with mum and understand dementia. The agency staff just sit and write notes." The staffing rotas showed that on the days we inspected, out of the 24 staff working each day, there four agency staff on duty on 25 May 2016, nine agency staff on duty on 26 May 2016 and three agency staff on duty on 31 May 2016. We discussed this with the manager who told us that the home had been experiencing difficulties with recruiting staff. However, this was in the process of being addressed and job adverts were in place. The manager told us that agency staff received a brief induction when they worked at the home and that the home tried to use the same agency staff when possible.

The home did not complete needs assessments and staffing was not designed according to specific needs assessments. We discussed this with the manager who said that regular needs assessments were not completed but if a change in a person's needs was identified, the home completed a 48 hour diary. The 48 hour diaries documented all care provided within that period. If there was a need to increase the care needed, the home spoke with the local authority to gain agreement for increased staffing. Following the

inspection we spoke with the local authority who told us that they were happy with this system and the home had been, "Very good with assessing people's needs."

Risk assessments were person centred, detailed and gave guidance for staff on how to support people in the least restrictive way. Falls risk assessments showed regular reviews and updates when people's circumstances changed. The falls risk assessment was detailed and gave people a score of low, medium or high. If the person was at medium or high risk a comprehensive risk assessment was put in place addressing all aspects of how to mitigate falls. However, it was unclear how the home had decided what people's level of risk was. We spoke with the clinical lead in the home who said that there was a tool to measure levels of risk. However, staff that we spoke with, including the manager, were unaware of how falls risks were measured. We spoke with the clinical lead of the home who said that they would ensure that staff understood how the falls risk assessment tool assessed people's risk of falling.

Risk assessments around swallowing difficulties were robust and gave staff detailed information on how to mitigate risks. Staff were able to tell us if people were on specialist diets and what type of food they required to ensure their safety and wellbeing. There were Speech and Language Therapists (SALT) assessments in people's files and recommendations had been carried through into risk assessments and care plans.

The manager told us that no people living in the home currently had any pressure ulcers. Risk assessments showed that, where people had been identified as being at risk of developing pressure ulcers, a risk assessment was in place that gave staff guidance on how to mitigate these risks. Repositioning charts were in place and completed appropriately for two of the people's care files that we looked at. There was a protocol in place if any person started to develop a pressure ulcer. Any person at risk would be referred to the GP and/or district nurses and Tissue Viability Nurse's (TVN). The GP also told us that they were informed when they visited each week if anyone was at risk of pressure ulcer and that the home could also contact them in between visits if they had concerns.

The home had a detailed 'Safeguarding Adults' policy which staff had access to. The policy stated that it was all staff members' responsibility to be aware of and understand safeguarding. The policy detailed what types of abuse there were, how staff could recognise abuse and what type of behaviours people may show if abuse was happening. There was clear guidance on how to report abuse.

Staff were able to tell us how they would keep people safe and understood how to report abuse if they thought people were at risk of harm. Staff were able to describe different types of abuse. One staff member said, "It [safeguarding] is to protect vulnerable people from harm and abuse. We need to report it, be transparent". Another staff member said, "It [safeguarding] is for the resident's wellbeing. To protect them from abuse." Staff understood what whistleblowing was and how to report concerns if necessary. Whistleblowing is where staff are able to report concerns within the organisation, often to the local authority, without fear of being victimised. One staff member said, "It [whistleblowing] is like if you find something you are not happy about and you are scared to tell management you call the number to report concerns. There are posters in the staff room with details of who to call." There were posters with information on how staff could whistle blow placed around the home.

There were detailed records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records showed what action the home had taken in the short term to address issues and also stated the outcome. Where necessary, care plans had been updated to included issues that had been identified. For example, someone with a high falls rate had been referred to the falls clinic and their care plan was updated.

The home followed safe recruitment practices. Staff files showed pre-employment checks had been carried out, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK.

There were up to date maintenance checks for gas, electricity, electrical installation and fire equipment such as fire extinguishers and emergency lighting. There were regular checks of the fire alarm systems. People that required specific help should there be a fire had Personal Emergency Evacuation Plans (PEEPS) in place. PEEPS provide staff with guidance on how someone that has a mobility or cognitive difficulty should be evacuated safely. The home also conducted six monthly fire drills to ensure that staff and people knew how to evacuate the home safely in case of fire. We looked at records of five fire drills. Three noted that further staff training was required around fire safety. However, there were no records to show that this had been completed or followed up.

The home employed cleaning staff and during our inspection the home was clean and tidy. Toilets, bathrooms and people's rooms were checked and cleaned regularly. We observed cleaning staff chatting with people and explaining what they were doing when people asked them. One person said, "It's always so clean and lovely here." Another person said, "The cleaners do a grand job here."

We walked around the home and looked at nine people's bedrooms. Bedrooms were personalised with family photos, ornaments, televisions and personal effects. Some people had a telephone line in their bedrooms.

Requires Improvement

Is the service effective?

Our findings

The home had a staff supervision policy which stated that supervision was, 'A set of processes aimed at providing guidance, support and development to all employees, enabling them to practice and progress effectively as an individual and as a team member.' The policy also stated that staff should, 'Receive a minimum of six formal supervisions sessions each year. Of these no more than two can be group supervision sessions.' The supervision record overview showed that 69 staff were employed by the service, 44 of these staff had been employed since June 2015. Of these, ten had received no supervision, 12 had received one supervision session and 12 had received two supervision sessions. The remaining ten staff had received between three and four supervision sessions. No staff had received the provider's required six formal supervision sessions.

One staff member said, "I've had two [supervision sessions]. A group clinical supervision and one with the new manager two or three weeks after [they] started. I didn't have any supervision prior to that." Other staff members said, "I had one a week ago. First one in a year" and "I've only had group supervision. I didn't know it was supervision, I thought it was training. Since being at Wellesley Road [in the last year] I've not had supervision one to one." We spoke with the project manager who told us that staff had more supervision sessions but these did not appear to be on the overview document. However, there were no records to show that this had been happening in the staff files that we looked at. Staff were not receiving adequate support as was necessary for them to carry out the duties they were employed to do.

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

Staff were not due an appraisal as the home had only been open since June 2015. Appraisals are completed each year to review staff performance. The manager told us that plans to begin the appraisal process were in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

DoLS were in place for 39 people that used the service. There were dates noted for when the DoLS needed to be reviewed. A further 16 DoLS had been applied for and awaiting outcomes. Where possible the home

discussed the DoLS applications with people. One person told us, "I can't get out' 'for my own safety. I can talk to you and the next minute I don't know who you are. I have no restrictions [in the home] until I get to the front door."

One staff member told us, "It's [MCA] is to decide if the person has capacity to make informed decisions. If they are unable to they would need an assessment and a best interests meeting." Another staff member said, "It's [MCA] to ensure that people are able to make decisions where they can. It's about trying to ensure that people have their best interests taken into account."

All care plans that we looked at were signed either by the person or a relative. Where people were unable to make decisions regarding their care there were records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. The manager told us that where people did not have relatives involved in their care, they were referred to the Camden Advocacy Service who provided an Independent Mental Capacity Advocate (IMCA) to act on their behalf and in their best interests where necessary.

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures and shadowing more experienced staff before being allowed to work alone.

Training records showed that staff received regular training in areas such as safeguarding, manual handling, Mental Capacity Act and catheter care. We asked for details of when staff would receive refresher training. This was not made available to us during the inspection. The provider subsequently assured us that there was a system in place to assist managers identify when staff need refresher training.

Wellesley Road provides care and support to people, all of whom have a level of cognitive impairment or dementia. The home opened in June 2015 and some staff were transferred from the local authority to Wellesley Road. Dementia care training had been provided to these staff by the local authority prior to starting work at Wellesley Road. The manager told us that dementia awareness was also covered in staff induction. When observing staff interacting with people with dementia, we saw some positive and supportive interactions, although there was some variability. One of the interactions we saw was caring, but did not fully demonstrate an awareness of how to support people with dementia effectively.

We observed lunch time on three units during our inspection. No menus were on display in the dining room or anywhere on the units. We asked staff how people knew what was being served that day. The staff member said that people were asked the day before what they wanted to eat the next day and it was recorded in a folder. We observed that whilst there were alternatives available, no person was asked if what they had chosen the day before was still what they wanted to eat. We saw that people were often unable to remember what they had chosen the day before. We discussed this with the manager who said that he would look at the system of how people were able to choose their meals.

On three occasions during the lunch times we observed, people that required help with eating had their lunch placed in front of them and staff then left for between five and ten minutes before returning to help. One person was told by a staff member that, "[the staff member] will come back and feed you." The person attempted to feed themselves but was unable to manage this. The staff member returned after around ten minutes and helped the person to eat. The person appeared to become frustrated and anxious whilst waiting for the staff member to support them with their lunch.

When people were being helped to eat, we saw that staff were patient and did not rush people. There was good communication between the care staff and the people they were supporting. People were observed to eat well with empty plates returning. Staff were able to tell us if people were on special diets, such as thickened fluids, pureed or mashed. We observed staff serving people and ensuring that they received the correct consistency of food for their needs.

Juice, cranberry and apple or water was offered throughout the meals. When people had finished their lunch, staff offered people juice, tea or coffee to relax with. We observed that staff ensured that people who chose to spend time in their room had jugs of juice or water to ensure hydration. Throughout the inspection we observed staff offering tea, coffee and hot chocolate to people. Where people asked for drinks, staff were responsive in providing them. However, on three occasions we observed staff giving people a drink but this was out of reach of the person. One staff member approached a person and said that their tea had gone cold and they had not touched it. Inspectors pointed out to the staff member that they had been unable to reach the drink.

The food looked and smelled appetising and portions were generous. Staff asked one resident if they were enjoying their food. The person replied, "The meats tough." However, staff did not respond to this or ask if the person wanted an alternative. Another person referred to food as, "Very nice" and was offered a second helping by staff. Following an observation of breakfast, we asked what people thought of the food. One person said, "Oh, it was beautiful, it's always good." Another person said, "I like the food here." There was a relaxed friendly atmosphere during meal times.

Staff checked and documented the temperature of food before it was served so that it was safe for people to eat.

One relative told us that they thought that the food provided by the home was, "Good quality." Another relative said, "Historically mum doesn't eat well. Staff are trying and are very aware of her low weight."

We saw risk assessments for people that had a loss of appetite or those prone to choking or with swallowing difficulties. Where people were known to have poor appetite or other nutritional risk factor, a daily food and fluid intake chart was in place. One person's fluid chart documented how much the person had drunk but did not state what the required amount was. Staff were unable to see if the person had drunk under or over what had been recommended. We spoke with the nurse in charge who was able to tell us how much fluid the person should be drinking in a day. The staff member said that the chart would be updated to ensure that this could be monitored appropriately.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by healthcare professionals was included in peoples care plans. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. One relative said, "I am very impressed with home with their responses, they picked up health issues for my mum very quickly."

We observed a SALT assessment by a visiting healthcare professional. They told us that, "Generally, the home are very good at referring people when there is a change [in their needs]." Records showed that following a SALT assessment for a person, their care plan and risk assessment had been updated. Records showed that people were referred to healthcare professional in a timely manner when the need arose.

Good

Is the service caring?

Our findings

We asked people if they felt that staff were kind and caring. One person said, 'Yes some, you don't get all the same. The ones in here are kind." Another person said, "Yes, staff are good to me." A relative told us, "Everyone is very approachable. They use a lot of agency staff, regular staff encourage mum to maintain her independence." There was a good atmosphere in the home and people appeared relaxed. There was good interaction between staff and people and staff knew the people well.

Where people were unable to communicate with us, we observed interactions between staff and people. Staff spoke kindly to people, and appeared to know people well. During one interaction, we observed a staff member asking a person about their family and how they were. The person was able to recall their younger years and was talking about their husband and what they were going to cook him for dinner that evening.

We also observed another occasion where a person was saying to a staff member that they wanted to go home. The staff member responded and said that the person was home now and reminded them that they lived at the home. This was said in a kind manner. However, the person became very distressed and anxious. During another interaction, a person said that they wanted to get the bus to work and needed to leave immediately. The person became quite distressed. The staff member present asked the person what number bus they needed to get and how long it would take to get to work. The person engaged in this conversation and was encouraged to sit with the member of staff and have a cup of tea. The person quickly calmed down and chatted with the member of staff.

A staff member reminded a person that they needed to keep their legs elevated. The person was guided to a chair and a foot-stool put in place to ensure that their legs were elevated. The staff member spoke calmly with the person, gently explaining why they needed to elevate their legs and said that the person had been advised by the GP to keep their legs elevated due to swelling of the lower limbs.

Staff told us that one person enjoyed folding napkins and cloth and would hang pieces of cloth up. The home and relatives had provided a box for the person with fabric and things the person could fold. A staff member said that the person would, "Spend ages doing what she [the person] calls; her work. She's got her little box with her bits, she potters about. It's lovely". The person had mobility issues and poor upper body strength. The manager told us that folding and hanging pieces of fabric not only made the person happy but also provided gentle exercise for their upper body. All staff that worked with the person were aware that they enjoyed this and ensured that the person was encouraged to 'do her work' whenever she wanted to.

Posters were on display around the home introducing to people staff who were dignity champions. Dignity champions are staff that have been trained in equality, diversity and dignity and act on people's behalf to improve their experience and quality of care. Staff told us that they felt that this was an important role as they were often able to speak up for people that were unable to speak for themselves. Relatives and people were able to talk to the dignity campions if there was anything that they wanted to raise.

Staff were positive about working with people who identified as gay, lesbian, bisexual or transgendered

(LGBT). Staff told us that this would not make any difference to how the person was treated. One staff member said, "I don't have any problem. It's about the care they receive." Another staff member said, "I would treat them like any other resident. Like a human being and respect people's choice. The home's 'Promoting Equality and Diversity for Service Users' policy was robust and talked about people having choice of staff of their own gender regarding personal care but failed to mention equality and diversity around LGBT and how the home and organisation would ensure that LGBT people's rights were respected and met.

Staff were able to explain how they treated people with dignity and respect. One staff member said, "I speak nicely with them, always ask if they want to go to bed, I ask if they want me to change them. The dignity is treating people with respect. If people say no or are anxious we change the subject or allow them to calm down and try again." We observed staff asking people if they wanted help or support and waiting for a response before carrying on. We observed staff knocking on people's bedroom doors if they wanted to go in and waited for the person to respond. We observed carers talking with people and asking their permission when hoisting from wheelchair to chair and explaining what they were doing.

The home catered for people's religious needs. The majority of people living at the home were Christian. On the first day of our inspection we spoke with the visiting priest that held a weekly service for people. The priest said that there was, "A good rapport with staff. Staff remind people that there is a service and help them to attend." The priest also provided pastoral care as well as doing, "Palliative care work if people or the family want us to." We asked the manager what they would do if they had a person with a differing faith that moved in. The manager said that depending on the faith they would ensure that the person's needs were met. For example, if it was a person with a Muslim faith, an Imam would be contacted if this was what the person wanted.

Staff told us that relatives could visit whenever they wanted and relatives confirmed this. One relative said; "Oh yeah, I can visit whenever I want. It's never a problem." Family and friends visited the home throughout our inspection. Staff talked to visitors and offering them tea or coffee.

Good

Is the service responsive?

Our findings

At our last inspection we were concerned that care plans were not adequate and gave the home a requirement notice in relation to this. During this inspection, we found that care plans were detailed and person centred. All people living at the home had new, detailed care plans. We looked at nine people's care plans. The manager told us that care plans were updated every six months but reviewed as and when people's needs changed. If there were any changes these were completed as and when necessary. People's care plans were signed by the person, or by relatives.

Within people's care plans was a document called 'About my life' which talked about where people were born, school, brothers and sisters, childhood, friends, children and grandchildren, employment, hobbies and interests and memorable life events. Care files noted what people's likes and dislikes were in all aspects of their life including, food, activities and hobbies. Staff knew people well and were able to tell us what individuals liked and enjoyed.

The home had a dedicated activities coordinator. The activities coordinator told us that the manager was in the process of advertising for a second activities coordinator to support more activities.

There were posters around the home with details of planned activities. However, these were hand written in very small writing and did not state exactly what was happening within the home. One activity was noted as 'Bus trip'. It did not state where or what type of bus trip was taking place. Posters were not dementia friendly and were not in a format that people living with dementia may need to be able to understand such as, large font or pictorial.

We observed a seated exercise class. The instructor was supportive of people, when they did not understand or could not follow a movement she went over to them and showed them. There was a lot of laughing and joking and people appeared to be enjoying the session.

The activities coordinator told us that the organisation had another residential care home nearby. The home had a memory café, where people could go and relax. The home organised trips to the café with people.

The home ran film nights with films people might have seen when they were younger. The home also involved people that were bedbound in activities. The activities coordinator told us that he spent time with people individually in their rooms to ensure that they did not get bored.

We observed that there were music therapy sessions available for people. Ten people took part in this activity playing a selection of instruments. People were very animated and involved in the activity with huge smiles whilst singing and playing. One person said, "It was fun, I enjoyed it."
However, a staff member told us, "Although we have an activities coordinator, there is no real one to one care and quality time. We don't have the time to do it. I like to spend time with residents. I like to know them and I like them to know me. I want them to maintain as much independence as possible."

The home had a complaints procedure that was available for staff and people to read. A relative told us, "I just go straight to the office." Another relative told us, "They [the home] didn't give me information on how to complain when [my relative] moved in. I had to ask questions all the time about how things worked in the home." However, another relative told us about a complaint that they had made and felt that the home dealt with it well and that the home had taken the issue seriously and provided feedback throughout the process. There were eleven complaints recorded since 31 November 2015. Records showed that all complaints had been dealt with, noted what had been done and what the outcome was.

A compliment received in February 2016 noted, "Thank you to all the staff who looked after mum. We would just like to say thank you for all your care and patience with mum." There were thank you cards displayed on the office notice boards from friends and relatives.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager. The registered manager also managed another home. From July 2015 until February 2016, the operations manager had been running the home whilst they advertised for a full time manager. A new manager was appointed in February 2016 and was in the process of registering with the Care Quality Commission at the time of the inspection.

At our last inspection we found that the home had breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for not completing medicines audits. At this inspection, we found that the service carried out medicines audits. Quarterly audits of the home were carried out. Audits of medicines were carried out as part of these audits. However, In April 2016, the audit looked at two people's medicines for one month out of 56 people over the three months. In May 2016, a new, monthly, auditing system was put in place. This audit looked at a sample of two people on each unit and checked eight people's MAR charts across the home. No medicines errors were identified in the audit carried out in May 2016. During the inspection, 21 people's medicines records were reviewed. We found a number of errors in the recording and administration of medicines. The home's audits had failed to identify the significant issues with the recording and administration of medicines. Audits did not include a big enough sample size for the manager to ensure that the auditing system was effective in identifying medicines errors.

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

The home had 39 Deprivation of Liberty Safeguards (DoLS) that had been authorised for people. When an authorisation for DoLS has been granted, it is a requirement that the home inform the Care Quality Commission (CQC). The home had failed to inform the CQC in all 39 cases. We discussed this with the manager at the time of the inspection. However, the manager was new and not aware that CQC had not been notified. The manager confirmed that they will inform CQC of all existing and future DoLS authorisations.

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

At our last inspection, there were significant challenges between staff and management. The morale of the staff was low and there was a lack of trust between staff and management. However, at this inspection staff morale appeared better and there was a more open atmosphere within the home. One staff member said, "There has been improvement. Communication is much better. Before, we couldn't approach senior managers. Now we can approach management and they listen. It's a massive improvement." Another staff member said, "[The manager] is supportive, got great ideas how to move the home forward."

Throughout the inspection, the manager interacted well with staff and people. Staff and people generally knew the manager's name and greeted him warmly. One person pointed to the manager and said, "Can't remember his name but he's the boss." The manager told us, and staff confirmed, that he did regular walks around the home, speaking to people and checking how things were.

There were notices in each of the units with dates for upcoming staff meetings. Staff meetings were booked each month until December. The manager told us that staff meetings were held twice, once in the morning and once in the afternoon, for each one so that different staff were able to attend. One staff member said, "Staff meetings have been more regular since [the new manager] has been here. A staff meeting that took place on 25 February 2016 and discussed the manager's vision, holiday policy, staff views and comments. It was recorded that staff had asked questions including a question around the use of agency staff. There had been an activity coordinator meeting where the agenda included, dignity in care, spring fair, activity schedules, cake stalls, clubs, newsletters and themed units. On 27 March 2016, the new manager held a relatives meeting which gave relatives the opportunity to express their views and meet the new manager. We were told a relatives meeting had been held on 25 November 2015, although no minutes were available at the time of the inspection. The manager said that relatives meetings were something that he wanted to continue to do but had not yet decided on how often they should be held.

There were results of a service user questionnaire from April 2016. The results were in the process of being analysed. The manager told us that the results of the survey would be shared with people and relatives.

The home produced a monthly report, which was shared with the local placing authority. The home only accepts referrals from Camden local authority. As part of their joint working and quality assurance the home is required to complete a monthly report to the local authority. The manager told us that if any issues were identified this would be addressed by the home and where appropriate, the local authority. This included reporting on any safeguarding's raised, audits carried out by the service such as, audits of care plans and risk assessments, complaints received and vacancies within the home. We noted that the report for April 2016 stated that there had been no medicines errors.

There were regular audits around fire safety, health and safety and the environment. Identified issues were addressed and signed off when completed.

The home had good joint working practices with healthcare professionals. There was a good relationship between the general practitioners (GP's) and the home. Two doctors that we spoke with said that communication between staff and the surgery regarding people's health and welfare was good. Other healthcare professional said that they were happy with the communication that they had with the home.

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 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Care Quality Commission about application or authorisation of Deprivation of Liberty Safeguards (DoLS) for any person within the home. Regulation 18(4A)(4B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to ensure that auditing systems for medicines provided a large enough sample size to adequately identify and address medicines errors. Regulation 17(1)(2)(a)

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 The registered person failed to ensure that staff received regular documented supervision as was necessary to enable them to carry on the duties they are employed to perform. Regulation 18(2)(a)