Mr C and Mrs LA Gopaul

Kenilworth Nursing Home

Inspection report

26-28 Kenilworth Road
Ealing
W5 3UH
Tel: 020 8567 1414
Website:

Date of inspection visit: 19 and 20 May 2015
Date of publication: 09/07/2015

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 19 and 20 May 2015 and was unannounced. The last inspection of the service was on 10 July 2013 and there were no breaches of Regulation identified.

Kenilworth Nursing Home is a nursing home registered to provide accommodation, personal and nursing care for up to 40 people, some of whom are living with the experience of dementia, mental health conditions and people that are being cared for under the Mental Health Act 1983. At the time of our inspection there were 31 people living at the home.

There was a registered manager in post. 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. People were not protected from the risk of infection because they were not cared for in a clean and hygienic environment.

Risks relating to the use of bedrails, call bells and managing behaviour had not been adequately assessed.

Summary of findings

People's capacity to make decisions about their care and treatment had not always been assessed. The staff did not understand the legal processes required when relatives consented on behalf of people.

The environment was not designed to meet the needs of people who lived with dementia or who were experiencing mental health needs. The environment did not promote people's emotional well-being.

Although care plans contained information about people's needs they were not comprehensive, some lacked sufficient detail to enable staff to provide personalised care. The care plans included a monthly review of people's care although these gave little information on the evaluation of the care that was planned for people and whether their needs were being met adequately.

People had limited opportunities to participate in meaningful activities that were based on good practice guidance.

There were quality monitoring systems in place however, these were not always effective in identifying areas where the quality of the service was not so good or used to make improvements.

There were enough staff to meet people's needs in the home and community and to keep them safe. Appropriate checks were carried out for new staff.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed.

Staff were knowledgeable about people's support needs, and received regular training and support to increase their skills. Staff had a good understanding of safeguarding adults procedures and knew the process to follow to report any concerns.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Where people were deprived of their liberty in their best interests, the provider had followed the appropriate procedures.

People told us that they were happy with the food and drink provided. They were supported by staff to eat and drink sufficient amounts to meet their needs.

Staff worked with other healthcare professionals if there were concerns about a person's safety or welfare.

People were treated with respect and their privacy and dignity was maintained. People were supported to access advocacy services

People were happy to talk to the manager and to raise any concerns that arose. There was a clear management structure at the service and people, staff and families told us that the management team were approachable, inclusive, and supportive.

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

People were not protected from the risk of infection because they were not cared for in a clean and hygienic environment.

Risks relating to the use of bedrails, call bells and managing behaviour had not been adequately assessed.

There were arrangements in place to safeguard people from abuse and to make sure there were enough suitable staff to care for people.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's capacity to make decisions about their care and treatment had not always been assessed. There was a lack of awareness about the legal authority that was required when relatives consented on behalf of people.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Where people were deprived of their liberty in their best interests, the provider had followed the appropriate procedures.

Staff had appropriate training, support and had the skills and professional development they needed to care for people.

People were provided with food and drink to meet their needs and were able to access healthcare services when required.

Is the service caring?

Good

The service was caring.

People were cared for by a staff team that were kind, caring and respectful.

Staff working at the home understood the needs and choices of people, and worked closely with people that were important to them.

People were supported to access advocacy services.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

Although care plans contained information about people's needs they were not comprehensive, some lacked sufficient detail to enable staff to provide personalised care. Records relating to people's care were not suitably detailed, or accurately maintained.

People had limited opportunities to participate in meaningful activities that were based on good practice guidance.

There were systems in place to deal with complaints. People were happy to talk to the manager and to raise any concerns that arose.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Although there were systems to assess the quality of the service provided in the home we found that these were not effective.

People, relatives, staff and healthcare professionals spoke positively about the manager and how they ran the service.

The manager ran the service in an open and transparent way. Staff were supported, felt valued and were listened to by the management team.

Kenilworth Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 May 2015 and was unannounced. The inspection team consisted of two inspectors and a pharmacy inspector. Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all the notifications, complaints and safeguarding alerts we had received about the service since we last inspected on 10 July 2013.

During our inspection we spoke with 15 people using the service and seven relatives. We spoke with the registered manager, deputy manager, three care staff, two nurses, two domestic staff, the chef, cook and two visiting healthcare professionals. We looked at six people's care records. We reviewed records relating to the management of the service including medicines management, staff records, audit findings and incident records. After the inspection we spoke with one commissioner and a healthcare professional and asked them for their views and experiences of the service.

Requires improvement

Is the service safe?

Our findings

People were not protected from the risk of infection because they were not cared for in a clean, hygienic environment. We carried out a tour of the premises. The lounge areas on the ground floor were not clean. We saw dirt on the skirting boards and the edge of the carpets and around the glass window frames to the large lounge. The doors leading to the garden were dirty and marked.

Whilst most of the rooms we looked at appeared clean and communal toilets and bathrooms were kept clean throughout the day, some people's rooms looked unkempt and dirty and had not been cleaned thoroughly for some time. Staff told us that this was due to some people not consenting for their room to be cleaned. The laminate on some over knee tables was damaged exposing the material underneath and paintwork on the table legs had worn away which would therefore be difficult to clean and may constitute an infection control risk. These were removed and replaced after we pointed this out.

During our visit we discovered that there was a problem with pests. Staff confirmed that this was a persistent problem particularly in the summer and steps were being taken to address this. We saw bait/monitoring boxes to monitor for pest activity in people's bedrooms. The manager was able to provide evidence of contracts with companies commissioned to eradicate these pests. These documents showed that a pest control company was actively employed and had recently inspected and treated the building. We noted that the most recent follow-up visit did not comment on the effectiveness of previous visits in respect of the success of treatment for cockroaches and we asked that a further visit was arranged due to concern raised by one person about the presence of these in their room. We saw that arrangements for a further visit were made during the time of our inspection and the manager showed us a fax confirmation of the visit date from the pest control company. We also referred our concerns to the local authority Environmental Health department who visited the service twice following our referral.

Where people required hoisting, the staff told us that people shared hoist slings. There was no evidence that there was a cleaning schedule for the slings, in order to minimise the risk of cross infection. We viewed the completed infection control audit for 1 May 2015 and saw that this had not identified the areas of concern and potential risks that we found on our inspection.

This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that a number of people who were either bed bound or unable to walk were left in their rooms at times without access to a call bell. The staff explained that one person was unable to use a bell. They said that another person's call bell had been broken by the person and was yet to be replaced or perhaps wouldn't be as this was ''part of their repetitive behaviour''. We viewed the care records for these people and saw that there was no clear explanation as to why people did not have access to call bells. This meant that there was a risk that people would not be able to summon assistance when they required it. Where people did use their call bells we saw that staff attended to them promptly.

Whilst the provider carried out a range of risk assessments, there were some areas where these were not completed comprehensively to fully ensure the safety of people and that of others.

People were not always provided with safe care and treatment because risks to their wellbeing had not been assessed or were not properly managed.

Where people were considered to need bedrails, an assessment of risks associated with this had taken place although it did not include consideration of the risk of a person attempting to climb over the bed rails. In another example a person's risk assessment clearly identified the need for bed rails to avoid falls. We saw the person in bed for a number of hours during our visit without the use of bedrails. The care staff we asked about this said that bedrails were not required. In discussing this with the manager who attempted to address this, it was clear that the person did not wish for the bed rails to be used. This suggested that either the risk assessment was incorrect or that staff were not familiar with the person's care plan and consent had not been properly obtained for their use.

For another person, we saw that the risk assessment did not detail sufficient information about their behaviour that challenged the service or others. For example, the risk assessment stated the person displayed sexually

inappropriate behaviour. Specific details about the behaviour were not recorded such as what this behaviour entailed and the potential triggers that needed to be considered to ensure consistency of approach and provide guidance for staff to minimise potential situations. Staff described the approach they used to manage the person's behaviour and demonstrated a good knowledge of the care they required, what their needs were and how they supported them. The manager was made aware of this and acknowledged additional information would be included in people's care records to ensure staff supported people as required.

This was a breach of Regulation 12 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for moving and handling, falls, nutrition and pressure sores set out the identified hazard, the control required to mitigate the risk and the actions staff needed to take. Not all these documents were dated, so we did not know when the risk assessment had been formulated. These assessments had been regularly reviewed along with an assessment of people's level of dependency.

The service followed safe recruitment practices. We viewed three staff recruitment files which detailed that the relevant checks had been completed before staff began work. These included two references, one from their previous employer, a check conducted by the Disclosure and Barring Service (DBS) to show they were not barred from working in adult social care and proof of the person's identity and right to work in the UK.

People told us that there was always someone available to help them if needed. We saw that there were enough staff to meet people's needs in the home and community and to keep them safe. The manager told us that the staffing numbers were based on the needs of the people using the service. There were always two nurses on duty during the day. They were supported by a team of carers, domestic, catering and administration staff. All the relatives and healthcare professionals we spoke with said there were plenty of staff on duty to keep people safe.

Throughout our inspection we saw that people were not left unattended in the lounge areas. Staff were sitting with people and chatting. We observed staff attending to and regularly checking on people that chose to stay in their bedrooms. Staff were observed supporting and giving time to people in a calm and unhurried manner. Healthcare professionals we spoke with told us that where people's needs had changed or additional support was required the manger ensured additional staff were on duty. For example, one person required the support of two people when attending hospital appointments. We looked at the staff duty rotas which confirmed this and that staffing levels were flexible to meet people's individual needs.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed. We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the medicine administration records for 25 out of 30 people. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines had been recorded.

When medicines were administered covertly (without the person's knowledge) there were signed agreements in place, which included the person's doctor and family, to show this decision had been made in the person's best interest. We saw that medicines were reviewed regularly by the GP, who visited the service twice a week and there were clear guidelines in place for the administration of insulin for those people who had diabetes.

Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Records showed that controlled drugs were managed appropriately, however at the time of our visit no people were prescribed them. We also saw the provider did monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

Some people who used the service told us they felt safe. Relatives told us their family members were looked after safely and where they had any concerns they discussed these with the manager. The manager told us that

Requires improvement

Is the service safe?

safeguarding and complaints were standing agenda items for the monthly residents' meeting. Two people we spoke with confirmed that safeguarding and how to keep safe was discussed at each meeting. We asked staff how people at the home remained safe and protected from abuse. All the staff we spoke to had understood the home's policies and practices regarding safeguarding. They had completed training in safeguarding people and training information we viewed confirmed this. Staff were able to describe different types of abuse which people might be vulnerable to including physical abuse, sexual, verbal, psychological /emotional abuse and institutional abuse. One staff member told us "Ignoring a person who wants something such as a cup of tea is a type of abuse." Staff were very clear about the procedures for recording and reporting any concerns and knew which external agencies to contact should they feel that management was not taking any concerns they raised seriously.

Requires improvement

Is the service effective?

Our findings

The provider had not always assessed people's capacity to consent to care and treatment. People were involved in making some decisions about their care, however we found that capacity assessments had not been carried out for people that had made a decision to share a bedroom.The records did not contain information about how some decisions had been reached for people. For example, we were told that there were four double bedrooms that were in use. We checked people's files and saw that they had either signed a consent form for this or written a note to this effect. Where they were considered to lack capacity to make this decision, their relatives and service commissioners had signed to say that sharing a room was in their best interests. The records did not detail how the person's capacity in relation to this decision had been assessed and whether the person had capacity to understand and consent to this arrangement. The manager and staff did not fully understand the process required to ensure that relatives signing the documents had legal rights to do so.

We spoke with the relatives of two people in shared rooms who confirmed that their relatives were content with this arrangement. One relative commented "my (relative) prefers not to be alone." However, we noted that some people had shared rooms for a considerable time, in one case following an emergency admission to the home, and the suitability of this arrangement and person's views about this did not appear to have been reviewed from the records we viewed. This meant that people who might have had a preference for a single room once one became available, or when their needs or preferences changed, were not offered this option.

This was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was two Victorian houses which had been joined together. Whilst there was an on going programme of redecoration and refurbishment we found the environment was not designed to meet the needs of people who lived with dementia or who were experiencing mental health issues. The environment did not promote people's emotional well-being. For example, there was a lack of prominent picture signage that did not easily identify people's bedrooms and areas such as the toilets and bathrooms. Whilst there were signs to the toilets and bathrooms these were paper pictures that had been placed in plastic wallets and attached to the door. All the bedroom doors were white, the corridors were cream and the colour schemes did not help with orientation.

We recommend the provider review the design and decoration of the premises in line with guidance on environment and surroundings from the Alzheimer's Society.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provides legal protection for vulnerable people who are, or may become, deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. For example, we saw that best interest decisions had been made for people that required their medicine to be administered covertly.

Care records showed where DoLS applications had been made or were being made for some people and evidenced the correct processes had been followed. Where permission had been obtained we noted that conditions attached to this were being monitored by the home. For example, one person's conditions of their Deprivation of Liberty authorisation concerned their access to the community and we saw that specific records were kept detailing when this person was assisted to go out of home. All the healthcare professionals we spoke with confirmed that the manager worked with them to ensure people's rights were safeguarded where there were concerns about a person's capacity to consent to a decision. The staff were knowledgeable about the Mental Health Act (MHA) 1983. Staff monitored people's compliance with their section of the MHA, where it applied. For example, where people had conditions applied to their section staff ensured people received care and support within the conditions, such as how they accessed the community and any treatment that was required.

People who used the service were supported by staff that had the skills and knowledge to meet their needs. There was a broad range of staff on duty, with different skills and qualifications, including nurses trained in mental health

and general nurses. Relatives we spoke with and three healthcare professionals told us the staff had the right skills, attitude, abilities and knowledge to support people who had complex mental health needs. One healthcare professional said "I have seen a dramatic change in one of the people I placed at the service, the level of aggression the person presented with has reduced, there is a high level of engagement and their overall well-being has improved." A relative told us "'My (relative) can be very difficult to care for. Things got really really bad when [relative] was at home. They do really well with (relative) and [relative] is well looked after here."

All staff confirmed they were supported in their roles. They said they received induction, training, development, supervision and appraisal which enabled them to carry out their roles and meet people's individual needs. They told us they could access a wide range of training courses, which were of good quality, some of which were mandatory and specific to the care needs of people living at the service, including training in mental health, managing challenging behaviour and dementia care.

Many staff had been working at the home for a considerable length of time, there was little staff turnover and this resulted in people receiving continuity of care by staff that knew them. A new member of staff told us about their induction which lasted two weeks. They said during this time they shadowed a senior carer to learn how to care for people at the home as well as receiving training on the homes policies and procedures. A staff member told us that they had started at the home as a carer but had been supported by the home to obtain a general nursing qualification. All the staff we spoke with said they had one-to-one meetings with their line managers as well as regular team meetings. The service had an appraisal system to assess the individual performance of staff and to support them in their personal development. Staff we spoke with said they had received an annual review of their performance.

People and their relatives told us they were supported to access healthcare when they needed to. Staff understood how to manage people's specific healthcare needs and knew when to seek professional advice and support so people's health and welfare was maintained. Care records detailed that people had received input from other healthcare professionals, including a GP, community psychiatric nurse, psychiatrist, optician, podiatrist and a tissue viability nurse to ensure their healthcare needs were being met. For example, we observed one person being collected by ambulance for a hospital appointment. People had been referred for routine health care and check-ups such as for chiropody, diabetes care and breast screening. People were also referred for specialist investigations where required. For example, one person who had persistently complained of pain had been fully investigated for a range of different conditions in order to attempt to diagnosis their condition. We spoke with two healthcare professionals who were visiting the service. They both told us the staff were proactive, and were knowledgeable in recognising signs and symptoms that a person's mental health may be deteriorating and supported the person to get the required help. Both healthcare professionals confirmed that staff worked well with them and where advice was provided the staff had followed the advice. This helped to ensure people's health care needs were being appropriately met.

Risks to people's nutrition had been assessed, their weight was regularly monitored and where required appropriate referrals were made to the dietician. All people we spoke with said they were happy with the meals offered and that they enjoyed them. We observed people being supported to eat. We saw that staff took appropriate care, sitting beside people and telling them what they were doing before offering food. One member of staff explained how they would encourage people who needed help with their food and drink to hold their own cups and utensils where this was possible, in order to promote some independence.

We spoke with the chef who told us they were aware of people's specific dietary needs. A list was kept in the kitchen and detailed people who were diabetic, had specific allergies and those who required pureed meals. The chef explained that two options for the main meal at lunch time were offered and was able to demonstrate knowledge of some people's individual preferences such as one person who preferred an Italian diet and another who was vegetarian. We were told that special meals would be prepared for these people at their request. Breakfast was served at 10.00am consisting of porridge or a cooked breakfast, bread and jam and tea and coffee. During our visit we saw that people were able to choose their preferred breakfast. Some people we spoke with told us that they were always up very early and said that they were not able to have breakfast until 10.00am. However, we saw evidence during our early morning visit that some people

Requires improvement

Is the service effective?

were served porridge or cereal in their rooms earlier than this if they requested it. Care plans referred to some people's preferences as liking a 'normal diet' although what was normal for the person was not made clear.

We viewed two wound care plans and saw that these were monitored appropriately. Records contained information on the treatment required to promote wound healing. Pain assessments had not been completed, however we saw that people had been prescribed and were administered medicines for their pain.

Good

Is the service caring?

Our findings

People and relatives we spoke with were happy and satisfied with the care and support they received from staff. Comments we received from people included “It’s ok. I am fine. The food is good.” And “I feel well looked after.”

Relatives spoke highly of the staff team and the care and support that was provided. One relative told us “The care here is excellent. Staff are brilliant and very welcoming of relatives."

There is enough for (relative) to do – (relative) can’t do a lot and it’s enough for them.” Another said “[Relative] has been here 8 years. The care is very good. If anything is worrying I can ask them. They can always tell me how [relative] has been.” Another relative said “They [staff] are all good, there is not one bad one. I come here regularly and have never seen anything that has worried me about the way staff care for people.” Relatives told us the communication was good and they were always kept informed of any changes. The healthcare professionals we spoke with said that people were treated with respect and that staff knew people well.

Where families required additional support and care this was provided by the staff, for example where people had behaviours that challenged, family members contacted the service prior to visiting to check how their relative was prior to making a decision to visit. The staff told us that some of the behaviours that the people presented with were distressing to the family and this was a measure they had put in place to support them.

We observed interactions between staff and the people using the service. Staff spoke to people in a kind manner, listening to them and involving them in choices about care. We saw that staff cared for people with respect and patience. For example, we saw one staff member gently escorting a person to walk, taking time to go at the person’s pace. Staff responded to people in a gentle and friendly and appropriate manner.

We saw other interactions that demonstrated that staff treated people respectfully, sometimes in difficult circumstances as a number of people at the home could be verbally abusive. Staff reported that some people were also physically aggressive at times. Although, some people we spoke to clearly did not like being at the home, all those commenting on the staff said that staff were “kind”. One person told us that the staff helped her with her shopping and we saw that people who spoke French and Italian were delighted to be addressed by some staff in their mother tongue.

People told us about their relationships with the manager and other members of the family that worked at the service. Both people told us the manager took them out for regular drives. One person told us the manager purchased their favourite Indian sweets for them.

People were involved in their care. We saw records which showed us that people had attended meetings about their care. During our inspection we saw that a review meeting was taking place. The person had been invited to attend but had refused, staff respected their decision and the meeting continued without their involvement.

Staff were able to describe how they maintained people’s dignity and privacy. For example, one member of staff described a method of supporting a person with their personal care in a way which achieved this. We saw that personal care was provided in the privacy of people’s rooms and where these rooms were shared we saw that screens were available. A relative we spoke to confirmed that staff did use the screens when attending to their family member. We saw that in the early morning many people’s doors were closed which demonstrated that people’s privacy and choice about this were respected.

People were supported to access advocacy services and those that were detained under the Mental Health Act were supported to obtain legal representation to attend Mental Health Act Tribunals. For example, a person had been supported by an Independent Mental Health Advocate in relation to a DoLS authorisation that was in place.

Requires improvement

Is the service responsive?

Our findings

Prior to people moving into the service pre-admission assessments were carried out by the manager or deputy manager to ascertain whether the needs of the individual could be met by the service. We saw other information was also obtained from family members and social services. Information on people's likes, dislikes and preferences and associated risks was also recorded in the pre-admission assessment. We found that although care plans contained information about people's needs they were not comprehensive. For example, some care plans required regular checks to be made on people. Staff confirmed that no written records of the checks they carried out during the day were made. For another person the care plan detailed that a behaviour record was to be maintained. When we asked to view this no records were available.

People's care plans were reviewed monthly. However, the records about these reviews were very sparse, repetitive and tended to reiterate care instructions rather than provide information indicating that a meaningful review of the care provided had taken place. There was insufficient information about the person's views were and what further support they wanted with their care treatment and support. The need for staff to form a "therapeutic relationship" with people living at the home was given as an action to a number of risks identified including a person's risk of aggressive behaviour. It was unclear exactly what this meant and what staff were required to do. Reviews of this aspect of their care plan made no comment as to the nature of the relationship established and how effective this had been in reducing or managing the risk. The reviews gave little information on the evaluation of the care that was planned for people and whether their needs were being met adequately.

The monthly review of care plans in two of the files we looked at commented consistently over a considerable period of time that the people continued to refuse personal care. There was no indication that specific consideration had been given to this in the reviews despite their levels of personal hygiene being a matter of concern. When we spoke with a healthcare professional who was responsible for overseeing the placement from the Clinical Commissioning Group (CCG) for one of the people, they told us that staff had encountered challenges in supporting the person with this aspect of their care, it was regularly discussed at review meetings and that the person was being supported in this area in line with their level of mental health functioning. From our discussions with the manager, the staff and healthcare professionals it was evident they provided a lot more care and support for people than was actually recorded within the care plans and review meeting records.

Where there were changes in a person's condition such as weight loss the manager told us that referrals were made to the appropriate healthcare professionals. However, from the care records we viewed it was not always possible to confirm the actions carried out by staff. For example, in one case we noted that observation of a person's weight reduction had led to staff being instructed to refer the person to a dietician. We could not find a record of the outcome of this referral. We asked staff about this but they were unable to find any reference to a referral to a dietician in the care records. However, the manager was able to provide an explanation stating that the person's weight had subsequently increased and so the need for the referral had diminished. The records for this person were not clear about the outcome of the referral, decisions made and actions taken.

We could not be assured that people were protected from the risk of unsafe or inappropriate care as accurate records were not kept.

This was a breach of Regulation 17(1) c of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted some good responsive actions had been undertaken in relation to the management of people's mental health and wellbeing. Staff had bought forward a psychiatric review meeting in response to deterioration in the mental health of a person. For another person we were told that the manager had raised concerns with the Clinical Commissioning Group (CCG) on behalf of the person so that additional funding could be agreed to support community activities. All the healthcare professionals we spoke with said staff were knowledgeable about people's health and were able to provide information they required efficiently.

People had limited opportunities to participate in meaningful activities that were based on good practice guidance. We received mixed comments from people such as "'We sit almost all the time. There is nothing of interest

Requires improvement

Is the service responsive?

for anyone"; 'It's pretty grim. I have bi polar. This place is very depressing. In most places there are things to do. This place has nothing. I am making the best of a bad situation" and "I go out with the manager, we have been to the seaside and last week there was an outside entertainer and we celebrated St George's Day." One relative told us "They have activities going on regularly." People were provided with information regarding different celebrations, festivals and religious days through a Diversity calendar which was displayed in the lounge. One person told us people could take part in any of the celebrations and this was their choice. Another person told us they had recently celebrated St George's Day, and a trip to Brighton.

There was a large board in the main lounge pictorially informing people of the activities available in the morning, afternoon and evening of each day. The activities person showed us lists of activities intended to support people with dementia, mental health needs and those supporting life skills. During the second day of our visit we saw staff playing board games with some people, people being offered newspapers and one person being escorted out to the shops.

There was little differentiation in some of the activities posted on the board. For example one afternoon's activities were listed as listening to music with the evening activity being of a similar nature. We asked staff about this and we were told that the type of music on offer was significantly different. As most people spent most, if not all the day, in the one large communal area it was difficult to see how people could actively engage in sessions listed such as 'listening to music', 'listening to the radio' or 'discussions of famous people' in a room where other people might prefer to watch the television, talk, or for some, receive their visitors.

Many of the activities on offer would not appeal to everyone for example, the offer of manicures or make up sessions or activities that could only be offered on a one-to-one basis such as shopping. It was unclear if any meaningful alternative was available when these sessions were planned for those people for whom the session was not suitable. This meant that the options available for individuals were significantly less than that suggested by the programme on the activities board. The activities person had no specific training in designing or delivering activities for people with dementia or mental health needs. We discussed this with the manager who told us that training would be arranged**.**

We recommend the provider review the activity provision in the home in line with the National Institute of Clinical Excellence (NICE) best practice guidance on the mental wellbeing of older people in care homes.

People were supported to maintain relationships with those who were important to them, to help protect them from social isolation. We saw one person being supported to visit their family at home and we saw several relatives and friends visiting on both days of our inspection.

The provider had a complaints policy and procedures to deal with complaints. A copy of the complaints procedure was displayed in the front hallway of the home. People or their relatives were aware of this and told us they would speak with the staff if they had any concerns. No complaints had been made in the six months previous to our inspection.

Requires improvement

Is the service well-led?

Our findings

There were quality monitoring systems in place however, these were not always effective in identifying areas where the quality of the service was not so good or used to make improvements. For example, we viewed care record audits, these showed that care plans and risk assessments were completed, they did not comment on the quality or accuracy of the records. The infection control audit indicated that the domestic staff had been told about dust in areas but did not identify which areas. The action plan document which was part of the audit had not been completed. When we spoke with the head domestic they told us this had been raised with them. Other checks we saw that had been carried out included health and safety checks, staff training, medicines and accident and incident monitoring. Our findings during the inspection showed that the quality assurance system was not always effective because issues identified at the time of our inspection had not been recognised during the internal auditing process.

This was a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives, healthcare professionals and staff spoke highly of the registered manager. Throughout our inspection we saw that the registered manager operated an open-door policy and the people who used the service, relatives, and staff could come in and out of his office whenever they wanted to discuss issues important to them.

The provider is a partnership and one of the partners is the registered manager, who is a qualified nurse with over 40 years' experience. The service had a clear management structure to ensure there were clear lines of responsibility and accountability. The manager was at the home daily, assessed new referrals and attended reviews of care where able.

Staff told us the manager led by example, was approachable and there was a fair, open and transparent culture within the service. A staff member commented "We have very little staff turnover, this is a family run business and they treat all the staff very well, that's why very few staff leave." Another said "The staff team is very friendly, very welcoming and we support each other." A relative said of the manager "He is terrific, brilliant, he has always fought for us and got things done." Comments from healthcare professionals included "I'm very impressed, we have placed some extraordinary challenging people here, the environment does need to be refreshed but it's the care that matters." And "If it was not for this service, some of the people would be in hospital. It is one of a kind."

People and their families were asked for their views about their care and support and they were acted on. A survey was sent to people and their representatives to obtain their views of the service. We saw the findings from the latest survey, these showed that the majority of people were satisfied with the service provided. The manager spoke to all the people who used the service on a daily basis. We saw that the manager knew people, their condition and families well. Regular residents meetings were held and people were encouraged to feedback their ideas where the service could improve and if they had any concerns that they wanted to raise. Minutes we viewed detailed people's feedback and suggestions for improvements such as activities and outings.

From the records we viewed, speaking with staff and relatives we saw the service worked in partnership with other agencies to ensure people's health and social care needs were met. Healthcare professionals who had involvement in the home, confirmed to us communication was good. They told us the staff worked alongside them, were open and honest about what they could and could not do.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service, staff and others were not protected against identifiable risks of acquiring an infection by the means of the maintenance of appropriate standards of cleanliness and hygiene in relation to premises or equipment used for the purpose of carrying on the regulated activity. The registered person had not provided safe care and treatment to service users because they had not assessed risks to their health and safety. Regulation 12 (1) and (2) (a) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users had been provided by the registered person without the consent of the relevant person. Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not effectively operate systems to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and did not maintain an accurate and complete record in respect of each service user.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17(2)(b) and (c)