

Lifestyle Care Management Ltd

St Johns Wood Care Centre

Inspection report

48 Boundary Road
London NW8 0HT
Tel: 020 7644 2930
Website: lifestylecare.co.uk

Date of inspection visit: 21, 23 and 29 December 2015
Date of publication: 13/04/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

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

This inspection took place on 21, 23 and 29 December 2015 and was unannounced. At our last comprehensive inspection on 8 August 2014, which was a part of our wave 2 new inspection approach and prior to the current provider taking over, the service was meeting all of the regulations we looked at. As a result of this inspection we

found five breaches of regulations, namely Regulation's 9 (Person centred care), Regulation 12 (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs) and Regulation 18 Staffing).

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

Summary of findings

The service was previously operated by a provider that went into administration in February 2015. Administrators then took over the temporary operation of the service until a new provider was identified in September 2015. This provider was then registered with the Commission in early November 2015. As the result of safeguarding concerns that had arisen in October and November 2015 we took the decision to carry out an inspection of the service earlier than we normally would for a service that had re-registered under a new provider. This was to respond to any risks about the way in which the service was operating and to ensure people's safety and well-being.

The staff of the service had access to the organisational policy and procedure for protection of adults from abuse. They also had the contact details of the London Borough of Camden which is the authority in which the service is located and other authorities who also placed people at the service. Staff said that they had training about protecting people from abuse and this training had been updated, which we verified on training records. However, some staff were not aware of what safeguarding and whistleblowing means.

We found there were the designated numbers of staff on each floor during our visits. Staff were regularly present in communal areas to identify and respond to immediate assistance that people required.

We saw that risks assessments concerning falls and those associated with people's day to day risks were in some cases not fully completed or updated. Measures to minimise emerging risks, and in particular those associated with falls, were not speedily identified or implemented and this added to the potential unnecessary risks that some people faced.

We saw there were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to

ensure that people who could not make some decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

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

The care plans we looked at were based on people's personal needs and wishes in some cases, but were unclear in areas such as nutrition and hydration and contained conflicting information about people's care needs. People's personal, cultural, religious and lifestyle preferences were not given sufficient attention in care planning.

People's views were respected in most cases but we also observed an incident of disrespectful behaviour by a member of staff. Although feedback from people using the service and relatives showed that the view was of a caring staff group we saw that there were conflicting approaches made with people in some cases. Not all staff were respecting people's dignity or right to make free choices.

The service had undergone a long period of uncertainty about its future ownership and operation. We found that oversight of the service had suffered as a result and needed to be addressed.

As a result of this inspection we found five breaches of regulations, referred to above, we also made two recommendations covering the areas of effective, and responsive. 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?

The service was not always safe. People's safety and any risks that were identified were not reviewed quickly and there was a significant degree of inconsistency among the staff team about how to respond to all potential risks.

At the time of our inspection there were sufficient staffing resources available to meet people's needs.

Medicines were being handled and administered safely and appropriately.

Requires improvement



Is the service effective?

The service was not always effective. Staff received training, although not always of the necessary type, and supervision was not occurring for almost a quarter of the staff team.

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

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

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

Requires improvement



Is the service caring?

The service was not always caring. Staff were mostly seen speaking with people in a respectful and dignified way, however, we observed instances where this was not the case. When staff were providing assistance this was usually explained, and support was mostly provided in an unhurried and dignified way.

Requires improvement



Is the service responsive?

The service was not always responsive. We found that people were engaged in activities in some instances where they were able to be in communal areas of the home and were not bed bound. However there was a lack of knowledge and training for the activity co-ordinator about what they could do to expand these opportunities.

The provider was not carrying out suitable or detailed care planning to ensure that the service could provide appropriate care that was responsive to the needs of all people using the service.

Requires improvement



Summary of findings

Is the service well-led?

The service was not always well led. We were informed that the provider had a system for monitoring the quality of care. It was too early for us to assess whether this was effective and the manager informed us that the systems were still being introduced at the time of our inspection.

Relatives and other visitors told us they were usually satisfied with the service provided.

Requires improvement



St Johns Wood Care Centre

Detailed findings

Background to this inspection

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

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Monday 21, Wednesday 23 and Tuesday 29 December 2015. The inspection team comprised of two inspectors, a pharmacist inspector and specialist advisor (who specialised in nursing and dementia care).

Before the inspection, we looked at notifications that we had received and communications with other professionals, such as the local authority safeguarding and commissioning teams.

During our inspection we also spoke with three people using the service, six relatives who were visiting, twelve members of staff (six care staff and two nurses, the activity coordinator and maintenance officer, the chef and a domestic), the manager, the deputy manager and the area manager for the provider.

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

Is the service safe?

Our findings

Almost everyone using the service was very frail and unable to give us their views. However one person told us when we asked about feeling safe “yes, yes I do thank you.” Relatives we spoke with did not raise any concerns about the safety of their loved ones at the home.

People’s risk assessments were not always updated in a timely way in care plans. Where people had suffered a fall, the response was discussed with the multi disciplinary team, but there was a delay in the manager responding to the risk and advising on action. In one case, a person had suffered two falls over a period of three weeks since their admission and had been injured as a result of the second fall. The service had notified CQC about the falls and this person had been included on the home’s falls log. However, there had been a delay in updating the action to be taken in the event of a fall on the person’s care plan risk assessment. This potentially placed the person at risk.

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

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

We were told that it was the policy of the new service provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. We were unable to verify this at this inspection as we were told that no new staff had commenced in post since the new service provider took over the service in September 2015 and were then registered at the beginning of November 2015.

The staff who we met had a variable, and some a limited understanding, of what constituted abuse and the action they must take, namely they must report it. A registered nurse said that they would investigate the matter and that this would need to be reported to the manager and through safeguarding and the local authority. Other staff were less clear on what action to take, they did know who to report safeguarding internally, although they needed

prompting and guidance on external organisations to whom they could report such issues. One staff member said only if they witnessed repeated abuse would she report it. Two other staff were unable to provide any information, nor did they appear to understand the term whistleblowing, which is a system where staff are able to raise concerns about poor practice. Staff did tell us they received training on the topic. However, this was still clearly not understood by at least some staff. A total of 77 out of 100 staff had attended training in safeguarding adults from abuse in the last twelve months.

Relatives said that there were enough staff, except at peak times when one relative said “it can be stretched when everyone needs something.” Staff feedback on whether there were enough staff available, was variable. Some felt there was sufficient staff, whilst one member of staff told us that shortages often occur and had done since last summer. This member of staff added that instead of five staff on duty, often there was three or four, causing problems with care delivery, as people using the service were very dependent. We were told that no agency staff were used as vacancies were covered by staff doing additional shifts, which helped to provide continuity in care delivery. However, we found by looking at the staff rota for the last two months that the designated number of staff for each floor were on duty for most shifts each week. On only a few occasions was a floor short of one member of care staff.

Call bells were not always in reach in all bedrooms. On asking a registered nurse about this they told us that many people were unable to effectively use the call bells, and that risk assessments were in place and regular checks were made on those people. We checked care plans and found that call bell risk assessments were recorded. Although the home had a working call bell system in place, there was no monitoring of response times. The registered manager told us that he only reviewed the system as and when needed to investigate a concern or respond to a complaint. In addition this data was currently inaccessible as the registered manager’s computer system.

We saw a large collection of wheelchairs and walking aids stored in the external area of the lower ground floor directly outside bedroom windows. We were told these had been there a number of months and needed to be disposed of.

We were shown records of health and safety checks of the building and the appropriate certificates and records were

Is the service safe?

in place for, electrical and fire systems. We saw that hoists and slings used to support people with transfers were regularly checked and these checks were up to date to support people's safety. The provider had emergency contingency plans for the service to implement should the need arise. The home could not confirm on records that a gas safety check had been carried out in the last year. The home subsequently provided evidence that a gas safety check would be carried out in the first week of January 2016.

We looked at the recruitment records of staff who had been employed by the home since our previous inspection. Each member of staff had the necessary background checks in place as well as verification of their identity and employment history.

Specific risk assessments were carried out to cover manual handling, skin integrity, falls, use of bedrails, nutrition and other specific areas. These were completed and reviewed regularly. Manual handling assessments included the type of equipment and size of sling to be used. Continence assessments referred to the incontinence wear to be used and frequency of monitoring. Body maps were used to indicate areas of injury/ bruising etc, we saw that observations of temperature pulse and blood pressure were taken. Urinalysis checks were also undertaken.

Where people were identified as at risk of pressure ulcers we saw that detailed and clear information was provided to staff to minimise this risk. Clear information was provided to staff to minimise this risk. Actions included provision of air mattresses and instructions concerning the monitoring of these, regular recording of a person's weight, their need for fluids and a balanced diet, checks required on skin integrity and the application of barrier cream. Where a person developed a pressure ulcer, or was seen to be beginning to, care plans we looked at showed this had been responded to and included liaison with the local tissue viability service where this was necessary.

Medicines administration records (MAR) were clear and administration was accurately recorded. Medicines received from the pharmacy were recorded in the MAR charts and the quantity could be reconciled with the administration record. Medicines were stored securely including controlled drugs. Room and fridge temperature was monitored daily. However, the minimum and maximum fridge temperature were not often logged.

There was evidence of best interest meetings for people whose medicines were administered covertly, as well as appropriate instructions for medicines administered to people via feeding tubes. Staff told us how they rotated the sites used for administering medicines supplied in patch form. There were plans for staff to follow for medicines administered only when needed. We also observed that nursing staff who administered the lunch time medicines offered people medicines prescribed as 'when needed' such as analgesia. Similarly insulin administrations were appropriately documented.

In the clinical rooms, there was evidence that recent alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) had been implemented. Nursing staff who administer medicines had been trained. Medicine management audits were carried out monthly.

Medicines were managed safely, and people that required regular blood testing and dose changes were appropriately monitored. Staff told us, and we saw evidence, that the GP visited twice weekly and undertook medicines reviews.

We saw that gloves and aprons were used by staff and that there were ample supplies of these available. We spoke with staff about infection control and they were aware of the precautions that needed to be taken. A member of the domestic staff team was able to us about what precautions to take when we asked about infection control and COSHH (Care of Substances Hazardous to Health). Domestic staff were seen to use mops and buckets correctly, in respect of colour coding for specific areas, and knew these must be kept separate. We saw that hand sanitizers were available, and soap and towels available in bedrooms that we looked at. We saw signage in bathrooms telling staff not to use hoist slings communally, and that they were to be used for individuals only.

We checked the communal areas of the service which were all clean but a number of areas to improve the fabric of the building were needed. We discussed this with the registered manager and area manager for the new provider. We were shown evidence that a full survey of the building was to take place in January 2016 followed by refurbishment and improvement works.

Is the service effective?

Our findings

Staff told us that they received supervision with the management, although the frequency of the supervision was variable. Supervision items included training and training needs, career progression and any other issues. One staff member they had supervision at six weekly intervals and they had an appraisal after six months in post. Two other staff said that supervision meetings were held at three monthly intervals. They were unsure if they had received an appraisal. One had been in post two years and another 10 years, whilst another care worker said it was monthly supervision and felt they had had their appraisal. As a new provider had taken over this service shortly before our inspection it was too early to assess the system they would use to ensure staff appraisals were undertaken. When we looked at staff supervision frequency since the new provider commenced we found that eighty staff had received supervision, while twenty staff had received none at all out of 100 care and nursing staff. The registered manager was unable to provide us with information about what the new provider's policy on supervision was.

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

We saw that prior to the admission of people to the service, a care needs assessment had been carried out, although these were in some cases incomplete. For example we saw that one person was said to be almost immobile, although clearly they were mobile as we saw the person moving freely around the home. In another, an advanced care plan for palliative care had not been completed prior to admission to the home or soon after admission to it. This meant that the manager could not be sure the needs of the individual would be met at the home, before offering them a place.

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

The care plans contained a lot of information in respect of eating and drinking assessments, care plans, weights and the malnutrition universal screening tool (MUST) scores. Some of the forms appeared to duplicate information and were confusing, such as the two separate screening tools one for nutrition and another for malnutrition. Most people were on food and fluid charts. The food and fluid charts were not fully completed. They were without the 24 hour

totals for fluid intake and on totalling the recorded entries, some low intakes were noted. Output was not recorded on many charts although this may not have required monitoring. Food charts detailed the portion size, although had little information on the type of food taken. Without accurate information on food and fluid intakes, staff were unable to effectively monitor people to prevent a deterioration in their health.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of directional aids and signage on the first floor, where people with dementia were living. In addition there was a lack of domestic style orientation aids such as clocks, calendars, daily newspapers all of which are good aids to orientation. Some rooms that had clocks, displayed incorrect times. This would not help people who have difficulties in remembering or maintaining their orientation about where they lived or what day, time of day or the part of the year

We recommend that the provider seek advice from a reputable organisation in respect of the use of aids which can be useful for people with dementia and orientation issues.

Staff told us that they received induction once appointed and this consisted of statutory training topics and shadowing of some shifts. The length of induction, we were told, varied between two days whilst a registered nurse said it was over a period of approximately two weeks including shadowing a night shift. We discussed this with the registered manager and area manager who told us that there had been no new staff undertaking induction since the new provider had taken over but that they were aware of an induction programme that would be introduced. It was too early for us to assess how the new provider would manage staff induction.

A registered nurse told us they had received medicines training and dementia training on-line with a test to complete afterwards. In addition they had completed other on line training including challenging behaviour. Some specific training needs were not being addressed in respect of End of Life care or Parkinson's Disease, the training matrix that we were supplied with showed that no staff had received these areas of training. The staff training matrix collated information for how many staff had received

Is the service effective?

training in the last twelve months. Thirty three staff had attended dementia training and almost all of the staff had attended training on nutrition, moving and handling and infection control.

Staff told us that they received updates on the mandatory topics and most of the training was addressed was through online training. We found that staff had been instructed to carry out online training during their breaks.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

An advocate from an independent advocacy organisation was visiting during the first day of our inspection. They told us that the service had been fully co-operative with their visits and had provided all of the information and assistance they had required to carry out mental capacity assessments.

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

We were told 'the food's very good, they feed us well'. People said they felt there was sufficient selection and enough to eat, people said they looked forward to meal times.

We observed lunch on each day of our inspection on all floors. Food arrived in a heated trolley and was plated by staff in the dining room. Most people ate in their rooms and we were told that only four people required physical support with eating on one of the floors. Staff were seen

wearing plastic aprons and placed clothing protectors on people before serving food or supporting people to eat. We noted these were removed once lunch was over. Tables were dressed with a table cloth and napkin and although condiments were available, we did not hear anyone being reminded of their availability. Staff seen assisting people to eat were appropriately seated next to the person. Although staff were heard asking people if they liked the food and people were offered some encouragement to eat, there was very little explanation or description of what people were being given to eat.

We did not hear any choice of meal being given on one of the floors where we observed lunch. We were told that people were asked the day before what they wanted to eat from the menu, but people were reminded and shown what was on offer. However, we noted over the lunch time a person was verbally offered eight different choices of food, to which they replied "goodness I need to think about that." Information was not being clearly verbally explained or visual prompts offered, although there was a menu on the table, and the tables laid in preparation for the meal and drinks provided.

We noted that the menu displayed throughout the home showed chicken as the main meal option on the first day. However, the main option available a beef casserole. On floor three we were told there was one person on a soft diet and one person on a pureed diet, we noted that the pureed meal was served as individual portions of food but was not presented to visually represent the food item. One staff member told us they had worked at the home for several years and knew peoples individual preferences, such as who had a large appetite and who would be put off by too much being served.

People were supported to maintain positive health and had access to health care support. Where there were concerns we saw that people were referred to appropriate healthcare professionals. A registered nurse told us a GP visited the home once a week, or when required, to attend to people's needs, and we saw that a GP was visiting on the first day of our inspection. Monthly multi-disciplinary team (MDT) visits and meetings to review people's conditions and needs took place. People also had access to a range of visiting health care professionals such as dentists, physiotherapists, opticians and podiatrists. We saw records on the multi-disciplinary sheets referring visits made by MDT members and recently the flu vaccine had been

Is the service effective?

administered to people. We saw in care plans that the NHS dental services had produced care records for staff to follow in respect of dental hygiene. Other visits such as those by the occupational therapist OT, for equipment assessments, were also recorded.

Pain assessments and pain care plans were in place detailing the pain experienced, and what medicine should be provided. End of life care was recorded through most care plans we viewed, but not in one other.

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

Is the service caring?

Our findings

Visiting the home was open and relatives were made welcome at any time. Several relatives were seen visiting throughout our inspection. Relatives were complimentary about the staff and service they received. One said that their relative liked to be smartly dressed and this was always what happened for them. The relative added that there was no need to ask for anything as it was always done. Another relative said of the service “staff are so hospitable they get chairs for us, very accommodating always a smile on their faces.” Another relative said “They are doing a good job staff are very very good.” They added the care was very good and staff were attentive to everyone they saw living at the home.

We were also told that there was a Christmas party on the evening of the first day of our inspection visit. There was however some confusion amongst both staff and people using the service as to when and where this was to be held. People told us that “staff were very good” and “The staff gave me a party for my birthday last Monday. I had a lovely cake.” Another person told us that they liked to watch T.V. saying I don’t have to go to the party if I don’t want to. I prefer to sit in my room. The staff don’t make you do things you don’t want to.”

We were told by a visitor whose relative had lived in the home for five and a half years prior to their death that they had been extremely pleased with the care their relative had received. They told us ‘Staff are very kind; they all do their best with what they have got. What they have to do they deserve all the praise’.

Most of the staff that we spoke with demonstrated knowledge of the people living at the home. They told us they knew about the care and support they needed, as well as their family support, past medical history, likes and dislikes and preferences.

Many bedroom doors were open, although we did not see staff knocking before entering bedrooms. The atmosphere in the home was usually friendly. Most staff took their time and gave people encouragement whilst supporting them.

We spoke with members of the staff team about how they sought the views and wishes of people who used the service. They told us that they made a point of asking people, which we saw on some occasions although not all.

We had observed staff giving confusing information to people at a lunch time and someone being told to wait for something that they had requested and were perfectly able to decide what they wanted.

Over a lunch time period we observed a person who was resisting being taken to the dining room. Three staff tried to assist them, although they all had different approaches. One member of staff told their colleagues to leave the person, another kept trying to get them to the dining table and another tried to offer the person a cup of tea.

Another concern we had was in relation to an interaction that we observed between someone using the service and a member of staff. The person had asked for their cigarettes and had been told they needed to wait. There was no indication that there was any restriction on this person freely being able to choose to smoke and they knew where they could go to do this. We raised this with the member of staff who had refused to give this person what they had asked for and later with the registered manager who accepted that the response was not acceptable.

People’s individual care plans, in most cases, did not include information about cultural and religious heritage, sexuality, activities, communication and guidance about how personal care should be provided.

We viewed the premises and found staff personal possessions stored in one person’s bedroom and in the lounge on the second floor. A refrigerator in one of the dining rooms contained food and drinks, which were accessible to people using the service. Some of these items were out of date and some did not contain opening or use by dates. The registered manager was initially unable to tell us who these items belonged to, although we were later informed that they belonged to staff.

We noted various memoranda, working guidance and other information relevant to staff displayed throughout the home on notice boards, dining room walls and the lift. We noted that on the second day of our inspection visit that most of this inappropriately displayed information meant for staff had been removed.

We also noted most bedroom doors throughout the home contained out of date information regarding the home’s ‘dignity champions’. We were told that one of the two people named as a dignity champion had not worked in the home for a year.

Is the service caring?

People's right to dignity and respect was not fully adhered to in the way that some staff communicated with people or how the service operated.

Do not attempt resuscitation (DNAR) forms in most care plans we looked at were completed. However, in one case this form had been completed when the person was in

hospital and not since they came to live at the home. In another case we saw that a person had "information not known" even though they had come to the home for palliative care. We raised this with the home manager who undertook to get this information updated.

Is the service responsive?

Our findings

A visiting relative told us they had seen their relative's care plan and been encouraged to be involved in its development.

Care plans and risk assessments were retained in individual folders on each floor. Staff had access to these and they were stored securely in the nurse's room. In addition there were charts and records retained in each person's own room for ease of access. The care files were large and contained a lot of information, which would take a new member of staff some considerable time to read and digest. When we raised this with the manager we were shown a new care file format which was targeted to be rolled out across the home after staff received training on this in early 2016. Consent to care was obtained where possible from the person using the service, or a relative if appropriate.

We viewed the premises and found that of all the bathrooms over the five floors, only one walk in shower showed signs of use on day one of our inspection visit. We were shown a bathing rota and told by a staff member that "showers depend on time constraints. If they are not able to have one on the day they scheduled, we do it the day before." We were told that of the three people named on the scheduled for a bath or shower on the first day of our inspection visit that "one person had one the day before because the morning is busy and the other two refused."

The provider was not carrying out suitable or detailed care planning to ensure that the service could provide appropriate care that was responsive to the needs of all people using the service.

Although areas of care planning were reviewed each month we found that information was in some cases contradictory and did not follow a logical or clear pathway. Specific areas of care planning that were not well addressed were in respect of specific conditions such as Parkinson, Dementia and Lewy Body Dementia, continence and nutrition. There was also a lack of information about people's religion, culture and sexuality in care planning.

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

We spent time observing the care of people on the ground, second and third floors. We also observed care of one person who was bedbound throughout a large part of our inspection. During this time we did not observe (see or hear) staff offer any form of activity or positive stimulation to three of the people we were observing. However, two people were engaged in positive conversation with a staff member.

During the first day of our inspection visit we saw one staff member (the administrator) reading the newspaper to people and discussing the articles (third floor lounge). We were told by staff and people that a church service had taken place during the morning and was scheduled again that afternoon. At 2pm we heard a member of staff (the activity co-ordinator) asking people if they wished to attend the afternoon service. We heard one person saying he would like to attend. They were taken in their wheelchair shortly after 2pm to another lounge in the home where the service was to be held. At 3pm we were told the service had still not started even though they had been sat waiting for an hour.

The activities co-ordinator was unable to confirm what training they had received about activities, and was unable to provide information when asked about suitable activities for people living with dementia. They did, however, say that activities need to be for short periods of 10- 15 minutes and added that they wanted more training in dementia.

We recommend that the provider considers seeking guidance from nationally recognised sources on the types of high quality activity provision for older people.

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

Is the service well-led?

Our findings

The provider of the service had only recently taken over from the previous provider and it was too early for us to assess the quality or standard of the organisational oversight of the home.

There was a clear internal management structure in place and staff were aware of their roles and responsibilities. Staff told us that all of the staff team worked well together, especially during the changes, and that the management were supportive and available for advice and guidance.

However, for most of 2015 the future of the home had been uncertain and support and oversight had been lacking. The service was still in the process of transition to the newly registered provider. Systems for liaison with other professionals, for example placing local authorities and healthcare professionals had been maintained and were effective. However, the way in which the new provider would be managing oversight and governance of the home remained unclear and were unknown to the registered manager. It is though noted that the area manager, who had been in the same position with the previous provider, was maintaining regular contact and visiting the service to support the registered manager.

We observed that staff felt able and comfortable to approach the registered manager and senior staff, however, no staff made any other comments about this. We also observed how visitors to the home were not hesitant about speaking with the manager, knew who this person was, and the manager was engaging openly with any person who spoke with him.

We were informed that the provider had a system for monitoring the quality of care. The manager informed us that systems of regular reporting had been sent for completion beginning in January 2016 although was unable to show us what these systems were. It was too early for us to assess whether this was effective and the manager informed us that the systems were still being introduced at the time of our inspection.

There has yet to be a satisfaction survey of people using the service, relatives or other stakeholders. We were, however, shown examples of communication that had been entered into with people using the service (where that had been possible), relatives and other interested parties about the change of ownership of the service.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not carrying out suitable or detailed assessments of needs to ensure that the service could safely provide care to all of those using it.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not carrying out suitable or detailed care planning to ensure that the service could provide appropriate care that was responsive to the needs of all people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Potential risks to be people were not being appropriately assessed or reviewed or addressed when risks were identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury

Regulation 14 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monitoring of people's nutritional and hydration needs was not always being carried out effectively.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not being afforded suitable time to undertake required training during their working hours and not all staff were being supported through supervision.

This section is primarily information for the provider

Enforcement actions

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