Bupa Care Homes (ANS) Limited

Middlesex Manor Nursing Centre

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

Our inspection of Middlesex Manor Nursing Centre took place on 28 and 29 September 2015. This was an unannounced inspection.

At our previous inspection of the service in October 2014, we found that the service was not meeting the requirements of the law in relation to the following: management of medicines; staffing; nutritional needs; safeguarding people who use services from abuse; assessing and monitoring the quality of service provision.

During this inspection we found that the provider had taken significant steps to improve the service in order to meet the requirements identified at the previous inspection.

Middlesex Manor Nursing Centre is purpose built and consists of three units of single rooms with en suite facilities. The home provides nursing care for up to 83

Summary of findings

people. At the time of our visit there were 63 people living at the service. Most were older people, some were living with dementia or with other conditions associated with ageing. Other people had physical disabilities.

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 who lived at Middlesex Manor told us that they felt safe, and this was confirmed by family members whom we spoke with.

Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

People's medicines were stored, managed and given to them appropriately. Records of medicines were well maintained.

People had up to date risk assessments to ensure that they were kept safe from avoidable harm. Most risk assessments contained detailed guidance for staff in managing risk to people. However, we were concerned that some risk assessments had not been completed which meant that we could not always be sure that people were safe.

There were enough staff members on duty to meet the physical and other needs of people living at the home. Staff supported people in a caring and respectful way, and responded promptly to needs and requests. People who remained in their rooms for some or part of the day were regularly checked on.

Staff who worked at the service received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. All staff members received regular supervision from a manager, and those whom we spoke with told us that they felt well supported.

The service was generally meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. The majority of staff had received training undertaken training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions. However the risk assessments for people regarding use of bedrails did not show that this was the least restrictive option available to meet their needs which is a requirement of the MCA.

Meals that were provided to people were nutritionally balanced and met individual health and cultural requirements. Alternatives were offered where people did not want what was on the menu. People appeared to enjoy their meals. Drinks and snacks were offered to people throughout the day. People's nutritional needs were recorded in their care plans and risk assessments with guidance for staff. Health professionals were involved where there were concerns about maintenance of weight.

People's care plans were person centred and provided guidance for staff about how people wished to be supported. The plans were updated regularly to ensure that they addressed people's current needs.

People told us that staff were caring and we saw some positive interactions between people and their care staff. People told us, and we observed that they were offered choices and that their privacy was respected. However we observed that a small number of staff did not speak with people when they were providing support at mealtimes.

The service provided a range of individual and group activities for people to participate in throughout the week. People's cultural and religious needs were supported by the service

People and their family members that we spoke with knew how to complain if they had a problem with the service

Care documentation showed that people's health needs were regularly reviewed. The service liaised with health professionals to ensure that people received the support that they needed.

Summary of findings

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Policies and procedures were up to date and staff members were required to sign that they had read and understood any new or amended ones.

People who used the service, their relatives and staff members spoke positively about the management of the service. We were told that the new manager had made a number of positive improvements.

We found two 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?

Aspects of the service were not safe. Risk assessments did not always contain guidance for staff about how to manage identified risks.

Staff we spoke with understood the principles of safeguarding vulnerable adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Medicines were well managed and recorded.

Requires improvement

Is the service effective?

Aspects of the service were not effective. Risk assessments for use of bed rails did not demonstrate that this was the least restrictive means of ensuring that people were safe as required under The Mental Capacity Act 2005.

Staff members received the training and support they required to carry out their duties effectively.

People were supported to maintain good health and to access health services when they needed them.

People chose their meals and were provided with the support they needed to eat and drink.

Requires improvement

Is the service caring?

The service was caring. People who used the service and their family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that many interactions between staff members and people who used the service were caring and respectful.

People's religious and cultural needs were respected and supported.

Good

Is the service responsive?

The service was responsive. People and their relatives told that their needs were addressed by staff.

Care plans were up to date and person centred and included guidance for staff to support them in meeting people's needs.

People were able to participate in of individual and group activities.

The service had a complaints procedure and people knew how to make a complaint.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of the service and we saw that these were evaluated with improvements made where required.

The registered manager demonstrated leadership and accountability. She was approachable and available to people who used the service, staff members and visitors.

Staff members told us that they felt well supported by the manager. People and family members of people who used the service felt that the home was well managed.

The registered manager had a good working relationship with health and social care professionals and organisations.

Middlesex Manor Nursing Centre

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 September 2015, and was unannounced. The inspection team comprised of two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with eight people who lived at Middlesex Manor Nursing Centre and three family members. We also spoke with five nurses, five care staff, an activities co-ordinator, the registered manager, and an area manager.

We spent time observing care and support being delivered in the main communal areas. We looked at records, which included 14 care records, eight staff records and records relating to the management of the service.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection the provider completed 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 reviewed the information included in the PIR along with other information we held about the home.

Requires improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. People knew who to speak to if they had a concern about their welfare. We were told that the staff "are good people," and, "I do feel safe here." A family member told us, "I feel [my relative] is safe and well supported."

At our previous inspection of Middlesex Manor we were concerned that medicines were not managed safely. This was a breach of Regulation 13 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2010.which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this visit we found that significant improvements had been made in this area. We saw medicines being given to people in a safe and caring manner. Medicines were offered in the way that people chose. For example we saw that one person's record stated that they liked to take their medicines with ice cream. This had been checked with healthcare staff and the times of administration of their medicines had been adjusted so the medicines were given at a time that was more suitable to take them with ice cream. Nurses made an accurate record of the administration or the reason medicines were not given on the medication administration record (MAR). We looked at the MAR charts for people in the home and saw that they were clear and contained information such as allergies, preferences, blood tests and protocols to support nurses when giving people their medicines. Separate charts were completed for topical medicines which included body maps to show care workers where creams should be applied.

Medicines were stored securely on each floor, including controlled drugs and medicines which require cold storage. There were medicines available for people and we saw how medicines could be ordered from a local pharmacy if they were required urgently. The manager ensured that monthly audits were carried out. We saw examples of these and saw that actions had been taken as a result. Nurses told us of the training and competency assessments they had in medicines handling and we saw this recorded.

Nurses told us that the GP visited twice a week and reviewed everyone living in the home monthly. We saw that people who had swallowing difficulties were prescribed liquids or had protocols agreed with the GP and pharmacist for crushing their tablets. Some of these protocols did not contain sufficient information to guide staff, although staff could describe to us how this was done safely for individuals. We discussed this with the manager who told us that they would ensure that the guidance associated with these protocols would be reviewed.

During our previous inspection of Middlesex Manor we found that staffing levels were insufficient, This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to. Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. On this visit we noted from the staffing rotas and the numbers of staff on shift in each unit that efforts had been made to address these concerns. For example, we observed that there was always at least one nurse available on each unit, and there were sufficient numbers of care staff on duty to meet people's needs.

The staff members that we spoke with told us that there were enough staff on duty to meet people's needs. However, one said, "we are coping well at the moment but we might struggle if the unit was full." We were told by two staff members that agency workers were used to cover vacancies and absences and this was confirmed by the manager. They informed us that this was a particular issue with nursing staff, and discussed how the service was currently recruiting to fill vacant positions. The manager explained that, where agency staff were used, these were always regular workers as this was essential for continuity of care. We spoke with an agency nurse who had worked at the service for some time. They were familiar with the needs of the people who used the service, and of policies and procedures relating to their work.

One person who used the service told us that they sometimes had to wait for their medicines at night when agency nurses were on duty. However they also said that they received their regular pain relief on time. Although the majority of people that we spoke with were satisfied with response times in relation to care, two people and a relative told us that these were slower at night. We discussed this with the manager, who was aware of these concerns. She described how she and the deputy manager had recently implemented an ongoing programme of unannounced visits during the night in order to monitor the quality and safety of care at the service.

Requires improvement

Is the service safe?

During our previous inspection we noted that people had to wait a significant amount of time for meals to be served due to staff members being engaged in care duties. At this inspection we also saw that people were waiting for up to 30 minutes for lunch in the dining rooms and longer if they were taking meals in their bedrooms. However, we saw that care staff were also waiting to serve meals and support people to eat where required, and that the source of the delay was in relation to food arriving from the main kitchen. We discussed this with the manager who told us that she would be addressing this issue with kitchen staff.

People's care plans included risk assessments that included risks, for example in relation to mobility, personal care and behavioural management. These assessments identified hazards that

people might face and guidance for staff members about the support they needed to minimise the risk of being harmed. These were generally up to date and reflected information contained within people's care assessments and care plans. However we identified that some risk assessments had not been fully completed and there was not always a risk management plan in respect of identified risks. For example, one person's file contained incomplete risk assessments in respect of falls, health, safety and eating and drinking. Another person's care documentation referred to a moving and handling risk assessment but we were unable to see a copy of this in her file. A number of people had had a falls risk assessment where the risk level identified was medium to high. Although the provider's assessment form specified that management plans should be put in place for these risks, we were unable to find any documentation showing that a falls risk management plan had been completed. This meant that we could not be sure that people were safely protected from identified risks.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014

We looked at the recruitment records of eight members of staff. We found that application forms had been completed which had included people's employment history, two references obtained and there was a record of formal interviews that had been carried out. Criminal record and barring checks had also been completed to establish that people were suitable to care for people living at the service.

There were systems in place to protect people from abuse and to keep them free from harm. Staff were knowledgeable in recognising signs of abuse and the related reporting procedures. Information about reporting abuse was displayed. Staff told us that they had received

training about safeguarding people and training records confirmed this. Staff members that we spoke with had a clear understanding of the organisation's whistleblowing procedures. The service maintained a record of safeguarding concerns and actions taken to address these. For example, we saw that a recent safeguarding concern in relation to medicines had been appropriately reported and that appropriate actions had been put in place to reduce any further likelihood of risk.

The service managed a small amount of cash for some people in the home. We saw that records including receipts of expenditure were available. Regular checks of the management of people's monies were carried out by the registered manager and other management staff to reduce

the risk of financial abuse. One person that we spoke with told us that they had a lockable drawer in their room for monies and valuables and that they were in possession of a key for this.

People's care plans included risk assessments that included risks, for example in relation to mobility, personal care and behavioural management. These assessments identified hazards that

people might face and guidance for staff members about the support they needed to minimise the risk of being harmed. These were up to date and reflected information contained within people's care assessments and care plans.

Staff took appropriate action following accidents and incidents. Incidents and accidents were recorded, investigated, reported to the provider and where appropriate, organisations including the CQC and local authorities were informed. There was evidence that action was taken to make improvements and minimise the risk of them happening again.

Staff knew about emergency procedures and the emergency services they would need to contact, for example, if there was a fire.

Requires improvement

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff. We were told that, "they do meet my needs," and, "they are good." However, one person and a family member told us that this depended on the staff members who were on shift at various times.

At our previous inspection of Middlesex Manor we raised concerns about the that there were no Deprivation of Liberty Safeguard (DoLS) authorisations in place and no applications for DoLS

authorisations had been made for any people using the service, despite this issue having been raised by an external professional. DoLS are part of the Mental Capacity Act 2005 (MCA) and exist to protect the rights of people who lack the mental capacity to make certain decisions about their care and wellbeing. People must only be deprived of their liberty if it is in the best interests of the person and there is no other way to look after them. It should be done in a safe and correct way.

During this inspection we found that the service had made applications for DoLS authorisations to the relevant local authority for people who were assessed as lacking capacity to make decisions about their care and wellbeing. There was also evidence that these had been authorised.

However, we had concerns about the service's understanding of the Mental Capacity Act (MCA). The majority of staff members that we spoke with were able to describe their responsibilities in relation to MCA. However one nurse told us that she had not received relevant training, although her training record showed otherwise. People's care files contained capacity assessments as required by The Act, but these were not always fully completed. In addition, information about best interest decisions and least restrictive options for people who were assessed as lacking capacity as required under MCA were not always recorded. For example, although the service had detailed risk assessments in relation to the use of bedrails, there was not always evidence that any decision about use of bedrails was in the person's best interests. In addition, none of the care files that we viewed showed evidence that less restrictive options (such as low profile beds and soft 'crash mats' or movement monitors) had been explored as an alternative prior to any decision about use of bedrails.

The care files that we viewed included consent forms. Although some consent forms had been signed by the person, this was not always the case, and there was no record indicating why the forms had not been signed. When we asked people if they were involved in discussions about their care, we received a mixed response with two people telling us that they had not been involved in the care planning process. People told us that they were asked for consent in relation to care tasks. One person gave an example of staff asking for permission to take their blood pressure. They said, "they always ask." We saw that staff members knocked on people's doors and waited for consent to enter, even when the doors were open. However, we observed some situations where consent was not asked for. During the lunch period, we saw a staff member touch the back of a person's neck which surprised them. The staff member said they were, "just checking," but did not say what they were checking for. We also observed a staff member wiping a person's mouth without asking them first.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014

We discussed our concerns with the manager. She provided us with a training plan that showed that staff members were scheduled to attend updated MCA/DoLS training within the coming months. She also told us that actions would take place to ensure that our concerns about evidencing best interests and least restrictive option particularly in relation to use of bedrails were addressed.

At our previous inspection of Middlesex Manor we had concerns about the use of MUST (Malnutrition Universal Screening Tool) charts and their accuracy. There was also limited evidence that significant reductions and increases in people's weight had been addressed. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.During this inspection we found that records had improved, although this was not always consistent across all units at the service. For example, in one unit we found that the weights of two people had not been recorded appropriately within the MUST chart. However, we noted that the care plans of people who had gained or lost a significant amount of weight showed that appropriate action, such as referral to a GP or other health professional had been made. People's care plans included dietary information where appropriate to address such concerns, and we noted that food

Is the service effective?

supplements had been prescribed for people who required these. Guidance on people's nutritional and eating needs (for example soft or pureed diets) was available, and people were seen to eat food that was appropriate for their needs.

People told us that they liked the food provided by the service. We were told, "it's good," and, "I eat what I like." One person told us that the food used to be "revolting" but that they had discussed their needs with the chef and, "it really has improved." We saw that there was a choice of meals, and people were asked to choose what they wanted to eat on the previous day. However, we observed they were also given choices at mealtimes. On one unit people were asked what they wanted to eat, and in another, a staff member brought a tray with alternative meals plated up to support people to decide. We observed that other options were provided to people who preferred to eat foods other than those which were on the menu. One person told us that they did not eat pork and the service provided them with food that met their needs. Another person, however, told us that the food was they did not like the food at the service, and that his relatives brought him food to eat regularly. We asked the manager about this. They told us that, although the service had provided a range of meal options, this person preferred to eat the food provided by their family. We looked at their care plan and saw that this was recorded.

Staff training records showed staff had received up to date training in key aspects of their role such as dementia care, moving and handling, health and safety, pressure area care, end of life care and behaviour that challenges. Training was refreshed regularly to ensure that staff remained up to date. For example, we saw that a programme of refresher training in cardio pulmonary resuscitation (CPR) had recently commenced. We found that staff development was supported as most care staff had achieved recognised qualifications in health and social care.

Staff had regular supervision meetings with senior staff where they had the opportunity to discuss best practice issues and concerns in relation to their work. Nurses also received clinical supervision, which was supported by a regular weekly clinical meeting. A programme of annual appraisal was also in place. This showed us that systems were in place to support and develop staff.

All the people we spoke with told us they were able to access health care services as and when necessary and this was confirmed by family members. Staff had regular contact with visiting health professionals and sought advice from them when needed. During our inspection a GP was visiting people who used the service and we saw that they met with nurses to discuss the health needs of the people whom they were visiting.

Good

Is the service caring?

Our findings

People who used the service and their family members told us that staff members were caring. Comments included, "the staff are very nice," and everyone is caring." People told us that they had the opportunity to express their views and that staff listened to them.

We saw that most staff members interacted with people in a positive, respectful and considerate manner. We heard staff initiate conversations with people and speak with them when providing them with support. One person told us that staff, "always explain what they are doing and do what I need." However, our observations during the lunch period showed that this approach was not always consistent. Some staff members supporting people to eat spoke with people throughout the meal, ensuring that they were satisfied with the food and checking they were happy with the support that they were providing. Other staff members supported people without speaking to them, and we saw two incidents where they were having conversations with other staff members when supporting a person. We discussed this with the manager, who told us that they would ensure that the importance of speaking with people and focusing on their needs when providing support would be raised with all staff as a matter of urgency.

People told us that staff members respected their privacy. We were told that staff members knocked on people's doors and asked permission to enter, and this was confirmed by our observations. Doors were closed when staff supported people with their personal care.

Comments from people who used the service and family members included, "they always ask my permission," and, "they are very respectful to [my relative]."

People maintained relationships with family and other people who were important to them. A family member told us that they could visit at any time, "as long as [my relative] is happy to see me." Family members that we spoke with told us that they felt welcome when visiting relatives.

People who used the service told us they were given choices by staff. A person told us that they decided when to get up and go to bed. Another person said that staff members help them to choose what to wear. We saw that people were provided with choices of food and drink throughout the day. We also saw staff members ask people what they wished to watch on television, and offering to fetch books or other items. One person wished to sit in a lounge area where workmen were replacing the patio doors. A staff member asked her if she wished to go to a warmer room, and when she told them that she'd prefer to remain where she was, they asked if she would like them to bring her a cardigan. We saw that the staff member brought this immediately.

The staff members that we spoke with talked about the people they supported in a positive and respectful way. One staff member described how they helped people who could not communicate verbally to make choices. For example, "I open the wardrobe and help the person choose what they want to wear." Another staff member told us, "sometimes it's difficult, but it's important that everyone has choices about what they want to do."

The care plans that we viewed identified people's individual needs and preferences.

Care plans included information about people's life histories, interests, religious and cultural needs. Staff we spoke with knew people well and were able to tell us about people's individual needs and their personal and family background.

We saw that people's personal and cultural needs and preferences were supported by the service. For example, people were offered meal choices that reflected their individual requirements. Representatives from local faith centres visited the service on a regular basis, and we some people told us that they attended local places of worship. We asked the manager about how people were supported to maintain personal relationships. They told us that when partners, friend and family members visited, staff members ensured that people were given privacy to spend time with them as they wished. She told us that although no one at the home was currently in a same gender relationship, but that this was discussed as part of the service's diversity training, and that staff were aware that all people should be treated with equal respect.

Care plans contained a record of people's wishes regarding end of life care and support. Some people had end of life care plans which included people's wishes about the care they wanted at the end of their life. People had support from the community palliative care team. The manager

Good

Is the service caring?

told us that they had arranged for a palliative care nurse to provide end of life care training for the nurses at the home to ensure that they were able to more effectively support people as required.

Good

Is the service responsive?

Our findings

People's care records showed that assessments were undertaken to identify people's individual care and support needs and care plans included guidance which showed how these needs were met with support from staff. People told us, "I am asked for my opinion," and, "they listen to what I have to say."

The majority of people told us that staff understood their needs and had involved them in decisions about their care. The care plans showed that people's relatives had been involved in reviews of care plans. One family member told us that they had asked for a change to be made and that this had been listened to and addressed. They told us, "they keep me informed of any changes, and make sure that I am involved as much as possible." Another said, "the service is very good, and I know that they take on board any changes in my relative's needs."

The care plans and risk assessments that we looked at were generally up to date. However, we noted that one person received one to one support in relation to behaviours considered challenging. Although the person had a challenging behaviour plan in place and staff members were aware of their need and how to support them, the fact that they received one to one support was not recorded in their care documentation. We asked the manager about this. They told us that this was a new arrangement and that the provider was paying for the one to one support in order to enable the person to continue to live safely at the home. An ongoing arrangement was yet to be formally agreed with the relevant local authority. However the manager agreed that the arrangement should have led to an updated care plan.

People were offered a range of activities. Recent events had included an Eid celebration, a cultural day and a visit from Zoolab where various animals were brought in for people to look at and pet. A planned shopping trip to Uxbridge was advertised on a notice board. We saw that photographs of people participating in activities were displayed. There was some evidence that activities such as arts and crafts and music sessions took place at the service, but the activities co-ordinator was away on the first day of our visit, and we saw no structured activities taking place. During the second day of our inspection a pampering session was taking place, and there was a birthday party in one of the units with singing and games. We also saw people engaged in individual activities such as knitting and crochet, reading and puzzles. Some people were sitting in the corridor next to one of the nurse's stations. They told us that they like to sit there every day. One person said, "it's because I'm nosy," and another said, "I like to watch the world go by." However, we observed that some people spent unstructured time sitting in the lounges or in their bedrooms watching television and dozing.

The manager told us that the number of activities offered by the service had increased and they were currently recruiting for a second activities co-ordinator so that they could develop more. The activities co-ordinator told us that part of their role was to visit people who were unable to leave their rooms for a chat, or any one-to-one activity of their choice. She said that this was particularly important for people who were bed bound as care staff and nurses did not always have time to sit and chat. We noted that these individual visits were recorded in people's care files, but the records did not specify the length of time that they took.

People had the opportunity to attend quarterly resident and relatives meeting and people spoke positively about these. The manager told us they tried to ensure that these were linked to a social event, as people were more likely to attend. We looked at a record of the most recent meeting and saw that people were consulted about changes to the service.

Audit records showed that the quality manager asked people for feedback about the service when they carried out their regular checks of the home. An area manager was undertaking a provider review at the time of our inspection and we saw that she took time to speak to people bout their views of the service. Some of the people we spoke with recalled being asked for feedback about the service. A person who used the service told us "staff talk to us about things that are happening."

A 'customer satisfaction survey' had been carried out during autumn 2014, and the results indicated that people were satisfied with the service.

The home had up to date complaints policies and procedures in place. This was supported by a simple complaints leaflet that was displayed on notice boards and given to people who used the service and their families. Staff had an understanding of the complaints procedure and they told us they would report all complaints to senior

Good

Is the service responsive?

staff. There was a comments book displayed in the reception area and we saw that family members had used this to raise concerns, give compliments and make suggestions. All the people we spoke with told us they felt able to

raise any concerns or complaints with staff including the manager and people were generally confident their concerns and complaints would be taken seriously and responded to appropriately.

Two people told us, "I would speak to the manager straight away." A family member told us that they had been unhappy with how complaints had been dealt with in the past, but felt more confident with the new manager. Complaints including actions taken to address these were logged electronically and monitored by the provider, and we saw that responses had been timely and constructive. At the time of our inspection two complaints were being addressed and we saw that this was being done in an appropriate manner.

Good

Is the service well-led?

Our findings

During our previous inspection of Middlesex Manor we were concerned that quality monitoring of the service had not always been appropriately carried out and there was limited evidence that concerns arising from monitoring had been addressed. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.Since that inspection the service had appointed a new manager and deputy manager, and there was evidence that actions had been put in place to address this.

We saw that there was a range of monitoring processes in place. These included regular provider reviews carried out by an area manager. The area manager was conducting a review at the service at the time of our inspection. We were able to see an online copy of the previous review which showed that actions were set and progress against these were monitored. We saw that the completed actions had been recorded. Regular audits took place in relation to care activities at the service, such as medicines, infection control, health and safety and care documentation. We saw that progress in relation to actions arising from the audits was fully recorded, and most had been completed. The manager told us that the care documentation that we viewed was in a new format, and that she was aware that there were still inconsistencies in recording information. She told us that the service was currently auditing the new care documents, and that these issues were being noted and would be addressed with staff members. We observed that the manager and a senior nurse were undertaking an audit of the care files on one unit during the second day of our inspection.

During our inspection we were able to see that improvements were being made to the service as a result of the monitoring process. For example, the call bell system that had been identified as faulty at our previous inspection was being replaced and new doors were being fitted to a downstairs lounge to enable easier access to the garden. We also noted that a representative from a furniture company was visiting in order to discuss options for replacement furniture for the communal areas that had been identified as an action from a previous audit. The manager told us that they would use this information to discuss preferred styles and colours of furniture with people who used the service.

Regular health and safety monitoring was up to date. We saw that checks of, for example, fire bells, call bells, fridge and freezer temperatures and hot water temperatures had taken place. Up to date certificates were in place in respect of checks of fire equipment, lift and mobility equipment, gas and electrical safety and portable electrical appliance testing.

People and their family members spoke positively about the new manager. One person told us, “I think she’s fine. Everybody seems to like her. That’s alright as long as she gets the job done.” Another person said, “the manager is a good person.” A family member that we spoke with told us, “I’ve’ seen some change. Positive change. She’s doing things to make the home better.” Staff members were also positive. One said, “She is approachable and tries to do everything better”, adding that they liked working at the service now. Another staff member told us that, “she listens to the staff and residents.” We were able to see that the manager had made significant improvements to the service, and that this was an ongoing process.

Staff told us that they had the opportunity to attend monthly staff meetings where they discussed a number of topics and explored ways to improve people’s care. The registered manager, nurses and care staff also participated in daily meetings where immediate issues and concerns were discussed. Minutes of these meetings showed areas of the service such as cleanliness of the environment, incidents and people’s health and care needs were discussed and actions were agreed to address these. Staff told us that they felt well supported and were comfortable raising issues and sharing ideas about the service. A staff member said, “there is good teamwork here.”

Policies and procedures were up to date and reflected current regulatory and good practice guidance. Staff members were required to sign that they had read and understood new or amended policies and procedures.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meetings and visits with such professionals was recorded in people’s care files.

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 11 HSCA (RA) Regulations 2014 Need for consent The provider was unable to demonstrate that peoples' consent to care and treatment had always been sought. Where people had been unable to give consent the provider had not always shown that they had acted in accordance with The Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used services and others were not always protected against risk because individual risk assessments had not always been completed. Regulation 12 (2)(a)(b)