

Life Style Care plc

# The Grange Care Centre

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

We undertook an unannounced focused inspection of The Grange Care Centre on 5, 6 and 9 February 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our August 2017 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe? is the service responsive? and is the service well led? This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The Grange Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Grange Care Centre is registered to accommodate up to 160 people requiring nursing or personal care. The service has eight separate units, each of which have individual bedrooms with en suite facilities and communal living, dining, bath, shower and toilet facilities. It caters for older people including those with dementia care needs, younger adults with a physical disability and/or mental health needs and people requiring end of life care. At the time of inspection there were 151 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service since August 2014. 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.

We identified shortfalls with the staffing deployment and received feedback from people, relatives and staff that there were times when the service was short of staff. There were systems in place for monitoring the service, however we identified areas that needed more robust monitoring such as staff deployment and the electronic records system.

Since our last inspection, there had been improvements in the management of medicines to ensure people received their medicines safely. Staff recruitment procedures were in place and being followed. Risk assessments for individuals and for systems, equipment and safe working practices were in place and identified the action to take to mitigate the risks. People and relatives felt people were safe living at the service. Staff understood and followed safeguarding procedures. Protocols were followed to learn from incidents and accidents to help prevent reoccurrence.

Since our last inspection there had been improvements with the care records and care plans were now person centred and up to date. Activities were provided and people had mixed feelings about the activities provision as it did not always meet everyone's needs. There was a complaints procedure in place and people and relatives felt able to raise any concerns. Records showed that any complaints raised were addressed appropriately. People's wishes in respect of end of life care were discussed and recorded.

The registered manager was responsive to our findings and was able to gather information to answer anomalies found with the care records. The provider was actively recruiting for more staff and was aware that further work was required on the electronic records system so that the records consistently reflected the care and support that a person received.

There were systems in place for gaining feedback on the service provision. The registered manager was involved with projects with other agencies to improve the overall care provision for people and to improve knowledge and learning for staff.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staff deployment and good governance. You can see what action we have asked the provider to make at the end of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Aspects of the service were not always safe.

Staff were not always deployed to meet the needs of all the people using the service. Medicines management had improved and these were now being managed safely.

Staff recruitment procedures were in place and being followed. Risk assessments for individuals and for systems, equipment and safe working practices were in place and identified the action to take to mitigate the risks.

People and relatives felt people were safe living at the service. Staff understood and followed safeguarding procedures. Protocols were followed to learn from incidents.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

Since our last inspection there had been improvements with the care records and care plans were now person centred and up to date. Further work was needed on the electronic care record system to ensure the care and support people received was always accurately recorded.

Activities were provided and people had mixed feelings about the activities provision as it did not always meet everyone's needs.

There was a complaints procedure in place and people and relatives felt able to raise any concerns, which were being addressed. People's wishes in respect of end of life care were discussed and recorded.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

There were systems in place for monitoring the service, however we identified areas that needed more robust monitoring such as staff deployment and the electronic records system.

**Requires Improvement** ●

Whilst there have been some improvements at the service, there were still some areas to further improve and we needed to see evidence that any improvements would be maintained and sustained over time.

The provider was recruiting staff and was reviewing the staffing levels regularly. They were aware that further work was required on the electronic records system so that the records consistently reflected the care and support that a person received.

The registered manager was responsive to our findings and was able to gather information to answer anomalies found with the care records.

There were systems in place for gaining feedback on the service provision. The registered manager was involved with projects with other agencies to improve the overall care provision for people and to improve staff knowledge.

# The Grange 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.

We undertook an unannounced focused inspection of The Grange Care Centre on 5, 6 and 9 February 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our August 2017 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe? is the service responsive? and is the service well led? This is because the service was not meeting some legal requirements.

The first two days of the inspection were carried out by two inspectors, one medicines 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. One inspector returned on the third day of inspection to conclude the inspection.

Before the inspection we reviewed the information we held about the service including the action plan the provider had sent us in response to our last inspection, notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

During the inspection we viewed four staff recruitment files for staff recruited since our last inspection, medicine administration records for 14 people, 16 people's care records, 14 people's risk assessments and some of the associated food, fluid, daily nursing and care workers records. We also looked at risk assessments for systems and equipment used to support the delivery of care and staff working practices, maintenance and servicing records, accident and incident records, complaints and safeguarding records, auditing and monitoring records and a sample of the provider's policies and procedures.

We spoke with 13 people using the service and eight relatives. We spoke with the nominated individual, the registered manager, the clinical manager, two deputy managers, four registered nurses, a team leader, six

care workers, two activities coordinators, the chef and two visiting healthcare professionals. We observed interaction between staff and people at various times during the inspection.

# Is the service safe?

## Our findings

At the inspection in August 2017, we found a breach of regulations relating to the safe care and treatment of people. We found shortfalls in the medicines management at the service. Following the inspection, the provider sent us an action plan to be met by 31 October 2017, which indicated how they would address the identified breach of regulation. At our inspection in February 2018 we found that improvements had been made.

At this inspection, a member of the medicines team looked at storage, administration, care plans, record keeping and systems in place for the management of medicines. We found medicines were being managed safely at the home.

At our previous inspection, we had found an error in records of controlled drugs (CD's) held in stock (CD's are medicines which are liable to misuse and therefore need close monitoring). During this inspection, we saw staff members maintained accurate records of CD's held in stock to meet requirements. During our last inspection, we had found out of date medicines in the fridge. At this inspection, the provider had adequate stock of medicines that were in date. Staff disposed of unwanted medicines appropriately stored these securely at appropriate temperatures.

Some people took their medicines themselves and stored them in their own rooms. The provider had carried out assessments to assess if people could take their own medicines. However, we found staff did not always monitor if people were taking their medicines regularly.

GP's visited the service to carry out medicine reviews to ensure people were prescribed appropriate medicines. We observed staff administer medicines to people in the morning and in the afternoon. This was carried out appropriately. The provider had carried out the necessary assessments and involved the required individuals for people who were administered medicines covertly. When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink, it is described as covert medication.

We looked at MAR charts for 14 people. We found no gaps in MAR charts, this provided assurance that people received their medicines as prescribed. Some people were prescribed medicine patches to manage their pain. Staff documented where the patch was applied on the body to ensure site of application was changed each time the patch was replaced. Some people were prescribed creams to be applied to their body. These were stored in people's own rooms, applied by care staff and recorded when applied.

We found there was an effective process to manage conditions of people who were prescribed higher risk medicines such as anticoagulants and insulin. Anticoagulants are medicines prescribed to prevent blood clots. Insulin is prescribed to some people with diabetes to help control their blood glucose levels. There was guidance in people's care plans for staff to identify likely side effects of these medicines and information on how to manage them.



The service had a medicine management policy in place. The provider had carried out regular medicine audits. We saw records to show staff received regular medicines management training and were competency assessed to handle medicines. The service had a process to receive medicine alerts and acted upon them if required. There was a system in place to report and investigate medicine errors and incidents.

We found that staff were not always deployed in a way that ensured staff were available at all times to monitor and meet people's needs. Many people stayed in their rooms for long periods of time, either by choice or because they needed to rest in bed. We observed times when staff were not visible in the long corridors and people could be heard calling out for help or call bells were ringing for long periods of time, for example we heard one ringing for over 20 minutes.

On the second day of our inspection on Daffodil unit we found three people in need of assistance and could not find any staff to help them. One person had been left alone in a wheelchair in the dining room and two people were calling for attention in their rooms, including one person who was clearly in discomfort and one person recently admitted who had been left in bed unattended for most of the afternoon. When queried it became apparent that five staff were deployed in three bedrooms providing people with personal care. Staff were not therefore available to attend to people who needed attention. One of the inspectors found two of the deputy managers who then attended to the people concerned to make them comfortable. The registered manager explained that it was usual practice for an additional care worker to be scheduled when there was a new admission, but this had not happened on this occasion.

The feedback we had from people about numbers of staff on duty varied depending on which units we were on. Those on the older people's units felt, in the main, that there were enough staff on duty and their comments included, "Yes generally, odd day when they are short of staff. Sometimes the bell is on for a while. I have had to wait for the loo for 30 minutes. Doesn't happen often. Things can be slower at the weekends as there are not as many staff", "Always a problem of staff shortages. There are long delays with things, like getting ready for meals, and serving the food. Things are supposed to happen but they don't. Overall they are pretty good", "Oh yes loads and the staff are brilliant. The girls are brilliant, the men are ok. I prefer the women" and "Yes, I am pretty much independent, not long (to wait) – best is two minutes, the worst is 10-15 minutes." When we asked people on the younger adults units their responses included, "No. Very few staff. Sometimes you have to wait up to an hour, I go in the corridor and ask for help", "No I can have to wait 20 to 25 minutes for help" and "I think there are staffing issues. They use this unit as a training unit. I don't think that is fair to use it all the time to train staff for the whole place." We discussed the deployment of staff with the registered manager who was responsive to our findings.

Staff commented that there were usually enough staff on duty on each of the units to meet people's needs, although some said there was a wide diversity of needs including many people who required the assistance of two staff for personal care and moving and handling transfers. Their comments included, "There are enough staff in the morning but we're often short in the afternoon", "There's usually enough staff although sometimes we have to use agency staff" and "Some people have a high level of need and many require two staff to assist them for personal care." We identified that on the younger adults units several people had a high level of need and one of the issues was ensuring care staff were available to answer call bells and supervise people when their colleagues were providing personal care to others. The registered manager said they would review the care and support people needed to ensure the staffing accurately reflected the numbers required to provide the care and support each person required.

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

On the residential unit for people with dementia care needs a care worker explained that because people tended to be disorientated to time and place they always had one member of staff in the corridor observing and available if someone needed assistance. We saw this was happening during our tour of the unit.

Recruitment processes were in place and being followed to ensure only suitable staff worked at the service. Staff completed application forms and any gaps in employment were explained on the form or during the interview process. Health questionnaires were also completed and a recent photograph was available in each recruitment file. Pre-employment checks included a minimum of two references, one being from the previous employer, a Disclosure and Barring Service (DBS) check, proof of identity including a copy of their passport and evidence of people's right to work in the UK. The registered manager confirmed that for agency staff a copy of the recruitment profile from the supplying agency was supplied and we saw samples during the inspection.

We asked people if they felt safe at the service. One person had some concerns relating to when the regular staff were not available to support them but otherwise people confirmed they felt safe living at the service. Relatives were also happy that their family member was cared for safely. Their comments included, "Oh yes definitely. She is so happy here. No problems at all" and "I am quite happy the way he is looked after, I have no concerns. He is safe, they do their best for him. They look after him." Call bells were available in bedrooms and also in the communal areas including bathrooms and toilets and were where people could reach them. We received some comments on the younger adult units that people were often disturbed by others who shouted out, both day and night. There were also dynamics between some individuals on these units and the registered manager and unit manager were aware of these. The staff team worked to occupy people and to keep them safe and people were reviewed by the GP and mental health services.

Staff all said that they received regular safeguarding training and could identify the different types of abuse. Staff said they would report any safeguarding concerns to the nurse on duty and could also go to the deputy managers and the registered manager. Staff were aware of whistleblowing procedures and said that if the provider did not take action to address a safeguarding concern then they would contact the Care Quality Commission or social services. We saw a flowchart for reporting any allegations of abuse, which included contact details for the local authority and copies were displayed on some units and in the staff signing in area. Not all staff were clear as to where they would find this information and the registered manager said copies had been available on all units and in the staff room and she would follow this up to replace any that had been removed. Staff did say they would search on the internet should they need to and would ensure any concerns were reported.

There was a range of risk assessments for individuals recorded on the electronic care planning system. There were assessment tools for different aspects of care and safety such as falls risk, skin integrity, nutrition and malnutrition risk, depression, pain and mental capacity assessments. Risk scores were all up to date for care plans inspected. There were also risk assessments for specific situations such as smoking or risks related to lack of mental capacity with capacity assessments in place where needed. Where risks had been identified these were also addressed within the body of the associated care plans and there were actions outlined on how to manage or mitigate risk, such as instructions on repositioning or ensuring that personal care was supported appropriately. People with diabetes had clear management plans including dietary advice, medication detail if relevant and information on how their blood sugar was to be monitored.

If someone had a significant change in their condition, for example weight loss that identified them as being at high risk of malnutrition, then the electronic system automatically generated a 'red flag' warning on the home screen of the person's records with additional instructions, such as to weigh the person weekly, refer them to a dietitian and monitor their food and fluid intake. However, for a person who had such a 'flag', the

associated care records did not always reflect the apparent changes either in the care plans or in the monthly reviews, so there was a discrepancy in the information. When we looked into the matter further it was found the person had received input from the GP and the care and support to meet their needs had been discussed, which was recorded in the nursing daily records. We saw that people's food and fluid intakes were recorded and any concerns had been discussed with the GP, with people being referred appropriately for further healthcare input.

Risk assessments for safe working practices were in place and the registered manager was aware they were due for review and said this would be carried out. The fire risk assessment had last been done in September 2017 and an action plan put in place to address the findings, with each section signed off and dated when action was complete. The last inspection by the Fire Safety Authority was in December 2017. At the time of our inspection the only outstanding action was work on replacing some of the fire doors, and this was done during the week of the inspection. Personal emergency evacuation plans (PEEPS) were included on the electronic care planning system and provided detail of the needs of each person if an evacuation of the premises was required. There were also 'at a glance' PEEPs and these provided an overview of the equipment and support each person would need if the building was evacuated. There had been some confusion regarding the running of both sets of PEEPs concurrently and this was addressed during the inspection, so all the information was up to date.

Equipment and systems were serviced at the required intervals and repairs carried out to keep them safe for use. In-house checks including water temperatures, fire safety systems, emergency lighting, bedrails, window restrictors and moving and handling equipment were maintained so people were living in a safe environment and equipment maintained in good working order.

The service was clean and fresh throughout and people on all units confirmed the service was kept clean. One person said, "Its clean, on the whole it's very good. Yes, they use aprons and gloves." The service was clean in all areas, including individual rooms and en suites as well as communal areas and bathrooms. We observed domestic staff cleaning throughout the units and using colour coded cleaning equipment. Personal protective equipment (PPE) including gloves and aprons were seen in use when supporting people with personal care and at mealtimes. There had been two influenza outbreaks and action had been taken to minimise spread and get healthcare advice and input. One healthcare professional was very positive about the way the service had managed the outbreaks and had also been proactive in encouraging staff to receive the vaccine, which had been taken up by approximately 80% of the staff.

There were systems in place to reflect on and learn from any events to minimise the risk of recurrence. The provider had a form titled 'corrective and preventative action request' and this was completed for any events that occurred that required corrective action to be taken. For example, two complaints had been received about relatives not having been informed of a change in a person's condition. Action had been taken to review contact details held, the processes to be followed for contacting the relative or friend and the follow up action to take in the event they could not be reached. A reflective meeting was then held with management and nurses to ensure learning took place and to embed the improvements.

## Is the service responsive?

### Our findings

At the inspection in July 2017, we found a breach of regulations relating to person centred care. We had found a lack of person centred detail in the care records. Following the inspection, the provider sent us an action plan to be met by 30 November 2017, which indicated how they would address the identified breach of regulation. At our inspection in February 2018 we found that improvements had been made.

All care plans seen were person centred with detailed information on people's personal history, family background, preferences and routines such as social engagement, how people preferred to spend their time, personal care wishes, food preferences as well as other individual needs and factors relating to their care. Cultural needs were well documented along with information on how to best communicate with people and to manage any behavioural issues. Care records were comprehensive and provided a picture of the care and support each person received. There were care plans for each aspect of care including communication, personal care, daily life, mobility, mental capacity, end of life wishes, medical care/medication, skin integrity and nutrition. The care plans could be viewed in summary or as individual plans.

Each care plans outlined the care needs, outcome or objective and care actions required. Wound care records were clear and up to date. Care and treatment was discussed at the daily 'flash meetings' and this included wound dressings, healthcare appointments and anyone whose condition gave cause for concern, so all the nursing and management staff were aware and could provide any input that was needed. A healthcare professional expressed their satisfaction with the way in which wounds were managed to promote healing.

Following the last inspection the registered manager had been working on ways to evidence the input from people and, where appropriate, their representatives in the care records. The system had a 'portal' for representatives with the legal right to do so to securely access the care records and one relative confirmed they had done this. A relative said, "Yes, I have access to the relatives' portal." Another told us, "The computer system was mentioned and that I could have a look. But I haven't yet. They keep me up to date with what's happening." Several people confirmed they had been involved with their care records so their views could be included. One person said, "Yes, I have been involved in review. I did a life journal and have had input into the care plan." The registered manager said they had sent forms to representatives to get written evidence to confirm that they had viewed their relative's care records and agreed to them, however they relied on people signing and returning these so they could be scanned onto the system. This was work in progress.

All the care records were stored on an electronic system using hand held devices carried by each member of staff and tablet devices kept on each unit to review and update the care records. Information about health professional visits was recorded by the nursing staff. We spoke with a healthcare professional who was positive about the service and said that communication from unit managers and care staff was efficient and responsive. They told us that records were well maintained and that the service requested medical intervention promptly when it was needed. Care staff were happy using the system and showed us how the

hand held device worked and that they could access a person's care plan to read about them. They said that the nurses also provided a full handover about any new people so they had the information they needed to meet their care and support needs.

The electronic care record system was comprehensive and staff could input information in real time so the risk of omitting to record an element of the care and support people received was minimised. However, there were some anomalies that we noted which meant the records did not clearly reflect the care that was delivered to people and could lead to inaccurate information about people being recorded.

We saw that the hand held devices had some icons that were very similar, for example, the 'bath temperature check' icon and the 'bath given' icon. It appeared at times the wrong icon had been used or the same icon used twice. If someone received care from two staff, both had to enter the information onto the hand held device, so the daily log recorded two showers had been given. Staff would record that someone had refused a bath or shower, however when we asked one person, they said they wanted to have a regular bath but were not getting this. The clinical manager then spoke with the person to understand the issue and reviewed the timings of their personal care to meet their needs and wishes. Another person said they had not been out of bed for some weeks. The daily record logs identified time spent out in their armchair and on other activities, however it was when we spoke with staff that they were able to explain to us the situation satisfactorily, which we had been unable to ascertain from the person's daily log entries. The provider said they were meeting with the software provider and would discuss all the issues with the electronic records so they could be addressed.

People told us how they felt about the activities provided. People's comments included, "I wish I could be taken out more. I would like to go to the shops. We don't get out much. They don't have enough staff", "They are geared up for the elderly people. [Staff member] has taken over [activities in] the garden. I helped out there occasionally watering plants. We go to the Movies place, we go to the cinema", "They do try. They started an art class before Christmas. But it's not happening any more as the carer has gone upstairs now" and "[Activities] Not too bad. They have been short of staff on that side of things. Some days you get nothing, particularly at weekends. I like the cafe bar, the quizzes, I go to the Karaoke but it's not my thing." A relative said, "She [family member] loves the activities, karaoke, bingo, particularly when she wins." Church representatives visited the service and people were asked about any religious wishes so these could be identified and met.

The activities coordinators were kept busy and as well as group activities they carried out one to one visits with people in their rooms. Some staff felt there was not enough time available and we saw that a lot of people remained in their rooms and spent time alone. Whilst in several instances this was people's own choice, there were those whose frail condition meant they spent most or all of their time in bed and were in their rooms alone. There were also periods when staff were busy providing care and support and did not have the time to sit and chat with people in the communal areas, so we saw people were sitting passively or sleeping in their chairs. In addition there were people whose conditions had improved significantly since they came to the service and who were now waiting for alternative suitable placements. Whilst they wait for this to happen, some told us they were bored and wanted more to do on a day to day basis. The registered manager was aware of these situations and said they would keep the activities provision under review.

The provider had recently employed an activities coordinator for the younger adults units and they were training with an experienced activities coordinator at the time of the inspection. There was also a rehabilitation assistant for these units and we saw they spent time with people, taking them out into the garden and engaging in individual activities they enjoyed. They told us about outings they had arranged and working with people on their rehabilitation and to achieve individual goals. There were three activities

coordinators who worked throughout the service to provide activities for people. There was a massage therapist and people said they enjoyed having hand massages, which we observed on two units.

We observed some activities taking place and people looked animated and were participating in the conversations and answering quiz questions. People congregated at the café on the first floor whilst waiting to have their hair done and one of the activities coordinators served tea and coffee, with a chosen film to watch, and it was a social occasion. People had access to the internet and could use computers to help with their interests and hobbies and the activities coordinators also had an electronic tablet to use in their work. The registered manager said they had access to the local authority transport and a weekly outing to an evening activity had recently been arranged and was due to start the week following our inspection.

There was a complaints procedure that was displayed in the service. People confirmed they could raise any issues they might have so they could be addressed. We saw the complaints file and noted that the registered manager ensured complaints were investigated and responded to according to the provider's procedure.

Each person's care record contained a care plan which documented wishes in relation to death and dying. This was detailed and clear in all the care plans reviewed with instructions on the person's resuscitation status, relevant contacts and any lasting power of attorney details, wishes with regard to hospital admission, medical support and other advance decisions. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records were kept in a separate folder on each unit and all those seen were completed and authorised by a doctor. They had been consistently and correctly referenced in the care plans. Staff could attend funerals and one told us they liked to go and pay their respects and missed the family members who used to visit their loved one at the service.

## Is the service well-led?

### Our findings

At our inspection in August 2017, we identified a breach of regulation relating to the good governance of the service. We had found that the processes for assessing and monitoring the quality and safety of the service provided to people were not always effective. Following the inspection, the provider sent us an action plan to be met by 31 October 2017, which indicated how they would make the necessary improvements.

During this inspection we found that the provider had made some improvements to address areas that needed to be improved such as reviewing people's care plans to make these more person centred and medicines management. However, we also identified some shortfalls that meant the provider had not identified or fully addressed all areas that needed to be improved. These included shortfalls with the deployment of staff, maintaining consistent and accurate electronic records and the provision of personalised activities for all people who use the service, including those who were confined to their bed because of ill-health.

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

We received positive feedback from relatives about the registered manager, one of whom said, "[Registered manager] is excellent. The relative's meeting was very informative and her door is always open." We asked people if they knew who the manager was. We got a variety of answers that covered the registered manager, the clinical lead and the deputy managers. The units for older people on each floor and the younger adults combined units each had a deputy manager who was overall in charge, with unit leaders also in post. The registered manager carried out a walk-around each morning to get an update from the staff on each unit and demonstrated a good knowledge of the people using the service and their various needs and treatments. The daily flash meetings, one of which we attended, were used to keep all the nurses, team leaders and management staff up to date on what was happening on each unit and this was an opportunity for people to provide input and to discuss individual cases and gain feedback from each other.

Staff were positive about the registered manager and felt that she was supportive and visible in the service. Their comments included, "The manager is lovely she comes round every morning", "Managers are very approachable and supportive" and "The manager is always visible and always there if I need anything." Staff were happy working at the service and said people worked well as a team and there were good management systems and a good working environment.

We saw the supervision diary and these recorded that each member of staff had one to one supervision approximately every two months, and this was more frequent if there were any issues highlighted that needed to be discussed and any additional support identified. Staff meetings were held, including unit meetings, daily flash meetings and heads of department meetings and minutes were recorded. Action was taken to address any points raised at the meetings. Some staff did not feel unit meetings had been held although they said they received good handovers from the nurses. The registered manager said she would ensure staff understood the different meetings, which ranged from staff on duty on a unit having a local



meeting to discussing specific issues, health and safety meetings, senior management meetings and care worker and nurse meetings. Minutes of the various meetings were taken and made available to staff to read. We sampled some of the minutes and saw that action was taken to address points raised. There were also meetings for people using the service and for relatives, with minutes recorded and action plans put in place. There was a 'What you said, what we did' poster in the reception showing action taken to address points that people had raised.

The provider carried out an annual survey to people and their representatives to gain their feedback about the service provided. Several people we asked did not appear to be aware of this practice, while others and relatives we spoke with confirmed they had received the satisfaction questionnaire to complete. When we asked people what they thought about the service, some people were positive and their comments included, "We have no complaints, she has everything she needs here, it is great", "Yes, I am well content" and "I think its run pretty well." There were people who felt the service did not meet their needs and wishes, whose conditions had improved and they wished to relocate to accommodation more suited to their current needs. This was an area the registered manager was working on with the placing authorities.

The provider had an auditing and monitoring system in place. Monthly unannounced visits were carried out on behalf of the provider and the assessor had two different documents to follow, so over a two month period all aspects of the service were reviewed. These were comprehensive and the assessor recorded any action points which the registered manager signed off once completed. People's care records were reviewed as part of the 'resident of the day' programme, where a person on each unit was identified to have their care and support reviewed once a month. The deputy managers and the registered manager carried out audits of the care records, drawing up action plans that were signed off once any shortfalls had been addressed. It was acknowledged that work was needed with the software providers to review some aspects of the electronic record system. There were several in-house audits done each month for areas including weight monitoring and wound management and any concerns were also discussed at the daily flash meetings, so they were being reviewed on an ongoing basis and medical input also sought.

The registered manager was on the 'Ealing Change Academy Team', an initiative set up by Ealing Local Authority and the Ealing Clinical Commissioning Group (CCG) to work together with the care homes to provide 'Enhanced Care In Care Homes'. For example, developing better communication between the care homes and the health services including the hospital discharge teams, so discharges to care homes were safe. Also, to agree a protocol for community nurses to provide intravenous antibiotic therapy where appropriate to people in the care homes, to avoid admissions to hospital. Survey questionnaires had been given out to people using the service as part of this and would be returned to the group for analysis so feedback could be used by the group.

The provider reviewed the results of audits and monitoring across all of their services so they could compare them and look for any company-wide trends and take action to improve training in certain areas, for example. They also had quarterly managers meetings and the registered manager said these were used to report any trends and see how best to address them. The registered manager attended the local authority provider forums and registered manager meetings. The registered manager said they were working with the GP surgery on a project to reduce the use of night sedation and had also been involved with other organisations on projects including hydration and developing training materials for dementia care and mental capacity. Two of the deputy managers were undertaking a leadership course being run by Skills For Care. The provider had training sessions for staff for whom English was not their first language to improve their English language knowledge and skills. This demonstrated that the provider was involved with projects to improve the care and treatment provision and to improve the knowledge and skills of staff working at the service.



This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider's systems for assessing, monitoring and improving the quality of the service were not always effective.  Regulation 17(1)(2)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The provider did not always ensure that sufficient numbers of staff were deployed at the service.  Regulation 18(1)