GCH (North London) Ltd

Drayton Village Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook an unannounced inspection of Drayton Village Care Centre on 15 and 16 May 2018.

Drayton Village Care Centre is a nursing home and is part of GCH (North London) Limited. It provides accommodation for up to 91 older people in single rooms. The home is situated within a residential area of the London Borough of Hillingdon. At the time of our visit there were 66 people using the service.

The provider transferred and re-registered Drayton Village Care Centre under a new limited company in May 2017. The location had previously been inspected and was rated Good overall, but this is the first rating for the service since the change in registration.

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

The provider reviewed incidents and accidents and identified actions with guidance for staff to help reduce a possible reoccurrence. Risk management plans had been developed providing staff with information as to how to help reduce risks to people who use the service. Care plans had been updated if a change to a person's support needs had occurred including copies of any referrals to healthcare professionals for further assessment.

Medicines were managed and administered safely with clear processes and procedures in place. People told us they felt safe when receiving care. The provider had procedures developed to respond to any concerns relating to the quality of care provided.

There was a robust recruitment process in place and staff received the training and supervision they required to provide them with the knowledge and skills to provide care to people in a safe and effective way.

We saw there were enough staff on duty to provide meaningful care and support to people in a timely manner to meet their needs but some people and staff felt the service could do with more staff on the first floor unit.

Staff carried out comprehensive assessments of people's support needs before the person moved into the home to make sure they could meet the person's needs. People were supported to eat healthy meals that met their dietary, cultural and religious needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

Staff supported people in a kind and caring manner, with positive and respectful interactions between staff and people using the service and relatives.

The care plans identified the person's wishes as to how their care was provided and were up to date. A range of activities were organised and we saw people enjoyed taking part in these.

The provider had a complaints process and people were aware of how to raise concerns. We saw complaints were investigated and responded to in line with the provider's procedure.

The provider had a range of quality monitoring systems including audits which were used effectively to help improve the quality of the service people received. People told us they felt the home was well led. All staff we spoke with told us that the senior management team was approachable and supportive.

Further information is in the detailed findings in the main body of the 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?

Good

The service was safe.

Incidents and accidents were reviewed and actions identified with guidance provided to staff to reduce a possible reoccurrence.

Risk management plans had been developed providing staff with information as to how to reduce possible risks to people.

Medicines were managed and administered safely with clear processes and procedures in place. People told us they felt safe when receiving care and the provider had procedures developed to respond to any concerns relating to the care provided.

There was a robust recruitment process in place and staff received the training and supervision they required to provide them with the knowledge and skills to provide care in a safe and effective way.

Is the service effective?

Good

The service was effective.

Assessments of people's support needs were carried out before the person moved into the home.

People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

People were supported to eat healthy meals that met their dietary, cultural and religious needs. There were appropriate arrangements to help meet their healthcare needs.

Is the service caring?

Good

The service was caring.

People were appropriately supported with their cultural and spiritual needs.

Staff supported people in a kind and caring manner, and engaged in positive and respectful interactions with people using the service and relatives.

Is the service responsive?

Good

The service was responsive.

The care plans identified the person's wishes as to how their care should be provided and were up to date.

A range of activities were organised and we saw people enjoyed taking part in these.

The provider had a complaints process and people were aware of how to raise concerns.

Is the service well-led?

Good

The service was well-led.

The provider had a range of quality monitoring systems including audits which were used to monitor the quality of the service and make improvements.

People told us they felt the home was well led. All staff, people and relatives we spoke with told us that the senior management team was approachable and supportive.

Drayton Village 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 comprehensive inspection took place on 15 and 16 May 2018 and was unannounced.

The inspection was carried out by two inspectors, a medicines inspector and 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.

The provider had completed a Provider Information Return (PIR) in November 2017. 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 sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with five people who used the service, two relatives of people using the service, the registered manager, the deputy manager, seven staff including nurses, care workers and ancillary staff. We also looked at records, including five people's care plans, four staff records, medicines administration records and records relating to the management of the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe when they received support and care from staff. Their comments included "Yes, they give me confidence, I like to know they are here and it helps", "Yes, it is secure and I choose what I want and the service is excellent" and "Yes, I don't see what could happen to me." Relatives we spoke with also confirmed they felt their family members were safe living at the home. The provider had a clear process to identify and respond to any safeguarding concerns which were raised. During the inspection we saw information relating to safeguarding concerns including investigation notes and statements from staff were kept securely in a folder in the registered manager's office. Information relating to safeguarding concerns was also recorded on the computerised management system which was used to identify any changes in support need or areas for improvement.

A range of risk assessments were completed for people using the service and risk management plan were in place for staff identifying how they could reduce possible risks when providing care. We saw risk assessments in relation to falls, skin integrity, moving and handling, nutrition and oral care. Where additional risks had been identified during the pre-admission needs assessment detailed risk management plans had been developed with clear guidance for staff which included choking, asthma, mental health issues and other life long medical conditions. This meant staff were provided guidance as to how they could reduce the identified risks people faced whilst using the service.

We saw there were enough staff on duty to provide meaningful care and support in a timely manner to meet the needs of the people using the service. We asked people using the service if they felt there were enough staff and in general people said there were enough staff. Relatives also confirmed they felt there were enough staff on duty with one relative commenting "Yes, most of the floor don't need nursing care. There is always someone around."

Some people commented that the service could always do with more staff. People told us "You could always do with more I suppose" and "As an observer, at times they could do with a bit more help." We also asked staff for their views on the staffing levels at the home and in general they felt there were enough staff on duty. One staff member commented "On the first floor the people have more and more complex needs. Don't always have time to do our job. Got a good team." Other staff members told us "I think it's enough staff. We know what to do and can help each other" and "Yes on this floor we have enough staff."

The registered manager confirmed the number of people using the service at the time of the inspection. There were 25 people living in the residential unit on the ground floor, 28 people living in the first-floor nursing unit with 13 people in the second-floor residential unit. We asked the registered manager about the number of staff on duty and he confirmed there was one senior care worker and three care workers on the ground floor during the day with one senior care worker and two care workers at night. On the nursing unit there was one nurse, one nursing assistant and five care workers scheduled to work during the day with one nurse and two care workers at night. The second-floor unit had one senior care worker with one care worker on a long day shift and one on a half day shift. At night there were two care workers on duty. We saw the support needs of each person using the service had been assessed each month and the registered manager

explained the staffing levels were based upon the level of support required in each unit. For example, there were 22 people who required the support of two care workers with personal care in the nursing unit and this was reflected in the number of care workers allocated to this unit. The registered manager confirmed that the number of staff on duty was under constant review and would be adjusted to meet the needs of people using the service.

The provider had clear processes and procedures in place for the administration of medicines. During the inspection we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service. Medicines were stored securely in locked medicines cupboards or trolleys within the treatment areas, and immobilised when not in use. We found that on the residential floors opening dates of liquids, creams and eye drops were not recorded when these medicines were opened. On the nursing floor we found that these opening dates had been recorded. We raised this with the registered manager during the inspection and a labelling system was introduced before the end of the inspection.

Current fridge temperatures were recorded daily each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. This assured us that medicines were stored at appropriate temperatures.

People received their medicines as prescribed. We looked at 19 MAR charts and found no gaps in the recording of medicines administered, which provided assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), warfarin administration records and also topical medicines. These were filled out appropriately by staff except for topical medicines, where we saw that some staff had not signed to say they had administered these medicines. For entries that were handwritten on the MAR charts, we saw evidence of two signatures to authorise this (in line with national guidance), along with people's allergies to medicines that were recorded appropriately. Running balances were kept for all medicines which had a variable dose (for example 1 or 2 paracetamol) and there was a record of the exact amount given.

Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff.

We observed that people obtained their 'when required' (PRN) medicines at a time that was suitable for them. There were appropriate protocols in place which covered the reasons for giving the medicines, what to expect and what to do in the event the medicine did not have its intended benefit.

We looked at the MAR charts for three people who were administered their medicines covertly. We found that they had a best interests meeting and the appropriate authorisation to enable them to have their medicines administered covertly. This assured us that people living at the home were administered medicines covertly in an appropriate manner in accordance with legislation and recommended guidance.

Medicines were administered by nurses or senior carers that had been trained in medicines administration. We saw a member of staff giving medicines to a person and were assured that staff had a caring attitude towards the administration of medicines for people.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a daily and monthly basis. A recent improvement made by the provider included ensuring that all PRN protocols forms were up to date and had been reviewed. This had been identified from a previous medicines audit which had highlighted that not all PRN forms were in place for all residents and had been updated.

We saw a clear process was in place for the reporting and investigation of incidents and accidents. When an incident and accident happened, staff recorded key information such as when and where it occurred, who was involved and if it was witnessed by a member of staff. The registered manager explained that a witnessed fall was recorded as a fall but if it was unwitnessed it would be recorded as the person was found on the floor as they could not confirm how it had happened. The incident and accident forms were reviewed by the senior staff and only signed off once all actions had been completed. For example, it would be discussed with staff if there had been an increase in the number of falls in people's bedrooms to identify actions to reduce possible risks associated with falls. Information was also added to the computerised monitoring system and the records were reviewed monthly to identify any trends such as location or unit.

During the inspection we observed people could reach their call bell when in bed or seated in their bedroom. When a call bell sounded we saw staff responded to it quickly and spoke with other staff on the unit as to why the call bell was used so they were aware of any issues. Assessments had been carried out to identify if a person was able to use their call bell and where they were unable staff carried out regular checks. Most people we spoke with confirmed the call bell was easily accessible with one person commenting "I pressed it by accident once and a care worker appeared in my doorway immediately."

The provider had a robust recruitment process in place to ensure new staff had suitable knowledge and skills to provide the support required by people using the service. The registered manager explained a minimum of two references were requested and the applicant asked to provide a record of their full employment history. Following a successful interview, a Disclosure and Barring Service records check was completed before the new staff member was permitted to start work. During the inspection we looked at the recruitment records for four staff and we saw all the information and paperwork was in line with the provider's procedure.

During the inspection we saw the provider had checks in place to ensure the environment was safe and maintained. Regular checks had been carried out in relation to fire alarms, emergency lighting and water temperatures with certificates to confirm this. Each person had a personal emergency evacuation plan (PEEP) in their care plan folder and in a folder in reception. These plans identified if each person required assistance to leave the building in the event of an emergency and any equipment such as a wheelchair. These plans were regularly reviewed and updated if there had been a change in the person's support needs. A fire evacuation plan for staff was displayed in the main reception area detailing the responsibilities of staff in case of an emergency.

Checks were carried out throughout the day to ensure pressure relieving air mattresses were at the correct setting and working appropriately. Staff were provided with personal protective equipment (PPE) which were easily accessible for example disposable gloves and aprons to be used when providing care. The home was clean with no indication of any malodour and housekeeping staff had a clear system in place to ensure the home was kept clean and tidy. Records indicated staff had completed training in relation to infection control and handling chemicals. During the inspection we saw all cleaning products in the kitchen areas were stored in locked cupboards when not in use and housekeeping staff had sight of their cleaning equipment at all times when cleaning bedrooms and communal areas. This meant the risk of a person

inappropriately accessing these chemicals had been reduced.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of 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 lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures 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.

The provider has systems in place to ensure people using the service were assessed and when required applications under DoLS were made to the local authority. We saw information for each DoLS application was recorded on the computerised monitoring system, This information included when the application was made, if it was authorised and if any conditions had been made as part of the DoLS authorisation. When an application had been made and a delay had occurred in receiving the decision the system identified that the registered manager should chase up the application with the local authority. We saw consent documents had been completed in relation to the use of bed rails.

During the inspection we saw Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in the front of some people's care plan folders. We saw the DNACPR form for one person stated they did not have the capacity to make decisions regarding their end of life wishes. The form had been completed by the GP and signed by a senior member of staff at the home but there was no record showing the person's family had been involved. We asked the registered manager if a mental capacity assessment had been completed for the person and it was confirmed that they did in fact have capacity to make decisions about their care which was not reflected in the DNACPR. This was raised with the registered manager who confirmed a new capacity assessment would be completed immediately and the DNACPR would be discussed with the person and their relatives to ensure it reflected the person's wishes. We saw that was completed by the end of the inspection.

We saw care plan folders included a care plan identifying if a DoLS had been authorised for the person and any conditions relating to how the person's care should be provided. The care plan folders also identified if a relative or representative had a Lasting Power of Attorney (LPA) in place. A LPA can be issued in relation to either financial matters or health and wellbeing and legally enables a relative or representative to make decisions in the person's best interests in the particular area where the LPA has been issued. Where a LPA had been issued a copy of the document was kept in the person's care plan folder for reference.

People and their relatives were involved in the planning of how they wanted their care provided. The

registered manager explained they would try and arrange for the person and their family to visit the home whenever possible including the person spending time at the home and having a meal. If the person was unable to visit the home a senior member of staff would visit the person where they were currently receiving care and a pre-admission assessment would be completed. This assessment included the person's care needs, their medical conditions and their preferences for how their care should be provided. The home also provided the option for respite stays where the person received support for a short, planned stay. The registered manager told us if the respite stay was for less than two weeks they would complete a needs assessment and shorter care plan but if the respite stay was for longer they would produce a full care plan based on the assessment information. During the inspection we saw copies of the pre-admission assessment were included in each person's care plan folder.

Staff completed induction, training and received support to enable them to provide safe and appropriate care. New staff completed a three day induction process which introduced them to the systems used by the home and the people they would be supporting. The registered manager explained the process was being developed to enable new care workers to complete the Care Certificate but at the time of the inspection this was not part of the induction process. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. We saw induction records which had been completed for three care workers and one member of the housekeeping staff, were detailed and had been signed by the staff member to confirm they understood the information.

Staff completed a range of training identified as mandatory by the provider. Annual training courses included fire safety, safeguarding adults, moving and handling, infection control and health and safety. Records showed staff had completed most of the annual training but 26 care workers had not completed the annual refresher session for moving and handling. The registered manager explained a care worker had recently completed a train the trainer course in relation to moving and handling. The outstanding training sessions for care workers had been scheduled by the end of June 2018 and the registered manager confirmed the planned dates following the inspection.

We saw all staff completed regular supervision sessions with their line manager and notes were recorded for these meetings.

The registered manager explained there were four GP practices providing support for people using the service. When a person was visited by the GP or another healthcare professional including the dentist, optician and podiatrist the information from that visit was recorded in the care plan folder and any amendments to the care plans or risk assessment were made. We saw copies of people's optician's prescriptions were kept in the care plan folder.

We asked people their views on the food provided by the home and we received both comments in praise of the food and some which were more negative. These comments included "It's not bad, it gets a bit bland because they don't use enough spice but there is loads to go around", "It is good and yes I have breakfast, a big lunch and a big dinner", "On the whole it is not too bad. It depends on if you like what they are serving" and "Its good, they give us lovely drinks at breakfast and the portions they are mega, too much."

We also asked people about the choice of meals they were offered and their comments included, "Yes we have quite a variation", "To my knowledge there is an option of two meals. I can also have things off the menu for example Chinese food from the shop" and "You've only got two choices, I don't think it's enough." During the inspection we saw staff encouraging and supporting people to eat their meals and drink enough fluids. People confirmed staff supported them during mealtimes with one person telling us "Yes I am never without help."

Relatives we spoke with commented "Yes there is enough [food], sometimes too much. There is a good variety, a choice at every meal. There are staff available if people need them. They are also encouraging" and "Mum has puree but there is always enough. She has a choice to sit in the dining room or she can eat in her room. If she has normal food not puree she will be supervised. She likes her food."

The head chef explained there was a four week menu programme with two menu options per week. We saw an action plan was displayed in the kitchen in relation to one person who had not been eating well with guidance as to how to increase their weight using fortified foods including using full fat milk and cream in food and drink. An information sheet was completed for each person identifying their food preferences, dislikes and any allergies. The head chef confirmed they had completed training in relation to diabetic and pureed diets. Meal options were available to meet people's religious and cultural needs and picture menus were also used to help people choose their meal. The head chef confirmed the activities coordinator carried out regular menu surveys with people to provide feedback on the food choices available and served to people.

People were encouraged to personalise their bedrooms and each bedroom door had a picture that the person liked. There were two lounge areas in each unit which people could access as well as garden areas at the side and back of the building. The signage in the communal areas of the home was clear and helped support people to make their own way around the home.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and their comments included "Oh yes, everybody is so nice and kind, they do everything you want, shopping and hoovering", "Yes, they are excellent", "Yes, they are very good. I don't really need a lot", "Yes they are very attentive, they have a lot to do" and "Yes, it is a good service, I have nothing against them." Relatives we spoke with also confirmed they were happy with the service being provided.

During the inspection we observed a range of staff interactions with people using the service in lounges, corridors and in dining rooms and we saw staff provided care to people in a kind and respectful manner. Staff clearly knew the people they were supporting well and would ensure the care reflected the person's preferences. For example, after lunch the staff knew which people liked to sit in the garden and who preferred to be in the lounge. A staff member also knew one person who wanted to go into the garden felt the cold so they got a cardigan for them before the person asked for one. We also saw staff interacting with relatives and being able to provide clear updates on the family member without having to review the records as they had supported them during the day.

Other staff members we spoke with provided examples of how they helped people maintain their independence during day to day activities. Staff comments included, "People can go into the dining room and make drinks", and "I offered one person tea but they did not want this so I showed then all the options including cold drinks and they enjoyed this instead."

People told us they felt the staff were kind and caring and they said "Yes, they are doing a marvellous job, I can't praise them enough. It is a wonderful place to be", "Because I am quite independent I don't see much of them but I see them from time to time and they are nice", "Mostly yes, they do whatever you ask them to do", "Yes they do their best"

People told us they felt the staff respected their privacy and dignity when providing care with comments including "Oh yes they are brilliant, no problem at all. I know there are times where they are under pressure, but they are here if I need them" and "Yes mostly. You get the odd occasion but I am not being ill-treated." Staff we spoke with demonstrated they understood the importance of maintaining a person's privacy and dignity when providing care and they gave a range of examples including "During personal care I close the door and curtains and aim to do it in the bathroom", "I explain what I am doing" and "I want to make sure the person is comfortable and we knock on doors before we go in to their room."

Staff and the registered manager gave us examples of people who recently had a respite stay and were supported to regain their independence and return home. Staff explained when a person came to the home they identified how they would support them to maintain their independence. The examples included people who had moved to the home with specific medical support or mobility issues such as using a catheter, requiring a PEG tube for nutrition or were able to walk a limited distance with support. A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach through a thin tube that had been inserted through the skin and into the stomach using a special

procedure in hospital. The staff told us by identifying how they could provide additional support for the person to help develop their independence and confidence, those people were able to return home without requiring a catheter and with increased mobility. One person could return to their home overseas with reduced medical support needs following the focused support of the staff at the home.

We asked people if they were supported to maintain their independence and their comments included "I am independent, it's always been my nature. They still do things for us like make cups of tea and take us around", "If I want to go out I just keep them informed of where I am going and how long I will be", "Yes I can do what I like, they bend over backwards for me" and "To a certain extent yes, I have made sure of that."

We asked people if the staff provided support in the way they wanted and they told us "If I have a problem or I am not feeling well they are there straight away. Every day they come and speak to us", "Whatever I need they are there. They do not make an issue. They check with me regularly to see how I am"

Staff members we spoke with explained how they communicated with people who had communication difficulties. which could include. They told us, "We used photographs as a visual aid with one person. One person is non-verbal, I still talk to them", "We speak slowly if it helps the person understand" and "Some of the staff may speak the person's language."

People's religious and cultural needs were identified in the pre-admission assessment and care plan. The activity coordinator explained the home was visited twice a month by a representative from one church and there was also fortnightly communion. They also supported people to attend their preferred place of worship or be visited by a religious representative according to their faith and beliefs. Information was available in people's records about any specific dietary requirements related to the person's religious or cultural needs. People we spoke with told us that if they had any cultural or religious needs these were identified and met by staff. The care plans also identified if the person preferred their care to be provided by either a male or female member of staff of if they had no preference.

Good

Is the service responsive?

Our findings

We saw care plans were kept securely on each unit and included a photograph of the person, the date of admission, the contact details for the person's relatives and their GP, any allergies and if a DNACPR was in place. In each person's care plan folder there were a range of care plans including personal care, mobility, oral care and communication. During the inspection we reviewed the care plan folders for four people and we saw the care plans clearly identified the person's wishes as to how they wanted their care provided. The care plans had been reviewed monthly and had been updated where a change in support needs had been identified. The staff completed a detailed record of care that had been provided for each person during their shift.

During the inspection we saw a summary sheet was in each care plan folder providing an overview of the person's care and support needs. These forms had been completed when the person moved to the home but there was no system in place to identify when they had been reviewed. We raised this with the registered manager who confirmed the summary sheets would be reviewed to ensure they provided accurate information and a review sheet was added to the care plan folder so staff could record when they were reviewed each month.

Where the person or their relatives/representatives had identified their wishes in relation to end of life care this was recorded in the care plan folder. Where a DNACPR was agreed and authorised by the person's GP this was located at the front of the persons care plan folder. A record of all the DNACPRs that had been agreed was kept on the computerised system which indicated when they were due for a six monthly review.

People we spoke with gave a mixed response when asked if they knew how to make a complaint with some people telling us they did not know how to raise a concern but other people were aware of the process. Their comments included "Never made a complaint but I would just ignore anything I didn't like" and "I wanted to make a complaint about an incident with a resident but I didn't because I felt it would be selfish because he couldn't help it." Relatives told us "No [I have not made a complaint], but I would go to the ladies in charge of the floor if not them then the manager, but things are resolved quickly", and "Never made a complaint, if she [family member] needed to she would wait until the manager comes around in the morning." Information on the complaints process was displayed around the home and was also included in the service user guide booklet which was given to people when they moved to the home. During the inspection we saw a flow chart was provided for staff at the front of the complaints folder showing the step by step process for responding to any complaints in line with the provider's procedure. We saw one complaint had been received during the last year and the records included correspondence, records of discussions and the outcome which showed that eventually the complainant was happy with the outcome.

During the inspection we saw people were enjoying the activities and interaction with staff. We asked people for their views on the activities available at the home and they told us "I don't get involved. I do a lot of thinking and reading. If someone asked me to I would otherwise I don't", "I don't because of my bad legs. It's not my scene. Nothing to do with them, I am just a different individual. I think it is brilliant here. But I play board games, I go in the garden and brought plants for the garden. I do sudoku, crosswords and reading"

and "I really enjoy some of the activities like being in the garden." Relatives also commented "My family member does some, she has only been here a few months. The staff are very good at getting her involved in other activities" and "My family member does not join in but she is always asked." During the inspection we saw people taking part in activities in the home and outside in the garden. When activities were taking place away from the home the staff provided both one to one and group activities in the units. The activity coordinator explained there was an activity programme during the week which included cognitive therapy sessions, visiting the hairdresser who came to the home and visiting a local day centre for people who were more mobile. The home was also visited by a representative of Disablement Association Hillingdon who ran sports based exercise sessions using football and golf. They also ran monthly reminiscence sessions using memory cards and music. There were visits to the local areas which were organised by the activity coordinator. We saw a range of theme days were organised for people's entertainment and enjoyment including a royal wedding garden party for the day following the inspection, St Valentine's day country and western party, St Patricks day and national pizza day where people could try different types of pizza prepared by the catering staff.

Good

Is the service well-led?

Our findings

The provider had a range of systems in place to monitor the quality of the service provided at the home. The registered manager explained a computer monitoring system was used to collate and analyse information from the audits and checks completed across the home. We saw information relating to care plan audits, safeguarding concerns, incidents and accidents as well as the number and outcomes of complaints and compliments received. For each area of information there was detail of any outcomes and action plans developed. The registered manager told us he met with the regional manager each week to discuss the progress on the various action plans. The regional manager told us they also met weekly with the chief operating officer for the provider to discuss progress on the action plans for all the homes within their remit.

Business improvement plans had also been developed for a range of areas including health and safety, maintenance, estate management and hospitality. The registered manager told us they encouraged staff to make suggestions on how to improve systems used in the home. For example, catering staff had identified an issue with the weekly deliveries of bread and milk where the use by dates did not last until the next delivery so food was wasted and additional supplies had to be purchased. They suggested the home moved to a twice weekly delivery to reduce waste and ensure fresh bread and milk was in stock.

People we spoke with told us they felt the home was well led with their comments including "He [registered manager] is fantastic! He comes over every day, asks how I am and shakes my hand. I can't praise him enough" and "They are brilliant. The registered manager walked past and checked on me to say Hi, he heard I had been in the hospital." Comments from relatives also confirmed they felt the home was well led with comments including "Very impressed. This was the first place we had looked at and we did not look any further" and "They [registered manager and deputy manager] are both lovely."

The view that the home was well led was also reflected in the comments made by staff we spoke with. They said, "The deputy manager working on the first floor has made a difference, staff are more relaxed", "The registered manager walks about the home and checks that everything is OK", "Yes, everyone does a good job. People and relatives benefit from good service. We are one big family, everyone gets on and any issues are dealt with" and "The manager is visible and the service is well-led. We are here for the residents." One staff member did identify that they felt the home was well led but additional support was required on the first floor unit "Yes, but not enough staff on the first floor. High needs and staff rushing around."

People using the service and relatives were supported to provide feedback on the care being provided at the home. The registered manager confirmed a questionnaire had been sent to people and their relatives in March 2018 and the completed forms were being analysed at the time of the inspection. The questionnaires included questions on dignity, care, choice, the environment, meals and activities. We looked at the completed forms which had been returned to the home and the majority of the responses were positive. In addition, there were regular meetings for people living at the home and their relatives to give feedback on the service and make suggestions for improvements.

There were monthly meetings for ancillary staff, care workers and nurses and notes were taken of each

meeting and circulated to staff. Staff we spoke with confirmed they attended regular staff meetings. When we asked them about the meetings they told us "We can speak up and share ideas", "Yes, we meet monthly, if I have anything to say I am sure I am listened to" and "Hard sometimes to speak up in a large team meeting."

Staff told us they felt supported by the senior staff at the home and their comments included "Yes, I do, the manager supported me through a difficult period", "The manager is very good and will offer advice", "Yes, they are approachable. If I have problems they will help" and "Yes, I feel supported. First time I've had a manager I can talk to. He listens, knows people's needs. Here all the time, the office door is always open"

The registered manager told us they kept up with good practice by attending regular provider forum meeting run by the local authority and reviewing websites including NHS and social care publications. The home also actively took part in initiatives run by the local authority and clinical commissioning group (CCG). These included a falls awareness programme and the red bag system. The red bag system helps to improve communication between nursing homes and hospitals when people become unwell. If a person becomes unwell and needs to go to hospital staff would pack a specific red bag including paperwork, medicines as well as personal items and clothing for them to use in the hospital and when they are discharged back to the home.