Care UK Community Partnerships Ltd

Lennox House

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 30 and 31 August 2017 and was unannounced.

The last inspection was carried out in January 2017. The overall rating for the service was inadequate. We found the provider was in breach of Regulations 12 (safe care and treatment), 13 (safeguarding) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was placed in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During our comprehensive inspection in August 2017 the service demonstrated to us that improvements had been made and no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Lennox House is part of the Care UK Community Partnership Company. It provides residential care and nursing care for up to 87 older men and women at purpose built accommodation in a residential area of North London. The home is divided over four floors. On the ground floor intermediate care is provided for a maximum of twelve people. Residential care for people using the service who do not require nursing care is provided on the first floor. Nursing care is provided on the other two floors. At the time of our inspection there were 68 people living at the home.

The home did not have a registered manager in place. 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. An interim regional manager had been appointed.

We found that the registered provider had made improvements in their quality monitoring systems. They had received support from the local authority and this was continuing at the time of the inspection. It was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time, including when support from the local authority is withdrawn.

Although, we saw some improvements, there had been a lot of input from the local authority. We were concerned about the length of time taken to address the concerns raised at the last inspection. However, recent developments such as the appointment of a new clinical leads, interim manager and new permanent staff had helped. However, we still received some negative feedback from some people using the service and some relatives about staffing and activities.

The provider has acknowledged this is work in progress. We saw evidence there was an active recruitment drive and a number of new staff had been appointed.

Overall, there was evidence risks to people had been identified, assessed and reviewed. The home had improved how it managed accidents and incidents, including falls.

Whilst we noted, that best interest meetings had been held with relatives and relevant health and care professionals for some people, this had not been consistently applied. We saw that the service did not always meet the requirements of the Mental Capacity Act 2005 in supporting people.

Improvements had been made in supporting people to meet their nutritional needs. People were able to make choices about the meals and drinks they wanted.

People were supported to meet their health care needs and had access to a range of external health care professionals.

Improvements had been made in ensuring people's privacy and dignity were respected. Staff cared for people in ways which recognised people's rights to make their own decisions. People's privacy and dignity were respected.

We saw positive interactions between staff and people. Staff knew about people's needs and interests.

People's religious and cultural needs were now being met. People were supported to worship if they wished to. Representatives of local churches visited the care home regularly for prayers with people. Where people could visit their preferred places of worship, we saw that this was supported.

People's needs were assessed and there were care plans and risk assessments in place. The care plans provided guidance for staff to follow.

There had been improvements in people's activities. However, further improvements were still required. Whilst we saw evidence the home was working to provide meaningful activities to people, progress had been slow since our last inspection.

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 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?

Requires Improvement

The service requires improvement.

We found that action had been taken to improve the safety to people who used the service. However, improvements were still required, to ensure people at risk of developing pressure ulcers and falls always received safe care.

People received the medicines they were prescribed and staff had received relevant training to ensure they administered medicines safely.

There was a high turnover of agency staff. However, there was an active recruitment drive and a number of new staff had been appointed.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

While improvements had been made, we could not improve the rating for Safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found that action had been taken to improve people's nutritional needs.

People had access to a food and drinks. People could choose what they ate.

There were gaps in the records to show evidence how the service was meeting their obligations under the Mental Capacity Act 2005.

People were supported by external healthcare professionals who provided staff with guidance.

While improvements had been made, we could not improve the rating for effective from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service caring?

Requires Improvement

The service had made improvements in caring for people.

We found that action had been taken to ensuring people were treated with dignity and respect.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs.

People were supported to be actively involved in choices around their care. Their religious and cultural needs were now supported.

While improvements had been made, we could not improve the rating for caring from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Further improvements were required to ensure people were enabled to access meaningful activities. We have made a recommendation regarding arrangements and provision of activities to people.

People were involved in their care plans, and when people's needs changed, staff responded to ensure they received the appropriate level of support

People's records were personalised and centred on their needs and choices. These records documented detailed information about how people preferred staff to deliver their care.

There was information about how to make a complaint. This was made available for people and their relatives. People knew how to make a complaint.

While improvements had been made, we could not improve the rating for responsive from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had started to make improvements in their quality monitoring systems. However, these needed to be tested over time before we could be assured of their effectiveness in sustaining improvements.

The service did not have a registered manager. Three managers the provider appointed had left the service in the previous two years.

The service had begun regular and thorough audits of the service.

Improvement plans were in place and some action had been taken.

While improvements had been made, we could not improve the rating for well-led from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Lennox House

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.

The inspection took place on 30 & 31 August 2017 and was unannounced.

On the first day the inspection team consisted of two adult social care inspectors, a bank inspector, a specialist nurse, a pharmacist and two experts by experience. An expert by experience is someone who had personal experience with this type of service. The expert's area of expertise was people living with dementia and older people. On the second day the inspection team consisted of two adult social care inspectors, a bank inspector and a specialist nurse.

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 also reviewed the information we had about the service such as statutory notifications. We contacted the local Clinical Commissioning Group and the local authority commissioning and safeguarding teams to ask for their views of the service.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We spoke with seven people who lived at the home and eight relatives. We also spoke the interim manager, a regional manager, deputy manager, regional clinical lead, three nurses, eight care workers, regional chef and tissue viability nurse. We observed the meal service at lunch time and observed people being supported in the communal rooms. We looked around the home. We looked at care records of nine people and looked at other records relating to the running of the service recruitment files for nine staff, accident and incident

records, Deprivation of Liberty Safeguard records (DoLS), safeguarding records, auditing which had taken place and all records relating to the health and safety of the building.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2017 we found the service was not safe and we rated the provider as 'Inadequate' in this key question. We found risks to people's health and safety were not safely managed. This was because systems were not in place to ensure people received their medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely. We saw that the temperatures of the storage areas were recorded regularly, but staff did not correctly record the maximum and minimum temperatures of the refrigerators on any of the floors. The service has since provided training to staff to ensure fridge temperatures are monitored and recorded accurately.

The medicines administration records we looked at included allergy information and a photograph of the person to make sure they were correctly identified. Staff had completed the records to show that medicines were administered regularly. Additional information was recorded to help staff administer medicines in the way that each person preferred, for example one person needed prompting and encouragement to take their medicines.

Some medicines were prescribed to be taken when needed, for example for pain. We saw plans were in place to guide staff on what the medicines were for and how much to give, and we saw that administration was clearly recorded.

At our inspection in January 2017 we reported that the home had undergone a prolonged period of uncertainty due to staffing shortages. At this inspection we found there were still ongoing staffing issues but the service was in the process of addressing this. We spoke with the deputy manager who confirmed that the service was currently short staffed with vacancies for five nurses and six care workers. These vacancies were currently covered by agency staff. At this inspection, there were four agency staff nurses covering shifts across the service. We asked the deputy manager how they calculated the number of staff required. She told us they used the Clifton Assessment Procedures for the Elderly. This is an assessment tool designed to assess the dependency levels in the elderly, to give an indication of current met and unmet needs. The deputy manager told us that staff allocation was based on this. The tool flagged up areas for changing staffing levels. For example, there were some people who were on one to one because of their dependency levels.

We received mixed feedback from staff regarding staffing levels. Whilst some staff felt there had been improvements, others told us the home used a lot of agency staff. A staff member told us, "Some days we get new agency staff. It's like working all over again. You have to go through policies and procedures with them." Another staff said, "We do not have time to spend with people." A third staff member said, "Permanent staff would be better."

Equally, relatives had expressed concerns about the high turnover of agency staff. Their comments included,

"There is too much agency staff", "Agency staff must read care plans so that they understand [people's] requirements", "The communication between permanent and agency staff is poor" and "Permanent staff are stretched."

We saw from the minutes of relatives' meetings that the issue of agency staff had been a long standing concern of relatives of people receiving care. This included the meeting that was held in September 2017. Whilst these concerns were valid, we saw that improvements were being made. There was an active recruitment drive and a number of new staff had been appointed with more staff in the recruitment pipeline. This included two clinical leads who had been appointed just prior to this inspection. The interim manager told us, "We have a good pipeline, but they can't start employment, until they are compliant in terms of safe recruitment." We noted this to be the case.

We observed care and support on the three floors. Although staff were busy, we found people's needs were met. For example, we observed the lunchtime arrangements on the first floor. There were16 people in the dining room who were attended to by six staff. There were two people who had one to one support with eating and drinking. We saw this was carried out carefully and with patience. People were given time to eat their meal.

Safe recruitment procedures were in place. This ensured all pre-employment requirements were completed before new staff were appointed and commenced their employment. At least two references were in place for all staff. A Disclosure and Barring Service (DBS) check had been completed prior to staff commencing work. We also saw checks had been undertaken to ensure nurses had a current registration with the Nursing and Midwifery Council (NMC).

Risks to people had been identified, assessed and reviewed. These covered a range of areas, including falls, behaviours that challenged the service, nutrition and hydration, diabetes, and pressure ulcer management. The assessments described measures to be taken to ensure people were safe. For example, people at risk of developing pressure ulcers had been assessed by a tissue viability nurse (TVN) and a plan of care put in place. We observed one person with a pressure ulcer. We saw appropriate planning around dressings, the use of an air mattress, weekly photographic evidence, repositioning regime, importance of good levels of hydration and nutrition and use of topical creams.

We found that strategies were in place where people were identified as being at risk of falls. For example, a FRASE (Falls Risk Assessment Scale for the Elderly) form had been completed as an important part of a strategy for the prevention of falls. The assessment assigned a score to highlight the level of risk. A FRASE score of 13 is considered high risk. We saw a range of interventions, including bedrails, and floor mats depending on the assigned level of risk.

However, we identified that the management of people at risk of falls were not always consistent. In one example, we saw that the service had not taken effective action to reduce risk to a person known to be at risk of falls. The FRASE score of this person was 14, meaning at high risk of falls. The care plan of the person highlighted a history of multiple falls in the home. It stated the person was unsteady on their feet, and required one person to supervise when mobilising. The accidents reports showed this person had 13 falls within the home since January 2017. The person had sustained various injuries during these falls, several of which had resulted in emergency admissions at a local hospital. Whilst there was evidence that the service had taken some actions, these had not been effective. The risks to this person had not been adequately assessed. There were no clear measures in place to minimise them.

We would have expected decisive actions to have been taken to minimise the risk of further falls given this

person's long and well-documented history of falls whilst at the home. We expressed concerns about current interventions. On the second day of this inspection we saw that action had been taken. The person was placed on one to one supervision and a 'chair and bed sensor' was recommended as 'a good option for the person to maintain their safety'.

We also found examples of where risks had not been managed well in relation to pressure equipment used to reduce the risk of pressure sores. Settings for pressure mattresses had not been set at the correct levels. This meant the mattresses were too firm and could have been a contributory factor in the development of pressure ulcers. We found this had been raised a few weeks prior to our inspection but no action had been taken. The issue was discussed during CQC feedback at the end of this inspection. We recommended a system to be put in place to ensure all staff knew how to identify if the mattress setting was correctly positioned.

The above is evidence of a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in January 2017 we had issued a warning notice for a breach of Regulation 13. This is because the service was not consistently reporting concerns about abuse to responsible authorities. At this inspection we found people who used the service were protected from the risk of harm and abuse. There was a safeguarding policy and procedure together with contact details of the local authority. Staff were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, the local authority or Care Quality Commission (CQC).

Records and observations showed that one to one care was now being provided to people who displayed behaviours that challenged the service. At this inspection we saw that two people who required one to one care were receiving it. We observed staff monitoring each person and they could do this discreetly, even if the person did not require or want the member of staff to engage with them. They remained close enough to intervene if any inappropriate behaviour was displayed. Care staff recorded their observations and the activities of the people they were observing at regular intervals. This ensured people remained safe.

We checked the communal areas of the home which were all clean and well maintained. Domestic staff were employed and covered a rota for the entire week. We spoke with the housekeeper regarding the suitability of domestic arrangements. This person told us that they had "a good team" and that they worked well at keeping the home clean and free of odour, which we noted during our inspection. We looked at an internal infection control audit that had been carried out in August 2017. This audit noted areas of good performance as well as an action plan to address any shortcomings and improvements needed. Other audits had recently been completed by a regional clinical lead who was supporting the home at the request of the provider. The clinical lead told us that there was an infection control 'Champion' who is the housekeeper.

We saw evidence there was a clear process in place for reporting and dealing with incidents and accidents. Records showed all incidents were logged and discussed at management meetings. The reporting process involved, completing a form, sending an alert to the regional manager, reviewing of the alert and then if required actions added by the home. The home undertook a reflective practice for each incident to ensure continuous learning.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in January 2017 we identified concerns around meeting people's nutritional needs. At this inspection we found that improvements had been made.

We observed lunch time at the home. We found a pleasant atmosphere with people provided with an appropriate mix of supervision and assistance where required. The meals were served in a calm manner and people were able to choose whether they wanted to eat in their room or go to the dining room if they preferred.

People were offered choices and were presented with "show plates" in order to help them to make a choice about what they wanted to eat. Show plates are plates that have a small amount of food on them so that people can visually see what the choices were. Staff also took time explaining what meals were on offer. Where people had specialised diets, either by choice or due to dietary needs, we saw these were catered for. There was a choice of rhubarb and custard or peaches and cream for pudding and again this was presented to people for them to choose.

Menus were displayed in the dining area and were reflective of the food that was served. Allergen information was also provided to the kitchen staff. Food looked appetising and was served hot. People ate well and were seen to be enjoying their food.

People told us the food at the home was nice and that they choose from an option of three meals each day. One person told us, "Food is nice, you choose what you want." Another person said, "I am a vegetarian and there was not much choice for me before. Now they give me a bowl of fruit every day and a decent vegetarian meal." A third person said, "We get breakfast and lunch. We get three choices of food." We spoke with one person who had finished their meal and she told us "I really enjoyed my food."

However, this was in contrast to some feedback from relatives. Whilst some relatives were pleased with the quality of food, others had reservations. Minutes from relatives' meetings had raised concerns regarding cold food being served and presentation of the food not being appetising. The manager advised that she was instructing staff to serve smaller portions and then offer second helpings to prevent food from getting cold. Other relatives thought there had been some improvements at the service. One relative told us, "I think [my relative] gets plenty of food and [the regional chef] has come in and is sorting it out." Another relative said, "Things are improving. The food is much better."

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. We found the service was not always meeting the requirements of the MCA in respect of decisions made for people using the service.

Whilst we noted best interest meetings had been held with relatives and relevant health and care professionals for some people, this had not been consistently applied. The requirements of the Act had not been followed in two examples. We reviewed the care plan of one person, which showed they were being given their medicines covertly (hidden in food or drink). However, the person did not have their capacity assessed for this aspect of their care. The service had not involved relevant people in the decision as to whether it was in the person's best interests for their medicines to be administered covertly. Following our inspection we received evidence that the necessary capacity assessments had been carried out.

We also saw that one person had been enrolled in a clinical trial by the local NHS mental health trust. Trial medicines were administered by nursing staff, hidden in food or drink in the same way as other medicines prescribed to the person. However there were no records to show that the service had made the appropriate checks before undertaking to administer these medicines. For example, the clinical trial consent form had been signed by a nurse working for the service but there was no record to show that the person or their relatives had been consulted. There was no record to show that the provider had consulted the clinicians running the trial about the decision to administer the medicines covertly. The service was not able to show that they had involved the appropriate people in determining whether it was in the person's best interests for them to administer the clinical trial medicines.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

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 to see if 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.

We also checked whether any conditions on authorisations to deprive a person of their liberty were being met. We saw from records that 39 people who lived at the home were subject to a DoLS authorisation. We also saw evidence a further six had been applied for and were awaiting review by the local authority.

Staff completed an induction using the Care Certificate framework before starting work. The Care Certificate is a method of inducting care staff in the fundamental skills and knowledge expected within a care environment. Staff had completed their induction and we saw that new staff were enrolled on the programme.

We reviewed training records and we saw that staff had completed essential training. Future training and refresher courses had been scheduled for 2017. Training included health and safety, infection control, safeguarding, manual handling and medicines management.

We also asked relatives if they thought staff were suitably skilled and knowledgeable about the care people required. One relative told us, "I think regular permanent staff are skilled, but there are a lot of agency staff [who are not so good]." Another relative said, "Things are improving.

Staff had not consistently received supervision and appraisal. This inconsistency was noted between January and August 2017. The deputy manager told us this was as a result of absence of managers. The deputy manager had recently returned to the home following a three-month break. We also saw that two clinical leads had recently been appointed. The deputy manager told us the regular supervision could now commence. We received a supervision schedule from the home manager to show the service had planned to

carry out regular supervision with staff.

People told us and records confirmed that they received support to see their GP and other relevant healthcare professionals. One person told us, "I have regular appointments at the hospital which I attend." Another person said, "The GP comes to the home every Monday and Thursday for any emergency issues with [people]." A third person said, "Course [staff] look after me, no complaints, very happy here. If I am unwell, I would tell staff and they call the GP."

Care records provided evidence people's healthcare needs had been assessed by the service. Care delivery was co-ordinated with a range of external healthcare professionals which included GPs, tissue viability nurse specialists, psychiatrists, chiropodists and district nurses.

Requires Improvement

Is the service caring?

Our findings

Our inspection in January 2017 found the registered provider was not meeting the regulations in regard to ensuring people were always treated with dignity and respect. At this inspection we found that improvements had been made. However, we could not improve the rating from 'requires improvement' because to do so requires consistent good practice over time.

We asked relatives if they thought the service was caring. Their comments included, "Permanent staff are caring. They know [my relative]. They know [my relative's] foibles and preferences. My relative often smiles at them which shows [my relative] thinks staff are caring", "[Things] have become better at the home since the previous [CQC] inspection, but there have been more agency staff", and "Staff seem to try their best."

Generally people told us care staff were kind. Their comments included, "Oh certainly", "I am very happy here", "I have not found anything wrong to worry me", "Staff are caring and I don't find any difficulty with them", "Yes they are respectful" and "Yes staff are very kind, I respect them and they also respect me."

At the last inspection in January 2017 we found that the home was not meeting people's religious needs. A relative had reported that their loved one was not supported to attend church. At this inspection we found people's religious and cultural needs were now being met. People were supported to worship if they wished to. Representatives of local churches visited the care home regularly for prayers with people. Some people were supported to visit their places of worship. There was a prayer room on the third floor of the home. The room contained three comfortable armchairs. We saw a Quran, Hebrew bible and a book of New Testament Psalms. The room was very quiet and peaceful and well-lit with four skylights in the roof and prayer candles that people could light.

At our last inspection we found that staff did not engage with people positively. At this inspection we saw that staff spent a lot of time talking with people and listening attentively to what people had to say. Staff spoke with people in a friendly way and gave people time to respond. For example, people were given a choice of meals. We saw staff presenting two plates of food to people who had forgotten what they had chosen, for them to choose the meal they wanted. We observed that people were assisted closely by staff. People were also asked if they had finished their meal, and those who were still eating were given time to eat their meal.

People's privacy and dignity were respected. When we spoke with staff they explained the importance of ensuring that people's privacy was protected. They told us that they would knock on doors before entering people's bedrooms, which we observed during the inspection. People could stay in their rooms if they preferred privacy. Previously people wore aprons or bibs when being assisted by staff at mealtimes, but this had been changed to napkins, which were more dignified.

We saw staff promoted people's independence where appropriate. For example, the provider had initiated a programme called "dining with dignity". This programme included practical measure such as obtaining specially adapted cutlery and crockery to enable people to eat independently. People with dementia were

provided with specifically coloured crockery to help them orientate towards being aware that they were having a meal and this encouraged them to eat.

The home ensured people received compassionate and supportive care when they were nearing the end of their lives. The interim manager told us that when a person's general health deteriorated discussions were held with other members of the multi-disciplinary team (MDT) on a monthly basis. The MDT included a GP, geriatric consultant, psychiatric nurse, consultant Psychiatrist, staff and relatives. During this meeting, DNACPR status, preferred place of care, treatment escalation plan and medication review were discussed. People were then referred to a palliative care team for assessment and advice regarding required medicines. This meant up to date healthcare information was available to inform staff of the person's wishes to ensure their final wishes could be met.

We observed that personal information was stored securely in locked cabinets. Relatives and people told us their permission was sought before their confidential information was shared with other healthcare professionals and we saw this documented in care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act 1998.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2017 we found a lack of meaningful activities and an out of date activities programme. At this inspection we saw that improvements had been made. However, further improvements were required.

We saw that there was an activities action plan in place. This had been shared with relatives. Two extra activities coordinators had been recruited in addition to one who had been working at the home for the past year.

During the day we did not observe many activities. A member of staff showed us a notice board in the dining room, which listed activities for each day. Activities included, newspaper reading, a visit by a hairdresser, hand massage, pampering and bingo. We observed that there were newspapers in the lounge. One member of staff told us that one person attended the hairdressers every Wednesday.

People told us about the activities they participated in. One person told us, "I am happy sitting watching TV so long as my bedroom is clean I am happy". A third person said, "I play dominos and so on." A fourth person told us, "I like to read my books and watch my favourite programmes on TV". A further person told us, "Islington library comes in every two weeks and bring books, they also gave me this CD player and I borrow classical CDs that I listen to". This person went further to tell us, "A friend comes once weekly for a meditation session which I have been doing for the past 15 years, and she will bring a week's supply of the evening news. Sometimes one of the cleaning staff will bring me a newspaper".

We received mixed messages from relatives regarding the availability of activities. We asked relatives if they thought people got to do activities they wanted to do. One relative told us, "I do not think there are enough activities." Another relative told us, "They used to do a lot of activities and then there was a slump. Now things seem to have improved. They have three activities coordinators." Minutes of relatives' meetings highlighted that relatives did not feel there were enough activities taking place. One relative had commented 'her father just lies in bed all day with no stimulation'.

We recommend that the service seeks advice and guidance from a reputable source regarding activities for people receiving care.

We saw person centred care in other areas. The care plans were person centred, with attention to areas such as, clinical conditions, care needs based on risk assessments, dietary needs, and personal preferences, behavioural issues, moving and handling requirements, PEEPs, and end of Life requirements. These records documented detailed information about how people preferred staff to deliver their care. Risk assessments were also in place and reviewed regularly. Room records were available for each person. These contained information such as hourly welfare records checks, daily oral care, bath/shower and water temp record, tropical medicines, and mattress cleaning record. Staff advised us that any changes to care plans were communicated in handover and updated within the communication book, which we evidenced.

Care plans were developed following assessments of people's needs. The care plans outlined how these needs were to be met. For example, one person displayed behaviours that challenged the service. We saw there was a standard DoLS authorisation in place with conditions and a referral had been made to the community mental health team. We also noted the home was exploring possibilities of assistive technology to manage wandering at night. This person's care plan was regularly reviewed. Where changes had been made this information had been shared with the relevant staff. This meant staff had access to the latest information about how people should be supported.

There was a complaints procedure in place. This set out how people's complaints would be dealt with. People said they knew how to make a complaint about the service if needed. One person said, "I would go to the office and find the head nurse or manager" - "I would bring to their attention anything untoward with me or any other resident". There was a process for managers to log and investigate complaints including, recording actions taken to resolve complaints.

Relatives' meetings had taken place in April, June and August 2017. Relatives challenged the provider about making improvements and expressed their own concerns about the care of their relatives in the home. We saw that their concerns had been taken on board. An action plan that had been presented by the service to the local authority has been shared with relatives. We saw evidence the service, with support from the local authority, was implementing this action plan.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in January 2017 we found that the registered provider did not operate effective systems to monitor the quality and safety of the service. As a result, we required the provider to make improvements in their quality monitoring systems. At this inspection we found that the provider had started to make improvements.

Whilst we were reassured with current improvements, we were concerned about the length of time taken to address the concerns raised at the last inspection. For example, the home had continued to be inconsistently managed. The registered provider is required to have a registered manager as a condition of their registration. Since the previous registered manager's departure in August 2016, the home had been managed by four operational support managers supplied by the registered provider on a temporary basis. This has been a constant source of concern to people receiving care and their families.

Following the last inspection, the provider had recruited to the manager's post in April 2017. However, following our last inspection in August 2017 we have been notified by the service that the new manager had left. The home was being managed by interim managers supplied by Care UK. This meant the home did not have a person who has registered with the Care Quality Commission to manage the service. We are looking at this further.

We asked people receiving care what they thought of the management of the home. Whilst some commented positively about the new interim manager, others had reservations. Their comments included, "It is very difficult to understand the management structure, you go into the office and do not know who you are talking to, whether a manager, head nurse or administrator." Another person said, "The management [provider] is not good because there are too many changes. There has been four managers since I have been here, but they don't stay."

People's relatives acknowledged there had been some improvements, but expressed concerns over the speed and other matters of the management of the home. Their comments included, "They are slowly trying to improve things but it is going to take some time for the home to change", "Why does the home not have a registered manager for almost two years", Communication is a big issue. They do not answer the phone", and "The communication between agency staff and permanent staff is not great. They [staff] do not pass information when they have agency staff coming."

We noted similar themes emerged in the recent 'residents' and relatives' meetings. For example, in the meeting held on 29 August 2017 relatives expressed concerns about the use of agency staff. They reported that they had seen agency staff not following procedures. Following this inspection, the interim manager informed us the service was now scheduling supervision for agency staff. The service had also made arrangements agency staff to attend a three day induction before commencing work with the home. This was a recurring theme in a similar meeting held on 26 September 2017. However, the service had started to promote an open and inclusive culture which welcomed and took into account the views and suggestions of people using the service and their relatives.

The new interim manager had significant relevant experience in health and social care. She worked for Care UK for the last 5 years and had managed with success two other homes for Care UK. She had worked for Care UK as an operational support manager for the last three years. People and their relatives had described the manager in complimentary terms, including 'approachable', and 'supportive'. Similar descriptions were used by staff. A staff member told us, "The organisation is moving in the right direction." Another staff said, "The manager is approachable. We need to give her time."

We found the interim manager to be well-informed about the issues at the home. Even though she had only been in post for a few weeks, she was familiar with important operational aspects of the home including the improvement programme of the home. She spoke knowledgeably about people's needs. She acknowledged there was on-going work to ensure the service continued to improve.

Following the last inspection January 2017 the home had made some improvements to their systems to monitor the quality and safety of the service. We saw that a detailed improvement plan had been developed with input from the local authority. This was based on a range of audits, including medicines management, infection control, nutrition, pressure ulcer management, and health and safety.

The issues identified in the last inspection had been highlighted within the improvement plan and action had been taken to address shortfalls. For example, more permanent staff had been recruited. At our inspection in August 2016, we had identified a breach of Regulation 18 of the CQC Registration Regulations 2009 as the provider was not notifying significant incidents as required. At our inspection in January 2017 we had found two incidents that had not been reported, however, since that inspection incidents had been reported as required.

Staff told us regular staff meetings were held and we saw the dates of future monthly meetings. We also saw the service had introduced 'flash meetings'. This was a short meeting, lasting not longer than 30 minutes, designed for sharing information specific to care needs of people. For example, recent increase in urinary tract infections was discussed and staff were asked to monitor fluid intake closely to minimise risk. The flash meetings had been introduced in early 2017 in order for a representative from each department, including catering, housekeeping, activities coordination, maintenance and senior management (internal management) to attend. This provided a further opportunity for quality issues and the findings of audits to be discussed.

Monthly visits were carried out by a representative from the provider's head office to speak to people and the staff regarding the standards in the home. Reports showed they also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, social activities, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. However, there were no significant changes such that the local authority felt the need to be actively involved in ensuring improvements were made.

Although we were reassured that current interventions were proactive, it was not clear, how the home would sustain improvements once the current support had ended. The local authority was providing support on a weekly basis. Furthermore, Care UK had sent interim personnel, including nurses. We spoke with the interim regional clinical lead deployed by Care UK who informed us their support would not end until they were satisfied that the two newly appointed clinical care leads were fully inducted to the home.

We concluded that improvements had started to be made to relevant areas of the service since our last inspection. However, it was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time.

We have rated this section requires improvement for the following reasons. Although there have been improvements our findings are that the improvements have come about because of the combined input from the provider and the host local authority. The LA has allocated staff to visit the home weekly, provide support and developed and overseen an improvement action plan. Recent appointments by the provider of the clinical leads and the interim manager have helped to improve the service as well. The LA continues to provide support and staff input to drive improvements. We did not identify matters that amounted to a breach of Regulation 17, which covers the governance arrangements, but we have rated this section as requires improvement because there are still improvements needed to the governance arrangements. We need to see a track record of provision at the service that is good and the provider needs to make sure that it can do this on its own, without the need for extensive local authority support.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service was not always meeting the requirements of the MCA in respect of decisions made for people using the service. There was no documentation to demonstrate consent was always sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to some people had not been adequately assessed. There were no clear measures in place to minimise them.