MMCG (2) Limited

St Johns Wood Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Johns Wood Care Centre is a nursing home which provides nursing and/or personal care for up to 100 people and at the time of this inspection there were 73 people' using the service. This is predominantly older people but there is a specific unit within the home providing a physical disability service for up to fifteen people. Fourteen were using that part of the service at the time of this inspection. Each person has their own bedroom and there are communal lounges and dining areas on each of the five floors of the home.

This inspection took place on 25 and 26 July 2018 and was unannounced. This is the first inspection of the home since the provider, MMCG (2) Limited, took over as the provider of the service in July 2017. We found that the provider had implemented oversight systems for monitoring of the performance of the service. These processes had not, until recently, picked up on all changes and improvements that needed to be made. These matters were being addressed but progress had been slow to begin with but was now gathering pace.

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

Risk assessments associated with people's day to day, and personal, risks varied widely in terms of how they were completed and the information about how staff could implement measures to reduce the risks. Information was in some cases incomplete. No harm was reported to have resulted from this. However, this along with other general health and safety risk assessment inconsistencies, posed a potential risk of harm being caused if the necessary information and required risk reduction measures were not made clear for everyone.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make some decisions for themselves were protected. The service was making applications to have DoLs assessed, and re-assessed where DoLS approvals were approaching their expiry date. There was a lack of documentary evidence of how this was being followed up. However, we saw that the local authority that mostly places people at the service met with the registered manager recently to discuss what was needed from the local authority to resolve the outstanding applications. Mental capacity was assessed, however, this was not always completed fully in some cases as not all of the required documentation about who was consulted or what had been agreed had been completed.

The care plans we looked at were based on people's personal needs and wishes and in some cases were good, but not so in other cases. Not all information that was known was recorded clearly to ensure consistency of approach by all staff. People's personal, cultural, religious and lifestyle preferences were not given sufficient attention in care planning.

There was an organisational policy and procedure for protection of adults from abuse. The service also had the contact details of the London Borough of Camden which is the authority in which the service is located and other authorities who also placed people at the service. Staff said that they had training about protecting people from abuse and this training had been updated, which we verified on training records. We found there were a suitable number of staff on each floor during our visits. Staff were regularly present in communal areas to identify and respond to immediate assistance that people required.

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

Feedback from people using the service showed that the view was mostly of a caring staff group and we saw that staff were respecting people's dignity and rights. Staff demonstrated compassion in the way that they worked with people.

As a result of this inspection we found two breaches of regulation in respect of Regulations 9 and 12. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

The service was not always safe. People's safety and any risks that were identified were considered. However, there was a lack of consistency about follow up to these or whether particular risks were in fact relevant for particular people.

At the time of our inspection there were sufficient staffing resources available to meet people's needs, although people we spoke with had varying opinions on this.

Medicines were being handled and administered safely and appropriately.

Is the service effective?

Requires Improvement

The service was not always effective. Although capacity was assessed this was not always completed to the level of detail required. Clearer evidence of follow up on deprivation of liberty safeguards (DoLS) applications was required to demonstrate how the service followed up the need to receive confirmed authorisations.

People were not always given suitable or consistent opportunities to choose what to eat or drink. The standard of how this was done by staff was good in some areas but much less so in others. However, the way staff supported people to eat and drink was done well.

Staff received training and supervision across the service.

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

Is the service caring?

Good

The service was caring. Staff were seen speaking and interacting to people in a respectful and dignified way.

Staff undertook care tasks in a compassionate and unhurried way. Staff were taking time with people and explaining what they were doing and why. People were re-assured whenever they

were needed to be and kindness was shown by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive. We found that people's care planning records were not always completed in a consistent way across each floor of the home. The care plan profiles used by the provider were a fairly new system to the home and these had taken some time to begin to be implemented.

Activities were provided but we noted that activities at times were not provided as often as some people would like.

People were able to complain if they wished to. People who were able to tell us about their views told us they felt able to talk with staff in most cases.

Is the service well-led?

Requires Improvement

The service was not always well-led. We were informed that the provider had a system for monitoring the quality of care, and we confirmed that systems were in place. However, the consistency with which this was done varied widely.

Staff felt supported and able to raise matters with the management team at the home, who they believed would listen to their views.

Visiting professionals and other stakeholders we spoke with told us that there had been improvements to the home but work was still needed.

St Johns Wood Care Centre

Detailed findings

Background to this inspection

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

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 25 and 26 July 2018. The inspection team comprised of three inspectors, a pharmacist, a specialist professional advisor and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care service.

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 held about the service including people's feedback and notifications of significant events affecting the service.

We received written feedback from the local authority that largely commissions the service.

During our inspection we spoke with twelve people using the service, two relatives, two friends of people using the service, two visiting healthcare professionals, ten members of staff (seven care staff and three nurses), the assistant chef, the registered manager, the deputy manager, the clinical lead, area manager and quality compliance inspector for the provider. This was a representative of the provider that visited to assess the quality of the service.

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

We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We did this on one floor as most people living at the home spent their days in bed due to their frailty or chose to spend time in their own

room rather than in communal areas.

Requires Improvement

Is the service safe?

Our findings

Many people using the service were frail and unable to give us their detailed views. However, those that could told us they felt safe with staff. One person said "Yes, the staff know what they are doing. I feel safe here."

People's personal risk assessments contained details of how risks were identified. Examples of risk assessments seen included nutrition, pressure care, moving and handling, use of bed safety rails and falls. However, these often lacked clarity as it was not always clear if a risk described was actually relevant to an individual or just a template document that had to be completed. A number of people who used the service had significant issues with symptoms due to their dementia. These had potential to put themselves, other people and staff at risk. There were no comprehensive risk assessments that considered all these areas. There was a safety risk assessment but it only considered the safety of the person using the service but not other people or staff. The care home liaison nurse told us that she advised staff regularly of the importance of risk assessment and safeguarding when necessary. Although no evident harm had been caused by the lack of clarity and lack of full consideration of risks assessed had not been evident it is of concern that the necessary diligence was not being applied in all cases.

We looked at the most recent health and safety meeting minutes for the home was held on 20 June 2018. It stated there were no issues. The registered manager explained to us the maintenance worker does checks and then hands them over to the registered manager for their audit. The system was not effective as records were kept in different places and important information about required maintenance works could be overlooked. We saw the audits for environmental risks for March and July 2018. These were overall risk assessments but the specific aspects referred to in them did not include a risk rating in most areas. The completeness of these audits could not be verified which meant that there was little evidence to show if all areas required had been risk assessed. The shortcomings in fully assessing risks for some people using the service in terms of their personal support needs and environmental risk factors is of concern.

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

People who were at risk of developing pressure ulcers had these risks assessed. Pressure relieving equipment such as cushions and mattresses were used and the person's care plan included guidance for staff related to the settings and the checks which should be carried out by staff. Registered nurses told us that they would contact the tissue viability nurse and GP when required and we saw evidence of this on care records.

There was an organisational policy and procedure for the protection of adults from abuse, which was appropriately detailed and was reviewed and updated in May 2018. This described types of abuse and action to be taken to respond to concerns. The service also had the contact details of the London Borough of Camden which was the authority in which the service was located as well as the other authorities that placed people. Staff we spoke with were able to tell us about what they would do with concerns about care

that might relate to keeping people safe from harm.

We were told that it was the policy of the service provider to ensure that staff had initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. We reviewed the induction records for all six of the staff who had been recruited in the last year, which confirmed that safeguarding people was included in their induction.

During our inspection the staff who we met had a good understanding of what constituted abuse and the action they must take, namely they must report it. The home had cooperated effectively with the local authority to any concerns that had been raised.

Feedback from people using the service, visitors and staff on whether there were enough staff available, was variable. Some felt there was sufficient staff, whilst others said it could be stretched at times. We spoke with the registered manager about this and viewed staff rotas for the five months leading up to this inspection. The staff rotas showed that the designated number of staff for each floor were on duty for most shifts each week. On only a small number of occasions was a floor short of the number of care staff required to be on duty and this was usually due to staff sickness. We observed throughout our inspection that staff were available to quickly respond to people's needs within a reasonable time, including responding to call bells and did not have any concern about unsuitable staffing levels.

The registered manager told us that six new members of staff had been recruited since the current provider took over the service in July 2017. We viewed the recruitment records of each of these staff. Staff files included full employment history, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with vulnerable adults. If staff required home office permission to work in the UK then this was obtained. For nursing staff, there was confirmation of their registration with the nursing and midwifery council.

We looked at medicine records for thirteen people. Staff had recorded important information such as the name, photograph and medicine sensitivities for each person at the home. However, we found information regarding how people preferred to take their medicines was missing for some people. This meant people may not always receive their medicines as they would like them. We found no gaps in the medicine administration records (MAR). This provided assurance people were being given their medicines as prescribed.

Medicines were stored securely at the home. We found staff checked and recorded room and refrigerator temperatures daily and these were within the required range. Some people were prescribed medicines on as required basis. There was guidance in place to advise staff when and how to give these medicines. Some people were prescribed creams and ointments to be applied to their body. These were securely stored in people's own rooms and recorded when applied by staff on separate charts.

The home had a medicine management policy in place. Only qualified nursing staff administered medicines and they were regularly competency assessed and received medicine-handling training. There was a process in place to report and investigate medicine errors. We saw evidence of medicines audits being carried out each month and any action required was taken.

Some people at the home were given their medicines disguised in food or drink. Records showed an assessment, involving the person's GP, had decided it was in their best interest to give medicines in this way. However, we found that staff had not always consulted a pharmacist to check whether the medicine was safe to be crushed or would be effective when mixed with certain foods. In one case the information about

covert medicines was not contained on the MAR sheet for that person for the current month.

The home had a process to receive medicine alerts. However, we did not see evidence that staff had recorded action and responded to the alerts. This does not meet guidance issued by The National Institute for Health and Care Excellence which states "Organisations should ensure that national medicines safety guidance, such as patient safety alerts, are actioned within a specified or locally agreed timeframe."

We recommend that the provider should review their policy and processes for handling, recording and taking action about medicines safety alerts and seeking pharmacist advice on crushing medicines for authorised covert administration and recording this clearly with the MAR chart records.

Call bells were heard being activated regularly during our inspection visits. These were responded to quickly and monitoring of response times was undertaken. There were no concerns identified about the time taken, or lack of action, to respond.

We were shown records of health and safety checks of the building and the appropriate certificates and records were in place for water safety, electrical and fire systems. A fire safety officer inspection visit earlier in 2018, had identified some areas of improvement and the provider had taken action to address identified issues. Almost all of the actions required had been completed with the action plan in place to address what remained. This was still within the recommended timeframe of the London Fire Brigade for completion.

The provider had emergency contingency plans for the service to implement should the need arise.

Infection control was managed appropriately. Staff were knowledgeable and were able to tell us about the way different types of waste were managed and various infection control procedures. We saw staff wearing gloves and aprons when handling food. We were told by the provider's quality and compliance manager and a nurse that each person using hoists had their own slings and there were individual slide sheets for all people who needed them, which we confirmed were cleaned and checked.

A mice and ant infestation issue had arisen prior to our inspection. The home was being visited monthly, or more frequently if the need arose, by a pest control contractor to monitor the situation. The ant infestation issue had resulted in a nest being discovered and destroyed two days before this inspection started. We found one person's bedroom did have ants present which we raised immediately with the registered manager, who instructed staff to address it immediately and it was. The registered manager told us that the pest control company had advised that the ants should fully disappear within a few days now that the nest had been destroyed. No recent issues regarding mice had arisen but this continued to be monitored monthly by the pest control contractor.

The home was clean and there was a current programme of redecoration and refurbishment taking place on the 2nd floor, which was vacant whilst this work continued. We found a toilet and bathroom on the third floor that needed repair due to cracked tiling and an unsecured carpet in room 101. We reported these to the registered manager who tasked the maintenance officer to address the loose carpet immediately, which they did.

Requires Improvement

Is the service effective?

Our findings

People using the service told us, "It is very nice, I feel ok here." While another said that, "The food is fine, you get three choices." All the people we spoke with except one and a relative said they were happy about the food they received.

A person told us that the staff were very effective if something happened, "They get in touch with your family straight away." They also added, "I feel safe here, it's a good place really".

Relatives told us, "They help my relative to eat, they get breakfast, lunch and dinner. The dinner is often cold food. I think it could be better, more fresh vegs and fruit, but it hasn't been bad." And another said their relative had an "Infection recently. The GP recommended that [relative] drinks more water. Every half hour someone pops in to give water."

About food people using the service said, "Yes I like the food and the staff help with eating" and "I usually eat by myself, I don't need help. Yes, that's one thing I would say they do provide good food."

Agency staff were only used for one to one work with people that needed this support and they generally had the same care staff from the agency. A visiting professional told us there had been high staff turnover during the two and a half years they had been doing monthly visits to the home. They also said there had been a lot of problems at the home but it was "picking up" and that "it is not a bad home".

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

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

There was evidence in the notes when DOLS had been applied for but in most cases there was no evidence of any follow up when there was a significant delay. One person had an application for DOLS not granted but there were key pads in place at all exits. It was not clear how their liberty was promoted on the dementia floor where they were living as many others were having their liberty restricted under DOLS. Thirty five applications for DoLS were still awaiting a decision, in some cases for over six months. The registered manager stated these were regularly followed up but these follow ups were not being recorded. However, we did see documentary evidence that the registered manager had recently met with the local authority, who mostly placed people at the home, to discuss these significant decision delays. The outcome we were

informed was that this work will be prioritised.

Best interest's decisions were usually comprehensively recorded although in some cases the form describing this had not been fully completed with a date and signature. Where people lacked capacity, there was a lack of documentary evidence for some people to guide staff about offering people as choice in a meaningful way whenever possible. Where people lacked capacity and had a family member or advocate with lasting power of attorney to make decisions on their behalf this was recorded. However, it was unclear in some cases who was able to provide consent on some people's behalf if they were unable to do so themselves as recording of this was unclear.

A care worker told us that they were working towards the care certificate and we looked at examples of eleven other staff who had completed this within the last year. We discussed training with the quality compliance inspector for the provider. They told us that staff training was a high priority and our examination of the staff training matrix showed this to be the case. Training about mental capacity, dementia awareness and moving and handling were examples of what was provided. Nursing staff had ongoing clinical training that had competencies which needed to be met. The provider's clinical services inspector was available to support staff to achieve the required competencies.

Two staff members told us specifically that they thought they [staff] were a good team. They also told us they had worked at the home for many years and that despite several changes of the provider managing the home that there had been little change observed until recently. They said they always tried to provide the best care for people whoever was managing and operating the service.

We found completed do not attempt resuscitation orders (DNAR) for a number of people. Most were comprehensively completed with consultation with family recorded for people who lacked capacity to make the decision themselves. Their clinical problems and the reason a DNAR was in place were well described and signed and dated by the GP. One person had a welfare attorney and this was appropriately recorded on the DNAR form. There was one folder where, on the outside it said, "Not for DNAR". The person did have a DNAR in place so this should have read not for CPR or DNAR, which we pointed out to the registered manager to ensure this was correctly described.

A nurse told us that as well as their mandatory training other training was made available to meet the needs of people using the service. This included dementia training, catheterisation, use of syringe drivers and use of PEG (this is a tube inserted into a person's stomach through which nutrition can be provided if they are unable to swallow).

Food and fluid charts were in place where appropriate and these were comprehensively completed. Fluid targets were specified and the charts that we observed showed that these had been reached or exceeded. It was a period of very warm weather when we inspected and staff were seen encouraging people to drink regularly, although we did see on the dementia unit that people were not always offered a choice of drink and it was not always placed in front of them. We raised this with the registered manager. The need to continue to offer people drinks regularly was raised at a morning team meeting between senior staff across the home that we attended.

Our specialist professional nurse advisor noted that one person had a pressure relieving mattress on their bed and in the care plan it stated that the settings should be checked monthly whereas it needs to be checked every hour or so. There was in fact a chart in the person's bedroom and the mattress was being checked regularly but this was not reflected in the care plan. Some people had end of life care plans. In one case it did not mention the DNAR, it stated that they wanted to stay in the home but did not say not for

hospitalisation so lacked clarity. There was some conflict in different care plans, one continence plan stated that if staff put pads on a person they would pull them off but in the overnight care night plan it just stated that their pads should be changed regularly. Care plans on communication were inclined to be generic for people living with dementia. They did always appropriately say how to explain what was happening when providing care and generally lacked guidelines for communicating this with each person.

Other professionals came to the home to see people. These included the GP, dentist, dietitian, podiatrist and podiatry assistant, speech and language therapists, optician, tissue viability nurse and older adults mental health team. Visits and telephone conversations with other professionals were clearly recorded.

Multi-disciplinary team (MDT) visits and meetings to review people's conditions and needs took place. People also had access to a range of visiting health care professionals such as dentists, physiotherapists, opticians and podiatrists. We saw records on the multi-disciplinary sheets referring to visits made by MDT members. We saw good care plans for diabetes, although in one case a person did not have a diabetes specific care plan although their diabetes was referred to in another part of the plan We raised this with the nurse on duty who placed a note on file that a diabetes care plan must be completed.

Copies of menus were displayed on the tables in the dining room, but not placed on each table on two floors. Jugs of water and juice were available on each table. We observed that staff, on two floors, seemed to assume what some people wanted for lunch rather than ask or remind them was the choice of meals were. When we saw staff assisting people to eat and drink, this was done gently and kindly and people were not rushed. However, other than the one to one staff we saw varied degrees of interaction between people and staff. Most care staff were very engaging with people whilst a small number of others were less so. One person we observed was unable to speak but a care worker assisting the person with their lunch said nothing to them. This meant that some people using the service may not have as pleasant and engaging an experience of their mealtimes whereas we saw other examples where mealtimes were a lively and engaging experience. We raised this with the registered manager for them to address with staff.

Good

Is the service caring?

Our findings

People we spoke with told us they felt that the staff were caring. One said specifically that staff are "very kind and caring".

Visiting times at the home were open and relatives were made welcome at any reasonable time of the day. A small number of relatives visited during the course of our inspection.

Many warm and caring interactions between staff and residents were observed, there was evidence of appropriate touch. The general atmosphere in the home was cheerful. The one to one staff were agency workers but came regularly and clearly had very good relationships with the people they were caring for. One of the people using the service was seen holding a care worker's arm and showed affection and the desire to be close to her. A visitor of another person who was receiving one to one care, told us that the agency care worker who was with her friend was excellent and very caring and good for her friend. They said, "Now she has [name of care worker] I don't worry about her, she is really good, I wish she was here every day."

Although most staff seemed to pay attention to finer details of care we saw one occasion where this detail was lacking when a person using their wheelchair had no foot rests attached. Staff had not noticed this until it was pointed out to them. When the footrests were attached the person was then able to adjust their seating position in the chair and make themselves comfortable, which clearly had a positive result for them.

Other than these minority of occasions of limited communication, generally all observations across both days were that staff were friendly, respectful patient and kind. People seemed well cared for and looked after which helped to maintain their dignity.

People living at the home seemed relaxed with the staff caring for them. When people were distressed or needed staff attention they would get it. If staff could not offer attention immediately they asked a different staff member to help or told the person they would come back soon, which they did. Someone new had moved into the home the day before our inspection started, the nurse on duty for the day shift who had not met the person before went to them, introduced themselves and explained that they were there to care for them.

As we were walking around the home a person approached us and said "just to make it clear I am not moving anywhere. I like it here and I am not going anywhere." We re-assured them we were not there to make anyone move and their comment evidently displayed what they thought about the home.

One of the inspection team overheard a nurse talking to a relative on the phone, they did not know we were listening to what they were saying. The nurse was very kind and reassuring and took her time, telling the relative, "This is my job and you can call anytime, it is no trouble". Almost all of the visitors we spoke with told us that staff communicated well with them, keeping them informed of any changes or concerns.

The bedrooms were single occupancy with en-suite facilities. Some bedrooms were personalised with people's own possessions, furniture, photographs and personal items where they had chosen to bring these possessions with them.

There were a number of people who were very poorly and could not go to the lounges but instead stayed in bed most of the time. Throughout the time we visited we saw staff popping in and checking on people and staying with them for a while when they couldn't leave their room. Activities co-ordinators also spent individual time with people on each floor when they were unable to become involved in group activities. We did see a voluntary group visiting the home on the first day of our inspection to perform a theatrical and musical event, which was well attended by people living here.

A local voluntary advocacy service representative regularly visited the home, which we confirmed, and this person supported people who did not have anyone to act in this role on their behalf.

Requires Improvement

Is the service responsive?

Our findings

A person using the service told us, "There is never enough staff because there is always someone else wanting something, which means I have to wait and I get impatient". However, the same person also said, "I am quite content because no one bothers me". Another person told us that the staff were "very quick" at responding to their needs. They said it is "very nice" and "peaceful" at this service.

A relative we spoke with was very unhappy with the service. The registered manager knew about this and was able to show us what was being done to address the relative's viewpoint about the service.

Care files included care plans, risk assessments, professional input reports and monitoring records. In general, care files were orderly. However, there were many instances where the information was contradictory and was not always up to date. For example, care practice witnessed and reported was not reflected in the care plan despite the care plan being regularly reviewed. It was unclear which was mostly up to date, the needs assessment, the records or the actual practice. There was a particular need to ensure care plans to manage and support "challenging behaviour" describe the behaviour and offer clear guidance to staff on how to minimise, manage and support the individual in this area. There were behaviour charts in people's care plan records. These were completed regularly for most but not for all and some that were completed were more detailed than others. For example, in one behaviour record it was noted that a person having a male carer support them was a calming influence but this was not included in the care plan. In another file, a person was said to be physically resistant to personal care and needed three staff to assist, but no guidance about how that should be done. Therefore, lessons from known positive methods of assisting people when distressed were not always learnt and there was no advice in care plans on considering potential physical causes of distressed behaviours.

There was some judgemental language in care plans around the psychological and behavioural symptoms of dementia, for example, "challenging behaviour", "excessive wandering".

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

There was not always a lot of detail in people's social history, cultural, religious and lifestyle preferences, including sexuality and orientation. We were told by the registered manager that this was because people either did not have a next of kin or they were too poorly to be asked. However, another element of inconsistency in care planning was that there was no information about what had been attempted by staff to gather a fuller picture of people's life history, lifestyle choices or preferences. Staff we spoke with did know people well but there was a lack of evidence about whether recording took place when new information was revealed or whether attempts to gather more details about life history or lifestyle preferences had been attempted.

There were, however, some other good examples of person centred care plans in place and dignity and privacy were considered in the plans. Care plans covered such things as nutrition, mobility, moving and

handling, pain control, skin integrity, personal hygiene and continence. People's like, dislikes and care preferences were recorded in some cases.

Information was accessible and the registered manager stated no one required care plans or other documents in different languages or formats. The quality compliance inspector for the provider stated that information could be supplied by the provider in other languages and formats as people required.

There had been four complaints made since the current provider began operating the service in July 2017. The provider had a clear complaints and comments system and this was on display around the home and the complaints made had been responded to. One of these had been due to significant disagreement between a person using the service, their family and the home. This had included specific elements of the person's needs and how these should be met. We did, however, verify the action taken by the home had been appropriate and had considered the person and their family's preferences.

We saw there were advance care plans on some people's care records where this had been discussed. Some were detailed enough but some others were not. For example, providing clear and concise instructions by the person as to how and where they wished to be treated at the end of their life. However, these could in some case go into more detail about specific instructions such as explaining or identifying if a person's wish to have a minister of religion had been identified, and details of other ways in which end of life wishes would be supported.

Requires Improvement

Is the service well-led?

Our findings

People using the service told us, "I know the Manager. I think it is a good service. I'm getting good care." Another person told us they thought the service had got worse, "Like all public services" and another did not think they knew the manager.

A relative told us, "I am able to communicate with management or the staff. I feel comfortable to speak with them. Initially I was not sure that she would be alright here but now I am confident."

The provider of the service had taken over from the previous provider in July 2017. This transition to using the new provider's systems, not least care planning procedures, had taken a long time to implement by the time of this inspection approximately 60 percent were completed, which we confirmed and was in line with what the local authority had told us shortly before this inspection.

The issues of concern had been wide ranging from care planning, to the environment to staffing and consistency of care. The provider concerns and restriction on new admissions had been lifted by the local authority shortly before this inspection. Significant improvements had been made although there were further improvements required, the progress on which was being monitored by the local authority. We have referred to specific areas we identified at this inspection and although we did not see the service as uncaring there was work still to be achieved. The home had potentially good systems in place but these were not being fully utilised and a lack of consistency in recording and following through on documented care and support needs was widely evident across the home.

There was a clear internal management structure in place and staff were aware of their roles and responsibilities. The service has a registered manager who had been in post since April 2016, and transferred to the employment of the new provider in July 2017. The registered manager was supported by a deputy manager and a clinical lead nurse. Staff told us the registered manager and deputy manager, were supportive and the recently appointed clinical lead had a high profile around the home.

The provider had a staff support structure in place which included supervision, appraisal and support with individual staff training portfolio management. Staff said that the manager was approachable and they were comfortable to take concerns to him and other senior staff.

A daily meeting was held where representatives from each floor, management, maintenance, housekeeping and kitchen are present. This was an opportunity to share information and flag up concerns. For example, on the hot days we were there, encouraging fluids was emphasised as well as other day to day matters.

Care staff told us there were weekly carers' meetings which, apart from daily handovers, was another opportunity to raise any concerns and for information to be shared. Staff meetings took place which had begun at the time the current registered manager was appointed. Staff were invited to raise issues which they were doing and the minutes of the meetings held in the last three months were seen.

We were informed that the provider had a system for monitoring the quality of care, and looked at these systems. Regular reporting to the provider was required and this included a monthly report to the provider's board about the progress at the home by the provider's quality assurance inspector. We looked at medicines audits, care plan audits, risk assessments of people using the service as well as general health and safety in particular. As referred to earlier in this report there was a lack of consistency in each of these areas with exception that medicines audits were effectively carried out. The care plans, although also audited and updated, were also not picking up on areas of inconsistency and completion. There were currently two care plan formats used. The provider, who took over the service in July 2017 had their own care plan system Transfer to using this system at the home had been very slow but was picking up with now just over 60% of care plans having been transferred.

There had yet to be a satisfaction survey of people using the service, relatives or other stakeholders, but the provider was receiving anonymised survey feedback. There was no extrapolation of this available at the time of our inspection. The registered manager informed us, which was also confirmed by other senior managers that we spoke with, that a survey across the whole service was about to take place. We were told this survey would include people using he service, relatives, friends, advocates and stakeholders was just about to be initiated. We were, however, shown examples of communication that had been entered into with people using the service (where that had been possible), relatives and other interested parties about the change of ownership of the service last year.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care planning lacked consistency and the care planning process did not suitably provide suitable information about people's are and support needs in some cases.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment procedures lacked clarity both for people using the service and in terms of auditing risks across the general operation of the home.