Care Quality Commission

Magicare Limited

Priscilla Wakefield House

Inspection report

Rangemoor Road
London
N15 4NA

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28 March 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

At our last comprehensive inspection in March 2017 the service was rated 'Requires Improvement'. At that inspection we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to the management of medicines and incorrect moving and handling procedures. At this inspection we found that the registered provider had addressed these breaches. At this inspection the service was rated as 'Good'.

Priscilla Wakefield House is a care home with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates a maximum of 117 people. At the time of our inspection there were 108 people living at the home. There are five units in the service. Copperfield and Havisham are units for people requiring nursing care; Nickleby for residential care. Dorrit unit for people living with dementia and requiring nursing care and Pickwick for younger adults who may have dementia, brain injury or a physical disability and who require nursing care and rehabilitation.

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

People told us they trusted the staff and felt safe in their care. People using the service were relaxed with staff and the way staff interacted with people had a positive effect on their well-being.

Staff understood their responsibilities to keep people safe from potential abuse, bullying or discrimination.

Risks had been identified and recorded in people's care plans and ways to reduce these risks had been explored and were being followed appropriately.

There were systems in place to ensure medicines were handled and stored securely and administered to people safely and appropriately. Medicines were being audited regularly so any problems could be identified and addressed in good time.

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

Staff understood the principles of the Mental Capacity Act (MCA 2005) and knew that they must offer as much choice to people as possible in making day to day decisions about their care.

People were included in making choices about what they wanted to eat and staff understood and followed people's nutritional plans in respect of any healthcare needs or religious requirements people had.

People had regular access to healthcare professionals such as doctors, dentists, chiropodists and opticians.

Staff treated people as unique individuals who had different likes, dislikes, needs and preferences.

Everyone had an individual plan of care which was reviewed on a regular basis.

The complaint process and subsequent investigations were not always transparent which meant the complainant did not always know what was happening with their complaint or if changes and improvements had been made and lessons learnt as a result. We have made a recommendation about the complaints process.

People, their relatives, staff and health and social care professionals were all included in monitoring the quality of the service. They told us the home was well managed and the management were open and supportive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Risks to people's safety had been identified and the management had thought about and recorded ways to mitigate these risks.

Staff understood their roles and responsibilities in relation to maintaining high standards of cleanliness and hygiene in the premises.

There were systems in place to ensure medicines were administered to people safely.

Staff understood their responsibilities to protect people from abuse and knew how to raise any concerns with the appropriate safeguarding authorities.

Is the service effective?

Good

The service was effective. Staff had the knowledge and skills necessary to support people safely and appropriately.

Staff understood the principles of the MCA and knew that they must offer as much choice to people as possible in making day to day decisions about their care.

People told us they liked the food and staff knew about any special diets people required.

People had regular access to healthcare professionals such as doctors, dentists, chiropodists and opticians.

Is the service caring?

Good

The service was caring. We observed staff treating people with respect, kindness and dignity.

Staff knew about the various types of discrimination and its negative effect on people's well-being.

Staff understood people's likes, dislikes, needs and preferences and people were involved in their care provision as much as they wanted to be.

Staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although people told us they were happy to raise any concerns they had with any of the staff and management, the complaint process was not always transparent and the outcomes were not always shared with the complainant.

People's care was individualised and the management and staff reviewed people's needs and made changes to people's care provision when required.

Staff knew how to communicate with people and acted on their suggestions and wishes.

Activities provided by the service met people's social and cultural needs and had a positive effect on their well-being.

Is the service well-led?

Good

The service was well-led. There were quality assurance practices in place and people said they were regularly asked about the quality of the service and confirmed the service took their views into account in order to improve.

The registered manager had a professional and open approach to working with other organisations and took on board feedback in order to continually improve the service.

Care Quality Commission

Priscilla Wakefield 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 checked 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 unannounced inspection took place on 27 and 28 March 2018. The inspection was carried out by two inspectors, a specialist advisor in falls management and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service. By law, the provider must notify us about certain changes, events and incidents that affect their service or the people who use it.

We spoke with thirty two people who used the service and nine of their relatives and friends. We were not always able to ask people complex questions about the service they received. We observed interactions between staff and people using the service as we wanted to see if the way staff communicated and supported people had a positive effect on their well-being.

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

We spoke with 11 care staff, four nurse managers, the home trainer, the cook, two administrative assistants, four housekeeping staff, the deputy manager and the registered manager. We also spoke with the home's GP, a district nurse and three social care professionals about their views of the service.

We looked at 18 people's care plans and other documents relating to their care including risk assessments and 15 medicine records. We looked at other records held at the home including meeting minutes, six staff files as well as health and safety documents and quality audits.

Good

Is the service safe?

Our findings

At our last inspection of this service in March 2017 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to the management of medicines and incorrect moving and handling procedures. This was because we found errors had been made in the administration of medicines and these were not being reported and people were not always being moved and transferred safely when provided with care. At this inspection we found that the registered provider had complied with these breaches.

People and their relatives told us they had no concerns about the management of medicines at the home. One person told us, "Yes, they explain my medicine they give me the right kind and are good at it." Another person commented, "Yes, they are good at medication and they explain it to me."

We checked the management of medicines on two units and saw satisfactory and accurate records in relation to the receipt, storage, administration and disposal of medicines at the home. All medicines were audited regularly so that any potential errors could be picked up and addressed quickly. People's medicines were being reviewed regularly by their GP. Only qualified nurses and senior care staff administered medicines. A list of staff signatures was available on file.

The Medicine Administration Record (MAR) folder contained a list of hazardous medicines and controlled drugs for staff information. Diabetes guidelines were also available detailing how blood glucose levels should be monitored. All records were complete and no gaps in recording were noted. Each person's record contained a resident ID sheet which detailed allergies and how the medicines should be administered.

Each person had a medicine care plan which detailed the medicines they had been prescribed, what it was for, any outcomes and actions to be taken. These had been reviewed and were reviewed on a six-monthly basis. PRN (when required) guidance was available which detailed when the medicine was to be administered and the desired effect.

An Abbey Pain Scale (APS) assessment had also been completed where people had been prescribed pain relief. This is an assessment used for the measurement of pain in people living with dementia who cannot verbalise.

Covert authorisations had been appropriately completed and had been signed by the relative, GP and pharmacist confirming that a best interest decision had been taken in regard to the administration of covert medicines. We noted for one person, their covert documentation had not been signed by the pharmacist and the care home. However, a recent audit completed by the unit nurse manager had already identified this issue and they had taken actions to address this. Covert medicines are medicines that are given without the person's knowledge but are deemed vital for their continued health. The covert administration of medicine is lawful where the person lacks capacity and it is in their best interests.

Cream application forms had been completed and forms for the application of pain relief patches had also

been appropriately completed with details of rotation of patch application sites on the body. Handwritten MARs had two signatures confirming that the details that had been written were correct.

Fridge and medicine room temperatures were recorded on a daily basis and were within acceptable limits. Medicines were returned to the pharmacy at the end of the medicine cycle and records confirmed this. CD (Controlled Drugs) requiring extra security and controls were kept and managed according to legislation and records tallied with the stocks available.

Medicine competency checks for all staff administering medicines had been completed and these checks were being refreshed every six months alongside refresher medicines training which was being refreshed annually.

All hoists were appropriately labelled and had been serviced in January 2018. All slings and slide sheets had been serviced at the same time. We saw that staff undertook a visual check of slings, slid sheets and hoists before they used them.

When staff were assisting people to transfer we observed staff explaining what they were going to do. They were observed getting down to speak to people on their level and were engaging with people with respect, dignity and were listening to them.

The moving and handling in-house trainer had completed train the trainer competency checks and had ensured that staff were up to date with appropriate moving and handling training. He undertook annual staff training and six-monthly observations of staff.

One person told us, "I do feel safe with the staff I have never had any safety problems." Another person commented, "I rarely come out of my bed, so I trust the people that can use the equipment. They should know what to do."

People and their relatives told us they felt safe in the home and they were well treated. One person told us, "They are great, they are really nice, and I can't fault any of them. Yes, I trust them, yes they know what they are doing, they know their job." Another person said, "The atmosphere makes me feel safe. It is very friendly and caring. Yes, I do find them to be trustworthy. I think the staff here are very good. Their English could be better but they do try." A relative told us, "My wife has been here for just over a year. The staff in here work very hard. Oh yes my wife is very safe."

Were people had not felt safe or had concerns about how they were being treated, there were policies and procedures in place to report concerns to the local safeguarding authority.

There had been a number of safeguarding concerns which were investigated by the local authority and the registered manager explained how lessons had been learnt when things had gone wrong. For example, there had been safeguarding investigations into missed appointments with outside healthcare professionals. The registered manager acknowledged that there had been problems with missed appointments and told us how the introduction of a new electronic system had made sure appointments were better recorded and how staff received reminders so they could plan ahead.

We observed interactions between people who used the service and the staff supporting them. We saw people were relaxed and comfortable with the staff and enjoyed their company. Staff knew how to recognise potential abuse and told us they would always report any concerns they had to the registered manager. They knew they could raise any concerns with other organisations including the police, the local authority

and the CQC.

Staff understood the potential risks to people in relation to their everyday care, treatment and support. These matched the risks recorded in people's care plans. Care plans identified the potential risks to people in connection with their care. For example, records showed risks had been assessed in relation to pressure care, catheter care and falls prevention. There was information for staff on how the risks identified should be mitigated. For example, we saw that when someone had a catheter, a catheter care plan was in place which detailed the risks associated with the catheter, including infection control procedures and signs to look for if the person may be developing an infection.

Everyone had a falls risk assessment in place which identified the risks as well as the steps needed to mitigate these risks. The issue of falls had been highlighted as a concern by the local safeguarding and commissioning teams. As a result, the service had been required to notify the local authority of all falls that occurred. Following a fall, staff completed an accident report which was viewed by senior management. The report was then sent to the local authority. Incidents of falls were being recorded on a 'Safety Board' on each unit and discussed at each shift handover.

The management of the service met monthly with the local authority and the Clinical Commissioning Group (CCG) to analyse any falls in order to identify any potential patterns or recurring themes. The service had also started working with a local Care Home Assessment Team (CHAT). The team is made up of healthcare professionals who advise homes on clinical issues including falls management.

We spoke with the registered manager about falls in the home and discussed a number of issues including consideration into the use of assistive technology specifically in relation to falls monitoring, that all falls risk assessments be updated after every falls incident and exercise classes, including strength based chair exercises to be encouraged throughout the units. We also noted that a number of cushions on chairs were hanging over the front of the chair seat base, which could present a risk of falls if that part of the cushion was sat on. The registered manager told us they would look into these issues and discuss further with the healthcare professionals who were involved in falls prevention at the home.

Everyone had a personal evacuation plan which gave advice about the most appropriate and safe way individuals should be evacuated from the home. Staff understood their responsibilities and knew how to raise concerns and record safety incidents and near misses and gave us examples of how they had done this in the past.

Staff told us they had sufficient amounts of personal protective equipment. Housekeeping staff had completed training in infection control and food hygiene and understood their roles and responsibilities in relation to maintaining high standards of cleanliness and hygiene in the premises. All parts of the home, including the kitchen, were clean and no malodours detected. The kitchen had been recently inspected by the environmental health department and had received the top score of five 'scores on the doors'.

Staff did not have any concerns regarding staffing levels and told us that these had been increased since the new registered manager had been employed. The registered manager confirmed that nurse managers on each floor were now supernumerary and were not included in dependency calculations and assessments. One person told us, "Since the new manager there have been lots of changes and much more staff have arrived." We saw that staff were busy throughout their shifts but did not rush and took time with the people they were supporting as much as they could.

People using the service and their relatives had mixed views about staffing levels. However, the majority of

people we spoke with felt there were enough staff on duty and said they did not have to wait too long for staff to assist them when they required support. People's views about staffing levels included, "There has been more staff since the manager changed, it's much better now," "I think there are plenty of staff here. They come in and they help me," "The staff here never stop, they are too busy they don't get a chance, they never seem to be still and always in someone else's room helping them" and "You ring for the staff you can't always get one straight away but the staff do the best they can."

We checked staff files to see if the provider was continuing to follow safe recruitment procedures. Staff files contained appropriate recruitment documentation including references, criminal record checks and information about the experience and skills of the individual. Staff told us they were not allowed to work at the home until the provider had received their criminal records check and references. This meant the provider could be assured they employed staff suitable to working in the caring profession.

Good

Is the service effective?

Our findings

Assessments of people's health and support needs and care were carried out holistically and using recognised assessment tools including the Falls Risk Assessment Scale for the Elderly (FRASE), Malnutrition Universal Screening Tool (MUST) and the Waterlow pressure sore risk assessment tool. In addition to these clinical assessment tools there was information about the background and life history of the individual so that staff could get an understanding of how the person lived their life before they moved into the home as well as their cultural and spiritual needs.

All staff had completed an induction, and told us this was useful. The first week of induction centred on training with the in-house trainer. The second week involved working with the unit manager and shadowing more experienced staff until they felt confident to work on their own. Staff we spoke with told us they were also undertaking the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Supervisions and appraisals were taking place for all staff and were used to develop and motivate them, review their practice or behaviours, and focus on professional development. One staff member told us, "Supervision for me is a teaching session. We talk about what training I would like to do to improve." Another staff member commented, "It's about my manager letting me know how I can improve."

Staff told us they were provided with the training they needed in order to support people effectively. We spoke with the in-house trainer who explained that training was delivered both through ELearning and face to face at the home. This training included data protection (GDPR), dementia awareness, equality and diversity, health and safety, moving and handling MCA and DoLS legislation, safeguarding and pressure ulcer prevention.

One staff member told us, "There is a lot more training opportunities, its good training." Records showed that staff completed refresher training when required. A staff member commented, "I've done all my training."

Staff gave us examples of how the training had improved their working practice. For example, they told us that recent safeguarding training had improved their understanding with regard to the different types of abuse including restrictions on people's liberty. People and their relatives were generally positive about the staff and their knowledge regarding supporting people safely and appropriately. One person told us, "I think the staff are well trained."

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.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the principles of the Mental Capacity Act and told us it was important not to take people's rights away and that they must offer as much choice to people as they could. One staff member told us, "We always talk to them and let them know what we are doing." We observed staff asking people for permission before carrying out any required tasks for them. We noted staff waited for the person's consent before they went ahead. People told us that the staff did not do anything they did not want them to do.

Staff explained how they offered choices to people in a way they could understand. Staff understood how each individual expressed their needs and preferences and we saw staff offering choice to people throughout the inspection.

Records showed that when people had to make major decisions about their care and treatment, best interest meetings had been arranged. These meetings included the relevant health and social care professionals to help the person make the right decision. Relatives told us they had been involved in these best interest meetings.

Where people currently using the service had been assessed as being unsafe to leave the home on their own, we saw people were always accompanied by someone when they went out. The home had a number of locked doors which could be opened by use of an electronic fob. These electronic fobs were provided to families and people who were able to leave the home unaccompanied. The registered manager informed us and records showed that people's deprivation of liberty and the associated safeguards had been assessed with the local authority and legal safeguards had been provided.

Most people told us they liked the food and were offered a choice of menu. Comments about the food included, "They don't need to feed me I can ask for what I want and I ask for certain things. They are pretty good on the food thing I get more than enough and quite a variety", "The food is good and I enjoy it and get enough", "They do quite a lot of foreign food and I will ask for potatoes instead of rice", "The food is really good actually and it is much better than the food in hospital where I was for two months. Normally the night before someone comes in with a small menu of choices and I choose. If I ask for a snack like sandwiches or biscuits I can pretty much get them" and "I like the food here. They give me a choice of food. No, I have never gone hungry or thirsty."

A relative commented, "The food provided is good. She gets pureed food. She can't chew she can eat any puree. She drinks orange juice. No, she has never gone hungry or thirsty."

Nutritional needs were assessed for all people in all the care plans reviewed with MUST (Malnutrition Universal Screening Tool) scores and weights updated each month. Care plans highlighted any particular dietary needs such a diabetic diet, food preferences and any risks associated with eating or nutrition such as risk of choking or risk of weight loss.

Information was clear and detailed with direction to staff on how to best support people and manage risks. For example, some people were at risk of dysphagia and care plans outlined specific measures with regard to food textures or how to position the person when eating to avoid any risk of choking. There was evidence of referrals to and input from the Speech and Language Therapist (SALT) team with guidelines and advice on individual needs and dietary plans.

The head chef was aware of the people that needed a special diet because of particular health requirements such as diabetes or if someone needed a soft diet. Menus reflected the cultural diversity of the people living

at the home and religious requirements such as Halal were being adhered to.

People were appropriately supported to access health and other services when they needed to. Each person's personal records contained documentation of health appointments, letters from specialists and records of visits. People told us and records confirmed that they had good access to health and social care professionals. People's comments included, "The doctor comes to see me if I need one I don't go out to GP", "The doctor comes and gives you a memory test. He says I have a good memory for my age. There was an optician testing eyes here not long ago. I also see the chiropodist.", "A nurse changes my dressing and puts a new one on", "they don't have physiotherapy here, but they can order them in" and "Yes, the doctor has come several times to see me. They have a special day when you can make an appointment to see the doctor."

We met a district nurse during the inspection who told us the staff were very helpful and good at communicating and following clinical instructions. We met with the local GP who visited the service each week. They were very positive about the staff and the management at the home. They told us that the leadership of the home and staff response times for contacting the surgery had improved. We saw that people's healthcare needs were recorded in their care plan and discussed at staff team meetings.

The home had accommodation and shared lounges and dining rooms set over four floors and was divided into five separate units catering for people's different needs. Where dementia care was provided the layout and decoration was designed specifically for people with memory problems. The laundry and kitchen were in the basement as were the staff rooms.

The registered manager told us that the third floor was shortly to be redecorated with input for the local dementia action alliance. Each person's bedroom door had a picture of the person with their name identifying the room as their bedroom. There was appropriate signage around the home for lounges, toilets and bedrooms.

There was a downstairs courtyard and upstairs roof gardens. All of these contained plants and garden furniture. In the front reception area there was a coffee bar called Dickens Café for both visitors and people who lived at the home to use. We saw that the home was accessible. One person we spoke with told us, "I have no problem using my wheelchair and I find that the home is more accessible than the hospital."

Good

Is the service caring?

Our findings

People were relaxed with staff and we saw that positive and supportive relationships had developed between everyone. One person told us, "Yes, the staff treat me kindly. I think they are fantastic given what they have to put up with". A relative commented, "I come here on a daily basis with her newspapers. I find that the staff here are excellent and that I can talk to them." Relatives told us they could visit at any time and that staff were welcoming and friendly.

People were able to express their views and make choices about their care on a daily basis. Throughout the day we observed staff offering choices and asking people what they wanted to do. Everyone had a care plan which gave information about their individual methods of communication. People told us they were as involved as they wanted to be in planning their care.

One person told us, "I am involved in care planning and making decisions about the service. For example, they come in and ask when I want my shower." However other people told us they were happy for staff to plan their care. People's comments included, "The planning of my care has never crossed my mind", "I am not involved in planning my care, no not really, they just seem to do what's right for me" and "I don't need to be involved in planning my care the staff should know what I need and why I am here."

Staff understood how people communicated non-verbally and explained to us how they looked at people's facial expressions and body language. Specific communication tools were used when people could not verbalise. For example, staff used the Abbey Pain Scale which is a specific assessment tool for staff to use if people have communication issues such as dementia.

Care plans detailed how staff were to encourage people's independence in a safe and supportive way. Each task had information about what the person could do for themselves and when they needed staff support. One person told us, "As much as I can I am an independent person and the carers support me."

Staff had completed equality and diversity training and this was also covered in staff induction. The registered manager and staff understood how issues relating to equality and diversity impacted on people's lives. They told us that they made sure no one was disadvantaged because of, for example, their age, sexuality, disability or culture. One person told us, "Yes they do respect my background and culture. I am Jamaican and they do a lot of Caribbean food such as jerk and oxtail."

People told us staff understood and respected their religious preferences. One person told us, "[A priest] used to come. He was a Jesuit he doesn't come any more but he arranged for a nun to come and visit me. She comes and gives me messages from the father." A relative commented, "[My relative is happy she does want she wants. There is a priest who comes to see her once a week."

People told us they felt the staff treated them respectfully and took into account the need for privacy and dignity. One person told us, "The staff are very good and kind. Nobody complains. They cheer you up. They make light of things such as soiling the bed. When you get old you do get sensitive but they don't make me

aware of it. They shut the door and pull the curtains. I am respected for what I am I am aged 89."

Another person commented, "They do respect my privacy for example, they are very aware of what might be showing when they take me to and from the bathroom. They make sure the door is closed and I am not sitting in my boxers when somebody comes to visit."

Staff gave us examples of how they ensured people's privacy and dignity were maintained and respected. These examples included keeping people's personal information secure as well as ensuring people's personal space was respected.

Requires Improvement

Is the service responsive?

Our findings

Staff understood the needs and preferences of people living at the home. This matched information detailed in people's care plans as well as what we observed and what people told us. Care plans were person centred and gave staff information about people's needs, goals and aspirations whilst being mindful of identified risks to their safety.

People's care and support needs were assessed and kept under regular review so any changes could be made when required. Records showed that people had been involved in reviewing their care. However, people we spoke with could not always remember if they had been involved. A relative confirmed, "I have been involved in his care planning." Another person told us, "I am not sure who reviews my care but I do have a chat with all of care staff."

Where people's needs had changed, we saw the necessary changes to the person's care plan had been made so all staff were aware of and had the most up to date information about people's needs. Staff communicated and updated each other about people's changing needs at regular staff handovers and through daily progress notes for each person. Both the GP and the district nurse we spoke with told us the management and staff were responsive to people's changing needs. One person we spoke with told us, "They listen to me to me and take notice of my requests".

Throughout the two days of the inspection we saw people taking part in varied activities that were socially and culturally relevant to them. We saw that the interactions with the activity coordinators and staff had a positive effect on people's well-being. One person commented, "We have some right laughs here. It's not like on the telly, everyone sitting in a room with long faces. It's alright here." Records and pictures on display throughout the home showed that people took part in varied activities either in groups or on a one to one basis if required.

People's comments about how they keep occupied and engaged included, "I do activities every day, movement. Yes, I do have enough to do" "There are activities, like reading and puzzle books. We go out and we do exercise and we can make cards, oh yea I am happy with what we do.
On Tuesday afternoon they have a shop and I buy my sweets" "I don't leave my bedroom. Sometimes I do some colouring in. I have some pictures on my bedroom wall that I have coloured in. The activities coordinator comes to my room and we have a one to one chat and she writes in my activities log in the blue folder. She came today" and "I go and see what is going on in the lounge. I go outside to a café with the care staff. A couple of weeks ago they took me shopping to Wood green. I have friends that come and visit."

A relative commented, "She has everything she wants we make sure of that. She is not bored or isolated she has a whole team of people visiting her."

Staff understood how people communicated and knew what to look out for if anyone was unhappy or concerned about anything. Relatives told us they had no complaints about the service but felt able to raise any concerns without worry.

People generally knew how to raise a complaint and said they had no concerns about doing so. One person told us, "I have never wanted to complain I am quite happy. Yes, I do know how to complain and am confident to do so." Another person said, "If you want to make a complaint you have to make an appointment with a nurse, somebody who associates with the management." A relative commented, "Yes I do know how to complain and I would talk to [unit manager]."

We saw that people were asked if they had any concerns or complaints at regular meetings. However, meeting records showed that some people had raised concerns yet there was no record of what actions had been taken as a result.

Although we saw that complaints were investigated by the deputy and registered manager, the detail of these investigations were not always being shared with the complainant. We looked at three recent complaints. In one case the registered manager had written to the complainant and apologised. However, the outcome of the other two complaints was unclear. This meant that the complaint process and investigation were not transparent and the complainant did not always know what was happening with their complaint or if changes and improvements had been made and lessons learnt as a result.

We recommend that the service seek advice and guidance from a reputable source, about the management of, sharing and learning from complaints.

The registered manager told us that the home was continuing to work towards the Gold Standard Framework for end of life care. This is a nationally recognised proactive, systematic evidence based approach to delivering quality end of life care.

We spoke with a healthcare professional who was part of a project run by the North Middlesex hospital and the local CCG. They told us their role was to discuss and develop advanced care plans with people at the home and their relative.

We saw advanced care plans which were in place and saw that these were detailed and included important information and people's wishes and preferences, discussions about accessing mental capacity and completing Do Not Attempt Resuscitation (DNAR) instructions. The healthcare professional told us the staff worked well with them and were very proactive and knowledgeable about the people they supported.

Good

Is the service well-led?

Our findings

At our last inspection of this service in March 2017 we found that audit and quality monitoring systems were not always identifying issues of concern. For example, the medicine audits had not identified the problems that we found at the March inspection. At this inspection we found that quality monitoring systems had improved and any issues, concerns or problems were being identified in good time so that action could be taken. For example, we spoke with one of the unit managers who showed us how regular medicine audits had highlighted issues such as missed administration before they became potential problems. We also saw how regular monitoring of repositioning and food and fluid charts meant that any gaps in recording were addressed straight away.

People using the service and their relatives were positive about the registered manager, the deputy manager and the unit managers. One person we spoke with told us, "I do think the home is well run because I can see that the staff do their work. The managers are all right. Both of them I like." Another person commented, "I think the home is well run. The manager who is on now is the lady and she is very nice and kind. I am all right." A relative told us, "I have visited a lot of homes in the area and I think this home is good, better than average."

Staff were positive about the management at the service. They told us the registered manager was open and supportive. One staff member said, "Management is better compared to when I started. The registered manager is fair and approachable." Another staff commented, "[The registered manager] talks to us a lot, she is very positive. I feel supported."

However, staff were not so positive about the provider and how their wages were dealt with. Nearly all staff we spoke with told us they were very unhappy about how their wages were calculated. We were assured by the registered manager and the administrator who dealt with the wages that no staff had been disadvantaged by the new, computerised wages system and that this had been explained to staff many times.

Prior to this inspection we had been contacted by staff who had left the service because they felt undervalued by the organisation and the way they were paid. We were told that when staff had received their wages there was a long queue outside the administrator's office which was causing high levels of stress for everyone. The registered manager told us that one of the main issues they were dealing with at the home was staff retention. As the issue of staff payment may have impacted on staff retention and therefore continuity of care, we requested that the provider look into this problem.

The registered manager and deputy manager carried out regular audits including health and safety, staff training, cleaning, and care records. We saw that environmental risk assessments and checks regarding the safety and security of the home were taking place on a regular basis and were detailed and up to date. This meant that there were systems in place to identify issues with risks and infection control so any problems could be addressed in good time.

One person told us, "I think the overall quality is really good. No really, I can't think of anything that needs to be improved. If something is not quite right they will fix it. My chair brakes went funny and the maintenance man fixed it. He also fixed the thermostat in the shower when it was broke. He fixed it straight away."

The registered manager explained to us how the service worked in partnership with other agencies and organisations. This included working with the local authority and CCG in relation to safeguarding and people's care provision. We spoke with a social care professional who met regularly with the management. They told us the registered manager and deputy manager were open and were always keen to take up suggestions for improving the service.

There were a number of different systems that the provider used to monitor and improve the quality of care at the home. These included surveys and meetings for people using the service and their relatives.

People who used the service and their relatives told us they were asked for their views about the quality of care provided at the home.

Some people we spoke with could not remember if they had completed a survey or attended a meeting but they did say they were asked about their care. One person told us, "There is a manager on each floor. If they are here they will come in and have a chat. I do feel listened to and believe my wishes would be taken seriously." Another person said, "I did attend a resident/ relative meeting and there were a lot of relatives there. It was quite good. Yes, they did ask for my feedback it was about the food." Another person commented, "The manager's all right. I have been asked for feedback. Yes, I feel listened to. It is all right here. I can't think of any improvements needed." A relative told us, "Oh sure I am listened too. They do have house meetings but I don't stay for them."

We asked the registered manager how staff are involved in developing the service. They told us, "We have regular team meetings and ideas generated from these forums form part of the continuous service improvement plan which is a working document and shared with all teams. Each heads of department and unit leads have their own staff meeting which feeds into the service improvement plans."

We saw that these service improvement plans were shared with the local authority and CCG and informed by the results of surveys, learning from safeguarding outcomes as well as CQC reports.