Sanctuary Care Limited

Carlton Dene Residential Care Home

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 31 July, 1, 3 and 10 August 2018. The first day was unannounced and the other days were announced. Carlton Dene is a 'care home' that provides personal care and accommodation for older adults. People living at the service require care and support as they are living with dementia and/or are frail due to chronic health difficulties and/or physical disabilities. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during the inspection. Carlton Dene can accommodate up to 42 people and 40 people were living at the service at the time of the inspection. The premises are purpose built and divided into four separate units. People are provided with a single bedroom with en-suite facilities and shared communal areas. The service provides permanent placements and respite care.

At our previous inspection we had rated the service as Requires Improvement. Safe, caring and well-led had been rated as Requires Improvement and effective and responsive had been rated as Good. We had issued two breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to dignity and respect, and good governance. We had also made three recommendations in relation to the use of topical medicines and the medicine fridge temperature checks, determining the correct staffing levels and meeting people's end of life care needs. Following the previous inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, caring and well-led to at least Good. At this inspection we found that the provider had met the breaches and recommendations.

At the time of the inspection the registered manager was on maternity leave. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider informed us that they were in the process of recruiting an interim manager. Temporary management arrangements were in place until an interim manager commenced at the service and completed their induction.

At this inspection we found that improvements had been achieved in relation to the use of topical medicines and medicines were being stored at the correct temperatures, in line with the manufacturers' instructions. We saw that prescribed topical applications were being stored securely in people's bedrooms and staff were correctly completing topical medicine administration records (MARs). We noted that some staff needed guidance to ensure they properly supported people to take their respiratory inhalers, which was discussed with the provider during the inspection. We were aware that there had been medicine errors since the previous inspection and saw that recent improvements had been made to the management of medicines, and actions were in place to support senior care staff to safely administer medicines. At the time of the inspection staff were being closely supported by the regional care development manager but this was a temporary measure and another medicine error occurred during the inspection. Therefore we could not be assured that systems were embedded to ensure the effective governance of medicines.

People told us they felt safe and at ease with staff. Records showed that staff had attended safeguarding adults training and were aware of their responsibilities. Safeguarding notifications were appropriately sent to CQC, in accordance with legislation.

Risk assessments had been developed to identify and mitigate risks to people's safety and wellbeing.People's risk assessments were in the process of being reviewed, and updated where necessary. However, we noted that risk assessments were not always sufficiently robust to adequately promote people's safety and wellbeing.

The safety of the premises had been addressed following an incident at the service. We noted some issues in relation to infection control practices. The provider took suitable action to address these issues during the inspection and speak with staff about additional training and support to ensure they adhered to the provider's infection control policy and procedure.

We saw that staff were busy at key points during the day. The provider had increased the number of staff prior to the inspection to ensure that senior care staff had uninterrupted time to focus on the safe administration of medicines. The management team stated that the staffing levels were due to be reviewed. Detailed recruitment practices were in place to ensure that people received their care and support from applicants with suitable skills and experience for their duties.

At the previous inspection we had found that the training matrix did not accurately demonstrate that staff had completed their mandatory training. At this inspection we found that the provider had clear records to show how they monitored staff compliance with their compulsory training requirements. Records evidenced that staff were supported with their roles and responsibilities through training, supervision and an annual appraisal of their performance and development. We received positive comments from visiting health care professionals in relation to how staff supported people to meet their health care needs.

We saw that people were offered choices at meal times and were able to meet with the chef to discuss their dietary needs and wishes, however this meeting wasn't always documented in their care plans. There was some evidence that people could access meals that met their cultural needs, although this area of practice could benefit from being considered in more detail by the provider. We carried out several observations at meal times and saw that people received the support they needed, except on one occasion.

The provider had processes in place to enable staff to assess people's capacity to make decisions and support people to make their own choices, where possible.
Although we observed some positive interactions between people and staff, we observed an incident where people were not supported to make choices.

Interactions between staff and people who use the service were predominantly positive. Staff spoke with people in a kind and gentle way and ensured that their support with personal care was carried out in private rooms with the door shut.

The care plans did not consistently demonstrate that people's needs were identified and understood, so that individual care and support could be planned and delivered. Where care plans had recently been reviewed we saw a more comprehensive and cohesive approach to identifying and addressing people's needs.

People were encouraged and supported to take part in activities, access community resources and engage with music and movement therapeutic sessions. The service had inspired local people to visit as volunteers

to enrich the lives of people who used the service.

Complaints were managed in a professional manner and where applicable the provider used their analysis of complaints to learn from their mistakes.

People and relatives we spoke with had no concerns about how the service was managed. They were asked for their opinions at meetings held by the service. We had issued a breach of regulation in relation to the quality of the provider's quality monitoring. The provider had taken action to improve the specific areas highlighted at the previous inspection. At this inspection we found that new areas for improvement were being tackled by the interim management team.

Accidents and incidents were documented and analysed in order to identify and address any concerns.

We have issued three breaches of regulation in relation to the safety of the medicines management, the robustness of risk assessments for people who use the service and the quality of care planning.

You can see what action we told the provider to take at the back of the main 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.

Some improvements had been made to the management of medicines and actions were in place to support senior care staff to safely administer medicines. However, the provider needs to ensure that appropriate governance systems are in place to support safe medicine practices.

Risk assessments had been developed to identify and mitigate risks to people's safety and wellbeing. These assessments were being reviewed, and updated if required. However, the quality of some risk assessments was not sufficiently rigorous to protect people.

People told us they felt safe with staff. The staff team understood their responsibilities to protect people from abuse and harm.

The safety of the premises had been addressed following an incident at the service.

Sufficient staff were deployed to meet people's needs. However some difficulties arose as staff were getting to know people they had not previously supported.

Detailed recruitment practices were in place to make sure that people were supported by staff with suitable backgrounds and skills.

Is the service effective?

Requires Improvement

The service was not always effective.

The design of the premises did not fit in with current ideas for creating residential settings for older people and people living with dementia. The provider took appropriate action to ensure the fixtures and fittings were safe.

People were provided with choices at meal times and individual preferences could be met by the chef. Staff knew how to support people with eating and drinking, apart from at one observed lunch time.

People were supported by staff to meet their health care needs and staff understood how to promote good hydration during hot weather conditions.

The provider had processes in place to enable people to assess people's capacity to make decisions and support people to make their own choices, where possible.

People received their care from staff who had received training, supervision and support.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we observed some positive interactions between people and staff, we observed an incident where people were not supported to make choices.

People were supported to meet their cultural and faith needs.

Staff ensured that people's privacy and confidentiality was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans did not consistently demonstrate that people's needs were identified and understood, so that individual care and support could be planned and delivered.

People were encouraged and assisted to take part in meaningful activities and meet supportive members of their local community.

Complaints were managed in a professional manner and where applicable the service learnt from errors.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although areas for improvement were being identified and addressed at the time of the inspection by the interim management team, the provider acknowledged that some issies for improvement had not been detected and managed in a timely manner.

People and their relatives did not express any concerns about how the service was managed. Systems were in place to seek their views and share information.

Staff felt supported and the provider had introduced ways to enable their employees to speak about any work related concerns.

Accidents and incidents were documented and analysed in order to identify and address any concerns.

Carlton Dene Residential Care Home

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 carried out over four days. The first day was unannounced and the subsequent days were announced. The inspection team comprised two adult social care inspectors on the first two days, and one adult social care inspector and a medicines inspector on the third day. One adult social care inspector returned to the service on the fourth day to conclude the inspection and give feedback to the provider.

Prior to the inspection we received information of concern from the local authority. We were informed that they had received anonymous concerns that people who used the service might have been overprescribed medicines. The local authority and Clinical Commissioning Group conducted monitoring visits in July 2018 and shared their findings with us. We also reviewed the information we held about the service, which included statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required by law to send us. We asked the provider to complete 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.

Some people who used the service were not able to tell us their views about living at Carlton Dene so 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 with us about the quality of their care and support. During the inspection we spoke with 14 people and four relatives. We also spoke with seven care staff, two unit leaders, the activities coordinator, the domestic supervisor, the chef, the deputy manager, the registered manager from a neighbouring service operated by the provider, the regional care development manager and the regional manager.

We looked at a range of documents which included eight care plans and the accompanying risk assessments, five staff files for evidence of training, supervision, appraisal and recruitment, the complaints log, policies and procedures, 15 medicine administration records (MARs), accident and incident records, minutes of meetings for people who use the service, their representatives and staff, and the provider's own quality monitoring reports and audits. We spoke with three visiting health care professionals during the inspection who provided their views about the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection the local authority had received anonymous information that alleged people who used the service were being overprescribed medicines. This information was shared with the local Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC). Two monitoring visits were conducted by representatives from the local authority and the CCG in July 2018. A CCG pharmacist conducted a review of people's prescriptions and two review visits were carried out by CCG pharmacy technicians, also in July 2018. The CCG pharmacy team did not find any evidence of overprescribing, apart from the use of a medicine for one person which was administered before staff supported the person with their daily personal hygiene care and support. However, the CCG pharmacy team detected issues of concern which included the signing of medicine administration records (MARs), the disposal of medicines no longer needed, the monitoring of the temperature for medicine fridges and protocols to ensure the safe self-administration of medicines, where required.

At this inspection, a pharmacist from the medicines team looked at policies, storage, records, training and systems for medicines management at the home. Medicines were stored and disposed of appropriately. We saw staff monitored medicines storage daily and took appropriate action when needed to keep medicines safe. However, governance systems to support safe medicines processes were not robust.

At the previous inspection we had found that both medicines rooms were hotter than the recommended maximum of 25 degrees centigrade, as the readings had been 27 degrees centigrade. Staff had responded appropriately by opening windows and switching on fans to keep the rooms cooler. At this inspection we found that the temperatures for the medicine rooms and the medicine fridges were maintained within satisfactory temperature ranges.

We looked at MARs and care plans for 15 people and saw they were receiving their medicines as prescribed. Some people were prescribed medicines on a when required basis. There was guidance in place to advise staff when and how to give these medicines and these were kept with the MARs. However, we found two people did not have protocols in place for their when required medicines. When staff administered these medicines, they were not always correctly recorded on the MARs as outlined in the providers policy.

People were prescribed creams and ointments to be applied to their body had topical medicines administration records (TMARs). At our previous inspection we had found that the TMARs were not always completed correctly. On this inspection we found creams and ointments were securely stored in people's own rooms and TMARs were completed accurately when applied by staff.

We saw that people that could self-administer their medicines, had a medicines risk assessment completed. Staff regularly checked the medicines to make sure people were safe. However, staff told us that they administered one person's eye drops daily. They did not keep a record of this on the MAR. Some people were given their medicines disguised in food or drink without their knowledge, which is described as covert administration. This was carried out in their best interests following assessment under the Mental Capacity Act and a documented best interests review. This included an advocate for the person, pharmacist and GP.

During our inspection we observed medicines being administered by care staff. We observed care staff administer inhaled medicine. However, the inhaler was not being used correctly and therefore the medicine would not have the desired therapeutic effect. We noted that the provider had implemented actions to ensure staff had appropriate training and competency assessments in relation to administering inhalers. We saw evidence that people's medicines had been periodically reviewed by their GP with the support of staff at the home. This meant people were being prescribed medicines appropriate for their health condition. We saw people with mental health conditions had their medicines reviewed more frequently with the GP.

The home had a medicine policy about systems to manage medicines safely. Staff received annual medicines training via e-learning and the provider assessed the competency of staff to ensure they handled medicines safely. There was a process in place to report and investigate medicine errors.

We found that there had been medicine errors, including MARs not being completed correctly, medicines being administered at incorrect times and missing medicines. We saw that since the home had additional support of a full-time regional care development manager to manage medicines, errors had reduced. The regional care development manager was a qualified nurse and part of the provider's regional support team. They were supporting staff at the service until the new interim manager was established in their role.

Staff who administered medicines from original packaging were required to keep a running stock balance. However, we found on two occasions that the stock balance had been incorrectly recorded and had been copied on consecutive days following. This suggested that staff were not carrying out a physical count of the remaining medicines after administration. Staff told us that they were following the medicine policy and some of the tasks were new to them. Management told us that they were implementing the medicines policy in the home and therefore staff needed time to get used to systems and processes of medicines management.

The issues we found highlighted in the paragraphs above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider found that a medicines error had occurred during the period between the third and fourth day of the inspection. The provider ensured that the person who used the service was clinically assessed by their GP without delay, raised a safeguarding alert and formally notified the CQC. The medicines error was being investigated by the provider at the time of the inspection.

At the previous inspection we had found that the care home was clean, except the activity room and the adjacent kitchen on the first floor. The provider had rectified this concern during the inspection. At this inspection we found that the premises were clean, however we noted some issues in relation to malodour and infection control practices. Two communal toilets had an unpleasant odour. The call bell and light cords in the communal bathrooms and toilets were discoloured, and therefore might have placed people who used the service at risk of illness due to cross infection. We identified that mops were not being air dried but stored in buckets with or without water. The dedicated laundry room contained broken and unused items, for example kettles waiting to be descaled were stored on the 'dirty flow' (items that require laundering) side of the laundry. These obstacles could potentially hinder the systems in place to prevent the decontamination of clean laundry. The hand wash sink did not have any hot water and we were informed by a staff member that this normally occurred when the washing machines were in operation. We spoke with the regional manager about our findings on the first day of the inspection and noted that these issues were resolved.

People who used the service told us they felt safe and this view was also expressed by the relatives we spoke

with. One person said, "[Staff member] and [staff member] are very nice, I get on with all of them (staff). I feel safe and would say if something was wrong." Another person told us they felt safe living at the service but had some concerns about the quality of the service. With their agreement we shared these concerns with the regional manager, who spoke privately with the person during the inspection. A relative commented, "I feel [my family member] is in safe hands. I turn up at different times of the day when I am not expected and [my family member] is always clean and comfortable."

We found that the staff team and the management understood their responsibilities in relation to keeping people safe and protecting them from abuse and neglect. The provider's safeguarding policy and procedure appropriately stipulated that the local authority must be informed of any safeguarding concerns and the CQC must be notified without delay. Records showed that staff received safeguarding training, which was confirmed by the staff we spoke with. Staff were provided with written information about how to whistleblow internally within the organisation and externally to other bodies, for example the local authority and CQC. Whistleblowing is when a worker reports suspected wrongdoing at work.

At the previous inspection we had found that risk assessments had been updated to accurately reflect people's needs. At this inspection we found that although risk assessments were in place within people's care plans, there were some issues in relation to how staff acted to mitigate identified risks. For example, the risk assessment score for one person identified that additional falls prevention documentation and an action plan needed to be completed but this had not been undertaken. The risk assessment for another person identified that they were at risk of malnutrition. The person was appropriately referred to a dietitian, however staff had not followed the new instructions from the dietitian in relation to the required frequency for monitoring the person's weight. On the third day of the inspection we informed the regional manager that three risk assessments were missing from the care plan of a third person, who was initially admitted to the service for respite care. These risk assessments were in place on the final day of the inspection. We were informed by the management team that a shorter style of care plan was written for people who were admitted for respite care and this was developed into a standard comprehensive care plan if they remained at the service as a permanent resident. The provider acknowledged that the absent risk assessments were overdue when we first looked at the care plan.

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

We noted that at the time of the inspection all of the risk assessments were being reviewed by the regional care development manager, as part of an overall review of the care plans. Where risk assessments had been subject to this reviewing process we did not find any concerns.

A range of environmental checks and had been carried out by the provider to ensure that people were provided with a safe home to live in and staff were able to attend to their duties within a safe working environment. We saw that a kitchen safety audit had been completed in July 2018 and the most recent external inspection of the kitchen by the Food Standards Agency in partnership with the local authority in May 2017 had resulted in the award of the highest possible rating of five. This showed that the hygiene standards were deemed to be very good. Other checks had been satisfactorily undertaken, which included gas safety, electrical installations inspection by a competent person, portable electrical appliances testing and the regular professional servicing of fire equipment. People who used the service had a current Personal Emergency Evacuation Plan (PEEP) in place. A PEEP is a bespoke 'escape plan' for people who may need help and assistance to leave the building in the event of an emergency evacuation. We noted that the PEEPs we looked at had considered whether people had cognitive and sensory needs in addition to their physical health needs and mobility.

We spoke with the regional manager about a recent accident at the service and confirmed subsequently that an audit of the safety of all the windows had been carried out. Where necessary, new window restrictors had been fitted. We did not see any windows which did not have a fitted restrictor, apart from one. We noted that the extractor hose of the free standing air- conditioning unit had been placed out of the window, which meant that the window restrictor had been removed. This room was kept locked and people who used the service did not have access. However, we advised that the provider should consider replacing the restrictor or undertake a risk assessment regarding potential access to the room by unmonitored visitors.

At the previous inspection staff had told us that they felt stretched and did not feel that the staffing levels were sufficient to safely meet people's needs. At this inspection people who used the service and relatives told us that staff were always busy. Comments included "These girls work very hard", "They are always on the go. [Staff member] and [staff member] are so attentive and will do anything to make [my family member] comfortable" and "Sometimes there isn't enough of them around and you will see them charging about to help people." We observed that there were times during the morning that we could not find staff in the communal areas as they were attending to people in their own rooms. The visibility of staff improved in the afternoon and we noted that some members of staff initiated conversations, played board games or jointly looked at the daily newspapers with people who used the service.

The regional manager informed us that staffing levels had been recently increased following medicine errors, to enable senior care workers to focus on their medicine administration responsibilities. Care staff told us that they had been informed by the management team that they would all be working across different units, having been previously allocated to a specific unit. Care staff told us that they felt uncomfortable with this new arrangement as they were not familiar with people's needs and stated that some people who used the service had shown confusion when supported by staff they did not know.

We spoke with the regional manager about the rationale for the new different units. The provider informed us that staff had been rotating units for over a year. The regional manager informed us about the operational challenge of getting staff once allocated to a unit to move to assist other colleagues. A short-term solution was to make an increase to the care staff number. The regional manager stated that a possible change to the unit configuration and allocation could be implemented, which would mean that staff would work across two units and be allocated to support named people who used the service. The regional manager shared with us that staff were initially not sure about this proposal.

The recruitment files demonstrated that safe processes had been followed to appoint staff who were suitable to work with people who used the service. The provider obtained a minimum of two relevant references and ensured that prospective employees had proof of identity and the right to work in the UK. Checks were undertaken with the Disclosure and Barring Service (DBS) before they were permitted to commence employment at the service. The Disclosure and Barring Service provides criminal record checks and a barring function to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People's care plans demonstrated that their individual needs had been assessed before they moved into the service, to ensure that the service was able to meet their health and social care needs. Systems were in place to ensure that the management and staff team provided care and support for people who used the service which was in line with national guidance and best practice guidelines. For example, at the time of the inspection the provider had assigned a regional care development manager with a registered nursing background who was undertaking a key role in supporting senior staff with medicine practices and carrying out detailed audits of care plans, which had resulted in some improvements. A visiting health care professional told us that staff appropriately adhered to locally agreed protocols for reporting health care concerns to the community nursing service.

People who used the service received care and support from staff who had received suitable training to carry out their roles. We spoke with people and relatives about whether staff understood and met their needs in a competent and effective way. Comments included, "Yes, they (staff) know my aches and pains and encourage me to keep moving about. They are a comfort to me on difficult days" and "We have no complaints with how [care staff] look after [my family member]. [He/she] is fond of them."

There were instances during the inspection when we identified gaps in the knowledge, skills and competencies of individual staff members, which we brought to the attention of the regional manager. We noted that the provider was aware of these issues and evidenced to us that individual staff members were being formally supported and/or managed through additional one to one supervision, training and/or capability measures.

Records showed that staff were provided with a comprehensive range of mandatory training, which took into account the needs of people who used the service. This included health and safety, basic life support, moving and handling for care, infection control, dementia awareness, equality and diversity, fluids and nutrition awareness, and safeguarding adults. Audits were undertaken to ensure that staff had completed their required training and where necessary staff were sent reminder letters. The provider's policy for staff compliance with their compulsory training and development was clearly understood by staff we spoke with, who told us that they were not allowed to work if they did not keep up to date. The provider informed us that they paid an enhanced rate to staff who successfully completed national vocational qualifications in health and social care, as an incentive for staff to continue their development.

We found that there were arrangements in place to support and guide staff. Records showed that staff received formal one-to-one supervision approximately every two months and an annual appraisal. Staff were also supported with their learning and development through team meetings. The minutes for the staff meetings showed that they were used as a forum to share information, discuss staff training issues and gather the views of participants. For example, a meeting was held in July 2018 and the agenda included discussions about the findings of the previous inspection report from the Care Quality Commission.

We were informed by the provider that the premises were owned by the local authority. The regional

manager told us that some aspects of the maintenance were the responsibility of the local authority and the provider escalated any concerns to the designated external contractor. The provider acknowledged that although the service was purpose built as a residential care home for older people, the building now required updating and modernisation to meet contemporary environmental styles and people's expectations. We were advised that a new care home was currently being built within the borough which would offer both residential and nursing care. Therefore, Carlton Dene was due to be decommissioned in the future. At the time of the inspection this information had been shared at a meeting for people's families and friends.

On the first day of the inspection we observed that the premises appeared tired and in need of redecoration and refurbishment. Communal toilets and bathrooms were stark and uninviting. One of the communal bathrooms was missing a bath. The provider confirmed that the bath had been removed the previous week as it was no longer fit for purpose and quotes were being sought for a replacement. We were told that people had access to communal bathrooms on other units.

We received mixed views from people who used the service about the quality of the food. Comments included, "It's alright and we get a choice. It's served at the right temperature", "I would like it to be bland as I need to eat plain food" and "[Chef] is very good and asks me what I fancy. I like a roast dinner. The portion sizes are good. There is always a decent pudding too."

We observed lunchtime on three days of the inspection and predominantly found that people were given the support they needed to have their meals. However, on the second day of the inspection we noted on one of the units that people required a significant level of encouragement and support to meet their nutritional needs. Although there were two care workers allocated to the unit, one care worker was observed to do very little other than plate up food. This resulted in one care worker having to offer people choices through showing them the available options, serving the plated meals and providing verbal encouragement and/or practical support to seven people. Most people required help with cutting their food into manageable portions and one person required physical support to eat their food. This person was seen struggling for more than 20 minutes to get their food from the plate onto a fork and spoon. This person had to keep waiting for the care worker to come back to put food on their cutlery and in some cases into their mouth. We assumed that the food would have been cold by the time the last of the meal had been eaten. In addition to this the hot sponge and custard which had been plated before it was required would also have been eaten cold.

Other lunchtime observations demonstrated that people were supported in a more dignified way. Members of the care staff checked with people if they were satisfied with their meals and asked whether they would like additional servings. Although we saw that staff chatted with people and endeavoured to make their dining experience relaxed and sociable, we found that additional work was needed by the provider to promote a consistently more enjoyable and hospitable ambience at meal times.

We found that the main kitchen was clean, tidy and organised. The chef told us that most food was prepared from fresh ingredients, however some items were purchased readymade if they were particularly time consuming to prepare from scratch. The menu was devised by head office staff and was divided into a summer and winter menu. Each seasonal menu had a four-week rotation, in order to offer people variety. We viewed the menu and found it be nutritionally balanced. There were two choices for lunchtime, which was the main meal of the day. One meal was with meat and the other meal was vegetarian. The chef informed us that in addition to these choices people could request special meals and we were shown a meal of pig tails and beans which had been prepared for a person who liked Caribbean meals. All meals on the main menu were suitable for people with diabetes and meat was purchased from a Halal butcher. Although

systems were in place to support people to meet their nutritional needs and wishes in relation to their known preferences, we occasionally saw in care plans no documentation as to whether people and their chosen representatives had met with the chef to discuss their dietary requirements.

People had access to healthcare services and received on-going healthcare support. The care plans we looked at showed that people received visits from health care professionals and were supported to attend appointments at hospitals and clinics. During the inspection we met a GP from a local practice which provided health care services for people who used the service. They told us that the management and care staff worked well with the local GP surgery. Staff were described as being supportive. Staff listened to advice and instructions from the GP, promptly raised any concerns or changes in relation to the wellbeing of people and appropriately contacted the out of hours and emergency services. The GP confirmed that there was daily telephone contact with a member of the management team to discuss people's medical problems. They were positive about how staff had supported people during the summer heatwave, as none of the people who used the service had experienced dehydration due to insufficient encouragement and assistance to maintain adequate fluid intakes. The GP felt that that staff had acted with integrity when they discovered medicine errors, which were reported to the NHS 111 helpline for urgent concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. The care plans we looked at showed that the provider had carried out their own capacity assessments, which took into account the findings of any recent assessments by external health and social care professionals. We noted that one person's capacity assessment had identified that their ability to make decisions fluctuated. We met the person and spoke about their cognitive and physical health care needs with a senior care worker, which enabled us to understand how staff had attained their evaluation. A senior care worker explained how acute health care conditions impacted on the person's cognitive abilities and the documentation within the care plan demonstrated that this issue was kept under review. People who used the service told us that they felt consulted about their daily choices, for example about when to get up in the morning, when to retire to bed and their food preferences. Staff were observed to be sympathetic to the person and understood their anxieties. Care plans referred to circumstances where decisions would need to be made through best interests meetings with staff from the service, relevant professionals, and people and their relatives if 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider evidenced that they were working in a cooperative manner with the local authority to refer people where it was considered that they were being deprived of their liberty. During the inspection we observed that staff supported people to move about the premises freely, for example people went to their bedrooms or the courtyard after lunch or chose to stay in the communal lounge. The layout of the building promoted this flexibility and the regional manager confirmed that this fitted in with the provider's ethos to enable people to not feel unnecessarily restricted.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection we issued a breach of regulation in relation to some staff not treating people with dignity and respect. At this inspection we observed that staff spoke with people in a respectful way and treated people kindly. Comments from people who used the service were positive, "They (staff) are nice", "We all get on. They are cheerful most of the time" and "[Staff member] will do anything to help you. They treat me right." Relatives described staff as being "caring" and "patient". One relative said, "It is inevitable that [my family member] and I will have our favourites. Most of them are alright, I have never been worried that any of the carers would not look after [my relative] kindly."

During the inspection we saw how staff supported a person who was reluctant to celebrate a special occasion. Staff respected the person's choice and spent time with them to offer reassurance and support. They gently encouraged the person to acknowledge the occasion in a low-key way that the person was comfortable with. We saw that members of the staff team were genuinely concerned about the person and keen to make their day as pleasant as possible.

A member of staff had ventured into the wider community to assist the public to understand ways to compassionately support people living with dementia. They had delivered training sessions to school students about the needs of people living with dementia, as part of an initiative by the Alzheimers' Society to create a national network of Dementia Friends and Dementia Champions. The staff member (the activities coordinator) told us they were initially asked to give a talk by the principal of a local school and decided to expand upon this by speaking at another school. They told us, "I was well supported by a colleague from our head office and I am pleased to have taken on this challenge to improve people's awareness."

However, we witnessed an incident that did not demonstrate that people who used the service were always treated with respect and given choices. This occurred during the distribution of ice creams and ice lollies on an extremely hot afternoon and was observed by the inspection team on two different units. People were not asked if they had a preference and were handed an ice lolly but staff were given an ice cream. We discussed this observation with the regional manager and noted that prompt action was taken to determine what had occurred and why. The provider's own investigation found that the staff member had rushed through the task without considering their actions as they were concerned that the items would melt. However the provider was clear to us that this was a staff training issue and would be addressed with staff as an unacceptable standard of care and support.

People were supported by the service to meet their religious needs. The local Salvation Army visitor came to the care home every week and monthly visits were carried out by Church of England and Catholic clergy, which provided people with pastoral support. Additionally, a Catholic rosary service was held each month. The activities coordinator told us that they endeavoured to support people from other religious faiths to practice their religious beliefs in accordance with their own wishes. For example, the activities coordinator had contacted places of worship on behalf of people to request a visit from a religious minister or a volunteer from within the congregation. The service's programme of activities reflected the cultural diversity of people who used the service. For example, the activity coordinator had developed positive links with a

local Islamic school. The students regularly visited the care home and provided companionship and entertainments for people who wished to participate.

Staff had received training regarding how to treat people with dignity. The care plans we looked at contained some information about how to effectively and sensitively communicate with people, taking into account that their communication skills could be affected by cognitive impairment, hearing loss or other factors due to their physical frailty. We observed that staff knew how to engage with people, for example a staff member advised us that we should sit at a particular angle so that a person could hear us. We also saw that staff communicated with people through smiling or holding their hand.

People and their representatives were provided with useful written information about the service, including guidance about their entitlement to make a complaint about any aspect of their care and support. Posters about how to access local advocacy services were prominently displayed, to assist people who may wish to obtain independent support to make a complaint. The regional manager confirmed that documents could be presented in different formats if required, for example large print or braille, in line with the requirements of the Accessible Information Standard (AIS). Since August 2016 all organisations that provide NHS care and/or publicly funded adult social care are legally required to follow the AIS. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services and their informal carers with a disability, impairment or sensory loss.

Care plans stated whether people had expressed a preference to receive their personal care from a care worker of the same gender. We noted in one of the care plans we looked at that a person had stated that they wished to be supported with a specific aspect of their personal care by a care worker of the same gender. Care staff told us that there had been times this wasn't possible.

We observed that staff knocked on people's bedroom doors and waited for permission to enter. Doors were kept shut when people were supported with personal care and staff approached people in a discrete and diplomatic way if they needed to remind people to use the toilet as part of an individual continence management plan. Throughout the inspection we noted that people were comfortably dressed in clean clothes, which were suitable for the hot weather conditions. Relatives confirmed that they were pleased with how their family members were supported to maintain their personal hygiene and self-esteem.

Systems were in place to ensure that people's confidentiality was protected. Care staff took us aside to a quiet area where we could not be overheard to discuss the needs of people who used the service. We did not detect any care plans or paperwork that related to people's needs left unattended in communal areas and noticeboards in public areas did not inappropriately display confidential information. However, we observed that a notice board in a corridor used by people and their representatives had information about issues such as staff employment terms and conditions. Although the information was general in its nature, this use of a notice board did not promote a homely environment.

People's views were valued. The provider held meetings for people's relatives and friends, and separate meetings for people who used the service. We looked at the minutes for the meetings for people living at Carlton Dene and noted that the provider sought their views about matters including the quality of the food and their preferences for activities and entertainments. We saw that these views were used to make changes within the service. Relatives told us that the visiting hours were flexible and they felt welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at during the inspection showed that the provider used an approach that took into account people's emotional needs as well as their health and social care needs. We saw some evidence that people had contributed their views to their care plan or relatives had been involved. However, we found several discrepancies that identified areas for improvement. For example, we found that a care plan had been established for a person in July 2018 to address a health care condition. However, the health care condition had existed since the person was admitted to the service 18 months earlier. We discussed this with the care development manager who explained that the need for a specific care plan for the health care condition had not previously been considered. The care development manager confirmed that they were now looking at other people's care plans to identify if the support people needed to meet their needs associated with chronic health care conditions were appropriately addressed.

Another person's care plan stated that when they felt upset staff should talk to them about their country of birth. We noted that their individual profile was blank although they had lived at the service for over 18 months. The individual profile document was similar in design to a 'life history' and sought information about people's childhood and young adulthood, as well as their later years, likes and dislikes. Therefore, a completed individual profile might have been a useful aid to support staff to reassure the person. We spoke with the management team about this finding. The document was given later that day to the person's relative and completed immediately.

The care plan for a third person had not been updated within the nutrition section to accurately reflect that they were prescribed nutritional supplements to drink. We spoke with the senior care worker for the unit the person resided on and confirmed that they were receiving these drinks in line with the prescriber's instructions. In a care plan for a fourth person we noted that the Waterlow risk assessment for tissue viability had not been updated to reflect a significant change in a person's skin integrity after they developed changes to their skin in an area susceptible to pressure ulcers. We noted that they were receiving appropriate care and treatment from community nursing services in relation to the skin problem.

We looked at the care plan for a person with complex needs. The care plan stated that Antecedent, Behaviour and Consequence (ABC) charts needed to be completed. These are documents that can be used to record behavioural concerns and can include any information about triggers, signs of distress or environmental information. We could not find any recent ABC charts and spoke with a senior care worker who told us that these charts had not been completed for a few months. It was unclear from the care plan as to who had implemented the ABC charts, if anyone was monitoring and analysing the entries and who had authorised the discontinuation of the charts. The regional manager addressed this matter with the senior care worker during the inspection and discussed an action plan to ensure the person's needs were appropriately monitored.

Other care plans had inaccurate information. In one care plan a person was at times referred to by their surname and another care plan had not been updated to reflect that a person's relative had been granted legal powers to make specific decisions for them. We discovered this information as we found a letter in a

separate file for correspondence. The end of life care plan referred to the person as having a specific relative they would wish to see in their final days, however other documentation within their care plan indicated a slightly different family structure and did not mention this relative. The management team confirmed that they would investigate this inconsistency so that the care plan was clear about the person's emotional needs and wishes.

The care development manager told us that they were currently reviewing every care plan and stated that they would finish this task while they were assigned to the service. We found that where the care development manager had completed their reviews the care plans were well written and clearly explained how staff proposed to meet the objectives agreed with people or their relatives. However, the issues we found during the inspection demonstrated we could not be assured that the needs, preferences and wishes of each person were reflected in an individual plan that would enable staff to improve the quality of people's lives and robustly respond to any changing needs.

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

People told us they enjoyed the activities and took part in sessions that interested them. One person said, "I like to go the high street with [activities coordinator]. She helped me with an errand I needed to do and then we went for a cup of tea. Another person told us they liked any activities that involved music. The activities coordinator had actively developed a network of local volunteers from schools and community groups to become involved in the daily life of the service. This enabled people to receive stimulation from engaging with a wide range of volunteers of different ages and varying experiences, and have contact with people from the neighbourhoods they used to live in. The service was visited by students from two local schools which reflected the cultural interests, faith and linguistic skills of some of the people who lived at Carlton Dene. One of the schools had invited the service to use their minibus one day a week, which had widened opportunities for people to have outings. There was also a monthly visit from young nursery children. We were told that people enjoyed this cross-generational contact and liked to engage with the children and accompanying adults. Other volunteers came each year from a National Citizens Service project for young people. The activities coordinator told us that their project this year was to present an entertainment at the care home and a tea party. Former participants of this scheme had maintained their relationship with the service and continued to offer voluntary services.

The service was visited every week by a therapeutic organisation that provided music and movement sessions. A separate music therapy service had visited the service between January and July 2018 and was due to resume in September. Previously people had been supported to take part in Music for Life at the Wigmore Hall, which was designed to support people living with dementia to connect with music. People were supported to activities at venues in central London, for example a group of eight people went each month to the Wallace Collection museum and gallery to look around and visit the tearoom.

We noted that outings took place to cafes, community centres, library events, local pageants and parks. The activities programme offered people opportunities to do arts and crafts, go for a walk in the gardens or nearby street with an historic church, reminiscence sessions and film afternoons. We observed people and staff join together to open up a box of theatrical props from Ladder To The Moon, which is an organisation that supports care services to improve the quality of care they deliver and provides creative projects to enhance relationships between people who use services and staff. We observed that people and staff laughed as they tried on theatrical props to dress up as celebrities from the 1950's. The activities coordinator told us that they also spent one to one time with people who were not able to join activities or did not wish to, which meant that people were not excluded from this social support. The activities coordinator was

passionate about their role and was in the process of joining the national association for activities staff to access training and other resources. We noted that a limited number of care staff initiated activities on the units. We discussed this with the management team, who acknowledged that the provider needed to do more work to change this culture. The provider informed us this was already identified as an issue with some care staff and had been made a priority action within the service's improvement project with Ladder to the Moon. The provider was working with this organisation to improve the attitude of care staff towards their responsibility to undertake activities.

People we spoke with told us they knew how to make a complaint if they were not happy about any aspect of their care and support at the service. One person told us, "I would speak first with [my relative] and then I would tell the manager." A relative said, "It wasn't a complaint as such but I have in the past spoken to the manager or whoever is in charge if something wasn't right and it has always been sorted out right away without any fuss." During the inspection a visitor spoke with us about some queries in relation to their family member's health care needs. They clearly explained to us that they were not making a complaint about any members of staff. With their consent we spoke with the regional manager about the issues they had raised and these matters were satisfactorily dealt with.

We looked at the complaints received by the provider since the previous inspection. The registered manager had been in post at the time of the complaints and the accompanying records showed that appropriate actions had been taken to investigate concerns and implement new measures to reduce the risk of similar events in the future, where necessary. Complainants had been responded to in a professional and sensitive manner, within agreed timescales.

The care plans showed that people's end of life wishes had been discussed with them and their chosen representatives. We noted that people expressed whether they wanted staff to call a religious minister, for example one person had stated that they wanted to see an imam and wanted a specified relative to be consulted about their end of life care. Other care plans clearly stated that people wished to spend their final days at Carlton Dene if possible. We noted that one Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form had been signed by a hospital doctor at a time that the person was an inpatient. We spoke with the regional manager about whether the person's GP should meet with the person and their relative to determine their needs and wishes now that they were living in a community setting. The regional manager agreed that this should be followed up by the management team.

At the previous inspection we had recommended that the provider ensured that staff were aware of when people had DNACPR forms in place, so that their needs and wishes were understood and accurate information could be shared with professionals such as locum GPs and London Ambulance Service teams. At this inspection staff confirmed to us that this information was shared with them by senior staff.

None of the people who used the service were receiving end of life care during our inspection visit. The provider told us they would ordinarily liaise with the person's GP and community nursing services, and work closely with people's relatives and friends.

Requires Improvement

Is the service well-led?

Our findings

We spoke with people who used the service and their relatives regarding whether they thought that the service was well managed. People and relatives were not yet familiar with the interim management team at the service, however they spoke positively about the registered manager who was on maternity leave. The relatives we spoke with were aware that the provider hosted relatives meetings and where family members had lived at the service for almost a year or longer, they had been offered opportunities to complete surveys.

At the previous inspection we found that regular audits were in place but the audits had failed to identify the issues we had found in relation to the safe management of topical medicines, determining the correct staffing levels, the accuracy of the training matrix, staff knowledge of people's end of life needs and choices, and the need for more thorough checks in respect of the cleaning in areas of the home. This had demonstrated that auditing systems were not always effectively monitoring or improving the quality and safety of the service. We had issued a continued breach of regulation regarding the effectiveness of the provider's systems to assess, monitor and improve the quality of the services provided.

At this inspection we observed that although the provider had addressed the issues we had identified, other issues that needed to be attended to were detected by the inspectors. For example, the previous inspection report had noted that two areas in the premises were not sufficiently clean and at this inspection we found that although the care home was clean, appropriate measures with the storage of mops to prevent cross infection were not being adhered to. We spoke with the regional manager, the care development manager and the registered manager from the neighbouring service operated by the provider regarding how the provider had monitored the service since the previous inspection. In addition to the audits conducted by the registered manager before they went on maternity leave in early July 2018, monitoring visits had been carried out by the regional manager and the provider's quality assurance team. The provider's own 'mock inspection' in February 2018 had indicated the service was compliant with regulations. The regional manager thought that the decline in the quality of the service had happened in recent months.

We were informed that specific issues in terms of staff competencies and performances had been identified by these managers since they began working at the service on a daily or regular basis. The regional manager confirmed that actions were being taken to address staffing concerns and improve the quality of the service. Our observations during the inspection showed that the temporary management team were effective in their abilities to identify concerns and ensure swift action to remedy these concerns. Improvements to the service were achieved during the inspection and the regional manager assured us that a visible regional management and care development presence would continue in the service until a new interim manager was settled in their role. For example, the regional manager spoke with us about her daily observations about the food service at the care home and felt that it could benefit from a new approach to better meet the cultural diversity of people living in the City of Westminster.

At the time of the inspection it was not clear how long this short-term management structure would be in place as the provider was actively recruiting an interim manager to cover the registered manager's period of leave. Our discussions with the provider confirmed they recognised that the service would require a high

level of ongoing senior management support and scrutiny to ensure that any improvements were sustained.

We saw that the provider sought the views of staff and checked whether staff felt supported. The staff we spoke with told us they felt supported although concerns were expressed about not having enough time to complete the online training, which meant that some staff had completed it in their own time. One staff member said, "Sanctuary are a good company to work for. The managers are open and approachable." On the first day of the inspection we saw that a human resources officer from the provider's head office was visiting the service. The regional manager told us that this had been arranged as some staff had raised concerns about their terms and conditions of employment. The human resources officer was available all day to confidentially meet with employees to discuss any issues they had about working at the service. It was felt by the management team that due to the unannounced inspection taking place on the same day staff might have felt that too much was happening within the care home and therefore did not utilise an opportunity to meet with the human resources officer. The regional manager informed us that she had arranged for the human resources officer to hold an 'open surgery' on a quieter date. Records showed that staff were also asked for their views in formal staff meetings, daily handover meetings, and during their one to one meetings and appraisals.

Systems were in place for the provider to analyse and learn from information gathered following accidents, incidents and other events. The regional manager explained that the provider used an external 'Accident Line' to report all accidents and incidents. Staff were expected to report all accidents and incidents via the telephone to this line. The information given was recorded and sent to the relevant organisation and service as an unchangeable document. This report was then added to by the staff at the service as and when additional information was received, for example the outcome of investigation and proposed follow-up actions. The records we saw were appropriately detailed and demonstrated that actions were taken to learn from the accidents and incidents. However, we noted that between January and June 2018 that out of the 46 recorded accidents and incidents, 26 had taken place between eight at night and eight in the morning. We spoke with the regional manager about whether this should be followed up with a night time monitoring visit and she agreed to carry out further analysis to determine if any actions should be taken.

The provider worked in a transparent manner with the local authority and other parties who supported people who used the service. We saw that safeguarding alerts were raised promptly and The Care Quality Commission (CQC) was informed of notifiable events. The provider understood the legal requirement to display their CQC rating in a prominent place at the premises and on the provider's website.

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 9 HSCA RA Regulations 2014 Person-centred care People must be supported to receive person-centred care that meets their needs and preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's needs must be assessed to identify risks to their health and safety. 12(1)(2)(a) People must be supported to receive their medicines safely and properly. 12(1)(2)(g)