GCH (Newstead) Limited

Newstead Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 19 and 20 November 2014.

Newstead Nursing Home provides nursing and personal care to older people who have nursing needs. The home can accommodate 36 people in single bedrooms. At the time of this inspection there were 21 people living in the home.

There was no registered manager in the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home has had a number of different managers in recent years which meant there has been a lack of continuity of management which had an impact on staff morale and on quality of care provided. There had been concerns about the standard of care and treatment provided to people at the service over the last six months. We took enforcement action against the provider in August 2014 and again in October 2014. At the last inspection in October 2014, we took enforcement action because some people in the home were not receiving safe and good care. We told the provider to take action to improve the care provided and we found this action was completed.

Summary of findings

The provider had increased staffing levels so that there were enough staff to keep people safe, meet their care needs and spend time with them talking and providing comfort and reassurance. People said they felt well looked after and that staff were quick to help them whenever they needed support.

Nineteen people were getting good support to eat and drink enough. Two people were not getting the right support to meet their individual eating needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This regulation requires care providers to provide suitable food to meet individual needs. You can see what action we told the provider to take at the back of the full version of the report.

Staff were not trained in end of life care. Community specialist nurses provided this support to people in the home. The provider had ensured staff had more training and supervision which helped them to provide a safer standard of care. However staff did not have enough training in communicating with people who have dementia or other difficulties with communication.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This regulation requires care providers to ensure staff have appropriate training to provide safe and appropriate care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

The organisation of the environment was not based on best practice for people living with dementia to help people have a more homely experience. Some people sat all day in the same chair and furniture was not placed in the best way to give people a choice of where to sit and whether to talk to others or watch television.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This regulation requires care providers to ensure the building is of a suitable design and layout . You can see what action we told the provider to take at the back of the full version of the report.

We found that staff formed good relationships with people in the home and got to know them well. There was a friendly atmosphere and staff and residents were talking and laughing together.

People living in the home and their representatives were satisfied with the care and thought their individual needs were met.

The temporary manager who began managing the home in July 2014 made significant improvements in the quality of care provided at this home. Staff, relatives and people living in the home told us they were all happy with the positive changes this manager had made.

The provider was regularly monitoring the standard of care and making continuous improvements.

We have made a recommendation about improving the quality of care records.

Summary of findings

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. People said they felt safe and well looked after. Staff were trained to recognise and protect people from abuse. People's risk assessments were specific to their needs and helped to keep them safe. The building was safe.

There were enough staff to meet people's needs. The provider had taken disciplinary action against staff who were not doing their job well.

Staff provided support for people to take their prescribed medicines safely.

Is the service effective?

Requires improvement

The service was not consistently effective. The provider had given staff more training and supervision in order to help them provide a better standard of care but staff did not have enough training on best practice in caring for people with dementia and people with communication difficulties and end of life care.

Although most people had good support with eating and drinking, two people did not.

Staff supported people to attend hospital appointments and arranged for professionals to visit people in the home to help them with their health needs.

Staff did not make good use of the space to ensure everybody had a choice of places to sit, could eat their meal at a dining table, move position regularly during the day and be able to watch television if they wished to.

Is the service caring?

Good

The service was caring. Staff spent time talking with people and had developed a good knowledge of people's needs and preferences. People living in the home said staff were kind to them. People's religious and cultural needs were met. Staff protected people's rights to privacy and dignity.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive. Since the last inspection the provider has reviewed each person's care plan so that it was a reflection of their current needs and wishes. Staff responded appropriately to people's requests and treated them as individuals.

People enjoyed some of the activities provided, for example a visiting entertainer but there were not enough appropriate activities for people with dementia to reduce social isolation.

Summary of findings

Is the service well-led?

The service was well led at the time of this inspection. The temporary manager had made improvements in the way the home was managed. This manager had made a positive difference in the culture and leadership of the home and the standard of care had improved significantly over four months. A new qualified manager was employed to start work in the home on 24 November, the week after this inspection.

We have made a recommendation to improve the quality of records of care provided

Requires improvement 

Newstead Nursing 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 unannounced inspection took place on 19 and 20 November 2014. The inspection team included two inspectors, two specialist professional advisors (one nurse and one speech and language therapist) and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This person's expertise was in the care of people who have dementia.

We took into account the service's inspection history, which included three inspections in the previous 12 months. We took enforcement action against the registered provider, GCH (Newstead) Ltd, as a result of our inspections. This took the form of four warning notices in August 2014, due to breaches of regulations about staffing, support for staff, record keeping and quality assurance (the provider's responsibility for assessing the risks to people in the home and the quality of the care provided). We then served another warning notice in October 2014 due to a failure to comply with the regulation about the care and welfare of people in the home, including a substantiated case of neglect of a person living in the home. The local authority had also made the decision to restrict further admissions of people into the service.

Before this inspection we reviewed all the information we held about this service, including the notifications sent in by the provider over the past six months, complaints, safeguarding alerts, inspection reports from July and September 2014, enforcement action taken against the provider, the provider's action plan for improving the service and information provided by the local authority and the local Clinical Commissioning Group.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care and how staff interacted with people in the communal areas such as the lounge and dining area and spent time with some people in their rooms. 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. There were 21 people using the service at the time of our inspection. We met 20 of the 21 people who were using the service and spoke with nine of them about their experience living in the home and views on the home. We also spoke with four relatives. We spoke with the temporary manager, one of the provider's directors, a quality assurance manager for the company, and eleven staff members, including kitchen and domestic staff, care assistants and nurses. We also spoke with four health and social care professionals during and after the inspection.

We looked at ten people's care and treatment records in detail. We also checked menus, risk assessments, six staff files, staff duty rosters, staff training, supervision and meeting records, accident and incident records, selected policies and procedures, quality checking records and medicine administration record charts.

Good

Is the service safe?

Our findings

People said they felt safe and well looked after. Relatives of three people who could not talk with us said they thought their relative was safe in the home. We saw that the manager and quality manager were regularly checking records of care provided, to ensure that people were safe and well cared for. One example was checking records to make sure night staff were helping people change position in bed regularly to reduce the risk of them getting a pressure sore.

The home had a safeguarding policy and the provider had trained staff in understanding how to recognise abuse and how to follow the safeguarding policy. Staff understood how to recognise and report any signs of abuse. In the last year there were two safeguarding alerts made about a person in the home being neglected and suffering harm because of neglect. Both were substantiated. The local authority investigations found that both people had been neglected in the home. We found that in the last two months since our last inspection the standard of care had improved and there was less risk of neglect. This was due to more effective management, increased staffing levels and, care plans were a more accurate reflection of people's needs. The provider had ensured staff were being trained and supervised better to deliver a better standard of care. In addition no new people had moved into the home while the provider was making necessary improvements to the quality of care provided. This combination of factors had reduced the risk of people being neglected again or poor care being provided.

Staff knew about whistleblowing. One said, "there is a lot more openness now and I would speak first to the manager. If I did not get satisfaction, then I would take it further." Staff said they would contact Haringey Council, the visiting quality assurance nurse from the local Clinical Commissioning Group (CCG) or Care Quality Commission (CQC) if they had concerns about the care in the home. Staff said they would feel confident to raise concerns if people in the home were not receiving good and safe care.

Everybody had a risk assessment to check their risk of falls, poor nutrition and risk of developing a pressure sore and other possible risks to their safety. Risk management plans instructed staff on how to help the person to reduce risks and keep them safe. We checked staff were following these and found that they were. One example was that staff stayed close to a person at risk of falls, monitoring them and sitting next to them to ensure they could offer help as soon as the person tried to get up.

Staffing levels had been increased since the last inspection. The increase in the number of staff on duty made it easier for staff to meet people's needs and spend more time with them. Staffing levels at the time of this inspection met the needs of people living in the home. One staff member told us that the last four years in the home had been unsettled but that since our last inspection staffing had improved. They said, "Management have taken responsibility and now plan ahead for extra staff on the rota for example to take people to hospital appointments." A nurse told us how they were given an extra shift every two or three weeks to ensure their recording was up to date and care plans updated. This was good practice by the provider as previously staff had to take time away from caring for people to write the care records. Another staff member said, "Nurses now have time to do proper nursing and maintain records and do assessments." We asked staff what impact the increased staffing had and all said the care had improved for people in the home. One nurse told us, "You can see the difference in the service users; there is enough time for them and they are getting the care they deserve."

Two people in the home told us they did not like having "a lot of new faces" working with them. There were not enough permanent staff so agency and bank staff were being used. The provider was recruiting new staff to try and ensure there was a permanent staff team who would be able to get to know the home and people living there well.

We looked at three staff records and found two references on each file relevant to the job applied for. There were no unexplained gaps in the applicant's employment history. All had Disclosure and Barring Service checks on record which showed they did not have any criminal record. This was evidence of safe recruitment practices to try and ensure new staff were suitable to work with vulnerable older people.

The provider had taken disciplinary action against eight staff in the last year because of job performance issues. This showed that the provider was monitoring staff to make sure standards of care were raised in the home and staff provided safe care, that bad practice was stopped and staff behaved appropriately. Although this number of staff being disciplined is high, it reflects our findings that there was

Good

Is the service safe?

bad practice in the home earlier in the year when the provider was not monitoring the home properly. The disciplinary action was evidence that our concerns were acted on appropriately by the provider.

We looked at a sample of medicine charts and observed a nurse giving the morning medicines. Staff provided support for people to take their prescribed medicines. One person was chewing their tablets as they were unable to swallow them whole. We had raised this as a concern at our previous inspection. We saw written evidence that a Speech and Language Therapist had visited this person and staff had contacted the GP and pharmacist to ensure the tablets were to be changed to liquids. The liquid medicine was going to be delivered a few days after the inspection. Therefore the correct procedure was being followed to make sure this person would be receiving their medicines in the best way for them.

The manager had carried out a medicines audit and arranged for a pharmacist to come and talk to the staff team to give further advice on medicines. Another audit was planned for December so there was evidence that senior staff were monitoring the administration of medicines to ensure people received their medicines safely. There was clear guidance for staff on when medicines should be given for those medicines that were "as and when needed" and people's photographs were on their medicine chart so that all staff could identify people before giving them any medicines. Allergies were clearly recorded for people. We saw some good practice, including staff explaining to somebody what their medicine was for and why it was a good idea to take it, and waiting to ensure people had swallowed the tablets before signing that it was given.

We saw evidence that the home's electricity, gas and water supply services had been inspected and were assessed as safe. We inspected the building and there were no obvious hazards to people's safety. Kitchen staff were taking temperatures of the fridges and freezers daily to ensure food was stored at safe temperatures. Bathrooms were being refurbished to better meet the needs of people who needed to use a hoist to get in the bath. Records showed that fire alarms, lighting and extinguishers were checked regularly and the maintenance manager carried out regular health and safety checks to ensure the building was safe for people living there.

We checked five electronic pressure-relieving mattresses in use. These were correctly set to provide pressure appropriate for the person's weight to help prevent pressure sores. A weighing hoist was broken. This made it difficult to weigh some disabled people. Weight monitoring is part of the care provided to support people with their health. We told the manager about this so it could be repaired.

Requires improvement

Is the service effective?

Our findings

In October 2014 we took enforcement action against the provider to tell them to make improvements in the areas of prevention of falls, pressure sores, dehydration, poor nutrition and choking. We had found that due to poor care planning people were at risk of receiving unsafe or inappropriate care. At this inspection we found that this action had been completed. There were improvements in all aspects of care and treatment. People told us they were satisfied with their care.

There had been an increase in training provided to staff. Staff told us the training was practical and face to face which they preferred to e-learning on a computer. Staff had been trained in preventing and treating pressure sores, Mental Capacity Act, safeguarding adults, dignity in care, dementia awareness, infection control and moving and handling in recent weeks. Staff were booked onto nutrition training soon after this inspection date which included how to assess people for nutritional support and how to use PEG feeds (where a person is fed directly into their stomach). The training they had completed helped staff to improve the quality and effectiveness of care provided. One nurse told us "we can give better quality of care with this training; the service users are getting better care as a result of this and they are more alert and happy."

Staff were not trained in communicating with people who had different communication needs due to loss of speech after a stroke and dementia. This was evident when watching staff with people as they did not always use Plain English, give enough time for the person to understand and reply and sometimes caused the person to be more confused. One person had a communication book but this was not with the person and staff did not use it to communicate with them. This limited the person's opportunity to make requests or to initiate any conversation. A relative also told us they thought staff needed more training in how to communicate effectively with people who suffer from some confusion and how to help them when they are distressed. Another said they thought staff were, "caring but poorly trained." Care plans did not have enough specific information about how to best communicate with the individual.

The above information was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager had ensured all staff received supervision since they began managing the home in July 2014. They told us they were waiting for the new permanent manager to start on 24 November, a few days after this inspection so that they could carry out staff appraisals together.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the main Mental Capacity Act 2005. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The provider was following the requirements of the Deprivation of Liberty Safeguards which require providers to submit applications to a 'Supervisory Body' for authority to deprive somebody of their liberty. The provider had submitted a recent application for a DoLS in relation to the use of bed rails to stop a person from falling out of bed. We saw on record that this was granted by the local authority.

Documentation in one person's care plan showed that when a decision had been made about a person's care, where they lacked capacity, this had been made in the person's best interests. As staff had attended training in the Mental Capacity Act they were able to understand the Act and support people to make their own decisions about their care and treatment and know when a best interests meeting is needed. We asked one care assistant about consent and they demonstrated an understanding of the need to gain consent, "we can only encourage people; for example, this morning a service user refused to have a shower as it is in their care plan to shower every day. I tried to persuade them and then told them I will ask again before my shift finishes this evening."

The majority of people living in this nursing home had high needs and required support with eating and drinking. We observed 20 of the 21 people in the home eating their lunch. We saw that staff were helping people to eat in a positive way, giving them assistance where necessary and encouragement. The meal time was not rushed and there were enough staff to help everyone to eat.

We found one person at risk of choking. This person was choking while we were observing them eating. The provider had not sought specialist advice from a Speech and Language Therapist regarding this person's swallowing difficulties and this placed them at risk of choking. We

Is the service effective?

observed this person removing some pieces of food from their mouth during the meal as if not able to swallow it. The manager took action to refer this person for an assessment of their swallowing immediately when we discussed this with them during the inspection.

In the kitchen there was information about people's nutritional needs and allergies so the chef was aware of each person's needs. We saw one person's care plan said they should not eat dairy foods but at a mealtime we observed this person being helped to eat cheese sauce and custard, both containing milk. Staff said that the person could eat cooked dairy products but not milk in drinks. There was a lack of clear written information about whether this person was able to eat dairy products or not. This meant the person was at risk as there was inadequate information about their needs. We told the manager that this needed to be addressed immediately on the day of the inspection and he agreed to do so.

These two concerns were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as these people did not get suitable food to meet their individual needs.

Ten staff were booked to attend training on assessing people for risk of malnutrition for the week after the inspection and we saw records showing the manager had showed nurses how to use this assessment tool. One person said they didn't like the food and gave the chef advice on how to cook. We saw that the kitchen staff were happy to prepare different foods for this person until they were satisfied with their meal. In between meals people had individual snack boxes containing items of their choice such as crackers, biscuits, fruit and crisps. Hot drinks were served mid-morning and mid-afternoon.

At the last inspection we found that some people were at risk of dehydration as staff had recorded on their fluid records that they had not had enough to drink, but had taken no action to ensure they were hydrated. Since that inspection, the manager showed us that staff were monitoring people's fluid intake properly. A nurse was checking the charts and informing all staff to make sure they were offering people more drinks. We saw staff regularly offering people cups of tea and glasses of water throughout the two days of our inspection. The GP looked at the fluid records on his weekly visits so they could monitor people who may be at risk of dehydration . We looked at fluid intake records and found that the risk of people becoming dehydrated had reduced as staff were offering them more drinks. Records showed that everybody in the home was drinking regularly throughout the day. As a result of these improvements, we found no concerns that anyone was dehydrated.

One person told us " the soup is always good and the chef makes it fresh from scratch." Other people said the food was "nice" or "alright." People were given food of their choice. There was a daily choice of two main meals which were usually English food, and a number of people had separate food cooked for them including Greek dishes and one person liked and received rice every day. We saw that the chef had a good knowledge of people's preferences and brought them food he knew they liked. Some people had fortified food (with extra calories) or pureed food which the chef presented so that it looked appealing. The home catered well for people's different cultural and religious dietary preferences.

Staff were monitoring people's weight and the manager was keeping a weekly check on weights and referring people to the GP or dietitian if they had lost or gained a significant amount of weight. This helped staff to know who needed support to eat more and helped people to aim for a healthy weight.

Everybody had a Waterlow assessment which assessed their risk of developing a pressure sore. We found people had appropriate pressure-relieving mattresses and cushions and staff were helping them to change position regularly at night to reduce the risk of sores developing. We checked a sample of records for six people who needed to be turned at night and saw these were recorded properly. During the day people moved less as staff did not ensure people moved from their chair regularly. Records showed four people who had a pressure ulcer previously had been treated appropriately and pressure sore treatment had improved since our inspection in September 2014. One person had a pressure ulcer but this was being treated well. Nurses contacted the local tissue viability nurse for advice when needed. We spoke with three nurses and one care assistant who showed a good understanding of how to prevent sores and knew what to do if there was a sign of any skin changes. We spoke with a relative of somebody with a minor sore who told us their relative's physical condition had improved and they were also now gaining some weight due to improved care in the home.

Requires improvement

Is the service effective?

We saw that in recent months staff had referred people for specialist health services and people had received physiotherapy, swallowing assessments by speech and language therapists and visits from dietitians. Staff supported people to attend appointments with hospital consultants by going with them to provide a medical history and support, if they had no relative or friend to take them. We saw that information from these appointments was shared with other staff during daily handovers so that all staff knew of any changes to a person's health or treatment. We checked a sample of five care plans to see if guidance from specialists about health was included and we saw that staff were following the advice of the professionals.

The available space was not used well to ensure people could choose whether to sit near the television or in a quiet area. In addition the lounge was used as a walkway between the two units so staff and visitors walked through the middle of the lounge and in front of the television frequently including staff with the cleaning trolley. There was another door which could have been used more discreetly so that people were not disturbed so often by others passing through, especially at mealtimes. Facilities for staff were poor. The staff toilet had been redecorated but the training room and staff room where staff had their breaks contained discarded items including a toilet seat and archived records and were not clean.

The dining room was too small for the number of residents but there was space in the lounge with tables which could have been used at mealtimes but was not. This meant a few people sat all day in the same chair including eating all their meals. Although they did not complain about this, one person told us they had backache and always sat in the same chair for over 8 hours a day. Lack of mobility increases the risk of pressure sores and discomfort.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which requires the provider to ensure suitable design and layout of the premises.

Since the last inspection in September 2014, the provider had made some improvements to the environment. An unused area of the lounge had been made into a seating area. A refurbishment plan had just started. Three toilets were being updated to make them large enough for people with a physical disability to use them with a hoist. New washing machines were being ordered along with a new oven and wet rooms were planned to replace shower rooms.

Good

Is the service caring?

Our findings

We found that staff acted in a kind way towards people. They spent time sitting down and talking with people. We saw staff laughing and joking with people throughout the day. We spoke with relatives of three people who were not able to express their own views about staff. One said, "He seems to be comfortable. I think they do care how he is." The others said that staff were attentive to people's needs and had a good relationship with their relative.

Staff demonstrated knowledge of people's preferences and daily routine and they used this knowledge to help provide good care. We saw that some people had a preference for male or female staff and this was respected. One example of this was when a female nurse told us that the resident would not eat but that she preferred male staff and might eat if encouraged by a male nurse. She asked a male nurse to come and support this person and they then ate their meal.

We saw staff being gentle to people while supporting them with tasks such as eating, taking medicines, getting changed and checking on their wellbeing. Staff were patient, spoke quietly and did not rush people. We saw that if somebody refused a request to have a drink or allow staff to help them get dressed, staff left them and tried again later or asked another member of staff to try a new approach. This was good evidence of respecting people's decisions while still encouraging them to do things that were in their best interest.

We saw that staff respected people's dignity and privacy when supporting them with personal care in the way they spoke to them and made sure bathroom and bedroom doors were closed when helping people with personal care.

We saw some good practice. One member of staff told us they would "sit close by, touch and use eye contact." They said, "it is also important to know a person; for example, one person is more able to talk earlier in the morning, so that is when I make sure I engage with them." We observed excellent interaction where a nurse communicated with a person using writing on a whiteboard. By spending the time to do this the nurse was able to explain to the person why they should take their medicines and encourage them to do so. In addition the board was used to help staff and resident enjoy a laugh and friendly conversation.

We saw that staff had limited training on communicating with people who had dementia but they were willing to learn and tried to make people feel comfortable. One care assistant said, "everything a person is trying to say makes sense to them; we must try hard to understand, make them comfortable and give lots of reassurance."

We saw staff spending good quality time with people, chatting, reading to them or making sure they had a drink or ate their meal.

Two people told us that staff supported them with their religious needs. One said that a staff member would pray with them and sing religious songs together which they enjoyed.

We also saw a member of night staff saying goodbye to people individually and telling them to "Have a lovely day. I will see you tonight." Two people told us they liked this staff member as they were so friendly. Some people were asking staff about their children showing that they had previously had conversations with them about their families.. One person said of staff, "oh aren't they lovely? I like it very much here." Another told us "I think everybody is nice. That matters doesn't it?"

We saw that the activities organiser knew information about some people's backgrounds and was able to talk to them about their families. We also saw her calm a person by touching their face and hug somebody which had a positive impact on the person's mood.

One staff member told us, "One of the things I am most proud of is we care workers really care for the service users and want to do our best."

A relative said, "The staff are very affectionate towards my mother. One is superb and another is very good too."

Some people wanted to stay in the home until the end of their life. Most staff had no training in palliative care so we could not be assured that people would receive the best nursing care at the end of their life. In the meantime the home used the services of a local palliative care team when needed to ensure people were cared for appropriately at end of their life so that lack of staff training did not have a negative impact on people. The manager told us that one nurse was attending end of life care training at the time of the inspection.

Requires improvement

Is the service responsive?

Our findings

We looked at ten people's care plans to see if there was an up to date assessment of their needs and a clear plan for their care and treatment. We found that care plans had improved since our last inspection two months ago. Each person had a new assessment and care plans had been rewritten, including involving people or their chosen representatives. Some plans had some information about the person's history and their likes and dislikes. Others had limited personal information. We observed whether staff knew people's needs as recorded in their care plan and whether they were following the plans. We found that with one exception where improvements were needed to support somebody with eating, staff knew the person's care needs and were providing the right care. When we spoke with staff they had a good knowledge of the residents and were able to tell us people's preferred daily routines and what their important care needs were.

We spoke to people about whether the home met all their needs. One person said, "It's alright here, it's ok. They know what I like." Another said, "they look after me. The girls are good to me."

We found that some people spent most of their time in their bedrooms which meant they were socially isolated. One person told us they were "lonely" and another said they were, "only half living." On the second day of the inspection staff supported everybody who was able to get up and come to the lounge. We observed the two people who had been unhappy the previous day when we spoke to them. We found their experience when out of their bedrooms was more positive. Staff interacted with them more frequently and both people who were initially withdrawn responded well to staff talking to them and were later smiling, showing interest in their surroundings and talking.

People enjoyed some of the activities provided, for example a visiting entertainer. One person told us, "I came to live here because I need help with everything. Now I'm here, I enjoy the activities." We saw other people joining in with singing. The activities co-ordinator works at the home for 6 hours, 5 days a week. One person told us, "the activities co-ordinator is very good, she's good with the very elderly. She talks to the other residents. When she doesn't come in, we miss her. She does quizzes and bingo and we play ball. Sometimes we sit and chat."

A large television was mounted high on a wall at one side of the room with daytime television on until the activity session began at 2.00pm. Nobody was watching the television but we also observed that people were sitting too far away to be able to see or hear it properly. We asked one person if they could see the television and they said, "No, it's on most of the day. I'm just aware of there being movement. There's nothing to do in the evenings, so I just go to bed at 6.00pm and watch my own TV in there."

We noted that staff had not been given training in organising suitable activities for people who have dementia. There were organised activities such as music, visiting entertainers, manicures, skittles and playing with a balloon. Staff did not always know how to engage people or how to help them carry on their daily routines and hobbies they had before moving to the home. There was limited choice of activities or opportunity to take part in normal day to day activities such as housework, making food or drinks or to go out of the home for a walk, shopping, to a cafe or local places of interest.

There were two noticeboards in reception with photos of activities, some clay shapes and drawings that residents had made. The noticeboards were placed so that visitors could see them as they walked into the lounge. Along with attractive flowers, books and magazines these items were placed where people living in the home were unable to see them. Staff took two people to sit in the lobby when we raised this issue and we saw they enjoyed a change of space and something different to look at.

We looked at the record of complaints made about the home. Complaints had decreased since the temporary manager took over. We found that concerns raised by relatives and staff were taken seriously and acted on.

We recommend that the service seeks advice and guidance from a reputable source about current best practice in relation to person centred activities for people living with dementia.

Requires improvement

Is the service well-led?

Our findings

This home did not have a registered manager. There had been a number of different managers and regional managers involved with the home over recent years. There had been inconsistency in the quality of care provided and a lack of support to staff. The provider failed to provide appropriate training, supervision and support to the previous manager and did not implement the company quality monitoring processes. Therefore the provider had not known that the standard of care being provided was not of an acceptable standard and people were at risk of unsafe or inappropriate care. People living in the home and relatives told us they did not have confidence in the provider and said the directors did not speak to them when they visited. They did have confidence in the manager and liked the staff.

Since we took enforcement action in August 2014, the provider and manager made improvements in the home. These included carrying out an audit of the quality of service, training and supervising staff, taking action where staff had not provided good enough care, improving care plans, providing better support for people with eating and drinking, preventing pressure sores, increasing staffing levels and improving the quality of care and treatment records. These actions had led to an improvement in the quality of care. There had been an improvement in people's quality of life because staff were able to respond more quickly to their needs and spend more time looking after them.

The provider had purchased a new call bell monitoring system so that they could monitor how long it took staff to answer call bells. The records of this monitoring showed a good improvement in responding quickly to people's requests for assistance. People living in the home also told us that staff responded quickly if they rang their bell to ask to go to the toilet at night.

We asked one experienced staff member how they thought things were going in the home after CQC enforcement action and extra monitoring from commissioners. They said, "fantastic." They explained that they thought the manager led the home well and encouraged the staff to work together for the good of people living there.

Recent staff meeting minutes showed evidence of good leadership of the home. We saw records of the manager meeting with nursing and care staff, catering staff and housekeeping staff. Meeting minutes were clear about what was agreed and who would carry out the action.

Staff were involved in decision making and two staff told us they felt "treated with respect." Staff told us they were happy with the manager and his leadership style. One staff member said the manager "always had time to listen" and another said he was "much more supportive, he listens to staff and has implemented more training." We observed the manager meeting with domestic staff and saw that he gave clear instruction and also listened to staff's suggestions. Staff said the home was "much happier." Staff morale had noticeably improved since our last inspection two months previously. Staff said they felt listened to. Staffing levels had been increased giving them more time to meet people's needs and spend quality time with them. At the same time they said they had clear guidance and "strict" rules from the temporary manager which ensured staff worked hard as a team. A relative of someone living in the home told us, "they have definitely stepped up."

Another relative said of the manager, "He is on it at all times of the day and night. Since he arrived, the morale has improved. We all dread his leaving."

Since the last inspection a regional manager and quality manager had carried out monthly audits of the quality of service provided at the home and made reports with actions they wished the manager to complete including by what date. This was evidence that the provider had improved their assessment and monitoring of the quality of the service. The reports showed that these managers found areas for improvement and brought them to the manager's attention and then checked that the improvements were made.

The provider informed us that a new qualified and experienced manager would be starting in post on 24 November, a few days after this inspection, and they would be supported by the current manager working alongside them so that there was a smooth transition and minimal disruption for staff and people living in the home. Staff said they were apprehensive about another change of manager but they hoped that the home had improved enough and that things would "now settle down."

Requires improvement

Is the service well-led?

One worker told us, “everything is shaping up nicely at the moment.” Another told us how they believed the quality of care had improved, as a result of which “there is a more vibrant atmosphere around the home.”

The manager was monitoring care at night after unannounced visits by Haringey Council commissioners and by CQC inspectors in May and July 2014 showed a poor level of care was being provided at night by insufficient numbers of staff and records of care were being falsely produced. Records showed the manager had visited three times at night since September. Care at night had improved and visits by senior managers had highlighted more areas for improvement and ensured these were acted on. One person living in the home told us they were checked more often at night than they were a few months ago.

Record keeping had improved in the last two months. The quality of information recorded about people’s care and treatment had improved and was more useful than it had been at the last inspection. However despite the improvement and recent training for staff on record keeping we found that some hourly monitoring charts often noted only if the person was asleep or awake and not information on their wellbeing and whether they were offered a drink, a chat or help to use toilet. Some daily records did not record how the person was.

We recommend that the quality of people’s care records is improved in line with best practice.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure staff received appropriate support and training to deliver care and treatment in the areas of caring for people with dementia and other communication difficulties and those needing end of life care. Regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person was not ensuring that each person was protected from the risks of inadequate nutrition through the provision of suitable food to meet their needs. Regulation 14(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person was not protecting people from the risks associated with unsuitable premises because the design and layout of communal areas was not suitable to meet people's needs. Regulation 15(1)(a)