Sanctuary Care Limited

Hawthorn Green Residential and Nursing Home

Inspection report

82 Redmans Road
Stepney
London
E1 3DB

Tel: 02077027788
Website: www.sanctuary-care.co.uk/care-homes-london/hawthorn-green-residential-and-nursing-home

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced focussed inspection of this service on 11 and 12 November 2015. Some breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to staffing.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found.

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

The home was arranged over four floors, with two units each on the ground, first and second floor. Each unit had 15 bedrooms, each with an en-suite toilet and washbasin. The third floor housed the kitchen, staff and laundry room. There were two residential units on the ground floor, two nursing units on the first floor and two nursing units for people with advanced dementia on the third floor.

At our previous inspection we found that there were not always enough staff at the service to meet people's needs. We also found that complaints were not managed effectively. People using the service and relatives were not adequately supported to feedback their concerns about the quality of care. At this inspection, we found that improvements had been made in both areas.

Although we received mixed feedback from people using the service and relatives about staffing levels, we found that the provider had undertaken steps in response to the concerns found at the previous inspection.

Staff rotas and discussions with the management team showed that the reliance on agency staff who were unfamiliar with peoples' support needs had reduced from the last inspection. There was good management oversight on the progress on any pending vacancies. A recruitment tracker was in place and monitored on a weekly basis to pick up any gaps and follow up on any issues that were holding up pending applications. The provider was piloting a formal staffing tool and had completed dependency questionnaires for each person to ascertain the level of support required.

A complaints form and a suggestions box was available for people and visitors to provide feedback. The complaints form was available in other languages. A complaints officer at head office monitored all the complaints that had been received and ensured timescales for responding to complaints were being adhered to. We looked over the complaints that had been received since the beginning of the year and saw that the majority of them had been responded to and resolved.

People told us they felt safe living at the home and we found that where concerns had been raised, the provider had investigated and acted upon recommendations made.

People we spoke with told us they were treated kindly and with dignity and respect and that staff observed their right to privacy. Relatives were mainly happy with the way that staff treated their loved ones. Staff demonstrated a caring attitude towards people, however on occasion we did see instances where staff could have acted in a more caring manner. People were happy with the quality of the food served and that there had been an improvement with the recent appointment of a new chef.

Where people did not have the capacity to understand decisions related to their care and treatment, best interests meetings were held which helped to ensure their rights were protected. The provider sought legal authorisation where people needed to be deprived of their liberty in order to keep them safe.

Medicines in the home were managed appropriately. Staff had received training in medicines administration and asked for people's consent when supporting them with medicines. Medicines were stored safely and records completed accurately. Regular audits were completed which helped to ensure medicines management was safe.

Regular checks on equipment such as hoists, slings, beds, wheelchairs and assisted baths were carried out. Care records included risk assessments that were individual to people's support needs.

Care plans included identified strengths, agreed outcomes and planned care tasks and were reviewed on a monthly basis. We found that care plan reviews were not always reflective of people's current support needs.

New staff completed an induction when they started and thereafter received ongoing training which helped them to provide appropriate support to people. There was good management oversight with regards to compliance against training, which training had expired, when it was due to be renewed and when it had been completed.

People using the service and their relatives told us their healthcare needs were managed appropriately. We spoke with two visiting health professionals who gave us positive feedback about the provider and how they were kept informed about people's current health needs.

Quality assurance audits at the home were thorough and covered a number of areas including medicines, care plans, ongoing monitoring of changes to people's health and analysis of any incidents and accidents.

We have made two recommendations in relation to staffing and person centred care.

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

Some aspects of the service were not safe.

Staff were not always deployed in a way that meant they were available to meet people's individual needs.

The reliance and use of agency staff had gone down since the last inspection. Although there were some vacancies, these positions were in the process of being filled and the provider had implemented systems to regularly monitor that sufficient staff were employed on a regular basis.

People told us they felt safe living at the home. Where safeguarding concerns were raised, the provider acted upon recommendations made.

People were assessed against any identified risks. Checks were carried out on equipment such as hoists and wheelchairs which helped to ensure safety.

Medicines management at the home was safe.

Is the service effective?

Good

The service was effective.

Staff received regular training which helped them to support people effectively.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Where people did not have the capacity to understand decisions related to their care, these decisions were taken by consulting appropriate people and making decision in their best interests.

People told us they liked the food at the home and we found that their dietary and health care needs were being managed appropriately.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People told us that staff cared for them and respected their privacy. However, we saw some examples of staff not treating people respectfully.

We saw examples of staff supporting people in a caring manner and people using the service and their relatives told us they were involved in care planning.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

Although care plans were in place for people, the reviews were not always reflective of current support needs.

Complaints were recorded and responded to in a timely manner.

There were a variety of activities on offer within the home, led by a team of activity co-ordinators.

Is the service well-led?

Good

The service was well-led.

There were a number of quality assurance audits which took place at regular intervals.

These included ongoing monitoring of any changes to people's health such as wounds, body mass index calculations and weight loss.

Medicines and care plan audits also took place.

Hawthorn Green Residential and 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook this unannounced comprehensive inspection on 4 and 11 October 2016.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 11 and 12 November 2015 had been made and to carry out a full comprehensive inspection.

The first day of the inspection was carried out by one inspector and an expert by experience. We told the provider we would be returning for a second day but did not tell them the date. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. One inspector carried out the second day of the inspection.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During our inspection we spoke with 14 people using the service, six relatives and 15 staff members, including the care development manager, regional manager, home manager, deputy manager, clinical lead and the chef. We looked at five staff files and spoke with two visiting professionals.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection which took place on 11 and 12 November 2015, we found there were not always enough staff to meet people's needs. Staff across all roles reported that frequent staff shortages impacted on the safety and wellbeing of the people using the service. One unit did not have a full complement of staff as required under the provider's policy.

At this inspection we found that improvements had been made as despite mixed feedback from staff, people using the service and their relatives we found that the provider had undertaken steps in response to the concerns found at the previous inspection and work had taken place to improve staffing.

Most people felt confident that help was on hand should they need it. Comments included, "There's always someone here if I need them", "They've told me they are always here to help if I need anything" and "They come if I ring." Some, however, felt that there was not enough staff and told us, "The staff are good but they are very short", "They come as quickly as possible if I call, depending on whether there's enough staff about", "Sometimes if there's only one on at night it's difficult for them but on the whole you are looked after and they generally come quickly enough" and "The night staff don't come quickly. I have to shout seven or eight times to get them. I tell them of it and they act as if they don't know what you are talking about."

Comments from relatives included, "Whenever I've been here, there is always someone around", "Sometimes there doesn't seem to be a lot of staff about but they are good and [my family member] is well looked after", "I think there could be more staff. I've seen residents call for attention in the lounge when I've been sitting there with [my family member]. Once I saw two staff at the desk in the corridor but they couldn't see the lounge and they couldn't hear the residents calling. There was only me there with them for what seemed like at least 15 minutes. This has happened on more than one occasion" and "They are kind to [my family member] but they seem understaffed. They are always busy and they haven't got the time to take [my family member] to the garden."

Staff told us, "I could do with an extra pair of hands. It can be quite hectic in the mornings. Some people need two people to help with personal care which can make it difficult with three staff on during the day. Once the medicines and breakfast period is finished, things start to calm down" and "It is busy in the morning but we can work it out between us, two of us are doing personal care and I'm doing the breakfast."
We looked at the incidents and accidents over from June 2016 to August 2016, in the analysis that was carried out for August, it stated that 'most falls happen during the early morning and evening' and the action was for staff to increase checks by half hour. It was not clear if this action was taking place.
We recommend that the provider seeks further support from a reputable source to further assess the appropriate deployment of staff in the service to ensure that people's individual needs are met in a timely way.

During the day, on the ground floor there was one team leader and two care workers per unit. On the first and second floor nursing units, there was one nurse and three care workers per unit.

During the night, on the ground floor there was one team leader floating across both units and two care workers per unit. On the first and second floor, there were two nurses on shift, one covering each floor. There were two care workers on each unit.

We looked at the staff rota over a three week period and saw that although there were some agency staff used, the numbers were lower than previously found. The deputy manager told us they compiled an occupancy summary looking at the staffing levels for the following weeks to see if any shifts needed to be covered. They told us, "The use of agency staff has gone down lot. It was previously around 10, now it is around three shifts per week." A staff member told us, "We very rarely work with agency now. I work with the same people. The levels have been consistent since April/May time."

We spoke with the manager and regional manager about the improvements to staffing numbers since the last inspection. They told us they had done a lot of recruitment and the majority of their posts had been filled. They said they had reduced their reliance on agency staff to around 12-24 hours per week as this had been identified as an issue. The regional manager told us, "The plan is to stop using agency by the end of October 2016."

A conference call was held weekly between the managers, clinical lead and a human resources (HR) officer to check on the progress on any pending vacancies. A recruitment tracker was in place which was maintained by both head office and managers at Hawthorn Green. We saw there were six applications in process, including two night care workers and three bank care workers. The recruitment tracker was monitored on a weekly basis to pick up any gaps and follow up on any issues that were holding up the applications.

The provider was also supported by a member of the Human Resources department to provide support with disciplinary, staffing issues and staff engagement. The provider had implemented a new system to monitor staff sickness that enabled them to identify and address serious absence levels and patterns of absence worthy of further investigation.

The regional manager told us they were piloting a formal staffing tool used by the NHS, known as 'the care home staffing model'. They said, "It will give us a guide as to our staffing levels so that we have something a bit more evidence based." They also showed us some dependency questionnaires that were completed for each person looking at their independence in relation to eating, transfers, moving, dressing, continence and behaviours. They said these findings would feed into the dependency tool.

The manager said their call bell system was to be upgraded which would enable them to have data in terms of how long staff take to respond to call bells and how long they spent whenever they were called.

Staff recruitment checks were thorough. Staff files contained their application form which included employment history, references and previous education and training. Staff also completed a questionnaire based on their understanding of the role. A recruitment and reference risk assessment form was completed to check if references covered the past three years and if they were satisfactory. Staff files contained offer letters and a final offer of employment which was sent after receiving confirmation of their Disclosure and Barring Service (DBS) checks, medical fitness references and eligibility to work. Staff contracts which were signed and dated were also seen. The DBS check assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people and includes criminal record checks.

People told us that they felt confident that the staff were competent and supported them well with their

medicines. They said, "They sort out my medicines for me" and "If I have to have medicine, they see to it for me." Staff had received training in medicines administration.

We observed a member of staff doing a medicines round. They greeted people in a friendly manner and asked people for their consent before administering their medicines. People's wishes were respected, one person said they didn't want their medicines at that time and this was accepted. The staff member went back to them later and offered it to them again. We checked the covert medicines authorisation form for one person and saw that appropriate guidance had been followed. The person did not have capacity to understand this specific decision and so authorisation was sought following a best interests decision in which family members, the pharmacist, staff and the person's GP were consulted.

People received their medicines from blister packs. Medicine administration record (MAR) charts were completed correctly. Each profile had a photo of the person, a risk assessment and best interests decisions for covert medicines if required and preferences for taking medicines. Liquid medicines and drops were labelled with the date they had been opened, so that they could be disposed of once they expired and these were all in date. We checked the controlled drugs in one unit, these were all accounted for correctly and records signed by two nurses as required.

We saw evidence that the team leaders and nurses underwent regular training and competency assessment in medicines administration.

People using the service told us they all felt safe living at the home. Relatives were equally happy about this aspect. Comments included, "Of course I feel safe here" and "I feel [my family member] is safe here. At home [they] kept falling."

A safeguarding leaflet was on display in the reception area. The provider alerted the relevant authorities when safeguarding concerns were raised and statutory notifications were sent to the Care Quality Commission as required. There was evidence that where actions had been identified for the provider to follow up during investigations, the provider took notice and acted upon the recommendations.

Where people had been identified as being at risk there were risk assessments and associated care plans in place which helped to keep people safe and gave staff the appropriate guidance. For example, the falls and mobility care plan had an associated falls risk assessment. The risk assessments looked at the risk of falling for people in different situations and scored them on each area. If people were identified as being at high risk of falls, there was a falls prevention list and action plan to help minimise the risk. However, we did find one example where a person had a falls risk assessment in place and had scored a four and a three from February 2016 until October 2016, which was identified as a high risk and so needed a falls prevention list and action plan. However, there was not one in place. We asked the nurse about this who agreed one needed to be done.

One person had a falls risk care plan in which it stated that staff were to monitor their safety in bed by conducting hourly checks or more often if required, and we saw records confirming this had been done. One person at risk of developing pressure sores was on a programme of four to six hour turning and their records were up to date. Moving and handling risk assessments were also completed in a similar way to falls risk assessments. A hoist safety checklist was done every quarter, the most recent one in August 2016. Other checklists included sling safety, bed safety, wheelchair safety, assisted bath safety, and call bell checklist.

A number of environmental checks were undertaken to assess risks to people and promote their safety at the premises. A maintenance task reminder sheet was used to monitor the frequency of tasks that were to

be done daily, weekly, monthly, quarterly and annually.

External contractors checked the hoists, slings and baths in April 2016. We also saw evidence of call outs for faulty equipment. A pest inspection visit was carried out in October 2016 and no issues found.

Electrical items owned by people using the service were tested by the maintenance engineer, in line with portable appliances testing (PAT) legislation. Those that were owned by the provider were tested by a contractor.

A certificate of inspection for the testing of the emergency lighting, nurse call bell system and door entry system were all done in September 2016. The call points and smoke detectors were tested March 2016. Weekly monitoring of the fire alarms, fire exit routes and emergency lighting was carried out. Weekly flushing of water outlets that were not used regularly were done and monthly temperature records and shower head cleaning.

There was regional management oversight into these checks, the last report we saw had the compliance level at 93% in terms of these checks. This demonstrated that there were robust systems to ensure people were provided with a safe environment.

Good

Is the service effective?

Our findings

People were supported by staff who had received appropriate training to enable them to meet their needs. Staff members said they were happy with the level of training they received. One said, "The training is really good." One of the activities co-ordinators said they found the dementia training really useful in planning activities for people living with dementia.

The staff noticeboard on one unit had details of upcoming training that was available, for example we saw planned training in dementia, diabetes and heart failure. We saw records that showed staff had received up to date medicines training and records were kept of the Nursing and Midwifery Council registrations for qualified and practising nurses. These were all up to date.

The manager told us that new staff underwent an induction when they started which took between three and six months to complete. We spoke with a staff member who had started recently and they confirmed they were currently going through their induction programme with the support of their mentor, the deputy manager. The manager showed us a copy of the 'carer induction booklet', which included e-learning, familiarisation with policies, shadowing shifts and supervisions.

Training modules covered during the induction included safeguarding, nutrition, first aid, dementia, and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were assessed in some areas of their work to ensure they were competent to carry out duties safely, these included medicines administration, washing and dressing, continence care, moving and handling including the use of hoists and slings and other areas of personal care.

Refresher training was completed as required, some annually and others every two or three years. We looked at the training matrix for the home. This enabled the manager to see what training had been completed, which training had expired, when it was due to be renewed and when it had been completed. Some training was up to date at an acceptable level of 90% or above including food safety, infection control, health and safety and equality and diversity. Other areas needed more attention and were below 70% compliance including MCA and DoLS and moving and handling which was at 64%. The manager told us they were aware of this and we saw evidence that action had been taken, moving and handling training had been booked for 17, 19 and 21 October 2016.

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

Staff demonstrated a good understanding of the Act and its purpose. One staff said, "You have to ask people

for their consent and permission before you care for them." Another said, "If a person does not have capacity then you need to discuss their care with their next of kin". Staff were aware of the importance of supporting people to make their own decisions about things such as what they wanted to eat, what they wanted to wear and if they wanted to take part in activities. We saw staff asking people for their consent when administrating medicines.

There was evidence of best interests meetings that had taken place where people did not have the capacity to understand certain decisions that needed to be made regarding their care and treatment.

Care plans that contained "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) forms had been recently reviewed. Where people did not have the capacity to make decisions about this aspect of their treatment, we saw that a best interests decision had been made in consultation with relevant health professionals and family members where appropriate.

The clinical lead completed a 'Best interests decision - mental capacity act' assessment for people. This included a checklist to determine people's capacity to make decisions, if any lasting power of attorneys (LPAs) were in place or if any advanced decisions had been made. We saw records of decisions to administer medicines covertly which were reviewed monthly. These were done in people's best interests and involving the GP, nurse, manager, and the pharmacist in the decision making process.

We saw one example where a best interests assessment had been completed for a person based around managing their diabetes. It stated the person lacked the capacity to manage diabetes and asked if other people had been involved in this decision making process. The staff completing the form had put 'no', however in the ability to sign care plans section it stated that the person's relative was to be involved in all decision making processes. We spoke with the clinical lead and manager about this who showed us evidence that the relative was involved in making this decision but the form had been incorrectly filled out, they then amended the form.

People had DoLS in place where restrictions needed to be imposed in their best interests. The provider had submitted applications to the local authority and kept a record of who was under a DoLS and the expiry date to ensure that these were reviewed at the required intervals and people's rights protected.

Most of the people we spoke with were happy with the food served and two mentioned that there had been an improvement with the recent appointment of a new chef. Comments included, "The food is good. We have proper dinners", "I love my porridge", "The food's not too bad. You can eat it and enjoy it", "Chicken and chips is great!", "I like the food, I'm a diabetic and they look after what I eat" and "I'm a vegetarian. I get the right kind of food but there's not much variety and there are far too many chips." One relative told me that their family member really liked the food, that there was plenty of it and they ate it all. Another said, "The food looks appetising."

A special dietary notifications board identifying people on a modified diet was displayed in the kitchen. This identified people on a pureed and/or diabetic diet, or those with cultural requirements. Eating and drinking care plans were in place for people. These documented any underlying health conditions they had which would affect their diet, for example diabetes. These also included a dietary notification form in which risks to people were identified, such as risks related to choking, any input from a dietitian and any food allergies.

We spoke with the chef. They said that they tried to go and speak with people every day. A new initiative had started so that they spoke with the 'resident of the day' and asked them if they wanted anything special for their meals the next day. This is where each day of the month, a particular resident will have a full review of

their care and wellbeing on a monthly basis by all departments.

There were four fridges and three freezers in the kitchen. Halal and kosher meat was stored and cooked separately. In the dry food store, food had a use by date and opened food in the fridge was covered with the date of opening so staff knew when to discard this. There were different preparation stations for sandwiches, fish, meat and fruit and vegetables to minimise the risk of cross contamination. A separate hand washing sink was available. Food temperature checks and cooking temperatures were recorded. Also the temperature the food was held and served at. Probes were calibrated every month. The kitchen was clean and the manager contacted us after the inspection confirming they had received a food hygiene rating of five.

There was a four week rolling menu in place, there was a good variety of meals available to people and alternative choices if they did not like anything on the menu. The menu was displayed on tables in the unit lounges. A cooked breakfast was available for those that requested it. Breakfast and lunch were brought down in a Bain Marie and the temperature checked by care workers before serving people.

People using the service and their relatives told us their healthcare needs were managed appropriately. One person felt that their pacemaker was effectively and regularly monitored, "Each week someone calls on the phone to see how my pacemaker is doing." One person who was diabetic was supported by district nurses who came to the home.

A relative told us their family member was well supported, "[My family member] can be a bit difficult but they manage very well." Another relative told us that although the staff had not noted themselves that their family member seemed not to be hearing so well, when they requested a referral to the GP for a hearing test, they did so. Other comments from relatives included, "He/she can only eat pureed food and needs thickener. They manage it well" and "They keep us informed, he/she got a chest infection recently and they told us about it."

The majority of people within the home were registered with one GP practice. Two people were pleased to be able to continue to consult their longstanding doctors, "I go to my own doctor if I need to. I've been with him for years."

Staff told us that the GP visited the home twice a week and they sent them a list of people who were feeling unwell prior to each visit. We spoke with two visiting health professionals who were positive about the home and how they were kept up to date with any changes. They said referrals were made in a timely manner. One said, "The communication is very good, the nurses are good." We spoke with a visiting Occupational Therapist (OT) working in the integrated care team within the community who provided support to the home on a weekly basis and was working with people living with dementia. They also worked with the activity coordinators in developing suitable activities for people.

We saw records of appointments and evidence of correspondence from the GP and other health professionals. Records were kept of people's observations, including temperature, pulse, respiration, blood pressure and weights. Evidence of input from the tissue viability nurse (TVN), psychiatrist and hospital reports was seen in people's records.

Requires Improvement

Is the service caring?

Our findings

Almost all of the people we spoke with felt that they were treated kindly and with dignity and respect. Comments included, "The staff talk to us nicely. They have time for me", "They treat us very well", "They treat me with respect and more!", "They don't have a lot of time but you do have a little conversation" and "They always say good morning and goodnight." Despite these positive comments there were some instances where the interaction between care workers and people could be better. On separate occasions, we saw care workers giving drinks, tissues and put bibs on people without telling them first. In one unit, care workers began sweeping the floor around the feet of a person at one of the tables who was having coffee at the end of the meal. There was no explanation given to the person and the staff member did not ask them if they minded.

People told us their privacy was respected, and we observed this to be the case during the inspection. "They are polite and always knock on the door or announce that they are there. Nobody ever barges in" and "They respect my privacy if I am in my room with the door closed."

Most of the relatives we spoke with were happy with the way that staff treated their loved ones. They said, "They treat [my family member] with respect and dignity", "Everyone is very nice", "[My family member] is happy living here." However, one relative commented about staff, "Some are kind and some are not."

One person spoke of how a night time care worker knew they did not sleep well and was happy to make them several cups of coffee at any time. Throughout the inspection, we observed several instances where staff were warm and kindly towards people. We saw one member of staff approach a person and show them some affection. Another person with severe dementia wandered up to two members of staff who were talking to each other. One of them instinctively reached for and held the person's hand and stopped the conversation to give the person their full attention for the next few minutes. We saw another example when a member of staff dealt very patiently and kindly with a person living with dementia who was convinced that they had a needle stuck in their hand. The member of staff took great pains to examine the hand and even agreed with the person when no needle was found that it was likely that they had dropped the needle.

We were able to observe the lunch service on two units on the first day and breakfast on the second day. Some people were unable to feed themselves and were helped patiently by care workers sitting alongside them. They were not rushed in any way. Other people were feeding themselves independently. Care workers were generally intent on their tasks although occasionally residents were asked "Did you enjoy that?" When care workers walked about the lounges they greeted each person there, often, though not always, by name. However, these exchanges were sometimes confined to "Are you all right [person]?" or "OK [person]?" and there were few examples of any actual extended conversations. There were not many instances where we saw a member of staff sit next to people and have a chat.

People said they were given a choice. One said: "We go to bed at 10pm after we've seen the news. I think I could stay up later if I wanted to." Another said they were able to get up and go to bed when they wanted: "I can choose my bedtime and I like to go early and I like getting up early, too." They also told us they were

able to choose their own clothes to wear. Two relatives told us that they were involved in their family member's care plans. They said, "I am well aware of the care plan and look at in whenever I come in."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection which took place on 11 and 12 November 2015, we found the provider did not manage complaints effectively. Relatives told us that they were not satisfied with the length of time that complaints took to be dealt with. The provider had not done all that was reasonable to support people to raise complaints or provide feedback about the quality of care.

At this inspection we found that improvements had been made.

There was a comments, complaints and compliment information sheet on display at the entrance to the home. It had details about the complaints process and details of the role of the Local Government Ombudsman (LGO), the final stage for complaints about adult social care services. A complaints form was available at reception and a suggestions box as well. The complaints form was available in English and Bengali.

A complaints officer at head office monitored all the complaints and ensured timescales for responding to complaints were being adhered to. The manager said, "All complaints, whether verbal or in writing will get logged." A summary of complaints was completed by the manager and complaints were documented according to the month they were received. We looked over the complaints that had been received since the beginning of the year. There were 10 recorded complaints. The complaints were acknowledged and responded to in a timely manner. Where further investigation was needed this was done. Nine out of the 10 complaints received were resolved at stage one of the complaints procedure and one had gone to stage two. Details were kept of the nature of the complaint, the stage it was resolved at, timescales for responding, the resolution and whether the complaint was upheld.

None of the people we spoke with were aware of formal complaints procedures but, equally, none of them felt that they had needed to make a complaint. "I don't complain and I wouldn't know how to" was a typical response. Several felt confident that they would just speak out, "If I had to complain, I'd go to one of the staff", "It's not hard to complain. Sometimes I mention little things, remind people and then they usually do it."

A relative said that once, when they complained to the care workers about their family member, they acted immediately. Another relative said, "If I have any problems, they will take it up." However, one relative said that although they felt the provider responded to their complaint, agreed changes were not consistently maintained.

Mandatory core care plans included comfort and anxiety, activities, falls and mobility, eating and drinking, washing and dressing, skin condition, communication, sleeping and waking, continence management, medicines, end of life care plans, ability to sign and consent to care and accommodation. Additional care plans were also available depending on people's individual support needs, these included pain relief, wound care, mental health, covert medicines, management of chronic disease, and behaviours that challenge. Care plans included identified strengths, agreed outcomes and planned care tasks and were

reviewed on a monthly basis.

In some cases the care plan reviews were not always reflective of people's current status. For example, in the eating and drinking care plan dated 12 June 2016 for one person it stated 'needs ongoing monitoring on his/her nutritional state. Staff to fortify his/her food and drinks. To ensure he/she meets his/her daily fluid allowance and to be weighed monthly.' We asked the nurse if the daily fluid chart was being completed and they said it wasn't because the person was drinking well. However, this was not clearly evidenced in the care plan reviews. The July review stated the person required a lot of encouragement with his/her diet and the September review said he/she ate independently but throws food and drink on the floor so needs supervision. In neither of these reviews was there any reference to indicate that the daily fluid chart was no longer needed.

We checked fluid intake charts for other people using the service. These included the amount given and taken and a running total. Each person had an agreed daily fluid target. We found that in some cases, the target was not being met. For one person, during a 13 day period they did not reach their target on nine days. In some of these reports, the action for staff was to encourage people to drink more which was not sufficient to ensure that people maintained adequate fluid intake.

There was a wound, pressure sore and skin integrity audit. Grade one and two pressure sores were managed within the home and referrals made to the tissue viability nurse (TVN) for grade three and four. We were shown the records for a person with a grade three pressure sore. The care plans and Waterlow risk assessment were in place and a wound care plan was in place. We noted that one of the recommendations of the wound care plan was for the person to be on a high protein diet, however this was not reflected in the eating and drinking care plan. Other records we saw indicated the person's pressure sore was being managed well and improving.
The three paragraphs above demonstrate that we could not be assured from the records we viewed that people's nutritional needs were always met. We recommend that the provider review the processes used to monitor people's nutritional needs to ensure that these are met.

Care plans were split into life history, risk assessments and core care plans, daily records, activities log/carers communication sheet, records of professional visits, weight monitoring, pre and post assessments and miscellaneous reports. Care plans included a section called life history which people or relatives completed. These included details of their younger years, young adulthood, middle and later years. It also included people's preferences.

We asked people about the activities in the home. They said, "I do word searches and the staff encourage me to do it. They say it keeps my brain going" and "There's not much going on here. I just listen to what's going on." Another person, who was bedbound, told me that there wasn't a lot they were able to do but they were able to entertain themselves with reading and the radio. They said they were visited occasionally by a member of the activities team. A relative told us, "They hold events outside and invite us to them."

An activities timetable which was in pictorial format was on display on the ground floor. Some of the activities included, aromatherapy, film night, carpet bowls, one to one time and exercises. There was also a visitor's information board in the reception area, giving details of the residents' satisfaction survey 2016 and information about the Care Quality Commission. There was an entertainments and events board giving details about upcoming events including visits from the hairdresser, a high tea celebration and pet therapy.

We spoke with two activities co-ordinators. They told us that they were part of a team of three at the home and they worked in shifts to provide a service to the home seven days a week. An activities co-ordinator told

us all the activities' co-ordinators met every quarter to share ideas and tips about activities.

The activities team had developed a box of activities which they took to people in their rooms in order to engage with them. They had also recently begun a 'Wish Tree' where people wrote something they would like to do and this was hung on a tree and the staff tried to make the wish come true in some way. Recently they had fulfilled the wish of a person who wished to go in a Porsche by persuading the local dealership to come and take them for a ride. This person was also presented with a small model car. Another person was wearing and using an activity apron which they seemed to enjoy. The home had an attractive garden which was appreciated by several people. One told us, "I stay outside all day if it's nice." A member of staff told us that people had, in the past, done a little gardening and had planted vegetables but a person said that this was no longer the case.

We observed a morning activity during which two activity coordinators and one care worker worked with up to 25 people with different levels of engagement. The activity was varied, involving appropriate chair-based exercise, singing, some quizzing involving completing clichés and sensory awareness involving smelling herbs and fruit. This latter part of the activity was further developed by an alphabet game in which people were invited to name fruits, herbs and vegetables for each letter of the alphabet.

Throughout the activity, the coordinators encouraged individual people by name and managed to ensure that everyone was engaged at some level. However, when there was no organised activity, there seemed little else going on for people other than TV or radio and in all the lounges we observed considerable periods where people sat dozing with little to stimulate them.

A person told us that the parish priest visited them each week and another said that the Imam visited occasionally. A relative said they took their family member to the mosque. Church services were featured on the weekly activity programme.

Good

Is the service well-led?

Our findings

Staff told us they had worked at the home for a long time and that they were very happy there and felt that they knew people using the service well. They were positive about the impact the manager and the rest of the management team had on the service.

Two people told us they knew the name of the manager and said that they were "Very nice" and approachable. One person told us they saw the manager often and, whilst we were talking to them, the manager appeared and greeted this person warmly and by name.

The relatives we spoke with were not aware of any kind of regular residents' or relatives' meetings. We found that meetings took place, although some were not taking place not as regularly as stated by the manager.

Minutes of the relatives meetings were seen from March 2016, May 2016 and July 2016. Relatives raised concerns at the March 2016 meeting that the previous minutes were not reviewed at subsequent meetings so it was difficult to keep track of actions that had been agreed.
Staff meeting minutes were available from May 2016 and March 2016. We found that identified actions were not always documented as being followed up at subsequent meetings. For example, we saw that in the meeting minutes held in May 2016, it stated that staff had requested a standing hoist and more wheelchairs on the ground floor. Also under consideration was to have photos of named nurses and key workers in people's rooms and for each staff member to spend 10 minutes a day with a person using the service. The manager said that the standing hoist and wheelchairs had been supplied following the meeting but this was not evidenced in meeting minutes. It was also not clear if the suggestions of the photos of staff in people's rooms and allocating 10 minutes were actioned or not. The minutes did not also adequately record the conversations that had taken place. The minutes of the night staff meeting from March 2016 were the same as the staff meeting minutes held in May 2016.

There were a number of thorough quality assurance audits that took place.

A resident of the day checklist was in place. This had been put in place recently to evidence the care provided, although the resident of the day practice had been in place for a while. The checklist was in place to ensure that all monitoring charts were up to date, and to show if the person had been visited by the chef, activities co-ordinator, housekeeping and the manager or deputy manager.

A care plan audit was done monthly. Care plans were audited, including the most recent admission and the care plan for someone with a wound or tissue viability needs. Where gaps were found, action was taken to rectify these.

We spoke with the care development manager who was supporting the home clinically in terms of checking and auditing the care plans. They had been asked to come in following a quality assurance visit to go through the care plans and check whether they were being documented and updated correctly.

We spoke with the clinical lead about the clinical audits carried out within the home. These included a daily medicines audit that was carried out by team leaders and nurses on each unit. They told us "I go through them and if there are concerns or issues with orders I follow them up." They said it acted as a good handover. The daily medicines audit covered whether medicines administration record sheets (MARS) were signed, any medicines not given, checking controlled drugs, temperature checks and whether there were adequate supplies.

A weekly stock count record of all medicines was carried out including an audit of all the controlled drugs with the nurses on the units. A more comprehensive medicines audit was carried out every month looking at storage, training and administration. We saw the monthly audits for September and August and there were no issues identified.

A clinical data request from head office was requested every month, the data requested was completed and sent back to them. A clinical audit alert register was completed monthly. This looked at a number of audits that were carried out within the service, including the latest Care Quality Commission rating, medicines audit, care plan audits, home manager quality audits, complaints, accidents, deaths, safeguarding, pressure ulcers, body mass index calculations (BMI), Deprivation of Liberty Safeguards applications and authorisations, staff turnover and agency staff. The latest register showed the use of agency was relatively low at 2%.

The clinical lead had started monthly monitoring of weight changes and BMIs and showed us examples where people who had lost weight were referred to dietitians and multi-disciplinary team meetings held.

Incidents and accidents were recorded electronically and then analysed on a month to month basis to help the provider identify possible trends. We saw that action had been taken in response to some of the findings. For example, in August, the analysis carried out by the deputy manager stated 'most falls happened during the early morning and evenings' and had identified that poor moving and handling techniques could be an underlying factor. It also demonstrated that there was learning from this. For example, it indicated that greater staff presence was required in communal areas, that increased monitoring of staff at these times was required and that staff needed further moving and handling training. We saw evidence that moving and handling training had been booked for staff. The analysis also stated that out of 12 accidents, eight occurred during the day. In June, there were no trends identified and in May 2016, it stated seven accidents happened early morning.

A home manager audit was done monthly, based on the Care Quality Commission Key Lines of Enquiry for inspections. A quality assurance manager carried out an internal monitoring visit audit, we saw the audit from July 2016 which highlighted areas of improvement for the manager to implement and the progress that had been made in some of the areas identified previously.

The manager told us about some of the changes they had planned for the home. This included refurbishing the hairdressing room and converting a guest room into a Namaste room. Namaste Care is a programme designed to improve the quality of life for people with advanced dementia. Namaste Care takes place in a designated space that helps to create a safe and comforting environment. They also had plans to convert a downstairs lounge into a café area for family and friends.