Care UK Community Partnerships Ltd

St Vincents House

Inspection report

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Date of inspection visit:
13 February 2018
14 February 2018

Date of publication:
13 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on 13 and 14 February 2018. At our last comprehensive inspection in October 2016 we rated the service "requires improvement" and found a breach of regulations regarding good governance. We subsequently carried out a focussed inspection in March 2017 where we found the provider was now meeting these requirements.

At this inspection we found that the service had significantly improved in many areas, but that this improvement needed to continue to reach a consistently good standard in some areas.
St Vincent's House is a care home with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Vincent's House accommodates up to 92 people across four separate units, each of which have separate adapted facilities. There are shared facilities such as a coffee bar and cinema on the ground floor. Two of the units specialises in providing care to people living with dementia. At the time of our inspection there were 82 people using the service.

The service had a registered manager who had been registered since January 2018. 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 registered manager had clear systems in place for monitoring the performance of the service, and when areas were identified for improvement there were action plans in place. There were good systems of communication with staff and relatives, including surveys and regular meetings. Where relatives had expressed concern about staff communication regarding their family member's wellbeing, the provider had implemented a resident of the day system, which combined a holistic review of the person's care with updating relatives. Relatives we spoke with told us they were now kept informed of their family member's care.

Managers had improved systems of recording, which were well maintained. We saw that risk management plans and care plans were of a greatly improved standard, but in some areas lacked detail on some areas of healthcare needs.

The service worked well with other agencies to promote good health, and we saw that there were good standards of wound management and pressure sore prevention in place. People's needs were assessed at the time of admission to the service and this was used to put together personalised and detailed care plans which staff followed to meet people's needs and preferences. People received well planned care at the end of their lives.

The provider was actively recruiting staff in order to reduce their reliance on agency staff, and this was carried out in line with safer recruitment measures to make sure staff were qualified and suitable for their roles. We found that staffing levels were safe to meet people's needs, but sometimes staff were stretched and were not always effectively deployed. The service was in the process of reorganising staffing roles; we have made a recommendation about this. Medicines were safely managed by staff with the skills to do so.

The building was clean and well maintained, and was designed in order to meet peoples' needs in a dementia-friendly way. There were thorough systems of checks to ensure it remained a safe environment. A system of key pads had been implemented to prevent people leaving the building in a way which may not be safe, but we have made a recommendation about how this was applied to the lift system, as people were able to operate lifts without knowing the code. People were assessed to see if restrictions were placed on their movement and the provider had applied to the local authority in line with legal requirements. The provider was meeting its responsibilities to assess people's ability to make decisions and to work in people's best interests in line with the Mental Capacity Act 2005.

People were consistently treated with kindness and dignity by staff, and received good support in order to eat and drink well. Concerns about people's nutrition were appropriately followed up and action taken to address this. People and their relatives felt involved in the planning of their care, and people were regularly consulted in order to contribute to a varied and interesting activity programme.

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.

Staff were recruited in line with safer recruitment measures. Staffing levels were adequate to meet people's needs, but at time staff appeared stretched and nursing staff were not always deployed in a way that was effective.

Medicines were safely managed and checked. Action had been taken to improve the safety of the service. This included improved measures of risk management and pressure sore prevention.

There were appropriate checks of the safety of the premises and measures to control the spread of infection.

Is the service effective?

Good

The service was effective.

There were clear systems of assessment in place and staff received appropriate training and supervision to deliver effective care.

People received the right support to eat and drink and staff monitored people's nutrition and took action when there were concerns. There was good joint working with other health professionals to improve people's health, this included wound care.

The building was designed to create a dementia friendly environment and memory boxes were used to present information on people's interests and help them to recognise their rooms.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were treated with kindness and respect by staff and there were no restrictions on visitors.

We observed positive and kind interactions which promoted listening and treating people with dignity. People's profiles contained information on what was important to them and how best to communicate and there were regular meetings with people and their relatives to obtain their views.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

People's care was well planned, but we saw some examples where care plans did not fully describe people's needs or the actions required by staff. People and their relatives felt involved in the process, and plans were detailed about people's preferences and wishes.

People were involved in the planning and development of a varied and interesting activity programme. Complaints were investigated and responded to appropriately, and the service had apologised when things had gone wrong.

Is the service well-led?

Good

The service was well led. People and staff praised the way the service was managed.

Managers had implemented clear improvements in the service and had detailed and effective systems of audit to ensure that this continued.

There were good systems of communication with staff which allowed managers to monitor performance and clearly outlined the expectations managers had of the service.

St Vincents House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

Why we inspected – This was a routine inspection, which was carried out because we rated the service "requires improvement" 12 months prior to this inspection.

Since the previous inspection the provider had notified us of 16 allegations of possible abuse We confirmed at the time that the provider had informed the local authority and that these incidents were being appropriately investigated.

We had been notified of a relatively high number of pressure sores, although not all of these had occurred whilst people were in the service. At the time the provider informed us of the action they had taken to manage individual's pressure sores, but we looked into the management of pressure sores across the service as part of this inspection.

Prior to carrying out this inspection we reviewed information we held about the service, including notifications of serious events that the provider is required to tell us about and complaints we had received from third parties. We asked the provider to complete a provider information return (PIR). This is a document which asks providers to give us key information about the performance of the service, including what is working well and how the provider intends to improve the service in future. We spoke with the local authority's safeguarding adults lead co-ordinator to obtain their views on the performance of the service.

This inspection took place on 13 and 14 February and was unannounced on the first day. The provider knew we would be returning on the second day. The inspection was carried out on both days by three adult social care inspectors with a specialist professional advisor who worked as a nurse. On the first day the team included a specialist professional advisor who was a pharmacist and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we looked at the records of care and support for 13 people who used the service and looked at records of medicines management for 18 people. We looked at records of training, supervision and the files of 6 staff members. We spoke with 15 people who used the service, seven relatives and a visiting health professional. We also spoke with the registered manager, deputy manager, regional director, four nurses, seven care workers, the clinical lead, chef, trainer, customer relations manager, premises supervisor and two members of the lifestyle team.

We carried out observations of activities, medicines rounds and mealtimes, including people who ate food in their rooms. This included using the Short Observational Framework for Inspections (SOFI2) tool in communal areas. SOFI2 is a tool developed with the University of Bradford's School of Dementia Studies and used by inspectors to capture the experiences of people who use services who may not be able to express this for themselves.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe living there. Comments included "I have no complaints, they are very kind" and "I know I am safe, the nurses are nice here." Care workers had received training in safeguarding adults as part of their induction and staff we spoke with were confident about recognising the different categories of abuse and understood their responsibilities to report their concerns. Staff discussed the provider's safeguarding policy and whistleblowing procedures in team meetings and had signed policies to indicate they understood these. Staff received laminated cards reminding them about their safeguarding responsibilities.

Where allegations of abuse had been made the provider took suitable action to inform the Care Quality Commission and the local authority and conducted suitable investigations where appropriate. The local authority told us that the service had been responsive when concerns were noted and that they had no current concerns about the service. Where incidents had occurred these were recorded by staff and actions taken were reviewed. These were recorded electronically and a monthly report was compiled so that managers could analyse trends and take action such as additional monitoring of particular people or areas of the service.

When people were admitted to the service a wide range of risk assessments were completed. This included a falls risk assessment, moving and handling assessment, choking risk assessments, a personal emergency evacuation plan (PEEP) and assessments relating to the use of bedrails, oxygen and smoking. The Clifton Assessment Procedures for the Elderly (CAPE assessments) were used to assess people's dependency and cognitive impairment. Where bedrails were in use an assessment of this was completed, with bumpers attached to beds if there was a risk of entrapment and beds set to the lowest possible setting and crash mats put in place if there was a risk of people attempting to climb the rails. Risk assessments were reviewed at least monthly or as people's needs changed. One person's risk management plan contained inaccurate information about whether they had experienced a fall in the last 12 months, however appropriate action was taken and the person had a crash mat in place to manage this risk.

There were some good examples of risk management. For example, a person had a risk assessment in place regarding the risk of choking. The person was referred to a Speech and Language Therapist (SALT) and prescribed pureed food and thickened fluids. Their care plan had clear guidance on how to prepare the person's food and drink, how to recognise that the person was choking and specific actions for staff to take to manage the risk.

Where people were at risk or not able to call for help, there were hourly monitoring charts in place. For one person the monitoring chart was not completed during the daytime on one occasion despite a clear management instruction to say this should be done for all people who were cared for in bed, however repositioning charts showed that the person received regular checks during this time. Managers had implemented new welfare check and turning chart forms which were in a bound book, which meant that pages could not be lost or become disordered.

At our previous inspection we had seen a person who was at risk from possibly unsafe behaviour and had severe skin ulcers. We noted at this inspection there was a greatly improved management plan for both these possible risks, including measures to address the person's behaviour and a more detailed wound care plan with details recorded about the dressing changes and condition of the person's skin, which was illustrated by photographs.

Where people required assistance to evacuate in an emergency this was indicated with a red dot on their door, which corresponded with the information on people's PEEPs. This included a detailed overview of the support people would need with guidance about moving and handling, visual and cognitive impairments, and categorised people on a red, amber, green scale. One person's plan was detailed about the equipment they used to move safely and highlighted that the person had behaviours which may challenge such as screaming and hitting out, with clear guidance on their care plan on how best to address this with the person.
The service had a new premises supervisor in place and rigorous and detailed systems of health and safety checks. Maintenance staff demonstrated a clear understanding of how their role protected people from harm. For example, the premises supervisor carried out weekly checks of bedrails and explained that the gap between the rail and bed needed to be measured twice to account for the person's movement. There were well-thought through systems in place, for example carbon monoxide detectors were checked on a weekly basis, but all batteries were changed on the first day of the month to prevent the risk of a battery running out undetected.

The maintenance team conducted a daily check of the overall condition of the building, which included checks of people's rooms, fire doors and the alarm panel, electrical items and cleaning matters. On a weekly basis there were checks of floor surfaces, handrails, door alarms, lifts, internal lighting, fire call points and blind cords. There were also weekly checks of the temperatures in a quarter of all rooms, with thermometers installed throughout the building. Premises staff logged faults which were reported to the maintenance team, these were then signed off when the job was satisfactorily completed.

On a monthly basis staff checked that large furniture items were secured to walls, window restrictors were in place, seat belts in baths were installed correctly, water temperatures were correct, and that self-closing doors closed correctly, and that the nurse call system was functioning. There was twice weekly flushing of disused outlets in line with the provider's legionella checks. There were up to date checks of portable appliances, electrical and gas safety. The building had a backup generator in the event of power failure, and fuel levels in this were checked monthly. Fire drills took place regularly, with records kept of what had gone well and what needed to improve. Premises staff had made a zone map of the building and attached these to staff pay slips, to improve staff knowledge of evacuation procedures.

Where moving and handling equipment was in place these were checked and records maintained including the date of the next scheduled maintenance. Premises staff also checked the safety of wheelchairs on a monthly basis. Baths were checked for safety and had built in thermostats which displayed water temperatures; this protected people from the risk of scalding.

We found that there was a signing in book in place and access to the building was controlled by a bell on the front door, this was monitored by administration staff during the day and there was a rota for answering the door out of hours. We found that restricted areas such as clinical and sluice rooms were kept locked.

Following an incident where a person had left the building without support, the provider had reviewed the security of the building. This included placing security codes on all stairwells, exits to the buildings and to access the lifts. Codes were displayed above the doors using a form of masking pattern, which meant it

would be harder for a person with dementia to enter the code in a way which might not be safe. We found this promoted a safe environment whilst minimising restrictions on people's movement. However, all lifts needed to have a delay to allow people to exit safely; a member of the inspection team saw a person enter the lift after they had exited and needed to ask a staff member to intervene. This particular lift could be used to exit the building and access an unstaffed lobby of a neighbouring service. Whilst access codes were appropriate in most cases, these did not control the operation of the lift, which might not be safe when the lift could be used to exit the service.

We recommend the provider take advice from a reputable source on controlling the operation, rather than access, of lifts which could be used to leave the service.

The building was kept clean and well maintained with a pleasant, clean odour throughout. Where spillages had occurred, we saw that these were promptly brought to the attention of the cleaning team by care workers and rectified. Although some furniture had minor staining, we checked under cushions and found no food residue anywhere in the building. Floor coverings were free of trip hazards and there was non-slip flooring in place in bathrooms.

At the time of our inspection there were some temporary electrical heaters installed in the building with protective covers in place, and a small number had protruding cords where there was a small chance of people tripping over them. The provider explained that a contractor's error had caused severe damage to the heating system which had broken down shortly before Christmas. They had taken appropriate action to maintain the health and safety of people using the service. The provider had a contract with a reputable pest control company, who had placed tamper proof bait throughout the building which could only be opened with a special key. We saw that this contractor attended on a monthly basis, with additional visits when there were concerns about pests.

The provider carried out yearly comprehensive audits of health and safety throughout the service, these showed a clear improvement based on previous years.

We looked at a month's rotas for the four units, and found that staffing levels were as described by the provider. We received mixed views on staffing levels. Comments included "They are a bit stretched at times", "There are plenty of staff", and "They are quick to check when I ring my buzzer" and "The carers are sometimes rushed and can be slow to answer the buzzer." There was no evidence that staffing levels were unsafe or unsuitable to meet people's needs, at times staff appeared very busy but did not rush. A number of staff told us that they found it difficult to take breaks, which could also reduce their effectiveness. The provider showed us that they were recruiting new staff, and were able to reduce their use of agency staff by a third in a period of a month as result. We found there were specific factors that affected the staffing levels. For example, there was a higher use of agency nurses at weekends, and some staff told us that at these times particular tasks such as wound management were sometimes not carried out. This meant that nurses at the start of the week had more to do in order to catch up. This was compounded by the fact that medicines rounds took a long time, which meant that nurses were unavailable during this time to see to other tasks. Staff worked hard in order to meet people's needs, but rostering and deployment of staff did not always support this.

We recommend the provider take advice from a reputable source on the effective deployment of nursing staff.

The provider operated safer recruitment processes. This included obtaining suitable references, checks of identification and carrying out a check with the Disclosure and Barring Service (DBS) before people started

work. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. Where staff held a nursing qualification, the provider had an up to date professional identification number (PIN) to show the person was registered with the Nursing and Midwifery Council (NMC).

People and their relatives told us that staff managed their medicine safely. Care plans did not contain detailed medicines instructions or allergy information, but this was contained on medicines administration recording (MAR) charts where it was accessible to staff. Changes to MAR charts were written in manually, and required two staff to sign this in line with the provider's policy. There were clear protocols for managing medicines taken "as needed" (PRN medicines), which were given in line with these. All MAR charts we checked were accurately completed, including reasons why medicines had not been administered. Where creams were applied by staff these were recorded on a separate sheet detailing where on the body they had been applied, and there were recording systems in place to make sure that patches were safely applied. We found that when thickeners for food and drink were prescribed for a particular individual often these were used for several people, without the use of bulk prescriptions.

Staff received suitable training of medicines and observations of their competency to make sure they had the skills to do this. This included carrying out additional checks of staff when medicines errors had occurred. External audits were in place, which included monitoring medicines which had a narrow therapeutic index such as Warfarin, where small differences in blood concentration may lead to adverse drug interactions. Where covert medicines were in place the provider had carried out suitable assessments of these, although we saw one case where a person was now concordant with their medicines but their assessment had not been updated to record this.

There was good communication between the service and the GP and supplying pharmacist. Staff maintained a file of faxed communication to evidence the measures they had taken and the follow up that was required to ensure medicines were supplied correctly. Where medicines came into the service records of this were maintained, these were not always dated and we saw one instance where a quantity discrepancy was not followed up; however two staff consistently checked medicines supplied against the MAR chart, even though this was not part of a local policy.

Controlled drugs were safely stored and checked by two staff at a time. Medicines were safely secured in a locked clinical room which, along with medicines fridges, were monitored to check that these were held at the right temperature. Medicines, including eye drops and liquids, were labelled with expiry dates and these were checked by staff before administration. There were suitable measures to dispose of unused medicines, including the use of kits to inactivate controlled drugs. There was a provider level policy in place for the management of medicines and a local policy, but we found the local policy was not always clear about procedures for the receipt of drugs and checking of MAR charts, although this was being carried out safely. There were monthly audits of medicines carried out by the clinical lead, and external checks carried out by the pharmacist.

Where people received their medicines in a communal area this was carried out in a way that promoted their dignity and privacy. Where medicines errors had occurred these were recorded and a reflective template completed, with other measures such as supervision taken to support the staff member. In one case we saw that a staff member had made two errors with controlled drugs in a fortnight, in both cases appropriate measures were taken to address this, but this was not discussed at a clinical review meeting to ensure that learning and preventative actions were disseminated to other staff.

We saw that there were measures in place to control the spread of infection. Hand sanitiser dispensers were

in place throughout the building and were kept filled. Staff wore appropriate personal protective equipment when carrying out personal care, as did catering staff when preparing food. Managers carried out audits of infection control risks, which included assessing the environment, cleaning, hand and food hygiene, the use of PPE and catheter care, which included a clear action plan for improvement. There was a monthly audit of infections such as those affecting the chest or urinary tract, which enabled managers to see trends. Managers discussed infection control in staff meetings and had identified steps they could take to reduce infection risks, such as phasing out the use of trolleys when providing personal care.

Good

Is the service effective?

Our findings

People's needs were effectively met as staff carried out comprehensive assessments to determine the care and support they required. There were clear processes of assessment carried out prior to and in the days following people's admission at the service. This included using information from different sources and professionals and relatives and completing a pre-admissions checklist. Pre-admission information was used to ensure that risk management plans were completed and medicines plans were in place. Following admission to the service, the service ensured that assessments of people's continence needs, eating and drinking, end of life and sleeping plans were completed. We observed that recent pre-admission assessments contained considerably more detail than older assessments that we viewed, which meant that the use of pre-admission assessments had improved within the last three years.

Staff received suitable training and supervision to carry out their roles. The provider had made changes to the training for new staff and had plans for further developing these. Since our last inspection the provider had appointed a full time training officer for the service, who delivered induction training in house and held suitable "train the trainer" qualifications for these courses. Care workers told us that the induction period for new staff had increased from one week to two weeks, this included time as a supernumerary worker on one of the units, shadowing a more experienced care worker. The trainer told us that in response to feedback they were considering changing the times of shadowing shifts so that new care workers could see different aspects of the working day. The premises team had provided written troubleshooting guides for care workers on how to operate beds and air mattresses and were planning to include active demonstrations in future induction trainings.

Care workers were positive about the training received. Comments included "There is great training for new starters" and "I was treated as a member of the team from the start". Comments from people who used the service included "They are knowledgeable" and "Training on the job for staff with an experienced carer seems to be a very good system". People told us that their staff appeared knowledgeable about their roles; the only exception to this was when we spoke with three people who had stomas. All felt that some of the care workers lacked knowledge on how to empty their bags and that they sometimes had to instruct care workers on how to do this.

Training took the form of both electronic learning (e-Learning) and face to face training. With regards to e-learning, staff undertook online courses in areas such as dementia awareness, fire awareness, food safety, health and safety, equality and diversity, infection control, mental capacity and safeguarding. There was a tracker in place for monitoring this which showed that overall staff were 96% up to date with this, although health and safety training compliance was lower at 89%, which had been noted in a recent health and safety audit.

Face to face training was also monitored by managers, who showed that overall 82% of staff were up to date with this. In some areas (managing safety, medicines competency and emergency first aid) 100% were up to date with this. Most other areas were around 95% (moving and handling people, care planning, pressure area prevention). Some were lower such as dementia at 80% and fire safety at 71%. However, sessions had

been scheduled to address this, and staff had received equivalent online training to cover this area.

All care workers we spoke with told us that they received regular supervision from managers. Managers maintained a system to monitor formal supervisions, which confirmed this took place at this frequency, but did not routinely flag up when staff were overdue for supervision. Supervisions were a mix of generic supervisions and those personalised to meet a particular member of staff's needs. We found in some cases supervisions were used to deliver information on a particular topic. For example, one supervision form was filled out by managers prior to the meeting and contained information on how research now showed that people did not benefit from having their mouths moistened by lemon and glycerine swabs, and the supervision record contained a large amount of information that could be shared with colleagues and people's relatives. Other themed supervisions included areas such as malnutrition screening tools, and reporting and recording of bruising.

People and their relatives told us that they received good support with nutrition. Comments included "I get food when I want it" and "I enjoy the food." A relative told us "They will stay with [my relative] and feed him" and "They keep a record, [my relative] seems to eat it all."

There was a choice of food on menus on the tables in the dining room that people could choose from. Whether people ate in the dining room or their own rooms we saw that people were consistently offered choices about what they ate and received food promptly in line with this. Menus also included foods of different textures for people with swallowing difficulties or those unable to chew their food. Textures were recorded in line with national standards for measuring consistency, and this was clearly recorded on care plans and we saw people receiving their food in line with what they required. Plans contained detailed information about people's preferences for their food, including cultural requirements for food and how they liked their drinks served. For example, we saw one person's plan stated they liked their water brought to them warm, we confirmed with the person that this took place.

People had drinks available with their meals, when people ate in their rooms we observed drinks were left within easy reach for people. We observed people being encouraged to come into the dining room and care workers helped to create a relaxed and sociable atmosphere, with pleasant interactions between people and their care workers. Care workers allowed people to eat at their own pace and allowed them to finish courses before offering further foods. People were encouraged to eat and drink by staff who demonstrated politeness and kindness. There were plenty of staff available at mealtimes to support people in communal areas, and we observed staff visiting people in their rooms to offer appropriate support to eat, with appropriate monitoring by team leaders or unit managers.

The provider used a malnutrition universal screening tool (MUST) in order to identify when people were at risk of malnutrition, and there was consistently good recording of people's food and fluid intake, including reviewing records to identify when people were not meeting targeted levels of intake. Where there were concerns about people's food or fluid intake or weight loss we saw that this was promptly raised with people's GPs and referrals made to dieticians. Recommendations from these professionals were followed.

The provider managed the risks of skin breakdown and pressure sores by carrying out a Waterlow assessment at admission. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person.

We looked at five care plans for people who had developed pressure ulcers and were identified as being at high risk of skin breakdown. Records showed that people were protected from the risks of their conditions worsening and also from developing further pressure ulcers. People's records showed clear guidelines on

how often people should be repositioned to relieve pressure on their skin, and care workers had recorded that they had done so on repositioning charts which were signed off by team leaders. Clear records were also maintained of the barrier creams used to prevent skin deterioration. When people were cared for in bed they had air pressure mattresses in place, which were set at the correct settings and checked regularly. Photographs were taken to show the progress of people's wounds. In one case a person had two pressure ulcers on their legs; photographs showed that with the care of staff, one had completely healed whilst one remained the same despite the efforts of staff and a Tissue Viability Nurse (TVN).

Records showed that Waterlow assessments were reviewed regularly with measurements and photographs taken of wounds by staff. When necessary, nurses had referred people to TVNs, who had attended the service and made recommendations, which were incorporated into people's care plans. There were clear policies and procedures on the management of wounds and care workers were knowledgeable and skilful about wound management. One staff member told us "The policy is quite clear on how and when we consult the TVN. The TVN service is very good and their response is excellent. We normally send them information to help them decide the urgency of the matter."

We saw other evidence of staff working jointly with other professionals to promote improved health. For example, one person had been referred to a TVN concerning skin problems, there was clear instructions from health professionals on wound management and photographs showed a clear improvement in the person's condition. We spoke with some people who had recently been unwell, they told us they had received good care at this time and that they were seen by the GP regularly. We saw the GP was visiting at the time of our inspection. Another person had a percutaneous endoscopic gastric (PEG) feed in place, and the care plan in place to manage this had been compiled with the input of a specialist nurse employed by the manufacturer who had offered training to staff and offered support and advice whenever needed. We observed care being delivered in line with this plan and records supported this.

The design of the building was suitable for the needs of frail people and people with dementia. The building was bright and well presented, and each floor was decorated with a different theme such as sport or the seaside, which helped people to orientate themselves. There were two sitting areas and a dining area on each floor, and a cinema room on the ground floor which was open to all in order to watch movies. There was a well-maintained and secure garden which could be accessed by anyone on the ground floor, this included sturdy and high quality outdoor furniture. People were able to mobilise safely throughout the building using handrails. People's rooms were clean and tidy and people were able to have a variety of their own possessions and furniture in their own rooms. There were memory boxes outside each person's door which contained personalised items such as family photographs and meaningful objects to the person such as DVDs on cricket and books of poems, which were important to the person. This helped people to recognise their own rooms and helped to personalise the service.

Most, but not all of the staff we spoke with were knowledgeable about the Mental Capacity Act 2005 (MCA). The Act 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. We saw examples of staff assessing people's capacity in response to concerns raised by other professionals. Staff received mandatory training in the MCA and were given laminated cards with a summary of the Act's key principals. Where people had capacity to make decisions there was evidence of their consent to decisions about their care. We saw some examples of where people were assessed as not having capacity to make certain decisions. This included decisions about where they lived and decisions about their care and vaccinations. Where people did not have capacity, there was evidence that staff had consulted with families

and other professionals in order to make decisions in their best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had conducted a review of safety in the premises in response to an incident where a person left the service, this included adding keypads to doors to restrict people's movements. The provider had conducted assessments for everyone using the service in order to monitor whether the changes had deprived people of their liberty. When this was the case the provider had made applications to the local authority in line with DoLS. There was a system in place for monitoring these applications, following these up with the local authority and tracking the expiry dates of when granted applications were due to expire.

Good

Is the service caring?

Our findings

People who used the service, their relatives and visiting professionals all told us that staff were caring and treated them with respect. Comments included "I'm very happy with [my relative] living here, the staff are wonderful", "The carers do a good job, they are always cheerful and explain what they are doing" and "They always give me time." Relatives we spoke with told us that they were able to visit at any time without restrictions and were able to take their family members out for the day if they were well enough, and told us that staff were good at keeping them up to date on any changes in their relative's condition.

Throughout the inspection we observed positive observations and interactions. Staff were polite and gentle, spoke softly and listened to people. We observed staff maintaining eye contact with people during conversation and getting onto their knees in order to get closer to speak with people. We noted that staff responded promptly to people and immediately offered support, we did not see any examples of people being asked to wait or being ignored. We saw two examples where staff were not immediately able to offer support as they needed another staff to do this with them, when this was the case this was clearly explained to people, with reassurances given that assistance would soon be given and people were not kept waiting excessively long periods of time for a second staff member.

There were good systems of engagement with people using the service, which included a weekly residents forum and a quarterly relatives' meeting, details of which were displayed in communal areas. Residents meetings were used to identify what people would like to do, and staff had also introduced a wishing tree, which displayed wishes people had expressed of things they would like to do. Examples of these included trips to the betting shop, day trips to particular places and a themed party based on one person's interest in reggae. People's views of the service and their impressions of what needed to improve were displayed prominently in the lobby. Residents meetings were also used to keep people updated on changes to the way the service worked, such as cleaning rotas, care plan reviews, maintenance issues and staff changes. There was a system in place for keeping track of people's birthdays, and we saw that balloons were attached to people's doors on their birthdays.

People had one page profiles, which staff had used to identify areas such as how best to support people, what was important to them and aspects that people liked and admired about them. This included meeting people's religious needs, for example through special diets and visits from ministers of religion. Profiles also included guidance on peoples' communication needs, including whether people were able to verbalise their needs, aspects of communication they may struggle with and how best to support people with this.

There was a multi-faith space available, which contained holy books, iconography and inscriptions from several major religions and a choice of religious literature in several different languages. There was an arrow which indicated the direction of Mecca and a prayer mat for people of the Islamic faith. Although this space met the needs of people of several different religions, there was no use of covering or curtains, which meant that the multi-faith space was not neutral in character.

We saw that people's doors were closed by staff when they were receiving care or support to eat. People we

spoke with told us that staff preserved their privacy such as by closing the doors, knocking before entering or drawing curtains. When requesting observation charts for people, we saw care workers knocking on doors to announce their presence and staff never just walked into rooms. The registered manager had measures in place to promote dignity and privacy; which included fitting door knockers to people's rooms and discussing the importance of using them in team meetings. The registered manager had recently set up a "dignity wall", where staff had begun pledging what they would do in order to promote people's dignity.

Requires Improvement

Is the service responsive?

Our findings

There were measures in place to promote person centred care; however there were some areas where staff did not fully respond to people's needs.

People and their relatives told us that staff knew them well and what they needed, and that they were involved in planning their care. Comments from relatives included "I have been involved at every stage. I can't ask for any more, but if I did I am confident they would respond positively."

There was good quality personalised information on people's care plans, which included evidence that information had been obtained from relatives about people's social history and family life. Care plans were broad in their scope and included information about people's medical conditions, maintaining personal hygiene and a safe environment and the support people needed to sleep and maintain a meaningful lifestyle. This included information about what was normal for people and their preferred habits. Care needs summaries clearly highlighted people's preferences and cultural needs and we saw examples of these being provided. This included people's preferred foods, support to read the bible or preferred radio stations and music. Staff were knowledgeable about people's needs and preferences, even staff who had only recently joined the service.

Plans were reviewed monthly in line with a new resident of the day programme. The registered manager had written to relatives to inform them of this new system, which meant that a person on each floor would be resident of the day once a month. As part of this all documentation pertaining to the person was reviewed and updated, and relatives were updated on the person's progress or condition. This was co-ordinated with kitchen staff, who reviewed people's dietary needs and preferences, and premises staff who checked their equipment and the condition of the person's room.

We saw good examples of staff responding to people's needs, but a small proportion of interactions were less positive. Where a person had fallen, staff responded quickly to provide appropriate support and reassurance and to check the person for injuries. Where people were distressed, staff responded quickly to this. However, we observed one person still had food on their face one hour after lunch. Another person had a catheter, but this was arranged in a way that it was visible below their clothing. We observed one person was walking the corridors and going into various people's bedrooms, staff did not offer any intervention or interaction with the person. Their care plan had highlighted this behaviour but there was no information on steps to manage this. Another person's plan stated that they were nursed in bed and could be "verbally challenging at times", we found that this person was now able to sit in a chair but their plan had not been updated accordingly, and there was no information on what this behaviour was and how to respond to it. In two cases there was limited or incomplete information on people's dentures and the support they required with these.
Welfare checks were completed consistently, with a clear coding system used to indicate the person's condition at the time, such as whether they were awake or asleep. We found that staff did not always detail the support that was offered or given at these times, such as changing pads or offering food or snacks. This was particularly relevant when people were only awake for short periods of time during the day, as we could

not always tell that staff were making the best use of an opportunity to engage with a person.

There were suitable systems in place to maintain good care for the end of people's lives. This included recording people's wishes for their deaths and funerals, as well as advance planning to refuse certain treatments and discussions with relatives about whether they would prefer their family member to remain in the home or to go into hospital. Plans were used to make sure appropriate end of life medicines were put in place promptly to support people to have a comfortable death. We found that Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders were completed by an appropriate medical professional and reviewed appropriately. These were displayed in line with the provider's filing system near the front of people's files. The provider told us that these were also flagged on the provider's computer system. In some cases we found these were difficult to find, and the provider agreed that in future these should be kept at the front of people's files.

There was a varied and interesting activities programme which people were supported to attend. The residents meeting on a Monday was used to review the week's plan and to make suggestions on what else could be done. People were given a weekly activities timetable, and up to date timetables for the week were displayed at the time we arrived. Regular events included storytelling, music events, community outings, coffee mornings, bingo, reminiscence activities and movies. There were activities of some form twice daily, and additional events to mark special occasions, which were arranged sensitively. For example, the first day of our inspection was Shrove Tuesday; lifestyle staff had determined that cooking pancakes would be difficult for some, so arranged this to be a pancake decorating activity, which was well attended. The second day of our inspection was Ash Wednesday and Valentine's Day. The provider arranged a Catholic mass in the morning, and a lively and well attended Valentines Disco in the afternoon. We observed the registered manager was supportive and involved with activities, and had arranged for staff from their previous service to come and give advice to the lifestyles team. There were also outings twice a week which were arranged by coach, these included trips to Richmond Park and to see the Christmas Lights in central London.

There was considerable engagement with external groups to provide inclusive activities. This included helping people who enjoyed knitting to knit squares for premature babies at a local hospital to promote bonding with their parents by scent. There was a project being set up with students at a local school to help run groups in drama, art and other projects. There was a newspaper called the Daily Sparkle which was supplied to help with reminiscence activities. The registered manager told us of a person using the service who was unable to attend a relative's funeral; the service arranged for a local church to come in and hold a private mass for the person at the same time. The registered manager told us they hoped to develop this into a regular mass to support people to remember people, including other people using the service, who had died.

Relatives we spoke with told us they knew how to make a complaint if required, but had not needed to do so. Comments included "I know how to make a complaint and who to go to. I did raise a concern…that was sorted out straight away" and "I know the manager well, she is lovely and will always get a problem sorted straight away." The provider maintained systems to monitor and respond to complaints. Where people had complained these had been thoroughly investigated and responded to, and where appropriate the service had apologised. We saw that responses to relatives made reference to contemporaneous records and interviews with staff involved. In one case we saw that a complaint was taken to stage two of the provider's complaints process, where it was reviewed and further investigated by the provider's head of regulatory governance. This resulted in a detailed, transparent and nuanced response, including apologies for when things had gone wrong.

Good

Is the service well-led?

Our findings

People we spoke with were positive about the management of the service. A staff member said "The new manager is great. It's a good decision and we need some consistency. She's good for the residents" and a relative told us "I am very impressed, good management and good communication." One resident told us "I do know the manager; she visits me regularly". We saw that the manager was visible in the service and played an important role in encouraging people to participate in activities.

There were a number of initiatives in place to improve the quality of the service, including the resident of the day system, which was used to review people's care across departments and to keep relatives informed. This had been introduced in response to a relative's survey, where a finding was that relatives did not always feel informed of their family member's wellbeing, and relatives been had been written to, to explain the changes they were making in response to this. There were also supervisions carried out with agency managers on how to maintain contact with relatives. A relatives' survey was carried out on a six monthly basis, and included asking questions about the atmosphere of the service, whether people were treated with kindness and respect and were routinely offered drinks.

There was also a system of monthly audits. These had been organised in a yearly schedule, which included checking health and safety, infection control, deprivation of liberty safeguards (DoLS), nutritional needs and choking risks. Audits were comprehensive in their scope and were applied consistently months apart, which meant the provider could illustrate clear and substantial improvements in areas such as health and safety and infection control. Audits also routinely included action plans for department heads to address. For example, the provider had carried out a dementia strategy audit, which included speaking with staff to see if they understood people's life stories, and their understanding of concepts such as dining with dignity and training programmes. This had highlighted the need for more detailed and meaningful life story work, and the provider was in the process of implementing "Three things about me", where staff had a summary of things which were important about the person. At the time of our inspection we found staff were very knowledgeable about people's needs and wishes.

The registered manager had reorganised key information and documentation in a way which demonstrated the system was meeting regulatory requirements. The registered manager told us "When I got here I struggled to find any paperwork". Some changes by managers were simple but effective. For example, at our last inspection we found that records relating to welfare checks, turning charts and food and fluid charts were frequently disorganised and parts of these were missing. Managers had replaced these by bound books, which meant that these could not be lost or separated and had contributed to an improved standard of record keeping. Staff commented on how much easier this simple change had made their roles. The registered manager had highlighted that some staff lacked awareness of issues relating to mental capacity and safeguarding, so had given simple laminated cards to care workers with key information in these areas.

The clinical lead also carried out weekly audits in areas such as fluid monitoring, wound care and mattress settings, and these were fed back for action to unit managers in weekly clinical governance meetings. Minutes of these meetings indicated that these findings were acted on. Nursing staff were invited to pick

areas of practice for discussion at these meetings. Team meetings were well attended and included outcomes from surveys, and outlining expectations regarding recording and safeguarding, and addressing recent complaints and issues within the service. Staff also received memos with clear information about management expectations around how to carry out and record important checks such as welfare checks and repositioning checks. Staff responsibilities and allocations at mealtimes were clearly displayed in kitchens which contributed to the high standards of nutritional support we saw.

Managers also monitored the performance of the service through daily "Ten at Ten" meetings. This is where the heads of all departments, including maintenance and lifestyle teams, met for ten minutes a day in order to exchange notes on the events and concerns of the day, including updating on resident of the day arrangements, activities, staffing issues, recruitment and induction and the work required on training, supervision and appraisals with staff. We saw that these were well attended and worked efficiently as a means of sharing information.

Managers had implemented an employee of the month award for recognising staff achievements and boosting their confidence. The registered manager told us "It was important to raise morale, we send out a message and send that person chocolates and flowers". The employee of the month was also highlighted in the monthly newsletter, which also contained details on recent events and photographs of these.

The provider was meeting their responsibilities to display their ratings in the service and on their website, and were appropriately informing the Care Quality Commission of significant events that had occurred in the service.