Central and Cecil Housing Trust

Link House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Link House is a 'care home'. People living there receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 52 older people across three floors, each of which have separate adapted facilities. The first floor specialises in supporting people with nursing care needs, whilst the ground and second floors support people with personal care needs. At the time of our inspection 32 people were residing at the care home, of which two-thirds were living with dementia.

At the last comprehensive CQC inspection of this home in September 2016 we found the provider to be in breach of two of their legal requirements. We therefore rated the service 'Requires Improvement' overall and for the two key questions, 'Is the service caring and well-led?' This was because the service did not have suitable arrangements in place to ensure people were always treated with dignity and respect and management oversight and scrutiny was effectively implemented.

We undertook a follow up focused inspection in February 2017 and found the provider had followed their action plan to improve and met their legal requirements. However, we did not change the service's overall rating at the time because we wanted to be sure they could sustain these improvements over a longer period of time.

At this comprehensive inspection we found the service continued to make the necessary improvements. We saw action continued to be taken to ensure staff received specific guidance and training so the remained aware how to treat people with dignity and respect, particularly during mealtimes. In addition, we saw the provider continued to have appropriate arrangements in place to monitor the quality and safety of the service people received. This helped managers and senior staff check people were consistently experiencing good quality care and were quick to address any issues these governance audits identified. We have therefore improved the service's overall rating from 'Requires Improvement' to 'Good 'and for all five key questions, 'Is the service safe, effective, caring, responsive and well-led?'

The service had a registered manager who had been in post for a year and a half. A registered manager is a person who has registered with the Care Quality Commission (CQC). Registered managers like registered providers 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 a positive impact at the home and was highly regarded by people living there, relatives and staff.

People living at the home and visiting relatives told us they were generally happy with the service provided at Link House. We saw staff looked after people in a way which was kind and caring. Our discussions with people living in the home and their relatives supported this.

There were robust procedures in place to safeguard people from harm and abuse. It was clear from comments we received from staff they were familiar with how to recognise and report abuse. The provider assessed and managed risks to people's safety in a way that considered their individual needs. Staffing levels appeared to be adequate. The premises and equipment were safe for people to use because managers and staff routinely carried out health and safety checks. The home looked clean and no infection control or food hygiene issues were identified. Arrangements for managing medicines safely had improved in the last six months and the number of medicines errors or near misses had been significantly reduced as a result. Staff recruitment arrangements were robust for new staff. However, the provider does not have a policy for renewing Disclosure and Barring Service (DBS) checks for existing members of staff. We discussed this issue with senior managers who agreed to look into this matter at provider level.

People said Link House was a homely and comfortable place to live. Bedrooms were personalised and the building was well-maintained. We saw the provider had made some recent changes to the environment to make it more suitable for people living with dementia. However, we found no consistency in relation to the pictures, photographs or signage that were being used to help people identify their room. We discussed this matter with the registered manager who agreed to ask people living in the home, or those acting on their behalf, how they might make it easier for people to identify rooms that were important to them.

Staff received appropriate training to ensure they had the right knowledge and skills needed to perform their roles effectively. People were supported to eat and drink enough to meet their dietary needs. People on the whole said they liked the quality of the meals they were offered. Managers and staff were aware of their duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing any care and support and followed legal requirements when people did not have the capacity to do so. They also received the support they needed to stay healthy and to access health care services.

We observed staff providing personalised care to people which was tailored to their individual needs and wishes. Each person had an up to date and person centred care plan, which set out how their care and support needs should be met by staff. These were reviewed regularly. Staff communicated with people using their preferred methods of communication. This helped them to develop good awareness and understanding of people's needs, preferences and wishes. Staff were also knowledgeable about people's backgrounds and cultural heritage. Staff encouraged people to actively participate in meaningful leisure activities that reflected their social interests and to maintain relationships with people that mattered to them. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were nearing the end of their life, they received compassionate and supportive care.

People were given choices about most aspects of their daily lives. However, we also received some mixed feedback from people about the choice of food they were offered at mealtimes. Staff supported people to choose their meals they wanted to eat the day before, which meant people might not remember the meal choices they had made. We discussed this issue with the managers who agreed to review how they supported people to make a real informed choice about the meals they ate.

People and relative's felt comfortable raising any issues they might have about the home with managers and staff. The service had arrangements in place to deal with people's concerns and complaints appropriately. The provider routinely gathered feedback from people living in the home, their relatives and staff. The provider also worked in close partnership with external health and social professionals and bodies. It was evident from the registered managers comments they understood their registration responsibilities particularly with regards to submission of statutory notifications about key events that

occurred at the service.

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.

There were safeguarding and whistle-blowing procedures in place and staff had a clear understanding of these procedures.

Appropriate recruitment checks took place before staff started work. There were enough staff suitably deployed in the care home to keep people safe.

The provider had assessments and management plans in place to minimise possible risks to people, this included infection control and food handling measures. The care home was clean, free from odours and was appropriately maintained.

Medicines were managed safely and people received them as prescribed.

Is the service effective?

Good

The service was effective.

People received support from suitably knowledgeable and skilled who were well trained and supported by senior staff and managers. Staff were able to meet people's assessed needs, preferences and choices.

The registered manager and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access health care services.

Is the service caring?

Good

The service was caring.

We found action continued to be taken to ensure staff received specific guidance and training so they always treated people with dignity and respect, particularly during mealtimes. We saw

positive interactions between staff and people and support was provided in a dignified and respectful way.

People said staff were kind and caring.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Is the service responsive?

Good

The service was responsive.

People were involved in discussions and decisions about their care and support needs.

People had an up to date, personalised care plan, which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and interests.

Staff encouraged people to actively participate in leisure activities, pursue their social interests and to maintain relationships with people that mattered to them.

People and relatives knew how to make a complaint if they were dissatisfied with the service they received. The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

When people were nearing the end of their life, they received compassionate and supportive care from the service.

Is the service well-led?

Good

The service was well-led.

The home had an experienced suitably qualified registered manager in post.

We found action continued to be taken by the provider to improve their quality monitoring systems to ensure they remained effective.

The provider routinely gathered feedback from people living in the home, their relatives and professional representatives. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

The provider also worked in close partnership with external health and social professionals and bodies.

Link 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.

This was an unannounced comprehensive inspection which took place on 6 and 7 February 2018. This inspection was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During this two-day inspection we spoke face-to-face with eight people who lived at the home and five visiting relatives or friends and a GP. We also talked with various managers and staff including, the registered manager, area operations manager, quality and compliance manager, three nurses (including the clinical lead), two team leaders, six care workers and the activities coordinator. We also spoke with the chef who is employed by a separate provider. We also observed the way staff interacted with people living in the home and performed their duties. During lunch on both days of the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included eight people's care plans, six staff files and a range of other documents that related to the overall management of the service including, quality assurance audits, medicines administration sheets, complaints records, and accidents and incident reports.

We also contacted various health care professionals who worked with staff to provide care to people living in the home and the Merton Seniors Forum. We received verbal feedback from a district nurse and a written

dignity in care report produced by Merton Seniors following their recent visit to the home.

Good

Is the service safe?

Our findings

People and their relative's told us they felt Link House was a safe place to live. Typical comments we received included, "I am very fortunate to be somewhere that I feel safe", "I feel safe here because there are always staff around" and "My friend is kept safe…It's a secure building."

New staff were appropriately checked to ensure they were suitable to work in the home. The provider maintained recruitment procedures that enabled them to check the suitability and fitness of staff they employed. This included checking staff's eligibility to work in the UK, obtaining references from previous employers and undertaking criminal records checks.

However, the registered manager told us the provider did not routinely reassess criminal records checks for existing staff, which meant there were no formal mechanisms in place for their on-going suitability to be routinely reviewed. This was confirmed by senior managers we spoke with. For example, from staff files we sampled at random we found two long standing members of staff had not had their criminal record checks renewed for over five years. We discussed this issue with the managers who acknowledged the provider did not have any recognised policies and procedures in place to monitor staffs on-going suitability and agreed to review the provider's staff vetting procedures. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

The home was adequately staffed. We received two negative comments from people about staffing levels, although most felt there were usually enough staff working in the home who were visible. Typical feedback included, "There seems to be less permanent staff at the weekends, which means the home is more reliant on agency staff who don't know people so well", "Sometimes I'm not sure there's enough staff to immediately meet everyone's requests for assistance, but they [staff] always do their best and come as quickly as they can" and "They're enough staff for what I need…They're [staff] always prompt to answer my call alarm when I use it." Throughout our inspection we saw there were enough nursing, care and auxiliary staff on duty on both days of our inspection. This meant people could alert staff whenever they needed them. We also saw numerous examples of staff responding quickly when people used their call bells or verbally requested assistance to stand or have a drink.

The registered manager told us in the last 12 months the service was less reliant on agency staff. This was confirmed in a report compiled by Merton Seniors Forum who visited Link House in January 2018 as part of their dignity in care campaign. They wrote in their subsequent report, "The new manager has ensured many fewer agency staff are used now at the home."

The provider had robust systems in place to report and act on signs or allegations of abuse or neglect. Staff had received safeguarding adults at risk training, which records indicated was refreshed annually. Managers and staff were aware of their responsibilities to safeguard people from harm and were aware of the reporting procedures if they had any concerns about a person's safety or the quality of care they received. Staff told us safeguarding matters were a fixed agenda item at monthly staff meetings.

We looked at documentation where there had been safeguarding concerns raised in respect of people living at the home in the last 12 months and were assured the provider had taken appropriate action to mitigate the risks associated with these incidents. We saw the registered manager had liaised with the relevant local authority about the concerns raised so they were aware of the outcome of the investigation and any learning to ensure people remained safe and to prevent similar incidents reoccurring. At the time of our inspection there were no on-going safeguarding investigations.

Managers assessed risks to people due to their specific health care needs. Care records included risk management plans for staff to follow to enable them to reduce identified risks and keep people safe. These plans included details about the risks associated with needs such as malnutrition or dehydration, falls, mobility and safe transfer using a hoist, and skin care. Our observations and discussions showed staff understood the risks people faced and took action to minimise them. For example, we saw staff followed individual guidance when supporting people to transfer safely from an armchair to a wheelchair using a mobile hoist. Another person's care plan made it clear some of their behaviours might be perceived as challenging. We found appropriate risk management plans were in place to help staff prevent or deescalate such incidents.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency plans to help staff deal with such emergencies quickly. For example, people had personal emergency evacuation plans which explained the help people would need to safely leave the building. Staff demonstrated a good understanding of their fire safety role and responsibilities.

The environment was well-maintained, which contributed to people's safety. Maintenance records showed environment and equipment checks were routinely undertaken by suitably qualified professionals to ensure the home remained safe. These included checks in relation to electrical and gas safety, fire equipment, heating systems, water hygiene and monitoring of water temperatures, servicing of mobile hoists, the passenger lift, bed rails and window restrictors. During a tour of the premises we saw radiators were suitably covered.

People were protected by the prevention and control of infection. People and their visiting relatives told us the home always looked and smelt clean. One person said, "It's a very clean and pleasant environment here." We observed staff using appropriate personal protective equipment. For example, we saw staff always wore disposable gloves and aprons when providing personal care to people. The clinical lead confirmed they were the home's designated infection control champion who was responsible for ensuring staff's infection prevention and control knowledge and practices remained current. Records indicated all staff had received up to date infection control and basic food hygiene training. We saw infection control policies and procedures were in place.

Medicines were managed safely. Care plans contained detailed information regarding people's prescribed medicines and how they needed and preferred these to be administered. We saw medicines administration records (MARs) and the Controlled Drugs register were being appropriately maintained by staff authorised to handle medicines in the home. There were no gaps or omissions on MAR sheets we looked at, and our checks of medicines stocks and balances, indicated people received their medicines as prescribed. Staff received training in the safe management of medicines and their competency to do this was routinely assessed. A medicines audit undertaken by a community pharmacist in January 2018 indicated they had been satisfied staff authorised to handle medicines on behalf of people living in the home managed them safely.

Good

Is the service effective?

Our findings

People told us Link House was a comfortable place to live. One person said, "It's nice here…I've got everything I need in my room." We found the premises to be warm, well-decorated and maintained. The registered manager told us the Merton Heritage Service (MHS) had recently visited and helped decorate the communal areas with photographs and memorabilia that reflected the local area and the age of people living in the home. We also saw a wide variety of painting's displayed throughout the home that people had chosen as part of the Paintings In Hospitals (PIH) project. PIH is a project that loans works of art to hospitals and care homes.

In addition, we saw the provider had made some recent changes to the environment to make it more suitable for people living with dementia. This had included painting people's room door's different colours and fitting them with a door bell or knocker. However, we found there was no consistency in relation to the pictures, photographs or signage that was being used to help people identify their room. We discussed this matter with the registered manager who agreed to ask people living in the home, or those acting on their behalf; how they might help people identify rooms that were important to them. Progress made by the service to achieve this stated aim will be assessed at their next inspection.

Staff had the right knowledge, skills and experience to carry out their roles effectively. People and their relatives were complimentary about the staff who worked at the home. Typical feedback we received included, "The staff are top notch…They seem very well-trained", "The staff know how to look after my [family member] and are lovely with it" and "No complaints about the staff…They know what they're doing." We saw there was a comprehensive rolling programme of training which helped ensure staffs knowledge and skills remained up to date and reflected current best practice. All new staff were required to complete an induction before supporting people unsupervised and achieve the competencies required by the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Where people had specific health care and nursing needs, staff received specialist training to enable them to effectively meet them. For example, nurses who supported people with urinary catheters or who used a syringe driver had been suitably trained to perform these specialist medical tasks. Staff spoke positively about the training they had received. One staff member told us, "We're expected to keep our training up to date…There's lots of it to be honest" and "The training is excellent. I've recently completed loads of e-learning courses."

Staff had sufficient opportunities to review and develop their working practices. There was a well-established rolling programme of individual and group supervision meetings and annual appraisals which enabled staff to reflect on their work practices and training and development needs. Records showed each year staff attended a minimum of six supervisions with their line manager who also appraised their work performance.

We checked whether the service was working within the principles of the MCA (2005) and DoLS. The MCA (2005) 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. 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. We found applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. Records showed the provider was complying with the conditions applied to the authorisation. For example, we saw these authorisations were up to date and the registered manager kept them under constant review to ensure they remained appropriate and in the person's best interests.

People's ability to make and consent to decisions about their care and support needs was routinely assessed, monitored and reviewed. People had signed their care plans to indicate they agreed to the support they were provided. We saw staff prompted people to make decisions and choices and sought their permission and consent before providing any support. Records indicated staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and it was clear from their comments they understood their responsibilities under the Act. For example, staff told us they asked people for their consent before delivering care or treatment and respected people's decision if they refused support.

People were supported to have enough to eat and drink. Most people and their relative's typically described the quality of the meals offered at the home as "good". Comments included, "The food is very good… I always like what they [staff] give me", "I think the meals are always freshly cooked" and "The food is OK. It's fairly healthy and I'd probably remember if it was ever unpleasant." We saw outside of meal times people were offered regular drinks and snacks. Care plans included detailed nutritional assessments which informed staff about people's food preferences and the risks associated with them eating and drinking. Staff confirmed nutrition and hydration was regularly discussed at their team meetings so they kept up to date about how exactly they should be supporting people to eat and drink enough to stay healthy and well. Staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these people continued to eat and drink adequate amounts. If they had any concerns about this they sought appropriate support from the relevant health care professionals.

People were supported to maintain their health and wellbeing. One person told us, "You can ask the carers and they will sort out an appointment with the doctor if you need it." Care plans set out how staff should be meeting people's specific health care needs. Staff carried out regular health checks and recorded daily the support provided to people including their observations about people's general health. This helped them identify any underlying issues or concerns about people's wellbeing. When staff became concerned about a person's health they took prompt action to ensure they received appropriate support from the relevant health care professionals.

The registered manager told us they were in the process of introducing the local authority's integrated red bag scheme, which was piloted through NHS England's vanguards initiative. These ready prepared bags would include documentation about a person's medical needs, their prescribed medicines, Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) status and information relating to their mental capacity. This meant, if required, this information would be available to be passed on immediately to ambulance crews and medical staff to help them determine the treatment a person needed if they required emergency hospitalisation.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. People and their relatives spoke positively about the care and kindness shown by staff working at the service. Typical comments we received included, "They're lovely staff here… I've always found them friendly and welcoming", "All the staff are caring. They are passionate and go that extra mile sometimes" and "Staff are friendly and delightful."

At our last comprehensive inspection of the service in September 2016 we found them to be in breach of the regulations. This was because they did not have suitable arrangements in place to ensure that people were always treated with dignity and respect by staff, especially during mealtimes. After we had carried out a follow up focused inspection in February 2017 we found the provider had taken the necessary action to meet legal requirements.

At this inspection we found staff continued to treat people with respect and dignity. Staff confirmed they had attended workshops on how to ensure people were treated with dignity and respect, particularly during mealtimes. The registered manager told us they and other managers routinely sat and ate a meal with people at randomly selected mealtimes to check staff were putting into practice what they had learnt at the workshops. The outcomes of these checks were shared with staff to enable them to reflect on their working practices. We undertook observations of the lunchtime meals being served on all three floors of the home on both days of our inspection. We saw interactions between staff and people had improved. Before the meal was served, staff offered people a choice of drink by showing them the different flavours of juice that were available. Throughout these mealtimes most staff maintained regular dialogue and communication with people. For example, we saw they explained to people what they were about to eat and checked they were happy with the food they had been presented. Staff supporting people to eat, did this in a dignified way. They sat next to people, maintained good eye contact and engaged people in conversation whilst remaining observant to signs that indicated people had eaten enough. The atmosphere on all three floors remained calm and unhurried during lunch on both days of our inspection.

People's care plans prompted staff to ensure support was provided in a dignified and respectful way. The deputy manager was the service's designated 'Dignity Champion' who was responsible for ensuring staff remained up to date and implemented recognised best privacy and dignity practice. Several staff told us during the week of national Dignity in Action day last year when the service held a number of dignity in care workshops and awareness session for relatives and staff. We saw several displays throughout the home giving information to people, their visitors and staff about how to promote dignity in care.

People told us staff respected their privacy. One person said, "The staff are so considerate, especially when I may be embarrassed about getting the personal care I sometimes need." We saw staff did not go into people's rooms without first seeking their permission to enter and personal care was provided in the privacy of people's rooms or in the bathroom. When people wanted privacy, staff respected this so that people could spend time alone if they wished.

Throughout our visit we observed many positive interactions between people, their relatives and staff. For

example, staff greeted people warmly and always responded positively to people's questions and requests for assistance. For example, during lunch we saw staff frequently asked people if they were enjoying their meal or needed a drink. People looked content and relaxed in staff members' company. Staff knew how to support people if they became anxious or distressed so that this was done in a caring and considerate way.

People were supported by staff who understood their needs and what was important to them. This was evidenced by the knowledge and understanding staff demonstrated about people's preferences, choices and how they should be supported with their care needs. For example, staff were able to explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people were able to do independently. In addition, people had a designated key-worker. This was a member of staff specifically assigned to a person to make sure their care needs were met, and their choices about their care were known and respected.

People's care plans contained detailed information about their preferred method of communication. Each person had a detailed communication profile which set out good information for staff on how people communicated and expressed themselves. This helped staff understand what people wanted in terms of their care and support. People's communication needs and preferences were well known to staff we spoke with. For example, staff were able to explain how each person communicated and made choices about what they wanted. During a tour of the premises we saw signs displayed in a person's room which had been translated into their first language. The registered manager told us they had employed a member of staff who spoke the same first language as this person who could not speak English.

People's relatives and friends were made to feel welcome at the home and were able to visit without being unnecessarily restricted. Typical feedback we received from them included, "Staff seem to welcome our visits", "I'm always popping in to see my [family member] and am not aware there's any rules about visiting times" and "I feel free to visit whenever I like and staff always make me welcome." The atmosphere in the home felt congenial and relaxed throughout our inspection, which helped reinforce its homely and welcoming feel. We saw staff greeted people's relatives and friends warmly.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. People told us religious leaders representing the Christian faith regularly visited the home and some staff led a Christian service in the main communal lounge every Friday. Information about people's spiritual needs, ethnicity and cultural heritage was included in their care plan. For example, one person's care plan made it clear staff must not interrupt them when they were wearing their brown hat as this meant they were praying, which staff we spoke with knew. The chef also demonstrated a good understanding of people's specific dietary requirements and knew who did not eat pork on religious grounds.

People were supported by staff to be as independent as they could be. During lunch we observed staff actively encourage a person to use their adapted cutlery to eat their meal independently. A relative gave us a good example of how staff actively supported their family member to maintain their mobility by ensuring their walking aid was always in easy reach of where they sat. Care plans reflected this approach and included detailed information about people's dependency levels and more specifically what they could do for themselves and what help they needed with tasks they couldn't undertake independently.

Good

Is the service responsive?

Our findings

People were given choices about most aspects of their daily lives. One person told us, "I go to bed when I want and staff allow me to eat in my room", while another person said, "Staff help me pick out the clothes I want to wear each day." People's care plans clearly stated their preferences. For example, we saw they contained detailed information regarding the times people preferred to get up and go to bed, where they ate their meals and the gender of the staff who met their personal care needs. Staff demonstrated a good awareness of people's needs and how they should be met in line with people's specific preferences and choices. For example, we saw staff had ensured one gentleman was wearing a shirt and tie in accordance with their expressed wish to wear this every day, which was clearly recorded in their care plan.

However, we also received some mixed feedback from people about the choice of food they were offered at the home. Typical comments we received included, "Staff do ask me what I would like to eat, but they do it the day before. So you do get a choice, but I must admit I often forget what I've ordered", "I never know what we're going to have for lunch, although am sure the cook does ask me what I want" and "It's always a surprise to me what the cook makes me, although it's usually nice." We observed staff supporting people to choose the meals they would be served the following day. Most staff told us people often had no recollection of the meal choices they had made the previous day. We discussed this issue with the managers who also acknowledged people often could not remember the meal choices they had made and agreed to review the current arrangements. Progress made by the service to achieve this stated aim will be assessed at their next inspection.

People received personalised care and support which was tailored to meet their individual needs. People and their relatives said they were actively involved in care planning process. One relative told us, "I was initially involved in the care plan." Several other relatives said they remained actively involved through regular discussions with the manager and staff regarding the care and support their family member received at the home.

We saw pre-admission assessments were completed in all instances. Information gathered from this initial assessment was used as the basis to develop a person's care plan, which set out in detail how staff should be meeting a person's needs and preferences. People's care plans were written in a person centred way and contained detailed information about each person's specific needs, abilities, likes and dislikes, life history, people and places that were important to them and preferences for how they wanted their care and support to be provided.

Care plans were reviewed at least monthly and updated as and when required if there had been changes to a person's needs and/or circumstances. Where changes were identified, people's care plans were updated quickly and information about this was shared with staff through shift handovers, each unit's communication book and various meetings. The registered manager told us they had introduced a 'resident of the day' scheme. This meant approximately once a month the person who was resident of the day had their care plan checked and would be offered the opportunity to have a special meal of their choosing prepared for them by the chef and/or participate in an activity or event that mattered to them. It was clear

from feedback we received from staff working on one floor they knew who 'the resident of the day' was. They told us the chef had been asked to prepare this person a special meal that originated from this person's country of birth. The registered manager also gave us a good example of how the care and catering staff teams had pulled together to meet the expressed wish of one 'resident of the day' who had chosen to have a romantic meal for two with his wife to celebrate their Wedding Anniversary.

People had opportunities to participate in meaningful social activities both inside the care home and in the wider community. One person told us, "I helped in the garden in the summer, which I really enjoy", "I did go on an outing to a local pub recently" and "The activities lady is marvellous. There always seem to be something going on around here. I don't think my [family member] gets bored."

The registered manager had appointed an activities coordinator to provide a dedicated permanent resource at the service for identifying and delivering appropriate activities and events for people to take part in. The activities coordinator sought creative ways to stimulate and engage people and told us about a weekly activities timetable they had introduced, which included knitting and quilt making, baking, musical bingo, quizzes, chair exercise classes, various art and crafts, aromatherapy and pampering sessions. We saw raised planters which meant people could do gardening. Several staff told us people had enjoyed a range of trips out in the last 12 months, which had included lunch out at the Mayor's office, various day trips to the coast and participation in a local singing competition. During our inspection we saw the coordinator initiate a number of activities and staff encouraged people to join in, which included a sing-along and a dance session, a quilt making class and various ball games.

The provider ensured people who choose to spend time in their room did not become socially isolated. The activities coordinator told us they made sure people who liked to spend time on their own also had opportunities to engage socially with staff on a one-to-one basis. One person told us, "Staff often bring up my paper to my room and we have a chat." The registered manager told us they had recently introduced an activity whereby all staff, including the domestic, catering and business support team, were expected to spend some 'quality' time engaging with people for ten or so minutes every afternoon.

The service had suitable arrangements in place to respond to people's concerns and complaints. People and their relatives said they knew how to make a complaint and told us they were confident that any concerns they had would be dealt with appropriately. One person told us, "If I needed to complain I would go to the person in charge of the floor first and then the manager, but fortunately I haven't needed to complain." During a tour of the premises we saw the providers complaints procedure was not displayed in the home. We discussed this issue with the registered manager who took immediate action to display easy to follow versions of the provider's complaints procedure throughout the home.

We saw when a concern had been raised the registered manager had conducted a thorough investigation, provided feedback to the person and offered an apology where this was appropriate and checked that they were satisfied with the actions taken to resolve the issue raised. The registered manager ensured any issues or concerns people raised were discussed at monthly staff team meetings to share learning and ways working practices could be improved to stop mistakes reoccurring unnecessarily.

When people were nearing the end of their life, they received compassionate and supportive care at the home. One relative wrote in a card they had sent to the service, "As a family we would like to say a huge thank you to all the staff for making my mother's life as comfortable and pleasant as it could be during her last days." Care plans contained a section that people could complete if they wanted to record their wishes during illness or death. We saw Do Not Attempt Cardio-Pulmonary Resuscitation (DNAR) forms in some of the care plans we looked at. Staff had received training to support people at the end of their life. This had

been delivered and accredited by a local hospice.

Good

Is the service well-led?

Our findings

The registered manager had been in post for a year and a half. People, relative's and visiting professionals all spoke positively about the registered manager's leadership style. One person said, "I like the new manager…She's friendly and easy to speak too", while a relative told us, "The manager is often about if you need to chat to her about anything." Merton Seniors Forum also wrote in their recent Dignity in Care report about the home, "The home suffered for a long period with no manager, but the present incumbent is making a very real difference." We observed the registered manager interacting with people living at the home during the course of our inspection. The registered manager told us they felt well supported by the providers operations and quality and compliance managers, who were regular visitors to the home, and her deputy manager and clinical lead nurse.

At our last comprehensive inspection of the service in September 2016 we found the provider in breach of the regulations because the service lacked continuous and consistent management oversight and scrutiny. After the focused follow up inspection we carried out in February 2017 we found the provider had taken the action they said they would and now met legal requirements.

At this inspection we found the provider continued to have appropriate arrangements in place to monitor the quality and safety of the service people received, which ensured the service continued to work towards making improvements that were needed. The provider's quality and compliance manager carried out quarterly themed audits of the home, which focused on a different aspect of service delivery. The outcome of these audits would then be shared with the registered manager to action. In addition, the registered manager and senior staff team were responsible for routinely undertaking their own audits, which regularly focused on care planning and risk assessments, medicines management, staff training and supervision, health and fire safety, the home's environment and maintenance, infection control and food hygiene and, safeguarding incidents, complaints and accidents. The managers and senior staff were also responsible for carrying out structured observations of staff providing care to people, for example during daily tours of the building, at mealtimes and at night.

We saw when areas for improvement were identified through these checks and action plans were developed to ensure improvements were made. The registered manager told us they regularly discussed these plans at meetings with staff and senior managers. They gave us a good example of action they had taken to improve the home's medicines handling practices after the occurrence of seven medicines errors in the first half of 2017. Records indicated staff had been retrained in the safe management of medicine's and managers now observed their competency to handle medicines safely at regular intervals. This had led to a positive outcome with no medicines handling or recording errors occurring in the last six months.

We also saw the managers followed up the occurrence of any accidents, incidents or near misses involving people living in the home and developed improvement plans to help prevent them from reoccurring. Examples included routinely analysing pressure ulcers people had developed and falls they had been involved in. The registered manager told us analysing falls and the prevalence of pressure ulcers at monthly intervals had helped them identify patterns so they could develop appropriate risk prevention and

management plans, which had resulted in a significant decrease in the number of falls and pressure sores people experienced in the home. The registered manager also told us they continued to report any maintenance issues that needed attention to the provider's maintenance department. The operations manager continued to hold weekly meetings with the maintenance department to check these issues were being progressed and dealt with promptly.

It was evident from the registered managers comments they understood their registration responsibilities particularly with regards to submission of statutory notifications about key events that occurred at the service. This was important as we needed to check that the provider took appropriate action to ensure people's safety and welfare in these instances.

The registered manager promoted a culture within the service that was open, supportive and willing to make changes when needed to improve the quality of support provided to people. People and their relatives were encouraged to share their experiences and views about how the quality of support could be improved through regular resident and relatives meetings and satisfaction surveys. One person told us, "I've often been to the residents meetings. I will always say what I think, and to be fair to the manager and staff here they do listen." The registered manager gave us a good example of how they had used people's views obtained through various meetings and surveys to improve the number of day trips people could chose to go on.

The provider also valued and listened to the views of staff working in the home. Staff told us the registered manager was supportive and they felt listened to. Several staff frequently described the registered manager as "approachable". Staff regularly attended team meetings where they could contribute their ideas to improve the care home. Records of these meetings showed discussions regularly took place which kept staff up to date about people's changing care and support needs, as well as developments in the home. Staff also shared information through daily shift handovers and a communication book. Several staff told us they felt valued by their employer and liked the 'employee of the month' scheme, which rewarded staff if they were nominated by their fellow co-workers. This scheme had been introduced by the registered manager to help motivate staff to work hard and continually improve their practice.

The provider worked in partnership with other agencies and professionals to develop and improve the delivery of care to people. For example, the registered manager told us they regularly discussed people's changing needs and/or circumstances with the relevant professionals and bodies including GP's, district nurses, the community mental health team, speech and language therapists, occupational therapists, the palliative care team and a local hospice. They also worked collaboratively with local authorities funding people's care so they remained well informed about people's current care and support needs, which enabled them to make appropriate decisions about their on-going and future care and support needs.