Life Style Care plc

The Grange Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of The Grange Care Centre on 4, 5 and 6 September 2018.

The Grange Care Centre is a 'care home'. 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. The Grange Care Centre can provide accommodation and nursing care for up to 160 people with general nursing needs and end of life care. The service had eight separate units, each of which have individual bedrooms with en-suite facilities and communal living, dining, bath, shower and toilet facilities. Support was provided for older people including those with dementia care needs, younger adults with a physical disability and/or mental health needs and people requiring care at the end of their lives. At the time of the inspection there were 151 people living at the care home.

We previously inspected The Grange Care Centre on 30 and 31 August 2017 and 4 September 2017 and we identified three breaches of regulations. These were in relation to person-centred care, safe care and treatment of people using the service and good governance. The provider was rated requires improvement in the key questions of Safe, Responsive and Well-led and overall. We carried out a focused inspection of the service on 5, 6 and 9 February 2018 and we reviewed the key questions of Safe, Responsive and Well-led. We found improvements in relation to person centred care. We found the continuing breaches of two regulations in relation to good governance and staffing. At this inspection, the rating for the service remains requires improvement. This means the provider has been rated as requires improvement since the August 2017 inspection.

Following the last inspection, we asked the provider to complete an action plan to show when they would meet the regulation. The provider's action plan stated they would be meet the regulation by 2 July 2018.

At the time of the inspection there was a registered manager in post who has been at the home since August 2014. 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.

We found some improvements had been made to the way care staff were deployed to support people around the home but feedback we received, from both people using the service and care staff, identified they felt that at times there were not enough care staff deployed to care for people. We have made a recommendation about the deployment of care staff.

The provider had a medicines procedure in place which was followed by care staff in relation to the storage, administration and recording of medicines but we noted some care staff were not aware of how to safely handle cytotoxic medicines. We have made a recommendation regarding guidance on handling these

medicines.

Records relating to people using the service did not always provide accurate information relating to the care and support they needed, so staff had all the information they needed to care for people

The provider had audits in place, but these did not always identify areas where improvement was required and where they had identified areas for improvement, action taken was not always effective in securing the necessary improvements.

People told us they felt safe when receiving care and the provider had procedures developed to respond to any concerns relating to the care provided.

Incidents and accidents were reviewed and the provider took action where required and provided guidance to staff to reduce a possible reoccurrence. Risk management plans had been developed providing care staff with information as to how to reduce possible risks.

There was a robust recruitment process in place and staff received the training and supervision they required to provide them with the knowledge and skills to provide care in a safe and effective way.

Assessments of people's support needs were carried out before the person moved into the home, so the provider was confident they could meet the person's needs. People were supported to eat healthy meals that met their dietary, cultural and religious needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

Staff supported people in a kind and caring manner, with positive and respectful interactions with people using the service and relatives.

A range of activities were organised to keep people stimulated and we saw people enjoyed taking part in these.

The provider had a complaints process and people were aware of how to raise concerns.

People told us they felt the home was well led. All care staff we spoke with told us that the senior management team was approachable and supportive.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person centred care (Regulation 9) and good governance of the service (Regulation 17). Full information about CQC's regulatory response to these concerns will be added to the report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider had a policy in place for the administration of medicines which was followed by care staff but we have made a recommendation in relation to the handling of cytotoxic medicines.

Some improvements have been made in the way care staff were deployed but issues were still identified by people using the service and care staff. We have made a recommendation in relation to care staff deployment.

People told us they felt safe when receiving care. Risk management plans were in place providing guidance for care staff on how to minimise risks for people using the service.

Is the service effective?

Good

The service was effective.

Assessment of people's support needs were carried out before the person moved into the home.

People were supported to have maximum choice and control of their lives and care staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

Care staff received the training and supervision they required to provide them with the knowledge and skills to provide care in a safe and effective way.

People were supported to eat healthy meals that met their dietary, cultural and religious needs.

People had access to a GP and other healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported with their cultural and spiritual needs.

Care staff supported people in a kind and caring manner, with positive and respectful interactions with people using the service and relatives.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not written in a way that identified the person's wishes as to how they wanted their care provided. Records did not provide up to date information relating to people's care.

People using the service could access a range of activities organised by care staff.

The provider had a complaints process and people were aware of how to raise concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had audits and other checks in place but these were not always effective in identifying areas where improvement was required or securing the necessary improvements.

People using the service and staff felt the service was well-led.

The Grange Care Centre

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 comprehensive inspection took place on 4, 5 and 6 September 2018 and was unannounced.

The inspection was carried out by three inspectors, a member of the CQC medicines team and two experts-by-experience on the first day of the inspection. Two inspectors on the second day of the inspection and one inspector of the final day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR) in July 2018. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with 19 people who used the service, three relatives, the registered manager, the clinical service manager, the quality director, three deputy managers, one nurse, seven care workers, one activity coordinator and the chef. We also looked at records, including 13 people's care plans and their daily care records, eight care staff records, medicines administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

During the February 2018 inspection we identified that care staff were not always deployed in a way that ensured they were available to monitor and meet people's needs. At this inspection we saw some improvements had been made and the provider was monitoring the level of people's support needs, nevertheless we received mixed feedback from people and care staff regarding staffing levels.

Some people told us they felt there were enough care staff but other people told us they felt additional care staff were required. Their comments included "Oh yes, plenty [of care staff]", "I think there are enough", "The staff are doing a great job, but they are a little overwhelmed", "Two girls as night staff is not enough to cope with it all" and "Yes and no. you get the core staff, but if someone is off there is not always cover. But sometimes we have agency and they are just as good as core staff."

In general, the care staff stated they felt there usually were enough staff but, on some units, it was busy with care staff working together to provide care. Their comments included "Sometimes there is not enough. One person needs a lot of attention and it can take away from others", "I have enough staff. I wouldn't mind if they gave me another", "One nurse and four care workers for 21 people [of which] 17 people need the hoist. Very busy but we work as a team", "Yes, but at the moment the dependency levels are very high", "Four staff for 21 people. Only a few need two staff to one person so it is OK", "We always have enough staff on Violet unit. Two double ups. Always six staff in the morning and five in the evening" and "We manage but would be happy if there was another one."

At the time of the inspection the registered manager confirmed there were four care workers and one nurse on the rota during the day on three units. On one of these units, which had 19 people, records indicated 15 people required the support of two care staff and four from one member of staff for personal care. Another one of these units which provided support for 20 people had 15 people who required support from two care staff and five people from one care staff. We saw one unit, which supported 25 people, had 21 people who required support from two care staff and four people supported by one care staff. The unit had six care workers on shift in the morning and five care workers in the afternoon with one nurse on duty all day. The registered manager confirmed an additional care worker had been added to the rota for one unit where a need had been identified. The level of support people required in each unit was assessed monthly or as and when a change was identified for a specific person. The assessments of needs were used to identify the number of care staff required for each unit.

During the inspection we observed there were times on some units where care staff were not available as those on duty were busy supporting people in their rooms which left people in the communal areas without access to support and supervision.

We recommend the provider review best practice guidance in relation to the deployment of staff to meet the needs of people using the service.

At our last inspection on 5 February 2018, we found improvements were needed for the secure storage of medicines in peoples' own rooms. At this inspection we saw evidence that the provider had made suitable arrangements to ensure that people who looked after their own medicines had secure storage in their rooms.

We found staff also stored other medicines securely. They monitored and recorded room and refrigerator temperatures for medicines storage areas daily and these were within the required range. Staff disposed of unwanted waste medicines appropriately.

We observed staff giving medicines safely to people during the morning and afternoon. Staff were polite, gained permission and signed the Medicine Administration Records (MAR) after giving people their medicines.

We looked at the MAR and care plans relating to medicines for 18 people. Staff had recorded information on how people like to take their medicines so they were all clear hot to administer these medicines. We found no gaps in the MAR, this provided assurance people were being given their medicines as prescribed.

Some people were prescribed medicines such as insulin and anticoagulants to manage their long-term health conditions which need regular monitoring. Insulin is prescribed to help maintain appropriate sugar levels in the body. Anticoagulants are medicines which help in reducing the risk of blood clots. However, we found guidance was not always available for staff in people's care plans on how to identify and manage the likely side effects of these medicines.

The provider had a policy in place to support medicines management. There was a system to report and investigate medicine incidents so learning took place to prevent reoccurrence.

Some people at the home were prescribed cytotoxic medicines to manage their health conditions. Cytotoxic medicines contain chemicals, which are toxic to cells and need to be handled with caution as per the manufacturer's instructions. We found some members of staff were not aware of the risks of handling these medicines.

We recommend the provider reviews current guidance and training in relation to the handling of cytotoxic medicines.

People we spoke with told us they felt safe when they received care and support from staff at the home. During the inspection we saw the provider had a process in place for investigating and responding to safeguarding concerns. Care staff we spoke with demonstrated a clear understanding of safeguarding. We looked at the records for three safeguarding concerns raised during 2018 and we saw they included information regarding the concern, copies of relevant information including minutes of any meetings, notes of any investigation and the outcome.

We saw risk assessments had been completed for people who were using the service and risk management plans were provided for care staff on how to reduce any identified risk. The risk assessments associated with the care provided included moving and handling, falls, pressure sore development and nutrition. The levels of risk calculated from each risk assessment were recorded as part of the care plan and guidance was provided for care staff as to the actions they could take to mitigate or manage the risks. The risk assessments were reviewed monthly along with the care plans to identify any changes in care needs.

People's care plans also contained detailed and clear information regarding people's risk of choking and

how to manage the risks. People at risk of choking had been assessed by a Speech and Language Therapist (SaLT) to identify any risks so appropriate plans could be put in place to mitigate the risks.

The provider had a process in place for the recording and investigation of incidents and accidents. If an incident and accident occurred a form would be completed and reviewed by a deputy manager to identify if there were any avoidable risk factors involved in the incident and if the staff followed correct procedure when providing care. They also identified if the person's care plan and risk assessments needed to be reviewed and if the local authority needed to be informed.

An analysis was carried out each month of the incident and accident records to identify any trends such as time of day or location. If any trends were identified a meeting would be organised with the care workers and nurses on the relevant unit to discuss the lessons learned from the investigation and support them to reflect on current practice.

The provider had a robust recruitment process in place to ensure new staff had the appropriate knowledge and skills for the role. We looked at the recruitment records for four care workers who had started to work at the home during the previous year. We saw a minimum of two references had been obtained from previous employers or from a suitable character reference. The provider also carried out checks to ensure the applicant had the right to work in the UK, an enhanced criminal record check and proof of identity.

During the inspection we found the home, including communal areas, bathrooms and people's bed rooms, were clean, tidy and free from any malodour. We saw housekeeping staff were cleaning throughout the home and they used colour coded cleaning equipment to reduce the risk of cross contamination. Staff had access to personal protective equipment (PPE) which included gloves and aprons and we saw that staff used them when they were supporting people with personal care and meals. The registered manager told us flu management and prevention training had been completed and a pop up clinic was arranged at the home for staff to receive their flu inoculations. They explained there had been a 98% take up of the flu inoculation by staff and people using the service.

Good

Is the service effective?

Our findings

An assessment of a person's care and support needs was completed before the person moved into The Grange. The registered manager explained when a referral for a new person was received, it was assessed to ensure the person's care needs could be met by at the home. Once this had been reviewed the person and/or their relatives were invited to visit the home to complete the assessment of their health and care needs. The information provided from the initial referral was then compared to the outcome of the assessment and the admission was organised. The information from these initial assessments was used to develop the care plan and risk management plans.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We saw care staff had completed training in mental capacity and the care staff we spoke with were able to clearly explain their understanding of the MCA and how this impacts on people using the service.

Mental capacity assessments had been carried out and DoLS applications had been made where required. We saw the registered manager had a folder containing the DoLs applications for people on each unit and if a DoLS had been authorised it was recorded on the electronic care plan. The registered manager confirmed they were in regular contact with the various authorising local authorities to monitor the progress of the DoLS applications.

If a person had been identified as not having capacity to consent to an aspect of their care a best interests decision had been recorded as part of their care plan.

People received care and support from care staff who had completed regular training and supervision to ensure their skills, competencies and knowledge was up to date. We asked people if they felt the care staff had the appropriate training and skills to provide their care. They told us "Oh yes, they know what they are doing. It can't be an easy job for them", "Yes and no some can be trained but don't understand, everyone is different and should be treated accordingly but that is only about 2% of staff" and "Oh yes they are really caring and they are really lovely."

Care staff we spoke with confirmed they had completed training and they felt it was beneficial. Their comments included "The training is good. I did very good dementia training", "Useful because I was new to this profession and it gave me a lot of help" and "Do refresher training every six months. Last time I did dementia training and I could ask the trainer about how to support someone I work with." New care staff completed the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

The training matrix we reviewed for all the staff indicated they had completed a range of training identified as mandatory by the provider. The records also indicated which care staff were either in the process or had completed a recognised training qualification in health and social care so they could train others.

Care staff received at least six supervision sessions with their line manager yearly including an annual appraisal. Care staff we spoke with confirmed they had regular supervision meetings with their manager and this was supported by the records of the meetings we looked at.

We asked people what they thought of the food offered at the home and we received a range of comments. Some people were happy with the choice of food available while other people told us they did not enjoy the choice of food offered and/or how it was presented. Their comments included "It is good. There is plenty", "Great food, enough food and drink", "I like the food", "Sometimes they do a nice curry or Chinese. They feed you enough to keep you alive. It is awful, all the food is the cheapest they can source", "I haven't enjoyed any of it. None of the food suits me. I am a cook myself. The food is piled up on your plate. Meat is always hard. I can't chew so well. Not enough mixed salad", "Horrible and sometimes there is not enough" and "Very bad, not tasty There is enough food supplied. The beef stew had hard bits of beef in it." Some people did tell us that their relatives brought food to the home for them as they did not like the options provided by the home.

During the inspection we met with the provider's head chef. They explained all meals were prepared in the kitchen. They were supported by a second chef and three assistant chefs. The chef explained the provider worked on a four week menu which had developed over time in consequence to people's preferences. We saw in care plans that care staff had taken time to ascertain people's wishes and preferences with regard to meals. The chef explained that every evening care staff discussed the next day's menu with all people at the home to ascertain their choice of food. He assured us that if a person identified that they preferred something that was not on the menu their wishes would be met.

The chef also showed us pictures of different meals which the care staff used to assist people who might have cognitive or communication needs to make choices. We saw the provider had a robust system in place to ensure any person requiring a special diet, whether this was due to health or cultural reasons, received the correct meal. The chef checked temperatures; covered all meals and placed the person's name and room number before they left the kitchen. Each person had a sheet in a file which explained special meals, allergies and preferences. We saw in the units for younger adult's snacks and drinks were readily available 24 hours a day.

People had access to a range of healthcare professionals including GP, district nurse and physiotherapist. A heath professional's record form was completed following each visit which included the reason for the visit, who visited and any outcomes, for example a change to medicines or how someone's care was provided.

People had access to a range of healthcare professionals including a GP, district nurses and physiotherapists. All but one person at the home was registered with the same GP who visited on a Monday and Friday. The GP also attended the daily meeting held by the registered manager with the senior staff when they visited to get an update on the health of people living in the home. One person had chosen to

remain with their existing GP. Following a visit from the GP notes from any consultations and outcomes were sent to the registered manager who added them to the computerised records.

Good

Is the service caring?

Our findings

Some people confirmed they felt care staff were kind and caring and they told us "Yeah, anything you need they will do it", "Oh yes, anything I need they get for me" and "Couldn't knock them at all." A few people commented that they sometimes felt the care staff did not always understand their support needs. One person told us that the care staff did not always communicate effectively with them and did not always take into account how they wanted their care provided. Other comments included "Just the one, doesn't realise how old you are", "On the whole pretty good. One or two are just doing their job" and "No, sometimes they are not."

During the inspection we observed the interactions between care staff and people in lounges, dining rooms and other communal areas of the home. In general, we saw these interactions were kind and respectful and demonstrated the care staff knew the people they were supporting including their references and support needs. For example, we observed lunchtime in one of the units. People could choose to eat their lunch in any part of the unit depending on their preference and they were supported by care staff to do this. We saw one person took their meal on a tray and went to another room to eat. Two other people had lunch in their rooms, one with a visitor.

People were engaged in conversation. The mealtime was in general a communal experience. We observed many positive interactions between people and care staff. We saw that when a care staff was asked a question they took their time to respond and did not ignore this communication opportunity. Staff appeared caring and took pleasure in spending time with people. There was a lively yet relaxed atmosphere; people were not rushed during their meal. We saw that care staff asked people if they had finished prior to removing their plates. We also noted the catering staff talking to people in the dining room, to check if they had enjoyed the meals.

People told us they there happy with the care and support they received and their comments included "They are lovely people, the nurses", "Yes with the care, just one or two little things. I was in bed recently for a few weeks and they were very good" and "Yes, I get on with them all. They are a good team. You can have a laugh with them." There were some people who were not always happy with the care provided by the home and they told us "Yes and no, some staff seem to think they can tell you what to do, only some though, some are good" and "On and off. It depends who does me. At times it gets you down."

We also asked people if they felt they were treated with dignity and respect by the care staff. The majority of people we spoke with told us they did feel care staff treated them with dignity and respect. Their comments included "Oh yes, all the time. They are a lovely bunch of girls", "I think so. On the whole they are alright. They could do with more staff. No bother with night staff" and "Yes very much so. Some are polite, on the whole very good. They knock at my bathroom door." Three people we spoke did comment that the way they were treated varied depending on the care staff who supported them. They said "Some do, some don't. They are not all bad, I am not trying to paint a bad picture", "Most of the time it is okay but it depends on the staff" and "Not all, I would say, 90%."

We spoke with care staff and asked them how they would help a person maintain their privacy and dignity when providing care. They provided similar answers relating to ensuring doors were closed, check with the person to ensure they were comfortable and happy for the care to be provided and not to rush the person.

People told us they felt the care staff supported them to maintain their independence by the way they provided care and support. One person commented "Getting up in the morning or going to bed they would help you if needed They are very considerate depending on who we have."

People's cultural and religious needs were identified in their care plan. People we spoke with confirmed that, where they had a cultural or religious need, care staff were aware of them and these were respected. Their comments included "Halal food is an option", "I say my own prayers", "Once a week they take me to the temple in Kingsbury I am a Buddhist", "They take me to mass" and "The chef makes Sri Lankan food for me, rice chicken curry and vegetables."

During the inspection we saw people were supported to attend and take an active part in a religious service held in a lounge on a unit. We saw there were care staff who were able to speak different languages which assisted people to have their preferences understood for whom English was not their first language.

We asked people if the care staff helped them in the way they wanted and they told us "If you ask them for something they will do it. They are not bad people, some are just more caring then others", "Yeah, if I ask them to do anything they do and help me with it" and "Anything I want they give it to me. I am as happy as I can be here."

Requires Improvement

Is the service responsive?

Our findings

The provider had not ensured the care plans contained detailed and up to date information to reflect how people wished their care to be provided and how to meet the person's care needs.

The care staff used a system of picture icons to record the care and support they have provided for each person during their shift. By selecting the relevant icon, the system records the time of the activity and additional text can be added by care staff to provide supporting information. During the inspection we reviewed the records of care provided for people in different units and we saw the information on the care activities was not always recorded accurately.

For example, the records for one person indicated the care staff had recorded 18 different care activities that all occurred at the same time. Some of these activities were not consistent for example it showed the person was undressed, dressed, was asleep, had their bedding changed, washed, had their incontinence care done twice once when asleep and once when awake and then had stayed in bed. The record then indicated that a minute later the person was in the lounge having a hot drink and was then assisted back to their room. This record did not clearly identify when the care was provided. The records for another person indicated 27 care activities had been completed at the same time and they had eaten their breakfast at a certain time but the person was in the lounge for the religious mass at this time. The records did not provide accurate information regarding the care provided for the person.

We saw the information in the care plans was not always accurate and did not reflect the person's care and support needs and wishes. We saw the care plan in relation to emotional support for one person indicated they had a tendency to walk without purpose but in another section of the care plan on safe environment stated the person was unable to support their own weight and required a hoist and wheelchair for mobility.

The information in the electronic care plan was not always clear in relation to the care a person required. For example, the risk assessment relating to developing pressure ulcers and the dependency assessment for one person stated they were incontinent of urine and faeces. We found the long-term care plan section stated the person was fully continent and did not require support from care staff in this area, but it also stated the person had occasional issues with continence and sometimes needed assistance. The records completed by care staff of the support provided each day indicated incontinence products were needed for the person.

We found there were care plan records for other people which also had inconstancies in the information recorded in the various assessments. This meant all the possible options were recorded in the care plan and it did not provide care staff with accurate information on the person's care needs.

We saw the emotional support records for one person which identified when they were agitated or confused but there was no information identifying the cause of the person's agitation and what action the care staff needed to take to support the person. This meant the care staff could not track events to identify any triggers and did not haveoptions to best support the person and to resolve any issues.

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

People's wishes in relation to how they wanted their care provided at the end of their life was recorded as part of the electronic care plan. We saw the care plan included information if the person wished to stay at the home at the end of their life, any religious requirements or preferences and when they wanted their family to be contacted. Where a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was in place for a person it was clearly recorded on the first page of their electronic care plan. We saw the forms for some people had been scanned and added to their electronic record with the original documents available in the units.

We asked people for their views on the activities provided at the home and some people told us "They take me in a wheelchair. They brought the animals in to me", "The favourite is bingo. Last night we played a connection game. There is painting. You have a choice", "Someone goes to the shops with me. This morning I am going to the hairdresser" and "I watch football on TV." Other people told us they knew about the activities that were arranged but they preferred not to be involved "I usually give them a miss and keep myself to myself" and "There probably are, but they aren't the kind of things I want to be involved in.

During the inspection we spoke with the activity coordinators and observed the activities that were scheduled during the day. The activity coordinators explained they worked with the care staff during breakfast and lunch time to provide support for people. The activities were usually from 10.30am and 2.30pm and would usually last for up to two hours. People could access the internet to keep up to date with their hobbies and interests. Staff could also arrange community transport where required to support people with visits outside the home. There was an activity planner which was available in each unit which identified the various activities which were planned as well as any religious services and outings which were scheduled.

The activity coordinators told us that if a person was not able to get to the activities based in a lounge they would try to visit people in their room for activities like pampering or reading to the person. They felt an additional member of their team would be beneficial for the people living at the home as it would mean two staff members could run the group activity which would free up a third member of staff to visit people in their rooms for one to one activities.

We asked people if they knew how to make a complaint and most people told us they knew the process but had not had a reason to raise any concerns. Three people commented that they had made complaints in the past but felt these had not been effective as they had experienced no changes to the care provided. During the inspection we saw the provider had a procedure for the recording and investigation of complaints. A log sheet was completed with details of the complaints, actions agreed and the date a response was sent to the person who raised the concern. We looked at the records for four complaints that had been received during 2018 and found information on the complaints and any actions taken to resolve the issue.

The provider had introduced an electronic care plan and records system which enabled care staff to access people's records using a hand-held computer tablet or a laptop. This meant the care staff could review information in relation to how people wanted their care provided and make any amendments if it was identified a person's support needs had changed. The registered manager explained relatives were able to access the electronic care plan records system remotely to look at the observations and records about their family members care.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of quality assurance processes in place but the ones in relation to the monitoring of care plans and risk assessments were not robust to ensure the information was complete and accurate.

During the inspection we saw information in some of the care plans and risk assessments were not accurate and consistent. The care plans and risk assessments were reviewed monthly and all the documents we looked at had been checked in August 2018, but these discrepancies had not been identified.

The deputy manager told us there had been an upgrade to the computer system at the start of August 2018 and they believed the issues with the records could be linked to that upgrade as response setting may have been reset.

The registered manager explained a care plan audit was carried out on each unit with the deputy managers reviewing 10% of the care plans on their unit each month. The registered manager also reviewed a random selection of 10% of the care plans and risk assessments from across all the units each month.

During the inspection carried out in August 2017 and February 2018 we identified issues in relation to the quality assurance process for monitoring the electronic care plan records. At this inspection we found these issues had not been resolved.

Whilst the management of medicines had improved, the checks carried out by the provider had not identified that appropriate precautions were not being taken to handle a particular medicine. This was addressed when we pointed it out.

We also identified during our inspection that the way staff were deployed did not always ensure that people were kept safe. While care staff were providing personal care in people's bedrooms, staff were not deployed in communal areas to support people. The checks and monitoring carried out by the provider had not identified this shortfall and if it had, the action taken to address the shortfall had not been very effective.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had other quality assurance processes in place including an audit based upon the requirements of specific CQC regulations to identify areas of possible non-compliance.

We saw the infection control audit was completed each quarter and it covered the general environment, the kitchen, handling and disposal of linen, waste management, hand hygiene and the handling and disposal of sharps. Where an issue was identified an action to be taken was recorded as part of the audit.

The registered manager completed a monthly audit which reviewed clinical wound care, pressure ulcer management, nutrition and hydration, people's experience and food safety.

An audit of the ordering, administration and recording of medicines was also completed regularly to ensure the safe management of medicines.

We asked people their views on the registered manager and they commented "She is nice, a good woman" and "She tries hard. "Relatives commented "Very nice anything we have requested has been dealt with" and "The manager was involved. She came out of the office and helped my mum out in supporting her to sit up straighter."

Some of the people we spoke with told us about the manager of the unit where they lived and they said, "[The unit manager] is alright he is an understanding bloke", "He is a good mate, very considerate" and "He is okay, but I think he gets swamped with unnecessary things." We were also told by some people that they did not know who the registered manager was.

We asked care staff for their views on the culture of the organisation and they were very positive. They said, "Not a bad employer, I would say they are fair", "It is very good. I am comfortable to work here. I get lots of training. We work as a team, they are very good, qualified staff. They do staff meetings and whatever changes are to be done they let us know" and "It is open. They tell us what is happening and what will happen in coming days."

Care staff felt the service was well-led. They were very positive in their feedback and their comments included "Yes the manager is very clear. If you ask anything she explains in a very good way", "The manager takes action when they need to. The service is very good here" and "Yes. [The registered manager] comes and inspects us at lunchtime. She even talks to some residents. She goes to every unit and checks. It's nice I have learned a lot."

The registered manager held daily meetings with the senior staff including deputy manager, nurses and managers from housekeeping, maintenance and catering. During the inspection we observed a daily meeting and we saw there was discussions about each unit which included if any hospital admissions had occurred, the number of people receiving antibiotics or treatment for pressure ulcers, if any referrals to healthcare professionals such as occupational therapy were required as well as any visits planned that day from assessments by healthcare professionals. In the resident of the day for each unit was identified, if any complaints or compliments had been received and any maintenance issues.

We saw the notes from monthly resident's meetings which included discussions relating to activities, choices for food and people's views on where they lived and if any improvements could be made to the units. There were also records of the weekly senior staff team meetings which discussed vacancies and recruitment activity, quality assurance information and training.

A 'resident of the day' system was in place on each unit where the care plan for the named person would be reviewed and the key worker would contact the person's relatives to update them on the person's care.

An annual questionnaire was sent to people who used the service and their relatives to gain their feedback on the quality of the care and support provided. The outcomes were summarised in a report to identify trends and patterns so learning took place.

The registered manager had an active role in the 'Ealing Change Academy Team' working with the London Borough of Ealing and the Ealing Clinical Commissioning Group (CCG) to help provide 'Enhanced Care in Care Homes'. The provider was working with the GP on a project to reduce the incidence and impact of urinary tract infections for people living at the home. Information from the 'How well is my resident' project

which is being introduced by the CCG has been circulated to care staff. This guide identifies 10 questions for care staff to consider when they are providing support to help them monitor the health and wellbeing of the person they are supporting so they could take prompt action if they identify that the person's condition was deteriorating.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity Regulation 17 (1)(2) (a)

The enforcement action we took:

We issued a Warning Notice requiring the provider to comply with the Regulation by 1 March 2019.