

Ganymede Care Limited

# The Chiswick Nursing Centre

## Inspection report

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Date of inspection visit:  
27 August 2019  
28 August 2019  
02 September 2019  
03 September 2019

Date of publication:  
31 March 2020

## 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?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service

The Chiswick Nursing Centre is registered to provide accommodation for up to 146 people with nursing care needs and at the time of the inspection 142 people were using the service. The service occupied purpose-built premises and accommodated people on five separate units. The service supported older people with physical frailties and/or people living with dementia, and younger adults with disabilities. People were provided with an en-suite bedroom and shared communal facilities which included lounges, dining areas, a passenger lift and gardens.

### People's experience of using the service and what we found

The management of people's medicines was not always sufficiently robust in order to make sure people consistently received their medicines in a safe manner.

People were protected from avoidable harm and abuse by staff who had received relevant training and understood how to report safeguarding concerns.

People's care needs were assessed and individual care plans were developed in consultation with people and their representatives, where possible. Risks to people's care and support were identified and addressed. Care planning was in place to meet people's end of life care needs. However, we received some negative comments about the quality of care, including palliative care.

People were supported to access external healthcare support from applicable professionals, for example podiatrists, dentists and NHS specialist nurses.

People mainly felt there were sufficient staff deployed to meet their needs, although some people thought staffing could be increased at mealtimes and night time. Staff received training, supervision and support to carry out their roles and duties.

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

People and their representatives told us staff were kind and caring and spoke with them in a respectful way. People's representatives felt staff kept them informed about their relatives needs, including significant changes to their health and welfare. We also received feedback about occasions when people's representatives felt staff were not supportive and did not inform them of important changes that impacted on people's safety and welfare.

People were supported to take part in activities and entertainments that offered social stimulation. This included activities designed for people living with dementia.

People and their representatives were invited to participate in meetings about how the service was managed.

People and their representatives were given information about how to make complaints or comments about the quality of the service. Complaints were managed in line with the provider's complaints procedure.

The provider had systems in place to monitor the quality of the service and make any required improvements, although this was not rigorous enough in relation to the management of medicines.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 19 September 2017).

#### Why we inspected

This was a planned inspection based on the previous rating.

#### Enforcement

We have found a breach in relation to safe care and treatment. Please see the action we have told the provider to take at the end of this report.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Details are in our effective findings below.

**Good** ●

### Is the service caring?

The service was caring.

Details are in our caring findings below.

**Good** ●

### Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

**Good** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# The Chiswick Nursing Centre

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

#### Inspection team

The inspection team consisted of four inspectors including a medicine inspector, as well as a Specialist Professional Advisor and an Expert by Experience. The Specialist Professional Advisor was a registered nurse with experience of working with older people and younger adults with a disability. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

#### Service and service type

The Chiswick Nursing Centre is a 'care home'. People in care homes 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We used the information the registered manager sent to us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well

and improvements they plan to make. This information helps support our inspections. We reviewed the evidence we held about the service. This included the last inspection report and any notifications of important events which the provider is required by law to send to us, for example safeguarding referrals and incidents when the police were contacted. We used all of this information to plan our inspection.

#### During the inspection

We spoke with 12 people who lived at the service and 10 relatives, as well as 24 members of staff including health care assistants, senior health care assistants, staff nurses, the activities lead and suite managers. We also met with the director of nursing, the registered manager known as the centre director, the human resources business partner, the training and quality assurance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with staff from the housekeeping and catering departments. 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.

We reviewed a range of records, which included the care plans and risk assessments for 15 people. Other records we looked at included six staff files to check recruitment, training, supervision and appraisals, medicine administration records, the complaints file and compliments, minutes for staff meetings, accidents and incidents records, health and safety checks, and quality monitoring audits.

#### After the inspection

We spoke by telephone with the relatives of four people who used the service. We contacted four health and social care professionals who had experience of working with the service and received their comments.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Using medicines safely

- The systems in place for supporting people to safely receive their medicines were not always sufficiently robust. Some people were prescribed medicines to be given on a 'when required' basis, however protocols were not in place to give these medicines consistently as prescribed. Prescribed creams were applied by care staff. However, nursing staff and senior carers who did not apply the creams were signing the medicine administration records (MAR) to record their application. This meant the records were not accurate and there was a risk if there was an error it could be difficult to identify the staff member who had applied the cream.

The provider has assured us that since the inspection they have introduced separate charts to record the application of emollient creams. This will ensure staff who apply cream will make a record of this appropriately.

- Medicine care plans were not in place for some people. Some medicine plans we looked at did not contain accurate and adequate information related to medicines which could impact on the ability of staff to support people's medical and health needs effectively. There was no information in people's care plans to help staff monitor or manage side effects of high-risk medicines, which presented a risk that staff may not be able to respond appropriately and ensure necessary action regarding high-risk medicines. Some people were prescribed medicines for seizures but there was no information in their care plans on how staff would monitor and manage their needs if they had a seizure.

- Although there was a medicines policy in place to support medicines management, staff members did not always follow it in order to safely support people.

This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

- Staff members were competency assessed and received training to handle medicines. Medicines, including controlled drugs, were stored securely at appropriate temperatures and there was a process to receive and act on medicine alerts. We observed that staff were polite and gained permission when they gave medicine to people, and they signed for each medicine on the medicine administration record (MAR) after giving it.

### Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse and harm, as the provider had appropriate systems in place. People who used the service and their relatives told us they felt safe, "Oh yes absolutely, I feel safe" and "I completely trust all the staff looking after [my family member], they are lovely."

- Staff were familiar with the provider's safeguarding policy and procedures, and they knew how to report any safeguarding concerns to managers within the organisation. Records demonstrated the management team reported safeguarding concerns to the relevant authorities.
- Staff took part in safeguarding training about how to detect different types of abuse and how to protect people from abuse and avoidable harm. The provider ensured staff had written guidance about how to whistleblow. A whistleblower is an employee who reports certain types of wrongdoings at their workplace.

#### Assessing risk, safety monitoring and management

- People were protected from risks to their health, safety and wellbeing. Care plans included detailed risk assessments, which were kept under review. Staff presented a thorough understanding of individual risks to people and explained to us the arrangements in place to minimise these risks.
- Environmental risk assessments were in place to minimise the risks of potential dangers to people, staff and visitors, for example the safe storage of cleaning fluids in line with COSHH (The Control of Substances Hazardous to Health Regulations 2002). Bespoke personal emergency evacuation plans (PEEPs) had been developed to safely support people to evacuate the premises, which considered their physical, sensory and/or cognitive needs. Equipment including wheelchairs, hoists and mattresses were checked regularly to ensure it was maintained in safe working order and good condition.
- Staff were provided with relevant training, support and guidance to enable them to promote people's safety. This included health and safety, fire safety, food hygiene, basic first aid and life support, and moving and positioning people.

#### Staffing and recruitment

- People were supported by safely recruited staff, who were deployed to meet people's needs in a timely manner. Staff rotas evidenced that the skill mix of nursing and care staff on each unit took account of people's individual dependency needs.
- People told us they were satisfied with staffing levels and felt they could access the assistance they needed within an acceptable time. Comments from people included, "When I ask for something they provide it" and "There are more staff now than there used to be." Although relatives informed us they were ordinarily satisfied with staffing levels, a few relatives thought there could be more staff to support people at mealtimes and at night time.
- Detailed pre-employment checks were conducted by the provider to make sure people received their care and support from staff with suitable experience, backgrounds and qualifications. These checks included a minimum of two verified references and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by identifying candidates who might be unsuitable to work with people who use care and support services.

#### Learning lessons when things go wrong

- Accidents and incidents were recorded and analysed to recognise any emerging trends and patterns. For example, equipment such as falls sensors mats were arranged for people if the provider's analysis along with other monitoring by staff identified they were now at risk of falls.

#### Preventing and controlling infection

- People were protected from the risk of infection due to cross contamination, as the provider had rigorous systems. This included training and the provision of personal protective equipment (PPE) for staff, for example disposable gloves, shoe covers and aprons. The provider's audits for infection control did not evidence the checking of the core of mattresses for evidence of internal damage; the provider confirmed they planned to incorporate this into future audits.
- People and their relatives told us they were provided with a clean and hygienic home, which we



consistently observed throughout our inspection visit. Domestic staff were employed to carry out routine cleaning and the cleanliness of the building was monitored by senior housekeeping staff and the management team.

- The service was awarded the highest rating of five following its food hygiene inspection by the Food Standards Agency in January 2019.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were subject to a detailed assessment by the provider and external health and social care professionals before they moved into the service. These assessments were used to ascertain whether the service could effectively meet people's needs and to collect additional information for the development of individual care plans which reflected people's personal histories, interests and preferences.
- A range of research-based clinical tools were used as part of the assessment and care planning process. For example, staff assessed whether people were at risk of acquiring pressure ulcers through using the Waterlow score which gives an estimated risk for the development of a pressure sore in a given person. The provider also used the Barthel scale to measure people's support needs in relation to their activities of daily living, including mobility.

Staff support: induction, training, skills and experience

- People received effective care and treatment from staff with suitable skills, competencies and knowledge to meet their needs. People and their relatives told us, "I'd say they're very well trained, even the new ones" and "Yes, they are very helpful."
- There were structured systems in place for the induction and training of newly appointed staff, including opportunities to shadow experienced colleagues. Staff who were new to working in the care sector completed the Care Certificate, which is an identified set of standards that health and social care workers adhere to in their daily working lives. Staff informed us they felt supported by their line managers through one to one supervision sessions, team meetings, and informal advice and guidance.
- Staff were provided with a broad range of relevant training to enable them to properly meet people's needs. The training programme included equality and diversity, dignity in care, prevention and treatment of pressure ulcers, end of life care, dementia awareness, how to support people with their posture and seating, and the care of people receiving nutrition via percutaneous endoscopic gastrostomy (PEG) feeding. Staff attendance at initial and refresher training was monitored by the management team to ensure staff achieved and updated the knowledge and skills they needed to deliver effective care.

Supporting people to eat and drink enough to maintain a balanced diet

- People received care, support and encouragement to meet their individual eating and drinking needs, and systems were in place to reduce the risk of malnutrition and dehydration. We saw that drinks and snacks were offered throughout the day and our lunchtime observations showed that people were provided with a relaxed, sociable and supportive experience. Comments from people and their relatives in relation to the food service were mainly positive although some criticisms were expressed, "The food is excellent and we can ask for things off the menu," "I enjoy it, the daily soup is nice", "It's acceptable...the staff help with

feeding" and "Sometimes it's good, other times not so good."

- People's care plans contained details about any dietary arrangements to meet their medical and/or cultural requirements, preferences and dislikes, known allergies and information about whether they needed support at mealtimes. The catering team were provided with current information about people's needs, for example if a person needed a soft diet and/or a fortified diet to effectively and safely promote their nutrition. The chef met with people and/or their relatives to discuss their dietary needs as part of their admission to the service and held subsequent meetings with people to discuss required changes to their diet and/or any concerns.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Health care professionals who regularly visited the service expressed positive views to us about how the staff promptly identified health concerns, sought external professional advice and correctly adhered to the guidance given. This was confirmed by care records.
- People and their relatives told us they were happy with how the service supported them to meet their health care needs. Comments included, "The GP comes every week which is reassuring" and "[My family member] has physio once a week." One person told us they had frequent contact with health and social care professionals, in line with their wishes to move to more independent accommodation. There was also an in-house physiotherapy and occupational therapy service.
- People were supported to meet their assessed oral health care needs, which were outlined in their individual oral health care plans. A dental service regularly visited the care home.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

- We found the provider was working within the principles of the MCA. Staff had received MCA training and they consistently asked people for their consent before they provided personal care and other support. People's capacity was assessed when they moved into the service and kept under review. The provider's mental capacity assessments reflected the views of external health and social care professionals involved in people's care and treatment.
- The provider appropriately submitted DoLS applications to ensure people's freedoms were not unlawfully restricted. Checks on the expiry dates for existing DoLS were carried out, which enabled the provider to liaise with the local authority in a timely manner.

Adapting service, design, decoration to meet people's needs

- The premises were well maintained and in good decorative order. At the time of the inspection a programme of refurbishment was being carried out on the ground floor unit for people living with dementia. The registered manager demonstrated the plans for redecoration, including the use of contrasting colours and directional signage, had been developed in line with guidance from Stirling University.
- People were provided with a spacious home environment, which included communal areas to relax

and/or take part in activities. There was an external landscaped garden with seating areas and also a terrace within the building which provided garden views. There were various facilities to meet people's mobility needs, for example handrails, wide corridors, accessible bathrooms and a passenger lift.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff were caring and compassionate, and we observed positive interactions between people and staff. Comments included, "It's extremely pleasant, the carers really care", "I find them all very nice and helpful" and "They are just lovely to [my family member] and to me." However, we received feedback from two people's representatives who felt the care of their family member or friend had not always met the person's individual personal care and emotional needs.
- We observed that staff upheld people's entitlement to be treated with respect and dignity. People told us they were asked if they wished to be assisted with their personal care by staff members of their own gender and their wishes were always followed. We saw that staff knocked on doors before entering and ensured doors were closed when delivering personal care.
- Secure systems were used to make sure confidential records about people could only be accessed by staff and external individuals with a legitimate need to access information. Discussions between staff about people's needs took place away from communal areas and information displayed on publicly viewed noticeboards did not disclose private details about people.
- We spoke with people who felt staff respected them as individuals and were not judgemental about their life and personal choices. One person told us they believed this genuine approach by staff had helped to improve their health and wellbeing.

Supporting people to express their views and be involved in making decisions about their care

- Although some people were not able to verbally give their views due to their health care needs, we observed that staff knew people well and understood their preferences and choices. For example, we saw how staff used eye contact and other non-verbal language with a person to check whether they had properly arranged the pillows to promote ample comfort. Care plans contained information about people's individual communication needs.
- People and their relatives or friends were invited to attend care plan review meetings, which provided opportunities for people to give their views about the quality of their care and express any changes they would like. People were offered information about local independent advocacy services if they needed support to voice their views.
- Group meetings took place for people living at the service and their relatives, which were also attended by representatives from the management team and other key staff. The minutes for these meetings showed the provider acted on suggestions from people and their relatives, for example ideas about future entertainments and celebratory events at the service.

## Is the service responsive?

### Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's needs were regularly reviewed and updated as required. The structure of the care plans meant people's established needs, for example daily support with maintaining their personal hygiene and/or managing a chronic health condition, were usually reviewed on a monthly basis. The unit managers routinely checked the quality of the care plans written by staff nurses and demonstrated a good knowledge of people's individual needs.
- Where people developed a new personal care or health care need, new care plans were promptly created.
- Care plans were personalised and contained guidance for staff about how people wished to receive their care. For example, people's preferred routines for getting up in the morning and how they wished to be settled to bed at night time, if they required a daily newspaper and whether they liked to attend the hair salon within the premises or had other arrangements for hairdressing.
- People's care plans contained relevant information about their backgrounds, interests and wishes, how they wished to be addressed and if they wished to have contact with a representative of their faith. This enabled staff to understand and meet people's individual needs. The activities manager had developed links with ministers of worship and community groups that reflected people's culture, which supported people to maintain connections that were important to their wellbeing.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were assessed when they moved into the service and were kept under review by staff who understood their responsibilities in line with AIS. The registered manager told us that information could be obtained in different formats to meet people's needs, for example large print and audio. A short film had been produced about the care home by the provider which could be used to inform people and their relatives about day to day life at the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People told us their visitors were made welcome at the service, which was confirmed by relatives we spoke with. Comments included, "Everyone is very pleasant" and "Staff are all very friendly with me... I have a joke with them." People and their relatives informed us staff came into their rooms to chat to them when they had opportunities to do so. We observed that where people were not able to leave their rooms due to

health care reasons or chose not to, staff had developed sincere and positive relationships with them to try to reduce people's sense of isolation.

- People were offered a programme of activities and entertainments organised by an activities team. The activities schedule was varied to suit a range of interests and needs and included arts and crafts, gentle exercise, knitting together for a project, table tennis, pamper sessions, a gardening club and reminiscence groups.
- Entertainments took place at least once a month, for example a party for the Queen's birthday, pantomimes, performances by tribute bands and a strawberries and cream summer garden party. Events at the service embraced the diverse backgrounds and interests of people, for example activities to mark Black History Month, Yorkshire Day and the Chinese New Year.
- Activities staff were available seven days per week, providing people with wider opportunities to participate in activities. The activities team had developed links with local individuals and groups, including a harpist who visited monthly, an amateur dance company and a local nursery which enabled people to participate in inter-generational activities with the visiting young children and accompanying adults.
- There were dedicated activities for people living with dementia to promote their wellbeing and provide stimulation. This included a therapeutic sensory room and mobile sensory equipment which could be taken to people on different units. The activities manager was a qualified occupational therapist and provided training for all care staff during their induction period about how to engage people with activities.

Improving care quality in response to complaints or concerns

- People and their relatives were informed by the provider about how to raise concerns and/or make a formal complaint. We looked at each written complaint received by the provider since the previous inspection including any additional care plan records where applicable, and found the responses to complainants were detailed. During the inspection people and their relatives spoke positively in relation to how complaints were managed, "It was handled well and I was given feedback" and "If something isn't done properly I'll tell them directly." Some relatives told us they had not made a complaint as their issue was resolved during discussions at the residents and relatives' meetings.
- We were contacted prior to the inspection by the representatives of two people who were concerned with the quality of care for their family member or friend and were dissatisfied with the standard of the provider's complaints investigation.

End of life care and support

- People were provided with the care and support they needed to meet their end of life needs. The care plans we looked at demonstrated that the reasons for end of life care were clearly stated where applicable and people's own wishes and/or the views of their relatives were recorded. Staff received end of life care training to meet people's end of life care needs and support their relatives and friends with empathy and compassion.
- There were clear processes available to ensure staff had correct and easily accessible information as to whether people, or their chosen representatives where applicable, had decided that cardio-pulmonary resuscitation should not take place. Staff demonstrated they were aware of people's individual resuscitation status and showed us how they could quickly check this information if required. This enabled staff to ensure people received dignified and appropriate care at the end of their life that respected their individual wishes and circumstances.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- The provider had professional guidance for safely managing medicines in place at the time of the inspection. This included guidance from an external qualified pharmacist service which had undertaken external quality assurance in 2019. The service also had external guidance and support from a qualified pharmacist attached to the GP surgery. The systems for monitoring and auditing the management of medicines were not sufficiently rigorous to safely meet people's medicine needs. We identified issues of concern with medicine practices which were not identified by the provider's own quality assurance processes.

We recommend the provider seek professional guidance to implement a more robust system for monitoring and auditing medicine practices.

- Minutes for management and staff team minutes showed there were clearly defined structures in place to ensure the smooth and efficient running of the service. For example, the suite managers we spoke with were clear about their roles and responsibilities on their unit in relation to the needs of people who used the service and their staff team. They escalated concerns and other observations to members of the management team and felt assured they would receive guidance and support.
- The management team maintained a constant oversight in relation to checking the quality of care documents. Audits of care plans and risk assessments were regularly carried out and suite managers were required to evidence they had achieved the recommended improvements.
- The provider sent notifications of significant events to CQC in a timely way, in accordance with the law.
- There were suitable systems in place for monitoring and auditing different practices within the service which included meal choices audits and unannounced night time checks by management staff on the suites.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff told us they enjoyed working at the service as the provider was dedicated to ensuring people received a high standard of personalised care and staff were offered opportunities to develop. People and their relatives stated they liked the approach of the management team, "They're fine, they are always accessible" and "[Suite manager] is kind, her door is always open. Someone I can talk to if I need to."



- We spoke with two members of staff who were undertaking training to qualify as nurse associates and other staff who were interested in future opportunities to pursue this. A nursing associate is a new stand-alone role designed to help bridge the gap between health and care assistants and registered nurses, which also provides a progression route into graduate level nursing. Staff were extremely positive about the provider's commitment to improving the quality of care for people by supporting this training and told us they felt personally valued by this investment in their professional development.
- The service worked in an open manner to achieve beneficial outcomes for people. For example, staff had collaborated with a dance scheme at a local theatre which was designed to provide stimulation and fulfilment for people at the service living with dementia. They had also participated in a research project with a nearby university to introduce innovative methods to promote people's hydration.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and senior staff at the service showed a clear understanding of their legal responsibilities. Accidents, incidents and other events were recorded in a transparent manner. The management team scrutinised these records to ensure they consistently fulfilled their duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were asked their views through surveys, individual care planning review meetings, and residents and relatives' meetings. People and relatives confirmed they felt consulted and listened to.
- Staff told us the provider sought their views about the service during team meetings and other group forums. Staff had opportunities to speak with their line manager during their one to one supervision and their annual appraisals. We saw that the provider involved staff in new initiatives, for example staff of different grades and departments were invited to speak about their experience of working at the service in a short film made about the care home.

Continuous learning and improving care

- At the time of the inspection the service was taking part in a pilot project working with an NHS frailty specialist nurse from a local general hospital. The nurse was providing training to staff and working with them to manage people's health care conditions within the service that might otherwise have resulted in hospital admissions. We received positive comments from the frailty nurse and from staff at the service in relation to how this pilot project had positively impacted on people's health and increased the knowledge and skills of nursing and care staff.
- The provider had introduced a system to check that staff had benefitted from their mandatory and other training. In addition to any tests and/or discussions that took place as part of the training session, line managers had short group discussions with staff a day or two afterwards. This enabled the provider to check whether staff were able to apply their learning to their roles or whether they needed additional guidance and support.

Working in partnership with others

- The service had established relationships with external health and social care professionals, for example opticians, dentists, dietitians and podiatrists. We received positive comments from the health care professionals we spoke with.
- People benefitted from the links that the service has formed with local individuals and groups, which included visits from ministers of different faiths, and support when required from cultural centres within the borough.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not consistently being managed in accordance with best practice. Reg12 (1)(2)(g)