Bondcare (London) Limited

Brook House Care Centre

Inspection report

20 Meadowford Close
London
SE28 8GA

Tel: 02083205600

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 25 and 26 September 2018 and was unannounced. Brook House 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.

Brook House Care Centre is registered to provide accommodation and nursing care for up to 74 adults. The service is provided over three floors and within three units. People using the service include adults with a range of disabilities including brain injury, older adults with nursing needs and people living with dementia. At the time of this inspection there were 48 people using the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was no registered manager in post. The home manager had applied to CQC to become the registered manager of the home. 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.

This is the first inspection of the home under the new provider Bond Care.

Records were not always complete, consistent, signed and legible as some care plans had been handwritten. However, the provider knew of this and was still in the process of updating their records since taking over the service in October 2017. There were systems in place for assessing and monitoring the quality of the service. The provider had values and an organisational structure in place and staff upheld these values when performing their roles. People, their relatives, other professionals and staff were encouraged to be involved in service improvements through regular feedback and meetings. There were systems in place to promote continuous learning and improve the quality of the service. The provider worked in partnership with key organisations such as the local authorities that commissioned services from them to ensure people's needs were met effectively.

The provider had policies and procedures in place to safeguard people from abuse and staff knew of the reporting and recording procedures if they had any concerns of abuse. There were safe recruitment practices in place to ensure staff employed at the home were suitable to work in social care. Checks had also been carried out on the registration of qualified nurses with their professional bodies to ensure they were suitable for the role. There were sufficient numbers of staff available on each shift to support people's needs and meet them in a timely manner. The provider had safe systems for acquiring, storing,

administering and disposing medicines and monitoring controlled drugs. Risks to people had been identified and assessed; risk assessments were person centred and included appropriate management plans to ensure risks to people were managed safely. There were systems in place to deal with foreseeable emergencies and each person had a personal emergency evacuation plan in place. The provider carried out checks on the environment and equipment to ensure they were safe for use. Appropriate infection control protocols were maintained to minimise and prevent the spread of diseases. Accidents and incidents were recorded, managed and monitored regularly to prevent future occurrences.

Staff assessed the needs of people before they moved into the home to ensure their needs would be met. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice. People were provided freshly cooked and nutritious food daily and in sufficient amounts for their health and wellbeing. Where required people were supported to use health care services including attending hospital appointments. The staff teams work in partnership with other health and social care professionals to provide joined-up care. The design, decoration and adaptation of the home was suitable and met people's needs. Staff were supported through induction, training, supervision and appraisals to ensure they had appropriate knowledge and skills required to perform their roles.

People were supported by staff who were kind and compassionate towards them. Staff respected people's privacy and dignity and promoted their independence. People and their relatives had been consulted and were involved in making decisions to the care delivery. People were provided with information before they started using the service to ensure they knew of the standard of care to expect.

Each person had a care plan in place which outlined their needs and provided staff with guidance of how these needs should be met. Staff understood people's diversities and supported them without any discrimination. People's communication needs had been assessed and information was provided in formats that supported their understanding. People were supported to maintain relationships that were important to them and their family and friends could visit them without any restrictions. People were supported to participate in activities that stimulated them. People and their relatives knew how to make a complaint and the provider acted to ensure they were satisfied with the service provided. Where required people were supported to have a peaceful, comfortable and dignified end of life care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People were protected from the risk of abuse because staff were aware of their responsibility to safeguard them.

The provider followed safe recruitment practices. There were enough staff on each unit to support people's needs.

Medicines were managed safely.

Risks to people had been identified and assessed. Appropriate management plans were in place to manage risk safely.

Staff carried out health and safety checks to ensure equipment was safe to use.

People were protected from the risk of infection.

Accidents and incidents were reported and recorded appropriately.

Is the service effective?

Good

The service was effective.

Before people started using the service their needs were assessed to ensure they could be met.

Staff sought people's consent. They also understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and acted in accordance to this legislation.

People were supported to eat and drink nutritious food in adequate amounts for their health and well-being.

People were supported to access healthcare services when required.

The provider worked in partnership with health and social care professionals to provide joined-up care.

People were supported in an environment that was suitable and

met their needs.

Staff were supported in their roles through an induction, training, supervision and appraisals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by the staff who supported them.

People and their relatives were involved in making decisions about the care and support they received.

Staff respected people's privacy and dignity, and promoted their independence. People were provided with information about the home so they were aware of the standard of care to expect.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their needs.

Each person had a care plan that provided staff with guidance about the care and support they required.

Staff understood the Equality Act and supported people without any discrimination.

People were provided with information in formats that met their need and engaged in activities that interested them.

The provider had an effective system in place to handle complaints.

Where required, people received effective support at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvement was required because records were not always complete, consistent, signed and legible.

The provider had systems to assess and monitor the quality of the service.

There was no registered manager in post. The home manager was in the process of applying to become the registered manager. The management team understood their responsibilities and had notified CQC of significant events at the home.

The provider sought the views of people, their relatives and staff to improve on the quality of the service.

There were systems in place to continuously learn and improve the quality of the service

The provider worked in partnership with key organisations to plan and deliver an effective service.

Brook House 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.

The inspection site visit activity started on 25 September and ended on 26 September 2018. It included a visit to the home on both days to meet with people, the manager and other staff; to review care records and policies and procedures.

Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We contacted the local authorities that commission services from the provider to gain their views about the home. We used this information to help inform our inspection planning.

The inspection site visit team on 25 September 2018 consisted of three inspectors, a specialist nurse advisor 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. On 26 September 2018 a single inspector returned to the home.

During the inspection we spoke with six people and five relatives to seek their views about the home. We also spoke with the manager, the regional support manager, the clinical lead, the HR personnel, a chef, three activities coordinators, four registered nurses and eight care workers. We looked at eight care plans and 11 staff records including records relating to staff recruitment, training, supervision and appraisal. We also looked at records used in managing the service including policies and procedures, health and safety checks, audits, surveys, complaints logs, accident and incident records and minutes of relatives and staff meetings. We spoke with two visiting healthcare professionals to seek their views about the home.

Good

Is the service safe?

Our findings

People felt safe with the service they received. One person told us, "I feel safe here; my family will tell you they are pleased I am here, where I am well looked after." A relative said, "[My loved one] says to me, "I am safe here with these people."" Another relative commented, "[Their loved one] could not be anywhere better than here to be cared for, [they] used to be on [their] own, and it was not too good."

People were protected from the risk of abuse. The provider had safeguarding policies and procedures which provided staff with guidance on the types of abuse, what to look out for, and on reporting and recording procedures. All the staff we spoke with knew of their responsibility to protect people from abuse and told us they would report any concerns of abuse to their line manager or the home manager. A staff member said, "The management are very strong on safeguarding, and on our joint and individual responsibilities. We know the importance of recording accurately." Staff were also aware of the provider's whistleblowing policy and told us they would use it to report any concerns of poor practices, if needed. Where there had been any concerns of abuse, the provider had notified the local safeguarding team and CQC, and had carried out investigations promptly to ensure people remained safe.

The provider had a recruitment policy in place and had followed safe recruitment practices. They carried out comprehensive background checks of staff before they started work at the home. This included checks on their qualifications and experience, as well as reviews of their employment history, criminal record checks, proof of identification and references from previous employers to help ensure they were suitable for the roles they had applied for. Checks had also been carried out on the professional registration of qualified nurses to ensure they had been correctly maintained.

There were enough staff on duty to support people safely and in a timely manner. The provider used a dependency tool to determine the level of support people required. This information was then used to plan the staffing numbers required on each unit. Actual staffing levels reflected the planned allocation on the rota based on the sample we reviewed. Records showed that staffing levels were consistently maintained on all the three units and met people's assessed needs. All the staff we spoke with confirmed there were sufficient staff available to support people's needs. One member of staff told us, "When we need more staff, for example, to take someone for hospital appointment, we get extra staff, and we do not take staff from the other units." Another member of staff said, "Staffing is very good here, we have the right numbers and the right staff, which is important. We believe in not rushing people, the important issue is that care is well done." Staff absences were covered by permanent staff as extra shifts or by the provider's internal bank staff; agency staff was rarely used at the home. This ensured people received consistent care from staff who knew them well.

Medicines were managed safely. The provider had a medicines policy in place and had safe systems for acquiring, storing, administering, disposing and monitoring medicines including controlled drugs. Medicines were kept securely in lockable medicines trolleys which were stored in locked medicines rooms on each unit. Staff took daily room and fridge temperatures to ensure medicines were stored at safe temperatures and remained effective for use. Each unit had named staff who were responsible for the administration of

people's medicines. All staff who administered medicines had completed medicines training and their competencies had been assessed by the clinical lead to ensure they had the knowledge and skills to support people safely. We observed a medicine round and we saw that it was safe and person cantered. For example, where people preferred a lie in their medicines were administered to them later if there was no clinical requirement to have them early.

People's medicines administration records (MAR) were completed accurately and without any gaps. Controlled drugs were stored safely and appropriate records were maintained, including evidence of quantity checks being carried out at every nurse handover. Where people were prescribed 'as required' medicines, such as pain-relief and laxatives, there were guidance available to staff on when they could administer these medicines. Topical creams were stored, labelled and applied appropriately, with the date of opening and expiry recorded on them. A pharmacist, reviewed people's medicines every three months to ensure they were appropriately prescribed and effective for their health and wellbeing. The clinical team completed weekly medicines audits to ensure there were no inconsistencies in the management of people's medicines. Where people received their medicines covertly, they had mental capacity assessments and best interest decisions completed.

Risks to people had been identified and assessed, and people had appropriate management plans in place. Risk assessments were person-centred and covered areas including moving and handling, falls, behaviour, nutrition, personal hygiene, skin integrity, continence, communication and the use of equipment such as call bells, lap belts and bed rails. Where risk to people had been identified, there were appropriate risk management guidelines in place for staff to prevent or minimise the risk occurring. For example, where a person was at risk of falls due to unwitnessed seizures, their guidance stated they must be assisted by staff for all transfers and in the event of a fall staff should raise an alert for a nurse and emergency services. The person also received one-to-one support to promote their safety and prevent the risk of falls. Healthcare professionals such as GPs, district nurses, speech and language therapists (SALT) and tissue viability nurses had also been involved in assessing areas of risk and providing support and guidance to manage risk in areas such as choking and pressure sores. Staff knew of each person's risk and followed appropriate risk management guidelines to ensure people they supported remained safe. People's risk assessments were also reviewed regular to ensure their changing needs were met safely.

There were procedures in place to deal with foreseeable emergencies. Each person had a personal emergency evacuation plan (PEEP) in place to ensure staff and the emergency services knew the level of support they would require evacuating safely from the service. A copy of the fire evacuation file was held at the reception to ensure this information was readily available in the event of an emergency.

Health and safety checks were carried out regularly to ensure the environment and equipment was safe for use. The provider had both in-house and external maintenance teams responsible for carrying out environmental and equipment tests. This included for example regular fire tests and fire drills, annual gas safety checks, legionella and water temperature checks and tests on equipment such as wheelchairs, hoists, call bells, window restrictors and smoke detectors. The lifts were also checked and serviced to ensure they were safe for use. At the time of this inspection, the provider was carrying out test on all portable electrical appliance such as radios and televisions to ensure they were safe for use.

People were protected from the risk of infection. The home appeared clean and free from unpleasant odours. The provider had an infection control policy which provided staff with guidance on the action to take to prevent or minimise the spread of diseases. We saw that cleaning equipment such as mobs, buckets and cleaning cloths were colour coded to prevent cross contamination. There were appropriate hand washing facilities for people and staff, and posters were displayed to promote effective hand washing. Staff

wore aprons and gloves when supporting people and knew of the provider's protocols for hand washing and waste disposal. They also offered people a handwashing bowl and paper towels for them to wash their hands and to orientate people into knowing it was meal time and this also promoted their dignity; especially for people living with dementia.

Accidents and incidents were reported, recorded and monitored regularly to prevent reoccurrence. Staff understood the importance of reporting and recording any accidents or incidents or near misses. Following an accident or incident such as a slip or a fall, investigations were carried out to ensure lessons were learnt to improve the quality of the service and prevent future occurrences.

Good

Is the service effective?

Our findings

People were cared for by staff that were trained and supported in their role. One relative said, "I can tell you, my [loved ones] needs are being met, I can't ask for more. The staff are very good at the care they provide." Another relative commented, "I feel [my loved one's] needs are met, I was helping them when they were at home but some of the care they get here, they would not have got that at home." A third relative told us, "The staff are doing their best to meet [people's] needs."

Staff were supported with an induction, training, supervision and appraisals. New staff completed induction training in line with the Care Certificate standards and in accordance to their specific roles. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. All staff completed mandatory training identified by the provider in areas such as allergen awareness, basic life support, food safety, health and safety, infection control, moving and handling, MCA and DoLS. The service provided refresher training to staff when this was due; however, some staff training required updating. The manager was aware of staff whose refresher training was outstanding and had reminded them to complete their training within a specific time frame. The manager further confirmed with us that all staff outstanding training would be completed by the end of October 2018. All staff we spoke with told us the standard of training they received was adequate and felt supported in their professional development. They also confirmed that the provider was taking robust actions to ensure they attended any training that was due. We found that the service was moving from on-line training to face-to-face training to enhance staff knowledge and understanding.

Records showed the provider supported staff through supervision and yearly appraisal. Supervision and appraisals included discussions about staff members' well-being and sickness absence, their roles and responsibilities, and their training and development plans. We noted that all staff had received a recent supervision; however, prior to that, supervision was not always taking place regularly for all staff in line with the provider's policy of three supervisions in a year. The manager was aware of the situation and had discussed with the senior staff to regularise staff supervision in line with the provider's policy. All staff we spoke with told us they felt supported in their role and could approach both their line managers and the home manager easily and openly without any restrictions.

Before people started using the service, their needs were assessed to ensure they could be met. Pre-admission assessments considered the support people required with their physical, mental and social health needs. The covered areas including physical care, medicines, behaviour, communication, nutrition and hydration, skin integrity and mobility, as well as people's religious needs, activities, interests, and their likes and dislikes. People living at the home continued to be assessed by staff to ensure their needs were met. Where required staff involved other healthcare professionals such as GPs and speech and language therapists (SALT) in these assessments to ensure care and support was delivered in line with legislation, standards and evidence based guidance including the National Institute for Health and Care Excellence (NICE) to achieve effective outcome for people.

People's rights were protected because staff sought their consent before supporting them. During our

inspection, we observed staff asking people for their consent before supporting them. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

Staff told us people could make day-to-day decisions about their personal care, they food they ate and activities they participated in. However, where people could not make specific decisions for themselves such as the use of bed rails, lap belts and covert medicines; staff adhered to the principles of the MCA and carried out mental capacity assessments and best interest decisions involving the person, their relatives [where applicable] and health and social care professionals involved in their care and treatment. Some people living at the home had been deprived of their liberty for their safety. We reviewed a sample of DoLS authorisations which were currently in place for people and we found that any conditions placed on them were being met.

People were supported to eat and drink nutritious food in sufficient amounts for their health and well-being. Care plans included an assessment of people's nutritional needs, details of the food they liked and disliked, any known allergies and the level of support they required to eat and drink safely. The home had a weekly menu planner and a picture menu identifying the food options available each day. Staff offered people a choice between two meals at lunchtime and people's choices were respected. Where people requested alternative options, we saw these were catered for. Staff checked the temperature of food before it was served to ensure it was appropriate. There were sufficient staff available to support people's needs during meal times and the atmosphere in the dining rooms were pleasant and relaxed. Staff were patient and did not rush people when supporting them to eat or drink. People had a choice of where and when they could eat their meals, including in their bedrooms if they preferred. Staff also catered for people's preferred mealtime routines. One person's care plan identified their preference to eat breakfast very late in the morning and we noted that their preference was catered for.

Meals were freshly cooked by kitchen staff. The chef maintained information about people's dietary needs including details of any clinical or cultural requirements and people's mealtime preferences. We observed kitchen staff preparing culturally appropriate meals for people. Where people were living with diabetes they were offered reduced sugar diets; those at risk of malnutrition or weight loss were given fortified meals and; people who had difficulty swallowing or were at risk of choking were provided with pureed food, in line with guidance provided by a SALT. People were weighed monthly or weekly where required to ensure they received prompt care and support to mitigate any nutritional risks. People's fluid and food intake were recorded where they had been assessed at risk of malnutrition or dehydration and they were supported with nutritional supplements where prescribed.

People were supported to access healthcare services where required. Both nursing and care staff monitored people's physical and mental well-being and made prompt referrals to other healthcare professionals when required. Each person was registered with the home's GP practice; a nurse prescriber from the GP surgery visited the home twice a week and where urgent, the GP attended to treat people's needs. Other healthcare professionals such as dentists, opticians, chiropodists, district nurses, tissue viability nurses, SALTs and staff

from the community learning disability team were all involved in treating people. Staff supported people to attend healthcare appointments where required. One both days of our inspection we saw visiting health care professionals attending to people's needs.

The provider worked in partnership with other health and social care professionals to provide joined-up care and support. Each person had a 'snap shot' care plan which contained information about physical, mental and social care need, as well as details of their medical history, resuscitation status and any known allergies. The plans accompanied people when they attended hospital to ensure they received effective support which met their needs. Healthcare professionals told us staff were to be commended for following their recommendations and referring people promptly where required. A healthcare professional commented, "I really work with the staff as a team; they are willing to learn and communicate effectively. If they are worried about people's care needs, they contact me promptly."

People's individual needs were met by the adaptation, design and decoration of the home. The entrance of the home was accessible for people living with physical disabilities. The home had lifts which enabled people easy access across the three floors, in addition to the stairways. Handrails were attached to the walls of the corridors and bathrooms to support people when mobilising. Corridors were wide and easy to navigate, and there was signage in place and the provider used different colour schemes to help keep people orientated. People's rooms were identifiable by signage which included both their photograph and preferred names. Individual rooms were bright, personalised, and had laminated floors where required to reduce the risk of infection. The lounge layout allowed for people to sit individually or in groups. A communal room on the dementia unit had been turned into an indoor garden with artificial grass flooring, hanging baskets, animal ornaments and a woodland mural to promote people's cognition We saw people and their relatives sat outside in the garden area enjoying the outdoor space. There was a physiotherapy room used to promote people's rehabilitation and recovery. Where required, doors were secured with codes to promote people's safety.

Good

Is the service caring?

Our findings

People were supported by staff that were kind, respectful and compassionate towards them. One relative commented, "Staff are very kind and compassionate in their work and when attending to people." Another relative said, "The staff show compassion and respect to [My loved one], it is a very difficult job to do and I am very satisfied with the staff.' A third relative commented, "The staff are good in what they do." We observed positive interactions between people and staff, and it was clear they had developed good relationships with each other. Throughout our inspection, we observed staff treating people with respect and engaging them in conversations that were friendly and relaxed. Staff called people by their preferred names and we saw people laughing and smiling whilst staff interacted with them. A staff member told us, "The manager puts emphasis on keeping conversation going with people and taking as long as it takes to give the care they need. We aren't in a rush, there are enough staff to work like that and management support us."

People were consulted about their care and support needs. People and their relatives told us they had been involved in making decisions about the care they received, and their views were taken into consideration when planning their care. Staff told us they offered people choices about the food they ate, the clothing they wore, their personal care needs and the activities they participated in. One staff member said, "We offer them [people] choices and we respect their choices." Care plans showed that people and their relatives, where appropriate had been involved in their care assessments, planning and reviews to ensure their needs were met.

People's privacy and dignity was respected. Relatives told us that personal care was always provided in private or behind closed doors to maintain people's dignity. One staff member said, "We don't talk about people's conditions unless on need to know basis., and we knock on people's doors before we enter." Another staff member said, "We give people choices and we take them to their room for personal care to maintain their privacy." A third staff member said, "We shut windows, doors and curtains, we don't leave people uncovered, everything has to be ready before you start with personal care." We observed that staff offered people discreet assistance with their personal care needs or where people required assistance to eat their food. People's records were stored in a locked office on each unit or in locked cabinets in people's rooms to ensure only authorised staff had access to them.

People's independence was promoted. One staff member told us, "We encourage people to walk so they don't lose their life skills. Another staff said, "We give people chances to assist themselves where they can." A third staff said, "Some people can do things for themselves and you must not prevent them." We observed people walking around the home with their mobility aids and eating independently where they had the capability to do so.

People were provided with information about the home in the form of a 'service user guide'. The manager told us the service user guide was given to people and their relatives, to ensure they had information they would find useful about the home. This included information about the provider's values, care staff and management teams, details of the services provided, visiting people, religious needs and attending hospital

appointment. This ensured that information was readily available to people and their relatives and they were made aware of the standard of care they should expect.

Good

Is the service responsive?

Our findings

People received personalised care that met their needs. People and their relatives were complimentary about the care delivery. Care plans were developed and based on an assessment of people's needs. They covered areas such as personal hygiene, communication, eating and drinking, mobility, their emotional, psychological and, social care needs, and their daily routines. Each care plan included information on the support people required with the various aspects of care and provided staff with guidance on how these needs should be met safely.

Care plans also included people's goals and the outcomes they would like to achieve, such as improving their level of independence, or participation in activities of interest. People's preferences, including their likes and dislikes were included in their care plans to ensure staff knew the of level of support to provide. Staff knew people and their needs well and were aware of the guidance recorded in their care plans. Care plans were up-to-date and reviewed regularly to ensure people's needs were met. Daily care notes including food and fluid charts completed by staff showed that the care delivery was in line with the care and support that was planned for.

Staff supported people's needs in relation to any disability, race, religion, sexuality and cultural backgrounds. A priest visited the home twice each week to support people practice their faith. Staff told us one person was supported by a friend to attend a local church service on Sundays. People's sexuality was respected and appropriate guidance was in place for staff to support them without any discrimination. People's meals were prepared in accordance with their cultural and spiritual needs and preferences.

The provider complied with Accessible Information Standard which is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Some people living at the home had dementia or learning disabilities and had varying communication abilities. Care records contained clear communication plans explaining how people communicated and provided guidance for staff on the support to provide. For example, by speaking clearly, slowly, using short sentences and simple words. Staff knew people well and understood individual requests and communication preferences. The service used large prints, easy read and/or pictures to communicate with people where appropriate, as well as providing information to people in different languages where they did not speak English. During lunch time we saw that people on the dementia unit were shown the alternative meals on offer to enable them to choose, and this promoted their understanding.

People were supported to maintain relationships with the people that mattered to them. Relatives told us they could visit the home without any restriction and were always made welcome by staff. During our inspection, we saw relatives visiting their loved ones at the home. Staff told us that relatives could also take people out into the community. Records confirmed that one person's relatives had been shown how to strap them safely in their wheelchair so they could take them out into the community if they wanted to. People were encouraged to maintain contact with their relatives through telephone calls to promote their relationship.

People were supported to participate in activities that interested or stimulated them. Residents on all three units enjoyed a variety of activities organised by the three activities coordinators at the home. Activities included both group and one-to-one sessions. Each unit had their own weekly activity planner which was presented in pictorial formats in line with people's communication needs. Activities included bingo, shopping, reminiscence, art sessions, watching television or a film, exercise to music and entertainment from a Motown singer. One person's care plan stated they enjoyed reading a newspaper and staff made this available to them each day. An activities coordinator told us that people also took part in baking sessions and McMillan coffee sessions every week and guest musicians or entertainers were also invited into the home once a month to perform. On both days of our inspection, we observed people participating and enjoying activities such as bingo, sing along and a painting session. One person was also supported by the activities coordinator to shop at the local stores.

There were effective systems in place to handle complaints. People and their relatives told us they knew how to make a complaint if they were unhappy with the service. One person told us, "If there is any dissatisfaction about anything going on I will take it up with the manager." The provider had a complaint policy and procedure which outlined actions they would take to respond to complaints including timeframes. Information about how to make a complaint was displayed in communal areas to encourage people to make a complaint if they were unhappy with the service.

Where people or their relatives had made a complaint, these were logged, investigated, and responded to, and action was taken to address any issues raised. For example, when a relative had made a complaint about an aspect of their loved one's personal care needs, a meeting had been arranged involving them and senior staff to help resolve the matter. We noted that staff had acknowledged their faults, apologised and acted to resolve the matter. The relative confirmed with the home that they were satisfied with how their complaint had been resolved and with the level of care and support their loved one had subsequently been receiving. In another example, a relative complained about their loved one being served a meat sauce with a fish meal. The provider acted promptly and apologised to the relative, then held meetings with kitchen and care staff. The provider created a poster of 'meat/fish and their sauces' to ensure people were served with the right sauces.

People received responsive support at the end of their lives, in line with best practice and guidance. At the time of this inspection, none of the people living at the home required end of life support. People who did not wish to be resuscitated had a Do Not Attempt Cardiopulmonary Resuscitation (DNACR) order in place which had been agreed with them or their relatives where appropriate, in discussion with staff and their GP. People also had advanced care plans in place which contained information about their end of life wishes. For example, one person's care plan stated they had a funeral policy in place and wished to be cremated. A visiting healthcare professional told us, "The staff are outstanding with palliative care needs, they are very caring and go out of their way to look after people."

Requires Improvement

Is the service well-led?

Our findings

Records were not always complete, consistent, signed and legible as some care plans had been handwritten. Information we found in two of the eight care plans were not always consistent in supporting people's needs safely. Personal emergency evacuation plans (PEEPs) we reviewed did not always consider people's cognition and mental health needs, and were not always consistent in identifying the level of support people would require evacuating safely. For example, one person's PEEP stated, "She is able to understand and follow instructions", however another section stated, "She is confused require 24 hours supervision." Their mobility care plan identified that they required a wheelchair to mobilise, but this was not referred to in their PEEP. In another instance, a person's call bell risk assessment stated they could not understand or remember how to use a call bell, and were at risk of strangulation, therefore, staff should monitor them hourly at night and in the lounge. However, guidance for staff in their care plan stated, "Staff to check on her regularly and make sure call bell is within her reach." Their falls care plans also stated, "Ensure call bell and snacks are within reach." In another example, one person who recently moved into the home had initial assessment that identified they 'wanders at night' however their sleeping care plan did not mention any risk that may be associated with their nocturnal behaviour and how this should be managed. Despite this, staff we spoke with knew people well and told us of the support they provided to ensure they remained safe.

The manager told us at the beginning of our inspection, "We have worked really hard to get care plans right and we are still in the process of updating them," Where we had identified issues, the provider was either aware of this and were acting to improve on records such as acquiring signatures from people and their relatives to demonstrate they were involved in the care planning, or had shown us action plans of the actions they would be taking to manage records. Following our inspection, the provider sent samples of completed PEEPs on a new template with the aim of capturing accurate information in line with people's needs and to provide appropriate support to evacuate them safely in the event of a fire. The home manager informed us all care plans had also been reviewed and updated in areas we had identified. However, we cannot confirm everyone's records were consistently maintained and we will check on this at our next inspection.

There were systems in place to assess and monitor the quality of the service. The provider carried daily, weekly, monthly, quarterly and annual internal audits which covered areas such as health and safety, medicines, infection control, accidents and incidents, falls, staff files and care files. Results from a quarterly audit carried out in July 2018, had identified issues in relation to end of life care plans, Lasting Power of Attorney, mental capacity assessments, best interest decisions and staff training. An action plan and timescales had been put in place to complete identified issues. We saw that action was being taken and the majority of these actions had been completed. However, areas such as staff training were still being addressed to ensure all staff refresher training was up to date.

External monitoring checks had also been completed by two local authorities that commissioned services from the provider. We compared an audit carried out by one of the local authorities in April to July 2018. We saw that where recommendations were made the provider had acted to improve on the quality of the

service. The London Fire and Emergency Planning Authority had carried out an inspection of the home in January 2018 under the Regulatory Reform (Fire Safety) Order 2005, at which time they found to be satisfactory. The Food Standard Agency also inspected the kitchen of the home in August 2018 and gave it a food hygiene rating of 5.

There was no registered manager in post. The home manager was in the process of applying to CQC to become the registered manager. The manager had experience of managing similar services and was supported by a deputy manager, clinical lead and a regional support manager. The management team including the home manager understood their legal responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and had sent CQC statutory notifications of significant events that had happened at the home.

The provider had a clear organisational structure in place, and all staff teams understood their roles within the home. Staff told us the provider's values included dignity, privacy, independence and providing person-centred care, and they upheld these values whilst undertaking their roles. A staff member told us, "We are a strong team, everyone is working towards the same goal. What I like here is that everyone is involved. The residents are all treated as individuals."

All staff we spoke with told us they were happy working at the home. A staff member said, "The home manager is very supportive, open, good but assertive. They have great management skills and are a good team player. We all work towards the same goals and the deputy manager is very good too." Another staff member said, "The home manager is very supportive; very involved in the care delivery, the new provider is very attentive and has a listening ear so staffing levels have improved greatly." Both staff and healthcare professionals told us they would recommend the home to their family and friends. A healthcare professional told us, "I would not mind living here myself; I would get good care here." Another healthcare professional said, "The home manager is very calm and staff are being led by example."

People's views were sought to improve on the quality of the service delivered. The provider used an annual satisfaction survey to gather feedback from residents, relatives and professionals. The result of a survey carried out in February 2018 was mostly positive but included feedback that activities could be improved. The provider acted on this and had increased the number of activities coordinators from two to three. Also during our inspection, we saw that the provider had invited a professional artist to support people to learn how to paint. At the time of this inspection, a sensory room was being designed on one of the units to enhance relaxation, reminiscence and/or stimulation. An indoor garden had also been designed to promote reminiscence with those who had dementia. Feedback received from professionals about the service were all positive.

People, their relatives and staff were encouraged to be involved in service improvements through regular meetings. Minutes of relative's meetings showed areas discussed included menus, activities, care plan reviews and housekeeping. Staff meetings were held to cascade information, gather feedback and share learning of good practice so staff understood what was expected of them at all levels. Handover meetings were also held between shifts to promote continuity of care. Daily 'flash' morning meetings were used to update staff teams about the happenings in the home and to ensure staff had the support they needed to deliver an effective service.

The provider had systems in place to promote continuous learning and improve the quality of the service. There were resources available to support staff development and drive improvements. There were arrangements in place to learn from audits, accidents and incidents, health and safety checks, safeguarding and complaints to improve on the service. There was a strong focus on continuous learning at all levels

within the home. For example, the chef carried out a monthly meal time observation and fed back to care staff on any areas that required improvement to people's meal time experiences. Also, following an incident that occurred at the home under the management of the previous providers, the service had made available choking guidance in each care plan to ensure staff knew of actions to take in the event of anyone choking and to prevent a reoccurrence.

The provider worked in partnership with key organisations such as the local authority, Community Learning Disability Team CLDT and other health professionals to ensure people's needs were met. These organisations confirmed with us that the provider worked with them to plan and deliver joined-up care and support.