Bupa Care Homes (GL) Limited

The Kensington Care Home

Inspection report

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Date of inspection visit:
10 August 2018
13 August 2018
14 August 2018
15 August 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We conducted an inspection of The Kensington Care Home on 10, 13, 14 and 15 August 2018. The first day of the inspection was unannounced. We told the provider we would be returning for the other days.

At our last inspection on 11 and 17 July 2017, we identified some concerns in relation to moving and handling techniques used, the maintenance of a calm environment and the provision of mealtime assistance.

The Kensington Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Kensington Care Home provides nursing care, respite and accommodation for up to 53 older people. The home is located in a Victorian terraced property, converted and arranged over three floors which each have lift access. At the time of our inspection there were 39 people using the service.

There was a registered manager at the service. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were enough suitably trained and safely appointed care staff working at the home. Care staff were given enough training and ongoing support.

Risks to be people's safety were managed appropriately, with clear guidance in place for care staff. People told us they felt safe living at the home. The provider had an effective safeguarding policy and procedure in place and care staff were appropriately trained and aware of their responsibilities.

Good infection control practices were operated throughout the building. The home appeared clean, tidy and odour free throughout our inspection.

People were supported to maintain a healthy diet. Care records contained a good level of detail about people's health and nutritional needs. Kitchen staff were also aware of people's nutritional requirements and offered people choices with their meals.

People were supported with their healthcare needs. People's care records contained a good level of detail about their current needs and care staff assisted them to access external healthcare professionals when needed.

People using the service and their relatives were involved in decisions about their care and how their needs were met.

The organisation had good systems in place to monitor the quality of the service. Feedback was obtained from people through quarterly residents and relatives meetings and we saw feedback was actioned as appropriate. There was evidence of further auditing in many areas of care and action was taken to rectify any issues identified as a result.

There were good systems in place for the safe management and administration of medicines. Staff had completed medicines administration training within the last year and were clear about their responsibilities.

Staff a good understanding of their responsibilities under the Mental Capacity Act 2005. Mental capacity assessments were completed when needed and we saw these in people's care files. Authorisation had been sought and obtained from the local authority where staff felt it was in a person's best interests to deprive them of their liberty.

People told us care staff were caring and our observations supported this. Care staff demonstrated they knew people's likes and dislikes in relation to their care and demonstrated an understanding of people's personal circumstances. Care staff respected people's privacy and dignity and people's cultural and religious needs were met. Care staff were trained to provide appropriate end of life care.

People knew how to make complaints and there was a complaints policy and procedure in place.

The service employed three activities coordinators who delivered a varied activities programme. People's feedback was sought in relation to the activities on offer and the timetable was altered in accordance with people's views.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff working at the service.

Risks to people's safety were assessed and managed appropriately.

Effective investigation and learning took place from incidents and accidents.

Medicines were managed safely. The provider operated safer recruitment procedures by carrying out appropriate checks of candidates.

Care staff knew what they were supposed to do to protect people from abuse. There was an appropriate safeguarding policy and procedure in place and safeguarding investigations were conducted when needed.

The provider operated good infection control practices throughout the home.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were managed safely.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff had a good understanding of their responsibilities under the act and the provider had obtained authorisation where people were being deprived of their liberty for their safety.

Staff were given appropriate induction, training and regular supervision and appraisals to carry out their role.

Is the service caring?

Good

People told us care workers were kind and caring.

Care workers had a good understanding of the people they were

supporting and helped people to be as independent as possible. Care workers treated people with respect and promoted their dignity.	
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Kensington Care Home

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 took place on 10, 13, 14 and 15 August 2018. The inspection team consisted of one inspector, an Expert by Experience and a specialist advisor. 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 this inspection the specialist adviser was a nurse with expertise in dementia care. The first day of our inspection was unannounced, but we told the provider we would be returning on the following days.

Prior to the inspection we reviewed the information we held about the service. We spoke with two healthcare professionals working with the home to obtain their feedback.

During the inspection we spoke with 10 people using the service and two of their relatives. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 14 care workers, two team leaders, three nurses, one activities coordinator, a member of the housekeeping team, the head chef, the clinical lead, the registered manager and the regional manager for the provider. We looked at a sample of 10 people's care records, seven staff records and records related to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection some people's relatives raised concerns about the safety of their family members and concern that the refurbishment programme within the home had caused disruption. At this inspection people and their relatives told us they felt safe living at the home. Comments included "I feel safe here" and "I am safe. There's nothing for anyone to worry about." We also observed that the refurbishment programme had been completed and the home was in good order.

At our previous inspection we identified some concerns in relation to moving and positioning people. We found that people were not always positioned correctly and we identified one example of a person being moved without the care worker obtaining their consent. At this inspection we found care staff used correct moving and positioning techniques. We observed care staff assisting people to move and asking their permission before doing so. Care workers received training in moving and handling people on an annual basis. This included a practical element which involved care workers using the equipment. We spoke with care workers about the training they received and they told us they found this useful. One care worker told us "We will practice on each other and understand what it is like being hoisted. It is very scary at first, you need to trust people. You can relate to the resident based on your training."

We spoke with the registered manager about how they assessed that people's moving and handling needs were being met appropriately. He told us that he and the clinical lead conducted various audits that included observations of the care provided. These happened on a daily and weekly basis. We spoke with a physiotherapist who provided care to some people using the service. They confirmed that they did not have any concerns about people living in the home.

At our previous inspection we found not all care staff had received safeguarding training. At this inspection we found care workers had received safeguarding training and they confirmed that they were aware of the provider's safeguarding and whistleblowing policy and procedure. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. Care workers told us they would report any concerns they had. One care worker told us "Everybody deserves not to be abused. We are looking after vulnerable adults. It does not matter who it is. I will report them" and another care worker commented "This is definitely the kind of place where we can whistleblow." We looked at the records kept of safeguarding concerns and we saw these had been appropriately investigated.

Care staff received adequate training in safety systems. This included fire safety, first aid and health and safety training. Care workers had a good understanding of how they were required to respond in the event of an emergency. They told us they would report any incidents to the nurse on duty in the first instance and would also request an ambulance when needed.

Care records contained advice for care staff in the event of an emergency and had personal emergency evacuation plans (PEEPs) in place. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any

emergency. These documents were detailed and showed the number of staff and type of equipment required for the safe evacuation of each person. For example, we saw one person's record stated that they required the assistance of one person to supervise their mobility in order to leave the building in the event of an emergency.

The provider had appropriate procedures in place for assessing, monitoring and mitigating known risks. Each person had specific risk assessments completed in areas of potential risk. For example, we saw detailed risk assessments in areas such as skin integrity, falls management and health matters such as people's risk of having a urinary tract infection (UTI). Assessments included advice for care workers to follow to minimise the risk. For example, we saw one person had a falls risk assessment in place that stated care staff were required to supervise them when they moved around. The guidance within the document also stated that the person needed their zimmer frame to be within reach, that their room should not be cluttered and that they required appropriate clothes and footwear when mobilising. The person also had a falls diary in place to document each occasion they had fallen as well as any lessons learnt and changes made as a result of this. We saw another person had a risk assessment conducted in relation to their skin integrity. Their record contained advice for care workers including details of the cream they needed to have applied, the frequency of application, advice from the tissue viability nurse (TVN) as well as wound care assessments which were conducted every two days along with photographs being taken to monitor the site of the wound and ensure it had not deteriorated.

We observed that people had call bells within reach and we observed care staff responding to these promptly. People confirmed their call bell was answered when they rang. One person told us "Yes they come when I ring the call bell." The provider conducted checks of people's call bells to ensure that they were working and within reach. The registered manager also reviewed call bell response times to ensure they were answered promptly. The results of the previous week's checks did not identify any issues.

Appropriate investigations were conducted into accidents and incidents. The provider used an electronic recording system that graded the severity of the incident that occurred. All serious incidents were investigated by the provider's head office. Records demonstrated that appropriate investigations were conducted into more minor incidents by the registered manager. This included questioning staff members and reviewing records. We saw changes were implemented as a result of investigations. For example, we saw one record in relation to one person's wound and the further actions taken as a result which included referral to a tissue viability nurse.

The provider ensured there were a sufficient number of suitable staff scheduled and working within the home. For the majority of our inspection we observed there were enough care staff working to provide care to people. However, we received complaints from four care staff within one unit of the building about staffing numbers. We reviewed the rotas and staffing numbers throughout the home and found that there was approximately one care worker for every four people using the service. From our observations, there were enough care staff working at the home and people told us there were enough staff to provide their care and support.

The provider conducted safer recruitment practices to help ensure candidates were safe to work with people. We reviewed seven staff files and saw these included evidence of criminal record checks, at least two references (one from the staff member's previous employer) application forms which detailed people's previous employment history as well photographic identification and people's right to work in the UK. Records for nurses also included their Nursing and Midwifery Council registration details.

The provider followed good infection control practices. We saw domestic staff cleaning the premises and

the home was clean, tidy and odour free throughout our inspection. Care staff confirmed that they were provided with personal protective equipment (PPE) such as gloves and aprons for use when providing personal care and had received training in infection control procedures. Records showed that staff had received training within the last year.

Care staff had a good understanding of best practice in infection control and gave us examples of this. One care worker told us "We do things like, dispose of gloves after we have used them in someone's personal care" and another care worker told us "We wash our hands constantly throughout the day." We also spoke with a member of the domestic staff. They also gave us examples of how they conducted their work and told us "I use different equipment for different areas of the home." People confirmed the home was usually clean and tidy. One person told us "Everything is clean."

Medicines were managed safely. Medicine administration records (MAR) showed that medicines were administered as prescribed, with signatures recorded by the nurse administering the medicine. We reviewed the MAR charts for four people and found these were appropriately filled in. We observed medicines being administered to people and found nurses checked people had taken their medicine before signing the MAR chart immediately to record this. People confirmed they were given their medicines on time. People's comments included "They give the medication on time" and "Yes, I get my medicines."

There were protocols in place for when medicines were prescribed on a PRN basis as well as pain management tools for nurses to assess whether people needed pain relief. These provided guidance for staff on how to administer these medicines safely, and included information on dosage, the manner of administration, frequency and maximum dose for each PRN medicine. Medicines classed as controlled drugs were appropriately and securely stored and managed. There was a log book which detailed each time a controlled drug had been administered, which was signed by two trained members of staff.

Medicines were stored appropriately and each unit kept a record of daily checks of the medicines fridge and clinical room. We checked the temperatures on the first day of our inspection and saw these were within an appropriate range.

We found the provider's use of homely remedies, did not have GP approval of maximum doses, frequency or route of the medicine. We spoke with the clinical manager about this and they told us they obtained homely remedies from the pharmacist and obtained appropriate advice from them. However, the provider agreed to look into this issue further and obtain GP advice as required.

We also identified that topical medicine administration charts were not signed consistently. For example, one person had been prescribed two topical creams and the body map location frequency of administration had not been documented and one cream did not have an open date recorded. We saw the provider had already identified this issue in their most recent audit and agreed to rectify this immediately.

Nurses administered medicines to people. They confirmed they had received medicines administration training within the last year and records demonstrated this. When we spoke with nurses they had a good understanding about how to correctly store and administer medicines to people.

Good

Is the service effective?

Our findings

At our previous inspection we found people who required assistance eating and drinking were not always being supported in an appropriate manner and mealtimes were not always taking place in a calm environment. At this inspection we found people were given the support they needed during mealtimes and that mealtimes were a calm and enjoyable experience for people. People chose whether they wished to eat their meals in the communal dining area or in their rooms. Where people chose to have their meals in their rooms we found they received their meals promptly and those who required assistance were given this. The dining area was calm and people were offered choices in relation to their meals and shown examples of the food on offer if they needed this. There was soft music playing in the background and people were provided with the different courses of their meal promptly with dining staff checking on their needs throughout their meal to ask whether they could provide any further assistance. Where people required assistance with eating their meals, we found care staff were in place to provide this. People and their relatives gave good feedback about the food. One relative told us their family member "has a pureed diet. The food is good" and another person told us "The food is good." We sampled the food on two days of our inspection. We found the food to be appetising, of a good portion and served at an appropriate temperature.

We spoke with the chef about how they met people's nutritional needs as well their likes and their dislikes in relation to food. They told us they obtained people's feedback in relation to food each day and not only when they were first admitted to the service. If people did not like a particular meal, it would be removed from the menu. If people did not like or did not want any food on offer on any day, there were other options available such as omelettes or sandwiches. Meals were nutritionally balanced as the provider devised a menu with a registered dietitian and people who required pureed had well-presented food that had been put in moulds before serving to make the food more appetising. Kitchen staff were aware of people's individual nutritional needs or allergies because details of these were kept in the kitchen area. We checked the kitchen area and found food available was in date and the environment was clean and tidy.

People were supported to eat and drink enough to maintain a balanced diet. People had nutritional care plans in place which specified whether they had any particular dietary needs or allergies as well as what their likes and dislikes were in relation to food. There were also additional instructions for care staff in how they were required to support people with their meals. For example, we saw one person's care plan stated they were able to hold their cutlery with supervision from care staff as their medical condition meant that the person's hands shook.

Where people had complex nutritional needs, we saw their care plan detailed this along with any additional instructions for care staff. We saw people had specific assessments conducted monthly to determine whether they were at risk of malnutrition. The records we saw did not indicate that any person was at risk, but we were told that where issues were identified with people's food intake, they would be referred to healthcare professionals as needed. For example, we saw one person's assessment scores indicated that they were at some risk of malnutrition when they entered the home, but at the time of our inspection, they had put on weight and were no longer at risk. We looked at the care record of another person who had complex needs and saw detailed instructions from a speech and language therapist as well as their GP in

relation to their food intake. The person took their food through a percutaneous endoscopic gastrostomy (PEG) tube. A PEG feeding tube is a tube which is passed into a person's stomach to provide a means of feeding when oral intake is not adequate. We saw their records indicated that they could take some food orally for pleasure, but under supervision. Care workers were clear about how they were supposed to assist the person and this included ensuring that they were in an upright position to prevent the risk of choking.

People's day to day healthcare needs were met by care staff. People's care records contained comprehensive information about what people's needs were and this included their physical and psychological healthcare needs. People's records contained a 'professional visits log' which recorded the date from visiting healthcare professionals such as GPs or physiotherapists as well as their advice to care staff. People also had care plans entitled 'healthier, happier life' which documented people's daily care needs along with information such as whether they had any medicinal allergies. For example, we saw one person's care plan contained details about their pain relief. The person had regular paracetamol for pain which they had four times a day. An additional monthly pain assessment was also completed to determine the appropriateness of the pain relief and whether the person needed this to be reassessed by their GP.

People's psychological needs were recorded within separate 'mental health and wellbeing' care plans. Initial assessments were completed in areas such as depression through the use of a 'geriatric depression scale' assessment or whether people had particular behaviour that challenged through the completion of a 'behavioural assessment tool'. The results of these assessments were collated and a plan of care was established and recorded within specific care plans that included advice for care workers. For example, we saw one person's depression scale assessment concluded that they did not have depression, but they experienced anxiety as a result of their difficulties in communication with care staff. Care workers were therefore given advice about how to communicate with the person effectively, which included speaking to them in clear and short sentences. Another person's care plan stated that they exhibited some behaviours that challenged with very little warning. Some details were recorded about the person's symptoms which included experiencing hallucinations. There were no listed triggers for the person's behaviour and therefore there was limited advice for care workers in how to manage this. We spoke with the nurse on duty about this person's care and they explained that the person had been referred for a psychiatric assessment and we saw evidence of this.

Care staff had a good level of knowledge about people's healthcare needs. For example, we spoke with one care worker and they gave a good description of the healthcare needs of people in one unit of the building.

People's care was delivered in accordance with current standards and legislation. We spoke with the registered manager about how he ensured that current guidelines were being followed and he explained that he ensured all policies and procedures were updated annually and that care staff received up to date training in different areas of their roles every year. We reviewed the provider's policies and procedures and saw these had been updated in line with current legislation and guidance. For example, we saw the provider's Safeguarding policy included reference to the Care Act 2014 and the Adult Support and Protection Act 2007.

The provider ensured that care staff had up to date training and support. Care workers told us they received annual training in various subjects relevant to their role and records confirmed this. Care workers told us "We get enough training to do our jobs properly" and "You can ask for extra training. I've asked for training in care plans and I'm getting this soon." We reviewed the provider's training records and saw care staff were up to date in the completion of their mandatory training. People also confirmed that care staff seemed experienced. One person told us "They seem quite skilled here."

Care staff were given an appropriate induction and ongoing supervisions and appraisals of their performance. Care staff confirmed they received an induction over five days during which they were trained in various mandatory subjects before shadowing other more experienced staff. They confirmed they found the induction to be effective. One care worker told us "I felt ready to start work at the end."

Care staff received appropriate ongoing supervisions and appraisals of their performance. Records demonstrated that care staff received a supervision every three months and were asked if they needed further training, whether they were experiencing any issues as well as discussing any relevant updates regarding matters occurring within the home. Appraisals were happening every year and records demonstrated this. Care staff confirmed both supervisions and appraisals were taking place and told us they found these to be useful. One care worker told us "I have wonderful support…They [supervisions] are useful."

People were supported to make decisions in line with current legislation 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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care staff had a good understanding of DoLS, and told us they obtained people's consent prior to providing people with care. One care worker told us "Even if someone does not have capacity, that doesn't mean you can force care on them. You ask them and if they don't want help you can come back later" and another care worker told us "If someone didn't have capacity to make a decision, I would report this."

People whose movement was restricted had an appropriate DoLS authorisation in place from the local authority. Mental capacity assessments for specific tasks or events were also in people's care records. For example, where people had bed rails in place we saw mental capacity assessments had been conducted and their relatives had been consulted.

Good

Is the service caring?

Our findings

People gave good feedback about their care workers. Their comments included "The staff are kind." and "The staff are gentle people, kind, tolerant, patient, sympathetic".

At our previous inspection we found that not all people were being treated with dignity and respect. At this inspection we found people's privacy and dignity was respected and promoted. Care staff gave us examples of how they promoted people's dignityay, particularly during personal care. One care worker told us "I am very careful when giving personal care and I try to make people comfortable… I understand this can be difficult for people. There is one lady who is very private and finds it difficult getting this care, so I tell her what I'm doing and make sure she is okay with it." Another care worker told us "You've got to make sure the door is closed and the curtains are drawn [when giving personal care]." We observed care staff knocking on people's doors and waiting for a response before entering.

At our previous inspection we found some care staff did not have a good understanding of the people they were caring for. At this inspection we found care staff did know the people they were caring for. We observed kind and caring interactions between people and care staff and overheard conversations that demonstrated that staff knew people well. For example, we heard one person speaking with a care worker about where they had grown up and we overheard another person speaking with a care worker about a member of their family. Care staff demonstrated that they knew people well and learned about their lives during the course of their work. One care worker told us "We try to get to know people while we are working."

Care records also contained details about people's life history including where they had grown up as well as important people in their lives and family members. We saw a document entitled 'My day, my life, my story' was completed for each person. This included information such as where people were born, what school they went to, their favourite subjects at school, their first job and their favourite job. The record also contained the person's family tree and further information about places that were important to them. Care workers told us they found the recorded information useful in getting to know people. One care worker said "It's a good start in getting to know people. It's good to read when you're new and you don't know anyone yet… but we talk to people to get to know them properly" and another care worker said "We don't only base our care on the care plans. We get to know people. We respect people's choices."

People were encouraged to be as independent as they could be. Initial assessments determined the level of people's needs and the exact level of support that they required, including the number of care hours they needed. This information was used in the formulation of their care plans and we saw written details of the types of activities that people needed assistance with. For example, we saw one person's care record confirmed that they could mobilise independently with the aid of a zimmer frame, but care workers were required to provide some assistance by ensuring that this was within their reach and that their environment was safe. Care staff gave us examples of how they did this. One care worker told us "It's good to let people carry on doing what they can, otherwise they will lose the ability" and another care worker said "In terms of personal care, we support people by asking them if they want to do things for themselves. We might hand them a flannel and ask if they want to do this. It's good exercise too."

Care staff prioritised people's choices in relation to their care. We observed care workers offering people choices in relation to their food and drink and waiting patiently for people's response before acting on this. For example, we overheard one care worker offering a person different hot drinks, before they made up their mind. Care workers told us they offered people choices in relation to a variety of matters including the clothes they wanted to wear. One care worker told us "It's important that we help people to have things the way they want... It's not up to me what they wear or how they take their tea… I do what people tell me."

Care records included details of people's cultural and religious requirements. Where people had specific requirements such as needing access to a place of worship or requiring changes to their diet for religious reasons, this was accommodated. For example, two people required halal meat and the provider ensured this required was accommodated in order to meet their religious needs. People confirmed their religious needs were met. One person told us "I go to Church every Sunday, somebody comes to pick me up."

Good

Is the service responsive?

Our findings

People were involved in their care and confirmed that they were asked how they wanted their care delivered. People told us "They do what I want" and another person said, "They ask me questions and do things for me."

Care plans covered different areas of people's needs including their physical, mental and social needs. We saw both risk assessments and care plans in relation to different aspects of people's lives and saw that the details were personalised to the individual. For example, we saw recorded details about toiletries that people used or particular foods that people liked. We spoke with care workers about how they met people's individual needs and they demonstrated a good understanding about people's preferences. One care worker told us "We always read people's care plans, but after working with people you get to know them and remember how they like things done."

People were encouraged to participate in a broad range of activities in accordance with their preferences. The provider had an activities timetable which included a range of activities both within and outside the building. This included activities such as visits to the cinema, accessing the gardens, music therapy sessions or having specific themed events. During the week of our inspection the service was operating a French themed week which included activities such as cheese tasting and French foods such as crepes. We spoke with a person who participated in this event and they told us they had enjoyed this.

The service employed three activities coordinators who ran the activities programme and devised a weekly timetable. We spoke with one activities coordinator and they explained that they obtained feedback from people using the service at the end of each session in order to ascertain whether or not they enjoyed the activity and based on people's feedback they would make changes to the timetable.

We saw people had specific 'lifestyle' sections within their care records which documented people's likes and dislikes in relation to activities. Records were also kept about their participation in activities and the activities coordinator confirmed they reviewed these records to assess whether people were at risk of being isolated or if they simply did not enjoy the activities on offer. For example, we saw in one person's care record that they enjoyed watching television and reading as well as spending time with their family, but did not enjoy organised activities and their records confirmed this. We spoke with the activities coordinator about this person and they explained that some people did not enjoy organised activities. In these cases, the coordinator explained that they risk assessed the person's risk of social isolation, invited them to participate in activities and events in case they changed their mind and also offered one to one activities or ensure they visited the person. We saw from the person's care record that they did have a social isolation risk assessment in place which concluded that they were at low risk of being isolated. This was due to the person receiving visits and accessing the community with family members as well as them accessing one to one activities such as music playing. We saw their records confirmed this level of activity.

The provider identified and met the communication needs of people with sensory loss. We saw people had 'senses and communication' care plans within their care records and these specified whether people had

any physical reasons for experiencing difficulties in their communication and how care workers could meet their needs. For example, we saw in one person's care record that they had a physical disability that meant they slurred their speech. However, it also stated that as long as the person was given time to express themselves they were able to do so. The person's needs were assessed within a 'care needs profile' which confirmed whether the person needed an interpreter or required communications to be available in different formats. For example, the provider's menu was available in an easy read format if needed.

The provider had an effective complaints policy and procedure in place. People told us they knew who to complain to if needed and felt their complaint would be listened to. One person told us "I can complain to any of the staff and I know they listen to me."

We reviewed the provider's complaints policy and saw that this included details of how complaints were to be investigated along with time frames for this. We reviewed the providers complaints records and saw that appropriate investigations were conducted with actions put in place when needed. For example, we saw one complaint was investigated extensively and care staff received further training as a result of the complaint.

Prior to our inspection we received a complaint about people's end of life care needs not being met. Although nobody was receiving end of life care at the time of our inspection, we reviewed a person's end of life care plan after our inspection had finished. We found the person's records included details such as whether they wanted care staff to attempt resuscitation in the event of a cardiac arrest and this decision was recorded within an appropriately authorised legal document. The person's specific religious needs were also recorded within these documents as well as information about where and how they wished to be buried. There was also information about who should be contacted when the person was at the very end of their life as well as other specific requests from the person.

Care staff had received appropriate training about how to manage people's end of life care needs and we saw evidence of this. This covered aspects of end of life care such as administration of medicines including, anticipatory medicines, symptoms of end of life, capacity, and people's end of life wishes.

Good

Is the service well-led?

Our findings

The provider monitored the morale of care staff and took action to improve this. We spoke with 21 members of staff throughout our inspection and found that whilst most staff members who included care workers, nurses and domestic staff told us they were happy working at the service, there were approximately four staff members who had experienced issues and were unhappy as a result. We also identified some strained working relationships between staff members at different levels. We spoke with both the registered manager and the regional manager about these issues. They were aware of the problems between staff members and evidenced the action they had taken to improve staff morale. The registered manager, who was new in post told us he wanted staff members to know "you are appreciated and we are grateful for the work you do." He told us that he had undertaken initiatives to improve morale such as encouraging care workers to take small breaks and have a snack and improving staff lunches. He explained that he was eager to personally speak with staff members on a daily basis to see how they were feeling and to take action in response to any concerns.

Care staff gave good feedback about the new registered manager and confirmed that he listened to them. One care worker told us the registered manager "has changed the atmosphere, it's great. ... He changed the culture a lot. Nowadays we are working better together. There is a far more positive environment" and another care worker said "He listens to the staff. He is kind hearted. If you are going to approach him, he is there for you. He is very supportive."

The provider had thorough quality monitoring systems in place to support the delivery of an effective service. This included a 'daily clinical walk round' audit conducted by the clinical lead. This involved a check of people with clinical concerns, those who had experienced falls, hospital admissions, any people who were the subject of safeguarding concerns or those who had any wounds. The clinical lead assessed the care these people were being provided with and made a written note on the audit sheet about any actions that needed to be conducted straight away. Actions were taken immediately and the following day's audit included a check that actions from the previous day had been implemented. We reviewed the audit sheets from the days prior to our inspection and found appropriate actions had been taken.

Further to this, a weekly clinical governance review meeting was conducted between the clinical lead and the nurses and this involved a further, more in depth check of people and their needs. Various checks were done including the implementation of a 72 hour protocol for new people using the service. This required the completion of assessments in skin integrity, nutrition and ensuring nutritional plans were in place to meet people's needs as quickly as possible. The meeting was also held to check that people had relevant equipment and medicines in place to meet their needs. The provider also conducted a monthly clinical governance review checklist to ensure that all audits were being completed. We reviewed these documents and saw they evidenced the checks were being conducted.

Further audits were also undertaken including medicines audits, a check of care records as well as call bell response times. Care audits were checked in accordance with a monthly tracker which documented that different records were checked as part of the audit every month.

The provider also conducted monthly night visits to ensure the care provided at night was appropriate. Various questions were asked as part of this audit, such as whether care staff appeared alert, whether people appeared comfortable, whether medicines and supplementary charts had been completed and whether call bells were plugged in and within reach. We checked the record of the last night visit conducted on 27 July and the results of this were positive.

The provider had a clear governance framework that supported the delivery of an effectively managed service. We met both the registered manager and the regional manager during our inspection. The registered manager was clear about his responsibilities within the organisation, but also received support from the regional manager. This ensured that higher levels of the management team were aware of what was happening within the service and that the registered manager had direct, senior management support to manage issues.

Care staff had a good understanding of their roles within the organisation and towards people using the service. We saw there were written job descriptions in place which stated what their responsibilities were and care staff had a good understanding of this. One care worker told us "It is very clear what our job is. When I was applying they gave me the job description. They also make it very clear during the induction."

The law requires that providers of care services send notifications of changes, events or incidents that occur within their services to the Care Quality Commission. The provider was aware of their obligation to submit notifications of significant incidents and we found information was reported to the Care Quality Commission (CQC) as required.

The provider had systems in place to ensure that people and staff were engaged and involved in the running of the service. Residents and relative's meetings took place every three months. We saw minutes of these meetings and saw issues were discussed including matters such as the meal service, activities on offer and the laundry service. Staff meetings also took place regularly and these were documented. For example, daily handover meetings took place for morning and evening staff and general staff meetings which took place every three months which included all staff and care staff.

The provider worked effectively with other organisations. This included the GP, physiotherapy team, occupational therapists, speech and language therapists and other professionals as required. Where issues were identified, action plans were put in place and incorporated within people's care plans. We spoke with two healthcare professionals and they commented positively on their working relationship with staff at the service.