

MMCG (2) Limited

# Knights Court Nursing Home

## Inspection report

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### Ratings

Overall rating for this service	Good ●
Is the service safe?	<b>Requires Improvement</b> ●
Is the service effective?	<b>Good</b> ●
Is the service caring?	<b>Good</b> ●
Is the service responsive?	<b>Good</b> ●
Is the service well-led?	<b>Good</b> ●

# Summary of findings

## Overall summary

This unannounced inspection took place on 10 July 2018.

Knights Court Nursing Home provides accommodation and nursing care for up to 80 older people, some of whom may also have dementia. There were 73 people living in the home when we visited.

The home was previously owned by another organisation but was taken over by MMCG (2) Limited. The home was registered with the CQC in July 2017. This inspection on 10 July 2018 was the first inspection for the service under new management.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Some people in the home had complex needs and were therefore unable to provide us with feedback. We therefore spent time observing interaction between people and staff. On the day of our inspection we observed people were well cared for and appeared relaxed and comfortable in the presence of staff. We observed positive engagement between staff and people. Staff were respectful to people and showed a good understanding of each person's needs and abilities.

The majority of people we spoke with told us they felt safe in the home and around staff and this was confirmed by relatives we spoke with. There were systems in place to keep people safe. Staff had received training on how to identify abuse and understood their responsibilities in relation to safeguarding people, including reporting concerns relating to people's safety and well-being.

Risks to people had been assessed, updated and regularly reviewed to ensure people were safe and risks to people in relation to treatment or care were minimised. We also looked at how the skin integrity of people was managed at the home and found that appropriate documentation was in place and the home took necessary action involving relevant parties.

Medicines were managed safely and staff were appropriately trained. However, we found that the home needed to improve record keeping in relation to topical creams applied by staff and we made a recommendation in respect of this.

The majority of people and relatives we spoke with told us that they did not think there were sufficient staffing levels. However, the majority of staff we spoke with told us there were sufficient numbers of staff to safely meet people's individual care needs. We discussed staffing levels with management in detail and they informed us that there were sufficient numbers of staff and confirmed that they assessed this using their dependency tool. They also advised us of the improvements they had made and were in the process of

making in relation to staffing.

On the day of our inspection, we found the home was clean. There was an infection control policy and measures were in place for infection prevention and control. However, on the day of the inspection, we observed that two soiled catheter bags had been left in one person's room. We immediately raised this with a care worker who took appropriate action. We also discussed this incident with the quality and compliance manager who advised that she would carry out an immediate investigation. After the inspection, the manager sent us their investigation report which set out the action the home had taken as well as steps taken to ensure such an incident did not occur again which included further staff training and management checks.

People's needs were regularly assessed to ensure the home was able to provide treatment and care appropriate to people's individual needs. Staff received ongoing training and spoke positively about the training they received. Regular planned supervisions and appraisals ensured staff performance was monitored. All staff we spoke with told us they were well supported by management at the home and said that morale in the home was good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The home operated within the principles of the Mental Capacity Act 2005 (MCA).

Where people were unable to leave the home because they would not be safe leaving on their own, the home had made applications for the relevant authorisations called Deprivation of Liberty Safeguards (DoLS).

People's health and social care needs had been appropriately assessed. Care plans were person-centred, detailed and specific to each person and their needs. Care preferences were documented and staff we spoke with were aware of people's likes and dislikes and preferred routines.

There were mixed comments about food provided in the home. The home had a four weekly menu and it included a variety of different types of foods. There were alternatives for people to choose from if they did not want to eat what was on the menu. During the inspection, we observed people having their lunch in the dining area on one unit. We saw that there was a relaxed atmosphere. Where people required support to eat, staff sat next to them in a respectful manner and took time to assist them to eat.

In January 2018 the Food Standards Agency carried out a check of food safety and hygiene and awarded the service three out of five stars, rating the service as "generally satisfactory". We discussed this with the registered manager who advised that following the inspection the home had taken action to address the issues raised.

Some people in the home had low weight and a low body mass index. We saw there was clear information about how to support these people with their nutritional needs, preferences and clear guidance for staff detailing how to encourage the person to eat.

The home had a varied activities programme which was devised monthly. Activities included reggae music marathon, knitting circle, reminiscing 1940's and prize bingo. The home arranged a monthly entertainer and celebrated calendar events such as Easter, Christmas, St George's Day and St Patrick's Day.

Accidents and incidents were documented and action was taken to prevent future incidences from

happening.

Procedures were in place for receiving, handling and responding to comments and complaints. We saw evidence that complaints had been dealt with appropriately in accordance with the policy.

There was a clear management structure in place and staff told us morale within the home was positive and staff worked well with one another. Staff told us management were approachable and there was an open and transparent culture. They said communication in the home was good and they were informed of changes through staff and handover meetings.

Management consistently carried out comprehensive checks and audits to monitor and improve the quality and safety of the home and took appropriate action when areas for improvement were identified.

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

We always ask the following five questions of services.

### Is the service safe?

The home was mostly safe. On the day of the inspection we found an infection control risk in one person's room and raised it with management.

There were arrangements place in relation to the management and administration of medicines.

Staff were aware of different types of abuse and what steps they would take to protect people.

Risks to people were identified and managed so that people were safe and their freedom supported and protected.

**Requires Improvement** ●

### Is the service effective?

The home was effective. Staff had completed training to enable them to care for people effectively. Staff were supervised and felt well supported by the registered manager.

People's nutritional needs were met.

People were supported to make their own choices and decisions. Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the implications for people living in the home.

**Good** ●

### Is the service caring?

The home was caring. Staff were aware of the importance of being respectful of people's privacy and dignity.

Care plans included information about people's individual needs including their spiritual and cultural needs and the service supported people to meet these needs

The atmosphere in the home was calm and relaxed.

Staff had a good understanding of people's care and support needs.

**Good** ●

### **Is the service responsive?**

The home was responsive. There were various activities available for people to participate in at the home.

Care plans were person-centred, detailed and specific to each person's individual needs.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints.

**Good** ●

### **Is the service well-led?**

The home was well-led. Checks and audits had been undertaken and we saw that these were effective as they highlighted areas where improvements were required.

People and relatives told us that the registered manager was approachable and they were able to raise concerns with her if they needed to.

Staff were supported by the registered manager and told us they felt able to have open and transparent discussions with her.

**Good** ●

# Knights Court Nursing 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.

This inspection took place on 10 July 2018 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the service in our records. This included information about safeguarding alerts, notifications of important events at the service and information from members of the public.

The provider also completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR also provides data about the organisation and service.

During our visit we spoke with eight people who use the service and six relatives. We observed care and support to people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven care workers, four nurses, one activities coordinator and domestic staff. We also spoke with the deputy manager and quality and compliance manager. Following the inspection, we spoke with the registered manager. We also spoke with three care professionals who had contact with the home.

We looked at nine people's care and support records and seven staff personnel files. We looked at other records related to the management of the service such as records of audits and checks, complaints, meeting minutes, maintenance records and health and safety records.



## Is the service safe?

### Our findings

The majority of people we spoke with told us they felt safe in the home and in the presence of care workers. One person said, "I feel safe. The staff are kind. If you want them they come as soon as they can. We have an alarm and they wander around and check on me and ask me how I'm feeling." Another person told us, "I feel very safe. The staff are very good and if I need anything in the night I have an alarm and they always respond if I need to go to the loo." Another person said, "I'm 100% safe. Everyone's frightened I'll fall over and make sure I have a frame."

Two people we spoke with told us that some people with dementia wandered around the home and sometimes went into people's rooms and this made them feel uncomfortable. We discussed this with management and they advised that they would investigate this further and take necessary action.

Relatives we spoke with told us they were confident that people were safe in the home. One relative said, "I think she's very safe. Staff know her and there are nurses around at night who are very helpful." Another relative told us, "Yes, [my relative] is safe. I will say that. 100%." Another relative told us, "[My relative] is definitely safe."

Appropriate risk assessments were in place and demonstrated that the home had identified individual risks to people and put actions in place to reduce these risks. These included preventative actions that needed to be taken to reduce the level of risk to people whilst balancing their wellbeing with the impact on others and the environment. Risk assessments included areas such as personal care, falls, diabetes, moving and handling and behaviour that challenges. Malnutrition Universal Screening Tool (MUST) risk assessments were in place where necessary. These are used to assess people with a history of weight loss or poor appetite. There was documented evidence that risk assessments were reviewed monthly and were updated when there was a change in a person's condition.

We looked at how the skin integrity of people was managed at the home. At the time of the inspection, there were three people with a pressure sore that was at grade three or above. We looked at people's care records to see what care arrangements were in place to manage pressure sores. We saw evidence that pressure ulcer risk assessments were in place which included the use of the Braden scale and Waterlow scoring tool. There was documented evidence that wounds were reassessed and dressed regularly. There was clear photographic evidence showing colour pictures and measurements of ulcers. There were also accurate records of repositioning charts. Wound assessment body maps were in place and we saw that the tissue viability nurse had been involved with people's care. We also saw that necessary pressure relieving equipment was available.

During this inspection, we looked at the efficiency of pressure relieving mattresses at the home. Pressure relieving mattresses are designed to reduce the chance of pressure sores for those people who have mobility problems and spend much of their time in bed. Pressure relieving mattresses were deployed according to risk and people's weight which was monitored monthly and clearly documented on the machines as to the recommended setting. We found pressure relieving mattresses were set at the correct

level with the exception of one person. We raised this with staff and this was addressed immediately.

Staff had received training around tissue viability and pressure sore care. Staff we spoke with had a good understanding of this area of care.

We spoke with people who used the service and relatives and received mixed reviews about staffing levels. One person said, "I don't worry about the number of staff. I get as much attention as I want. The standard of care is very good across the board." However, the majority of people who used the service told us that there were not enough staff. When asked about staffing levels, one person told us, "I can't get outside and it would be nice to go outside, but I need a carer with me and they don't have enough staff to do that. They seem short staffed and get a lot of agency staff." Another person said, "There's not enough staff." Another person said, "There's not enough staff although they're good at their job. They could do with one more permanent carer during the day."

The majority of relatives we spoke with told us that there were occasions where there were not enough staff. One relative said, "There are always key staff who you have complete confidence in but they're sometimes overstretched and rushed, or briefing Agency staff (especially at meal times). Some agency staff are good and some just don't seem to care." One relative said, "Staffing is more of an issue on weekends."

On the morning of the inspection, we were informed by management that three care workers had called in sick and that they were arranging cover from an agency. We noted that cover was arranged appropriately.

The majority of staff we spoke with told us there were generally sufficient numbers of staff. However, they advised that they experienced difficulty when care workers called in sick and they required agency staff to cover shifts. They explained that this created pressure as they had to explain things to agency staff and this took time and took them away from their tasks.

We discussed the feedback received from people, relatives and staff about the staffing levels with management. They explained that the home did not use agency nurses and that nurses were always permanent staff. This ensured that there was consistency in respect of the care people received. The service confirmed they used agency staff to cover care worker shifts but explained that the home worked with agency staff to include them fully in the team by attending staff meetings and receiving training.

We asked how the home determined how many staff they required on each unit and they provided us with the staff dependency tool they used in order to decide this. This included a monthly staffing level report which detailed the number of care hours support the home provided, the dependency level of people and the number of people in the home.

The quality and compliance manager explained that management continuously reviewed staffing numbers depending on people's needs and occupancy levels and at the time of the inspection there were sufficient staffing levels. She further explained that the home had made improvements in respect of staffing within the last year and were still making improvements. She advised that the home was in the process of recruiting another nurse to "bring the establishment to over the 100% budgeted, to provide contingency for absences." She also acknowledged that the staff turnover for care workers had been high but that in response to this the home had recruited a considerable amount of care workers and "have a lot of starters in the pipeline." She also confirmed that absence was consistently managed and "absence hours have reduced by nearly 50%."

In response to the feedback received from people and relatives about staffing, the quality and compliance

manager advised that she would discuss staffing levels with the registered manager. She also explained that she was confident that people and relatives would start to see improvements in respect of staffing with the reduction in agency use, consistency of staffing and leadership by a strong nurse team. She also advised that the home would invite people and relatives to a meeting in due course to discuss staffing levels.

We looked at the recruitment process to see if the required checks had been carried out before staff started working at home. We looked at the recruitment records and found comprehensive background checks for safer recruitment including enhanced criminal record checks had been undertaken and proof of their identity and right to work in the United Kingdom had also been obtained. Two written references had been obtained for staff.

During this inspection, we looked at policies, storage, records, training and systems for medicines management at the home. We found the home was managing medicines safely but needed to improve the record keeping of topical creams applied by staff.

Medicines were stored safely and appropriately including controlled drugs which require additional security and medicines needing refrigeration. We saw that weekly checks were done on all controlled drugs (CD's) and there were records to show nursing staff were quality checking the blood glucose monitor weekly. CD's are drugs liable to misuse, therefore need close monitoring. Unwanted medicines were disposed of appropriately.

We looked at medicine administration records (MAR) and care plans for ten people. The home had recorded important information such as the name, photograph and medicine sensitivities to help staff give people their medicines safely. We found that not all care plans for people had an up to date medicines list and when there was a list of medicines, there was little or no information about what the medicine was for and its side effects. However, medicines listed on the administration record were accurate.

Some people were given their medicines disguised in food or drink (covert administration). This was carried out in their best interest following assessment under the Mental Capacity Act and a documented best interest review, which included an advocate for the person. Nurses signed for each medicine after giving it on the MAR.

Some people were prescribed medicines to be taken on a when required basis. There was guidance in place to advice staff about the when required medicines and these were kept with the MARs. Some people were prescribed creams and ointments to be applied to their body. These were stored in people's own rooms and were applied by care workers. However, records of application were not being managed consistently across the home. Some records of topical creams were kept in people's rooms and others were found with the MARs. Care workers did not have access to MARs and therefore would not know when to apply creams and would not be able to record their application.

We recommend that the provider needs to review their policies and procedures on topical creams recording of creams and provide evidence that they are being applied appropriately.

We saw evidence that people's medicines had been periodically reviewed by their GP. This meant people were being prescribed medicines appropriate for their health condition. People who were on medicines for diabetes had blood glucose tests at regular intervals. This assured us that people were getting the correct doses of medicines for their condition.

Staff received annual medicines training and the provider assessed the competency of staff to ensure they

handled medicines safely. There was a process in place to report and investigate medicine errors. Medicines systems were regularly audited for service improvement.

There was a record of essential maintenance carried out to ensure that people lived in a safe and pleasant environment. There was a daily health and safety checklist which included checks of the premises to ensure they were safe. Safety inspections had been carried out on the hoists and slings. The gas boiler had been inspected. Hot water temperatures were checked and documented. The quality and compliance manager explained to us that the water temperature was controlled to ensure the water temperature did not exceed the recommended safe water temperatures. The electrical installations inspection had been carried out and there was documented evidence of maintenance work carried out on the home's wiring.

There were suitable arrangements for ensuring fire safety in the home. Each person had a PEEP (personal emergency and evacuation plan). There was an evacuation plan for the home. There was an updated fire risk assessment and fire equipment contract. The fire alarm was tested weekly to ensure it was in working condition and fire drills were carried out.

On the day of our inspection, we found the home was clean. Each person's room was cleaned daily. We noted that on the morning of the inspection there was a smell of urine in one of the units. The quality and compliance manager informed us that she was aware of this and took action to address this. We noted that by 12pm this odour was no longer present.

There was an infection control policy and measures were in place for infection prevention and control. On the day of the inspection, we observed that there was a soiled catheter bag containing a small amount of urine propped up and attached to a stand against a piece of furniture. The cone connection was not covered with a cap. In this person's room there was another soiled catheter bag. We raised this with a care worker who immediately identified it as an infection-control hazard and took action to remove the bags. We raised this infection control issue with the quality and compliance manager. She advised that the home would carry out an investigation.

Following the inspection, the quality and compliance manager provided us with the investigation report. This detailed the action that the home had taken following the incident which included a staff meeting to discuss the incident with all staff and ensure that they were aware of their responsibilities in respect of this and necessary action they should take. They also advised that the staff involved in the incident would complete a competency assessment and that the person's risk assessment would be updated to include this risk. The report also detailed that a member of senior staff would ensure that daily walk arounds would also cover infection control risks.

Staff had received training in safeguarding adults procedures and knew what to do if they had concerns a person was being abused. Care workers and nurses knew about the different types of abuse, told us they would immediately report any concerns, and knew to contact the local safeguarding authority if necessary. Our records showed that the home had responded appropriately to allegations of abuse and cooperated with local authority investigations.

The home had a whistleblowing policy and contact numbers to report issues were available. Staff were familiar with the whistleblowing procedure and were confident about raising concerns about any poor practices witnessed.

Accidents and incidents had been consistently recorded. This included information about the accident/incident as well as action taken by the home.

## Is the service effective?

### Our findings

People told us they were generally satisfied with the care provided by staff at the home. One person said, "The care is good and if I need anything I can ask for it and they'll respond." Another person said, "I'm very happy here".

Relatives we spoke with told us they were confident that permanent staff had the necessary skills to effectively look after people. One relative told us, "The permanent staff are excellent. They know people's needs well." Another relative said, "The care staff are very good."

Staff received training to ensure that they had the skills and knowledge to effectively meet people's needs. Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included manual handling, safeguarding adults, infection control, first aid, fire awareness, dementia awareness, food safety and infection control. Staff we spoke with told us that training was helpful and it helped them ensure they carried out their roles and responsibilities effectively. Management also ensured that staff completed competency assessments in various areas to ensure they had the necessary knowledge and skills.

Staff had undergone a period of induction to prepare them for their responsibilities. The induction completed was in accordance with the Care Certificate. This provides an identified set of standards that health and social care workers should adhere to in their work. Newly recruited staff spent time shadowing more experienced staff as part of their induction. This enabled people who used the service become familiar with new staff whilst accompanied by staff they were familiar with.

All staff we spoke with spoke positively about working at the home. They said that staff worked well as a team and received the support they needed from their colleagues and management. They told us that management encouraged staff to develop their skills and knowledge and promoted progression within the service. One member of staff told us, "Management encourage me to progress in my role. Training is always there." Another member of staff said, "We have good training. This company are really good with training. They motivate you to have more qualifications." Another member of staff said, "There are good opportunities here."

Feedback we received about the food provided in the home was mixed. When speaking about food in the home, one person told us, "I like the food – we haven't got much choice but it's quite nice". Another person said, "The food is very good – well prepared, well delivered and you have a choice." Another person told us, "The food isn't brilliant but has improved. One chef is good and the other not so good." Another person said, "Sometimes the food is alright and sometimes I don't fancy it. It doesn't look very appetizing. It looks overcooked."

The home had a four weekly menu and it included a variety of different types of foods. There were alternatives for people to choose from if they did not want to eat what was on the menu. During the inspection, we observed people having their lunch in the dining area on one unit. We saw that there was a

relaxed atmosphere. Dining tables were laid attractively. However, we noted that the food menu displayed did not reflect what was offered and was for a different day. We raised this with management who confirmed that they would ensure that this was dealt with appropriately. People sat at tables with one another and were able to engage with staff and people. Where people required support to eat, staff sat next to them in a respectful manner and took time to assist them to eat.

Care records showed that nutritional needs of the people who used the service were met. We observed some people had low weight and a low body mass index and saw that there was clear information about how to support the person with their nutritional needs, preferences and clear guidance for staff detailing how to encourage the person to eat. People's weights were recorded monthly so that the service was able to monitor people's nutrition.

In January 2018 the Food Standards Agency carried out a check of food safety and hygiene and awarded the service three out of five stars, rating the service as "generally satisfactory". We discussed this with management who advised that following the inspection the home had taken action to make improvements.

On the day of the inspection, we found the kitchen was clean and there were sufficient quantities of food available. There was documented information in the kitchen which showed each person's specific dietary needs and preferences.

The home carried out a dining experience/mealtime audit every two months. This was carried out by management and involved reviewing the environment, staff interaction and the quality of food. Where necessary an action plan was in place with details of areas of improvement with a timescale.

The home provided care which was individualised and person-centred. People and their representatives were involved in planning care and support provided. People's needs had been assessed prior to them moving into the home. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs. Care plans were prepared with the involvement of people and their representatives and were personalised. Care plans were reviewed monthly by staff and were updated when people's needs changed. Regular reviews enabled staff to keep up to date with people's changing needs and ensured that such information was communicated with all staff.

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. We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We noted that care records contained mental capacity assessments including information about people's mental state and cognition. Staff had knowledge of the MCA and training records confirmed that the majority of staff had received training in this area. Staff we spoke with were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and social care professionals would be involved in making a decision in the person's best interests.

We also found that, where people were unable to leave the home because they would not be safe leaving on their own, the home had made applications for the relevant authorisations called Deprivation of Liberty Safeguards (DoLS). We noted that the home had made necessary applications and some authorisations were in place and some were awaiting approval which management was fully aware of.

People had their healthcare needs closely monitored. Care records of people contained important information regarding medical conditions, behaviour and any allergies people may have. There was evidence of recent appointments with healthcare professionals such as people's dentist, optician and GP. Information following visits by GP and other professionals were documented in people's records.

## Is the service caring?

### Our findings

The majority of people we spoke with told us they were well cared for in the home and that they were treated with respect. One person told us, "The permanent staff are all kind and helpful." Another person said, "Permanent staff are definitely kind and helpful. They're good to me. I have a regular nurse on every day and I feel I can talk to them." Another person said, "The regular staff are very kind." However, one person told us, "Staff are average. If they can help they will do but they might have something else on."

Relatives spoke positively about the care provided in the home. One relative said, "The majority of staff are great. One or two maybe not. Some staff are fabulous." Another relative said, "The team is excellent. On the whole the care is absolutely super. First class." Another relative said, "The staff are caring."

During the inspection, we spent time observing the atmosphere in the home and interaction between people and staff. We saw that people were relaxed and appeared comfortable in the presence of staff. Nurses and care workers were patient when supporting people and communicated with them in a way that they understood. We observed people were treated with respect and dignity.

Management explained that they had systems in place to ensure staff interacted with people in a positive and meaningful manner. The registered manager carried out a daily walk around of the home observing interactions and checking on the care provided. The quality and compliance manager also carried out monthly audits looking at observations of care, staff interactions, activities provision and dining experience. Staff had also received training around interaction. Some staff attended a Virtual Dementia Bus training in February 2018. This training was practical hands on course which enabled staff to experience what it's like to have dementia. Senior staff also completed Leadership and Dignity in Care training in February 2018.

Staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. They also understood what privacy and dignity meant in relation to supporting people with personal care. We saw staff knocked on people's bedroom doors and waited for the person to respond before entering. Bedroom and bathroom doors were closed when staff supported people with their personal care needs.

The home had a policy on ensuring equality and valuing diversity and staff had received training in ensuring equality and valuing diversity. They informed us that they knew that all people should be treated with respect and dignity regardless of their background and personal circumstances. One care worker we spoke with told us, "I treat people as though they are my grandparents. I interact with people and ask how they are. I talk to them. I always respect people's wishes." Another care worker said, "Communication is key. This helps to make them feel valued. I ask them. I give people choice." Another care worker told us, "I always knock on doors. Talk to people. I tell them what I am doing to do. I explain things to them."

Care records included information about people's likes, dislikes, interests and hobbies. Care records also included information about people's background and the home used this information to ensure that equality and diversity was promoted and people's individual needs met. Care support plans included



detailed information about people's individual cultural and spiritual needs. Each person's care records included a section detailing people's religious and spiritual beliefs. Care records we looked at contained a good level of detail in respect of this which enabled staff to support people meet these needs.

The home supported people to continue practising their beliefs for example by helping them to access church ministers, local leaders or any other representation of their chosen culture or religion.

Kitchen staff were fully aware of people's cultural meal requests and we saw that this information had been documented. Halal, Kosher and vegetarian meals were provided for some people who used the service.

People were supported to maintain relationships with family and friends. Relatives told us that they were well treated whenever they visited the home and they were kept informed about their family member's progress.

We discussed the Accessible Information Standard [AIS] with the provider. The Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand. It is now the law for the NHS and adult social care services to comply with AIS. The quality and compliance manager explained that the home ensured that each person's AIS needs were assessed at preadmission and admission stages. This was then recorded in the communication section of people's care plans and we saw evidence of this. Further, the home's audits look at whether a person's AIS needs were met and action required is documented. We also noted that some policies were available in large print and pictorial format.

The home had a comprehensive service user guide which was provided to people who used the home. The guide provided useful and important information regarding the service and highlighted important procedures and contact numbers.

## Is the service responsive?

### Our findings

People and relatives told us the home was responsive to their needs and they felt able to complain if they needed to. One person said, "I don't have any complaints. I can tell people if something is worrying me." Another person told us, "I've never raised a complaint. If I raise any concerns though, they do respond." Another person said, "Generally, they're quite responsive." One relative said, "The manager is very responsive. I have raised issues with no problem. She responds. I have raised issues at the relative's meetings and the new management have responded."

There was a comprehensive complaints policy which was displayed throughout the home. This detailed the procedures for receiving, handling and responding to comments and complaints. The home had a system for recording complaints and we observed that complaints had been dealt with appropriately in accordance with their policy. We noted that complaints were audited monthly by senior management to ensure that the home had addressed these and taken appropriate action.

The home had a varied activities programme which was devised based on people's individual interests. The home had two full time activities coordinators who were responsible for arranging activities. There was a monthly activities timetable in place and the activities coordinator explained that they planned activities in advance. We looked at the timetable for July 2018 and found that there were various activities available such as a reggae music marathon, knitting circle, reminiscing 1940's and prize bingo. The home also provided a popular activity called "storytelling with Billie". This was provided by an external person who provided people with a choice of pictures and then asked people to create a story from the pictures. This activity encouraged people to engage with one another. We also saw evidence that a garden party was arranged for the end of July. The home arranged a monthly entertainer and celebrated calendar events such as Easter, Christmas, St George's Day and St Patrick's Day.

There was a therapeutic programme for people who were bedridden and an activities coordinator we spoke with explained that they ensured they spent time interacting with these people. He explained that they did one to one room visits twice a week.

An activities coordinator explained that the home was in the process of refurbishing and developing the home's garden. He showed us the plans for this and explained that there were plans to have a water feature and various sensory areas.

The home had a weekly newsletter called "Weekly Sparkle". This provided information about world events that had occurred on the same date but in different years as well as a section called, "The way we were" which provided information that people could relate to. There was also a quiz included. The aim of this newsletter was to enable people to reminisce and encourage people to talk with one another and have topics to discuss.

Quarterly meetings were held for people living at the home and relatives where they could give their views on the day to day running of the home. It also provided people an opportunity to come together to discuss

issues and meet one another.

Since the home registered with the CQC in July 2017, the home had not yet carried out satisfaction surveys. We discussed this with management. The quality and compliance inspector explained that the next satisfaction survey would be carried out in 2018. The home had carried out a satisfaction survey in 2017.

People's care plans and risk assessments were reviewed at least six monthly by the home with people using the service and when applicable people's relatives to ensure that that they reflected current needs. The provider told us people's care needs were also reviewed when their needs changed and we saw documented evidence of this.

People receiving end of life care had the appropriate plans in place. They also had "Do not attempt cardiopulmonary resuscitation" (DNACPR) forms in place. DNACPR forms we viewed were signed by the GP, relatives and nursing staff and were up to date. There were also care plans in place which clearly stated the end of life wishes for people.

## Is the service well-led?

### Our findings

The majority of people and relatives spoke positively about management at the home and said they found them to be approachable and felt comfortable raising queries with them. One person said, "I think the management is alright. I get the impression that things are well run and nobody seems to have any complaints. I see the manager daily and she asks me if I'm comfortable and if I have any complaints." Another person told us, "It's very well run. The manager is very nice. I see her every day normally." Another person said, "I think they have the right person in [the registered manager] running it. I have 100% confidence."

Relatives spoke positively about the registered manager and the majority of them said that they had confidence in her and the management at the home. One relative said, "The manager is brilliant. I can come and see her whenever I like." Another relative told us, "[The registered manager] is excellent." Another relative said, "The manager is a terrific lady. She knows her patients. She responds. I go to [the registered manager] and it is done. She is dedicated to the patients. She is so professional and always in good spirits." However, another relative said, "There have been changes with management. The communication about this could have been better."

A manager had been registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

There was a management structure in place with a team of nurses, care workers, kitchen and domestic staff, the clinical lead, the deputy manager and the registered manager. The home had appointed a new deputy manager in May 2018. Feedback from staff was generally positive about the management team. They told us the morale within the home was very good and that staff worked well with one another. They told us management was approachable and the service had an open and transparent culture. One member of staff told us, "The manager is very supportive. Her door is always open." Another member of staff said, "The manager is very good. She is very supportive. She helps with tasks and gets involved. She appreciates our hard work." When speaking about the registered manager, one member of staff told us, "She manages very well and if I raise issues, she deals with it straight away. She listens and points me in the right direction. She is very supportive and is really accommodating and understanding."

There was a system in place to obtain feedback about the level of care provided to people. These were carried out by the registered manager and quality and compliance manager and covered various areas relating to care people received, maintenance and management of the home. Management also carried out monthly and quarterly audits in respect of care documentation, health and safety, safeguarding, medicines, complaints/compliments, infection control, activities, staff files and training. These were comprehensive checks which looked at various aspects including accidents, staffing, health and safety, complaints, training competence. We noted that audits detailed a list of actions required and a timescale agreed for completion. The quality and compliance manager explained that this ensured that the service dealt with areas for

improvement timely.

We saw evidence that management carried out regular observations around the home and these were documented. It was evident that where areas of improvement had been identified, the home had taken necessary action to improve as a result and this was documented.

We observed care documentation was well maintained, up to date and comprehensive. The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.