

GCH (South) Ltd

# Kent House

## Inspection report

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Good** ●

Is the service caring?

**Good** ●

Is the service responsive?

**Good** ●

Is the service well-led?

**Good** ●

# Summary of findings

## Overall summary

### About the service

Kent House is a residential care home providing personal care and accommodation to 36 people aged 65 and over. At the time of the inspection the service supported 36 people.

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

We have made a recommendation about the management of some medicines. We judged that improvements were required to the medicines audit system used at the home. This is because, in as much as audits were being undertaken, they had not identified some of the gaps we found during this inspection. Apart from this, we found people were protected from the risk of harm and abuse. There were safeguarding policies and procedures in place and staff were aware of this. Staff had been recruited safely. They underwent appropriate recruitment checks before they commenced working at the service. This same scrutiny was subjected to volunteers who worked at the home.

There was a system for managing accidents and incidents to reduce the risk of them reoccurring. There were adequate systems for reviewing and investigating when things went wrong. Staff understood their duty to raise concerns and report incidents and near misses.

There was evidence of on-going and relevant staff training. People told us staff had the right skills to support them safely. There was an infection control policy and measures were in place for infection prevention and control. The environment was clean. Staff wore personal protective equipment (PPE) such as gloves and aprons.

People received individualised care that met their needs, preferences and interests. People were supported, if needed, to express their views and preferences in relation to their care and support. The service identified and recorded how people wished to communicate and their communication needs. Assessments of people's needs were in place. There was evidence of improved safety of people, including reduction of falls and pressure ulcers. This showed risks were being managed properly.

The environment had been adapted to meet their specific needs of people with dementia. People received co-ordinated input from a range of specialist services, such as psychiatrists, health professionals and community pharmacists.

People's nutritional needs were met. They had been involved in drawing up the menu plans, and choices were regularly adapted in line with their preferences. Specific needs in relation to equality and diversity issues were recorded in people's care plans and addressed. The menu plans fully catered for different cultures and cuisines.

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

this practice. When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed.

People were supported and treated with dignity and respect. People's relatives confirmed that staff were kind and caring. People's care records contained information about their choices and independence. The service recognised people's rights to privacy and confidentiality. Confidentiality policies had been updated to comply with the new General Data Protection Regulation (GDPR) law.

There was a complaints procedure, which people and their relatives were aware of. The procedure explained the process for reporting a complaint□

There were methods of monitoring the quality of the service in place. Regular checks and audits had been carried out in areas related to maintenance of the premises, health and safety, medicines management, infection control and management of accidents and incidents. Although we found shortfalls in medicines management, the home rectified the concerns raised during and soon after our inspection. We judged, the likelihood of this happening again in the future was low. Therefore, we judged the service to be 'Good', overall.

Rating at last inspection:

At our last inspection, the service was rated "Requires Improvement". Our last report was published on 30 January 2019.

Why we inspected:

This was a scheduled inspection based on the previous rating.

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

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

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Details are in our effective findings below.

**Good** ●

### Is the service caring?

The service was caring.

Details are in our caring findings below.

**Good** ●

### Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

**Good** ●

### Is the service well-led?

The service was well-led.

Details are in our well-Led findings below.

**Good** ●

# Kent House

## Detailed findings

### Background to this inspection

#### The inspection

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

#### Inspection team

The inspection team consisted of one inspector, a nurse specialist 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.

#### Service and service type

Kent House is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

The inspection was unannounced.

#### What we did:

We reviewed information we had received about the service since the last inspection. We assessed the information in the provider information return. This is key information providers are required to send us about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection, we spoke with 14 people who used the service, to ask about their experience of the care provided and two visiting family members. We observed staff providing support to people in the

communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether they were comfortable with the support they were provided with.

We spoke with 10 members of staff including the deputy manager, registered manager, regional manager, quality manager, chief executive and five care staff.

We reviewed a range of records about people's care and how the service was managed. This included care records of nine people and 11 people's medicines administration records. We reviewed records of meetings, staff rotas and staff training records. We also looked at records of accidents, incidents, complaints and quality assurance audits.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as Require Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Using medicines safely

- We reviewed 14 medicine administration records (MARs). Each person had their own profile sheet which contained information to correctly identify the person and to assist staff to administer medicines safely.
- We asked people if they took their medicines on time and they told us, "I would say so. I take my medicines on time" and "Yes, I take my medicines on time."
- Some medicines were prescribed to be given when required (PRN). Plans were in place to guide staff on what the medicines were for and the administration was clearly recorded. This assured us that staff could make an informed judgement to appropriately administer these medicines.
- Prescribed medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely and we saw evidence of appropriate stock balance checks. This assured us that medicines were available at the point of need.
- High risk medicines such as anticoagulation medicines and insulin were managed safely. Anticoagulation books were present and up-to-date for people using these medicines. People who take anticoagulants (blood thinners), are required to have a regular test and this was being carried out by the GP service.
- That said, we still found some discrepancies in the supply chain, from ordering, storage and administration. For example, on the first day of the inspection, we observed that the process of administering medicines had not been adhered to. Six people were given their medicines in succession before their MARs were signed. We also noted some medicines which had been administered had not been signed for at the time. We raised this with senior management who told us the staff concerned would be offered refresher training.
- On the first day of the inspection we observed a medicine requiring refrigeration was not being stored in the medicine's fridge in accordance to its storage instructions. We raised this with the provider. However, we could not ascertain how long it had been left out for. This medicine was discarded, and a replacement was received on the same day.
- On the second day of the inspection we found that the home had rectified some of the areas we had identified as falling short. Furthermore, the home had identified concerns with medicines ordering and this was being rectified at the time of our inspection. They were also exploring opportunities to establish clear and active links with community pharmacists and other stakeholders in the medicines supply chain to improve medicines management.
- In our conclusion, we have judged that improvements were required to the medicine audit system used at the home. This is because, in as much as audits were being undertaken, they had not identified some of the gaps we found during this inspection.

We recommend the provider seeks advice and guidance from a reputable source, about the management of

medicines.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm and abuse. There were safeguarding systems and processes to support staff to understand their role and responsibilities to protect people from avoidable harm. Staff had received safeguarding training to ensure they had the skills and ability to recognise signs of abuse. They knew and were able to tell us about the signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager or where appropriate, the local authority or Care Quality Commission (CQC).
- People told us that they felt safe. One person told us, "I feel safe here". This was confirmed by other people spoken with. Safeguarding information was on display in the communal hallway, which provided staff with immediate access to information and guidance on how to report any concerns about people's safety. This was also available in easy to read so that it was accessible to a wider audience.

Staffing and recruitment

- Staff had been recruited safely. They underwent appropriate recruitment checks before they commenced working at the home, which included at least two references, proof of identity and Disclosure and Barring Service checks (DBS). The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.
- Review of staff rosters confirmed there were enough staff deployed to provide care and support to people when they needed it. We observed staffing levels throughout the day and we could see that staff were busy, but they had time to engage with people. A staff member told us, "I like to spend time with people and I try my best to make time, but sometimes this can be hard as we are busy."
- We noted there was also a team of volunteers who undertook a range of roles throughout the home. Similarly, relevant recruitment checks had been carried out, including their training and qualifications.

Assessing risk, safety monitoring and management

- There were effective systems and processes in place to minimise risks to people. Prior to people using the service, people were assessed to inform care plans and risk assessments. There were a variety of care plans and risk assessments in place for people who may have needed further provision and help to keep them safe.
- There was information to guide staff to minimise risk to people. For example, one person was at risk of developing pressure sores and their support plan contained a set of instructions to reduce the risk. Another person had diabetes and was at risk from the effect of high and low blood sugar levels. Likewise, their support plan contained action to be taken to minimise risk.
- There was evidence of improved safety, notably in the reduction of falls and pressure sores. For example, since our last inspection in September 2018, none of the people at risk or any other had developed pressure sores.

Preventing and controlling infection

- The environment was clean. There was an infection control policy and measures were in place for infection prevention and control. There were arrangements in place for managing waste to keep people safe. Staff wore personal protective equipment (PPE) such as gloves and aprons.
- We were concerned, as we saw a communication relating to the storage of urine samples in the medicine's fridge. However, we saw no evidence of the urine samples being stored in the fridge during our inspection. We suggested the review of this communication.

Learning when things go wrong

- Accidents and incidents were monitored. There were adequate systems for reviewing and investigating



when things went wrong. Staff understood their duty to raise concerns and report incidents and near misses.

- The service had identified themes and acted to improve safety. For example, on the second day of this inspection, we saw that improvements had been made in medicines management.

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- People received effective care, based on best practice guidance. Agreed goals of care were delivered in line with standards, guidance and the law. For example, the service followed guidance from reputable sources such as the National Institute of Health and Clinical Excellence (NICE). The registered manager agreed that standards for medicines optimisation could be improved upon.
- The service carried out assessments of people and developed person-centred care plans. These identified people's likes, dislikes, medical and mental health needs. People's choices had been considered. We asked people if they liked the food offered, including whether they could choose what they wanted to eat. One person told us, "I am happy with meals and choices available. I like fish on Fridays. Staff come around and ask me and this is supported." This was confirmed by other people spoken with.

Staff support: induction, training, skills and experience

- Staff had knowledge of people's care and treatment needs and were skilled and confident in their practice. They confirmed their training was comprehensive and up to date, which we saw from their records. This included, moving and handling, medicines management, safeguarding, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People and their relatives were complementary. Comments made included, "The staff are competent and friendly."
- New staff had completed an induction programme based on the Care Certificate framework. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. New staff shadowed experienced members of staff until they felt confident to provide care on their own.
- Staff spoke positively about their line management. They described management in complementary terms such as, approachable, open-minded and reliable. We evidenced staff received regular supervision and yearly appraisal of their performance.

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

- People's nutritional needs were met. Everyone had a nutritional assessment and those at risk of malnutrition were referred to relevant healthcare professionals, including, GP, speech language therapists (SALT) and dieticians.
- People's dietary requirements were known to staff. Staff had taken steps to meet people's nutrition and hydration needs. For example, one person was on soft diet and normal drinks. Another person was on an iron rich diet due to having anaemia. In either example, there was a plan of recommendations from the SALT team outlining suitable food for these diets.

- People were provided with a choice of suitable and nutritious food to ensure their health care needs were met. We observed people having their lunch. There was a comfortable atmosphere and food appeared appetising and plentiful. Lunch menus on the tables reflected the food options of the day. There were four main options and two deserts.

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

- Some people living at the home had dementia. The environment had been adapted to meet their specific needs. Items of familiarity were in place to support them with orientation and reminiscence. This was consistent with current evidence, which suggests benefits of reminiscence for people living with dementia.

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

- People were supported to maintain good health and have access to healthcare services. We saw documented evidence of this. Care records included information about appointments with health and social care professionals such as GPs, allied health professionals and community pharmacists.
- Referrals to the health care professionals were made in a timely way. There was evidence of regular scheduled visits by GP, occupational therapists (OT), speech and language therapists (SALT), and important others to review people's care. Staff recorded and followed advice and instructions from them.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Mental capacity assessments and best interest decision forms had been completed for specific decisions. People were always asked for their consent before staff could proceed with support. Where possible, people, or their next of kin, had signed the care records to show that they had consented to planned care.
- Early and ongoing opportunities for advance planning were offered to people living with dementia so that they were fully involved in their care.
- The home had ensured that covert administration of medicine took place in the context of existing legal and good practice frameworks. In one instance we saw that an appropriate process had been followed for covert medicines administration. The GP and the family had been involved. However, the same process had not been replicated when changes in medicines had occurred. We raised this with the provider, who took swift action.
- There were 12 people who were subject to a DoLS for their safety. Conditions on authorisations to deprive people of their liberty were being met. This was monitored to ensure people did not remain restricted unnecessarily even when their needs changed.

# Is the service caring?

## Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity

- The home promoted equality and diversity. Staff understood and addressed people's religious and cultural needs. They had received training in equality and diversity. There was a policy and procedure to guide staff around ensuring people were not discriminated against on grounds of diversity.
- People's spiritual or cultural wishes were respected. One person of Afro-Caribbean background liked Caribbean food, and we saw the menu plan included Caribbean salt fish, callaloo dish and yam. Drinks such as coconut water and ginger beer were included in the person's care plan. Another person from Hindu background had their meals according to Hindu dietary custom, including vegetarian meals.
- Religious services were held at the home. Representatives of local churches visited the care home regularly for prayers with people.

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

- There were systems and processes to support people to make decisions. As stated, the home complied with the provisions of the MCA 2005, which meant people were involved in making decisions about their care.
- The home received feedback in a variety of ways and acted to improve people's care. Regular meetings were held to gain people's feedback, which were recorded. There was also a 'you said, we did' board, which encouraged staff and people to think of what could be improved.
- The menu plans provided a varied selection of meals based on people's likes and on individual nutritional needs. People's choices for meals and drinks were regularly adapted in line with their preferences. Those people who did not choose from the menu were offered alternatives.

Respecting and promoting people's privacy, dignity and independence

- People told us that staff respected their privacy and dignity. They told us, "My privacy and dignity are respected", "Staff are always respectful" and "My privacy is respected. I don't have any complaints." We observed staff spoke with people in a respectful way, giving people time to understand and respond.
- Staff communication with all people was warm and friendly, whether conversations were outwardly meaningful or not.
- People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. They supported people to manage as many aspects of their care that they could. For example, people were supported to maintain their independence to eat meals at their own pace without being rushed.
- Privacy and confidentiality were maintained in the way information was handled. Staff made sure

information about people was always kept confidential. Confidentiality policies had been updated to comply with the new General Data Protection Regulation (GDPR) law. People's care records were stored securely in locked cabinets in the office and, electronically, which meant people could be assured that their personal information remained confidential.

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's needs were met through good organisation and delivery.

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

- People's support plans gave an account of their needs and actions required to support them. Staff were knowledgeable about people's needs. They knew people well and could describe to us how people liked to be supported.
- All the information that staff would need to know about people's care was available in an easy to read, point by point format. For example, a care plan of one person with diabetes reflected their diabetes status and a plan to support them safely. Their moving and handling assessment considered any possible diabetic neuropathy pain (diabetic neuropathy affects legs and arms, causing numbness and tingling sensation). Their eating and drinking care plan highlighted they had diabetes, and therefore their dietary requirements. An effective plan for managing low and high blood sugar levels was also in place.
- Less positively, some care plans for people living with mental health conditions or dementia could have been more detailed. For example, one person lived with a mental health condition. Although their care plan highlighted associated symptoms of their mental health condition, it did not specify what the mental health relapse indicators were or what behavioural changes staff needed to look for. Even though we found no instances where care needs had been neglected, there was a risk that staff might miss specific relapse indicators and therefore delay interventions. On the second day of the inspection, the home had begun to review relevant documentation.
- People were offered a variety of activities and outings, both in groups and as individuals. There was a programme of activities organised by the home. There were board games, musical instruments, sensory items and art materials, all of which were accessible to people. People's artwork was displayed in the hallway. A picture board in the hallway showed people's scheduled activities, some of which we observed taking place during this inspection.
- Commenting about activities provided at the home, one person told us, "I like the guardian crossword. There are a variety of activities here." Another person said, "I get to the pub for a pint and lunch." Relatives were as complementary, with one commenting, 'We have been very impressed with the care given at Kent House so far. People are well looked after and regularly stimulated with activities.'

Meeting people's communication needs

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

- People were supported, if needed, to express their views and preferences in relation to their care and support. The service identified and recorded how people wished to communicate and their communication needs. People's care plans contained details of the best way to communicate with them and staff were following these. For example, there were pictorial meal choices. One person who was visually impaired had been supported with audio reading material.

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

- The home supported people to maintain their relationships. They used information technology (IT) to support people who had relatives and friends who lived away from the home. A relative had found this to be beneficial as they were able to visually interact with their loved one. The relative had commented, 'We live abroad and enjoy watching all the activities. Our relative looks happy. My siblings have only good things to say about Kent House and the staff.'
- We observed people's relatives could visit at any time and were welcomed. Relatives told us that they were invited to special events held at the home, including birthdays and all other events. People also told us they took trips with family members to local cafes.

Improving care quality in response to complaints or concerns

- There was a complaints procedure, which people and their relatives were aware of. The procedure explained the process for reporting a complaint. Relatives told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with.
- Two complaints had been raised in the last 12 months, which had been investigated and concluded satisfactorily.

End of life care and support

- There was documented evidence that the home had considered advance wishes. End of life care plans were in place and included diagnosis and prognosis, next of kin contact arrangements, directives, wishes and concerns.
- Staff had received end of life training. There was an end of life champion at the home. One person was receiving end of life care. Their file contained documented information about end of life preferences and needs. This included information about whether people wished to remain at the home rather than being admitted to hospital. We saw that family members had been involved in supporting people with these decisions where required.
- The home participated in the end of life project, which was facilitated by a local hospice. This meant all people receiving care at the home were registered to a single point of access service (SPA). The aim of SPA was to improve people's experience, by coordinating care for those receiving end of life care and facilitating real choice over the place of care and death and increased the number of people at the end of life who achieved their preferred place of care and death. We saw evidence these goals were being met.

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- In as much as some care files could have been expanded for detail, people were receiving care and support that was tailored to their needs. There was evidence that staff had regular meetings with people to discuss aspects of people's care. The service also sought feedback from professionals, people, and their relatives which was acted on.
- People experienced good care, as evidenced by good health outcomes notably in areas such as pressure sore prevention. We also noted prevention of acute sector admissions, which meant people remained and died in their preferred place of death.

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

- The leadership complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of notifiable events and other issues.
- The registered manager had kept care records related to the management of the service well maintained and up to date.

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

- The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet people's needs. These addressed topics such as end of life care, equality and diversity and safeguarding.
- We judged that the medication policy was limited. The process for reporting medicines incidence was not well explained. This had been corrected by the time we undertook second visit, on the next day.

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

- People and their relatives, staff, health and social care professionals were involved in the way the service was run. There was evidence of regular visits by GP or other health care professionals to carry out routine reviews or attending to people's changing needs.
- The home used a range of information gathering approaches, including surveys and meetings. The home's website and Facebook were also used as feedback platforms, amongst other purposes. We saw from the



service improvement plan that the home had acted on this feedback.

- The registered manager was knowledgeable about the characteristics that are protected by the Equality Act 2010, which we saw had been fully considered in relevant examples.

#### Continuous learning and improving care

- There was an ongoing effort to improve the service. Regular checks and audits had been carried out in areas related to health and safety, infection control and many more. Improvements had also been acknowledged in a recent report by the local authority.
- At our previous inspection we had identified unsafe practices in areas such as risk assessments and dementia care. Additionally, staff had not received regular supervision and appraisals. At this inspection we saw that improvements had been made.
- The home had received positive reviews from Care Homes UK, achieving a score of 9.7 out of 10. The provider, Gold Care Homes, was nominated in the top 20 Care Home Group Awards 2019. The award highlighted the most recommended Care Home Groups in the UK.
- Less positively, we found some issues with medicines management. Although there was no current impact on the people receiving care, our own judgement was that, the system of audits used at the home should have helped to identify some of the irregularities found. However, the home rectified the concerns raised during and soon after our inspection. Therefore, the likelihood of this happening again in the future was low. Therefore, we have judged the home to be 'good' overall.

#### Working in partnership with others

- People received care from a range of healthcare professionals. There was a reliable communication system across all the disciplines. The home was also exploring the possibility of working with the Clinical Commissioning Group, medicines management team.
- As stated, the home used the single-entry point access system. This provided advice and a co-ordination service through a single telephone number, 24 hours a day, seven days a week for emergencies relating to end of life care. Direct care was also delivered through the rapid response team between the hours of 7am until 11pm. Palliative care registered nurses from a local hospice were also involved.