Sanctuary Care Limited

Princess Louise Kensington Nursing Home

Inspection report

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26 February 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our last comprehensive inspection of this service took place on 24 and 25 November 2016. We rated the service 'Requires improvement'.

At this inspection we found improvements had been made in relation to medicines management. People using the service and their relatives told us staff were kind and caring and that the service had improved. However, plans to re-install kitchen facilities within the home had stalled. This meant the service was unable to provide meals that were freshly prepared and cooked on site. People's views were not always positive when asked to comment on the quality of the food provided at mealtimes.

We rated the service 'Good' overall.

This inspection took place on 22 and 26 February 2018. The first day of the inspection was unannounced. The registered manager was informed that we would be returning for a second day to complete our visit.

Princess Louise Kensington Nursing 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 service is set out over three floors and provides nursing and accommodation to 44 adults with complex continuing care needs. An NHS rehabilitation unit occupies most of the ground floor and is operated as a separate registered service which was not visited as part of this inspection. Two upper floors are divided into four units. The first floor is primarily for people living with a diagnosis of dementia with the second floor providing nursing care and support to elderly frail residents. The home is fully accessible, with a lift serving all floors. There were 40 people living at the home at the time of inspection.

The service had a registered manager in post. 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.

Where possible, people were involved in decisions about their care and how their needs would be met. Where appropriate, relatives and healthcare professionals contributed to the care planning process.

Systems were in place to identify and reduce risks to people living in the home. Risk assessments and management plans were in place to mitigate risks in relation to people's mobility, nutrition, personal care, physical and mental health and well-being.

People were protected from avoidable harm and abuse because the provider had effective safeguarding systems in place. Staff understood how to recognise the signs of abuse and told us they would speak to

nurses and the registered manager if they had concerns about a person's safety or welfare.

People's medicines were managed and administered safely. People's current medicines were recorded on medicines administration records (MAR) along with their allergy status in order to prevent any inappropriate prescribing. Medicines audits were completed weekly and checked by senior staff members.

The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss.

Recruitment practices ensured the right staff were recruited to support people to stay safe. Staff were appropriately trained and skilled to care for people and understood their roles and responsibilities. Staff received supervision and guidance where required and confirmed they felt supported by the registered manager.

Staff had received training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). These safeguards are there to make sure that people receiving support are looked after in a way that does not inappropriately restrict their freedom.

People's human rights, privacy and dignity were respected and promoted. Staff told us they always asked people's permission before providing support and respected people's individual preferences.

Staff supported people to attend healthcare appointments as required and liaised with people's relatives, GPs and other healthcare professionals to ensure people's needs were met appropriately.

The provider maintained positive relationships with multi-disciplinary professionals, commissioning and safeguarding teams.

Staff sought advice and guidance from palliative care teams when needed to ensure people remained comfortable and supported at the end of their lives.

The service employed a full-time activities co-ordinator and a range of one to one and group activities took place within the home. Staff demonstrated a good knowledge of the people they cared for and encouraged them to maintain their usual routines.

People and their relatives, visitors and staff were asked for their views about the running of the service via regular meetings, feedback forms and annual surveys. People were positive about the home environment and the support they received from staff.

People and their relatives felt able to raise concerns and were confident that any issues would be dealt with satisfactorily and in a timely manner.

Monthly audits were carried out across various aspects of the service; including the administration of medicines, care plans, infection control and health and safety checks.

Good infection control practices were followed. The home was clean and tidy and free from any unpleasant odours.

We have made one recommendation in relation to meeting people's nutritional and hydration needs.

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.

Recruitment practices ensured the right staff were recruited to support people to stay safe.

People were protected from avoidable harm and abuse because the provider had effective safeguarding systems in place.

Systems were in place to identify and reduce risks to people using the service.

The administration of medicines was safe and staff were knowledgeable about the provider's medicines policies and related procedures.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People's views about the meals they were served were not always positive.

People's needs were assessed and evaluated on an ongoing basis.

Staff demonstrated a good understanding of consent and capacity issues.

There were systems in place to provide on-going support to staff through regular supervision, training and development.

Is the service caring?

Good

The service was caring

Staff were fully aware of the need to promote people's dignity and protect their privacy.

People's cultural and religious needs were considered and respected.

Staff demonstrated a good knowledge of the people they cared for and encouraged them to maintain their usual routines.	
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains well-led.	**Good**

Princess Louise Kensington 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 checked 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.

We inspected this service as it was 12 months since it was rated 'Requires improvement'. During this period we have received eight notifications relating to safeguarding concerns from the provider and one complaint from an external organisation. The registered manager has fully investigated all of these concerns.

This comprehensive inspection took place on 22 and 26 February 2018. The first day of the inspection was unannounced.

Before the inspection took place we looked at information we held about the service including registration information and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We received and reviewed a provider information return (PIR). This is information we ask providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Three adult social care inspectors and two experts by experience visited the service on 22 February 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector returned on 26 February 2018 to complete the inspection.

During our visit we spoke with seven people living in the home, six relatives and a friend of a person using the service. We spoke with the registered manager, a regional manager, a deputy manager, administrative staff, five nurses, eight care assistants, an activities co-ordinator, domestic and kitchen staff. We looked at six

records relating to staff recruitment, staff training and supervision, auditing systems and service quality monitoring. We looked at 10 people's care records and risk assessments, policies and procedures relating to the service and other relevant information.

Following our inspection we spoke with a commissioning lead and a local authority safeguarding lead to gain their feedback about the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and comfortable with the staff supporting them. Comments included, "Yes we do [feel safe] and yes, we do trust the staff", "Largely I trust the staff" and "I'm happy with the staff and the service."

People were protected from avoidable harm and abuse because the provider had effective safeguarding systems in place. Staff had completed safeguarding training and were able to access up to date guidance and information via the provider's safeguarding policy and related procedures. Staff had a good awareness and understanding of what constituted abuse and listed racism, homophobia, neglect, verbal attacks and physical aggression as examples. Staff told us they would report any concerns they may have to their managers, social workers, CQC and the police if they suspected a crime had taken place. Staff were familiar with the provider's whistleblowing procedures. Whistleblowing is when a worker reports suspected wrongdoing at work. A worker 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. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns.

Systems were in place to identify and reduce risks to people living in the home. Risk assessments were completed for each person and contained guidance for staff about how to support people to manage risks in relation to mobility, moving and positioning, falls, nutrition, skin integrity and continence. Some people had been assessed for risks in relation to leaving the building without support, the use of bed rails and for one to one support where people's behaviours challenged the service and staff. In these instances, appropriate assessments had been undertaken and decisions made in accordance with the Mental Capacity Act (MCA) 2005 and relevant safeguards.

Repositioning charts were in place for people at risk of developing pressure ulcers. Records were mostly accurate and up to date. Where we noted omissions and/or inaccuracies, staff were able to provide an explanation. Following further discussion with the registered manager, all records relating to the care and treatment of pressure wounds were updated appropriately by the second day of our inspection. Staff confirmed they had been shown how to use hoists correctly and were confident using them to ensure people were supported safely. Care records were stored securely in locked cupboards and accessible to the relevant staff and visiting health and social care professionals.

The administration of medicines was safe and staff were knowledgeable about the provider's medicines policies and related procedures. People and their relatives told us medicines were administered appropriately. Comments included, "The nurse makes the rounds with the [medicines] trolley five or six times a day. Yes, I'm satisfied and yes, they do give me pain relief" and "Yes, they encourage [my family member] to take [their] medication." Medicines were stored securely and access was restricted to authorised staff. Where people were being given their medicines covertly (disguised in food or drink), the appropriate medicines management risk assessments had been undertaken and decisions made in accordance with the MCA. Staff completed medicines training and were assessed as competent before being able to administer people's medicines. We sampled medicines administration records (MAR) and

found these were completed in full with no evident errors or inaccuracies. A range of medicines audits were completed weekly and monthly by managers and external quality monitoring teams.

Good infection control practices were followed. The home was clean and tidy and free from any unpleasant odours. Staff were provided with infection control training to ensure they followed good infection control principles. Staff used disposable gloves, aprons, hand gels and paper towels and we saw that these were freely available throughout the home and used during meal times, when administering medicines and during the delivery personal care. Staff wore uniform tunics and badges indicating their name and position.

Recruitment practices ensured the right staff were recruited to support people to stay safe. Staff records included evidence that pre-employment checks had been made before new staff were appointed and commenced employment. This included requests for written references, Disclosure and Barring Service (DBS) checks and confirmation of identity. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands helping employers reduce the risk of employing a person who may be unsuitable to work in care.

On the day of inspection we observed sufficient numbers of trained staff were available to meet people's needs. Relatives told us, "There is always a member of staff around" and "Staff are well trained, they know what they are doing." We saw that people had access to call alarms and observed that most of the time these were within people's reach. One person told us, "When I ring the call bell, I never have to wait long; they're responsive, about half a minute and they're here." Another person commented, "Sometimes [staff] come straight away and other times you have to wait." We tested this person's call bell and observed that staff arrived in a timely manner. Some staff members told us they were sometimes short staffed but that they usually managed to complete their tasks. A person using the service said, "I'd give them eight out of 10. They need more staff for a nine." The registered manager provided us with information regarding their ongoing recruitment plans and confirmed they had new nursing staff waiting to start once all pre-employment checks had been completed.

Accidents and Incidents were thoroughly investigated by the registered manager. Actions taken following investigations included additional monitoring of people and referrals to other agencies. Monthly audits were conducted by the registered manager and overseen by regional managers. This enabled patterns and trends to be monitored and, where appropriate, lessons were learnt and plans implemented to improve future service provision.

Personal Emergency Evacuation Plans (PEEPs) were in place for each of the people who used the service. PEEPs provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. Records showed staff undertook regular fire alarm testing and that the service had recently been visited by the London Fire Brigade.

Requires Improvement

Is the service effective?

Our findings

People's views about the meals they were served were not always positive. Comments included, "You get three choices for your food – they all seem to have foreign names. I like sweetcorn but I never seem to get it" and "The food is typical mass catering with a limited choice and lack of imagination." Relatives told us, "[My family member] has views about the food. [They're] not picky but [are] attuned to having proper food", "The food is horrible. It lets the care home down without a doubt" and "The food is the weakest point here. Out of seven days a week, I would say that it's acceptable once a week. The food is over-cooked and bland. Why can't it be provided on the premises?"

Plans to re-install kitchen facilities within the home had faltered and therefore people's meals continued to be prepared and packaged offsite. Meals were delivered chilled to the home where they were heated and served from trolleys. Staff tested and recorded food temperatures before serving. There was a choice of main meals, including vegetarian and halal options. People who required pureed or fork mashable food were provided with meals in line with the guidance and recommendations recorded in their care records. People who required support to eat and drink were assisted by staff who were seated, and who undertook this task with patience and at an appropriate pace. People were offered fruit juice and water during the meal. We tasted meals on both days of the inspection. We noted inconsistencies in the temperature, taste and presentation of food. For example; on day one we noted that food was served onto cold plates, that the soup was tepid and some of the vegetables overcooked and cold. On the second day, food was hot, served on warm plates, looked and tasted good. Table top menus were not always showing the correct meals available on the day.

We recommend that the provider reviews nutritional provision at the service to ensure people are provided with a good range of hot and cold meals and snacks that are freshly prepared and cooked; nutritionally balanced, wholesome and appealing.

People's views about whether or not staff had the skills and knowledge to meet their needs was mostly positive. We were told, "[Staff] seem to have lots of training sessions", "[Staff] probably are [well trained]; of course they are; well, the nurses must be" and "I think there's a need for training throughout the whole organisation. They're OK with the equipment but it's about the culture more than anything."

There is an expectation that CQC regulated providers ensure induction programmes for new staff meet the requirements of the national standard of good practice. New staff completed an induction which included elements of the Skills for Care common induction standards which have now been replaced by the Care Certificate. Staff had the opportunity to shadow more experienced staff until they felt confident in their skills and abilities. Staff completed mandatory training such as safeguarding, infection control, equality and diversity, basic food hygiene, mental health legislation and various other health and safety topics. In addition, staff had opportunities to access specialist training in areas such as dementia awareness, managing behaviours that challenge and falls prevention. Nurses told us there were opportunities for continuing professional development and spoke positively about the training provided. There were systems in place to provide on-going support to staff through regular supervisions. The registered manager told us a

new system for annual appraisals would be introduced by the end of March 2018.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were able to demonstrate a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. The registered manager had submitted DoLS applications where restrictions had been considered proportionate and appropriate.

People's needs were assessed and evaluated on an ongoing basis. A relative told us, "The nurse assessment was brilliant." The involvement of health and social care professionals was evident in people's accounts of the care they received, care documentation, correspondence and meeting minutes. People had access to a GP who visited the service at least twice a week, tissue viability nurses, occupational therapists, physiotherapists and chiropodists. People were referred appropriately to hospital services when needed and in a timely manner to ensure they maintained optimum health and well-being. Not everyone was able to consent to care and where this was the case, appropriate steps had been taken to ensure best interest's principles were followed.

Good

Is the service caring?

Our findings

The service was caring. People we spoke with told us staff were kind and caring. Comments included, "It's very difficult to look after people with dementia. [Staff] are good here" and "The care is excellent."

The premises were well-appointed and close to local amenities. Most rooms were spacious and comfortable and all had en-suite shower facilities. People were able to personalise their rooms as they pleased with photographs, pictures and soft furnishings. Bedroom doors displayed people's full name and the name they preferred to be known as. A relative told us, "[The home] is clean, warm and there seem to be enough staff. People are kind and polite." People were able to access a landscaped garden area which provided plenty of separate seating areas, a range of plants, shrubs and flowers and a calming water feature.

People's privacy and dignity was respected and promoted. 'Protected times' were observed during meal times. This meant that people were not disturbed or disrupted when having their meals. Doors were closed and paper curtains covered door windows ensuring people's privacy and dignity was respected when people were receiving support with personal care tasks. A relative commented, "They do things like cover the window, shut the doors so no one can walk in while they wash [my family member]." Staff told us they always asked people's permission before providing support.

Staff demonstrated a good knowledge of the people they cared for and encouraged them to maintain their usual routines. People told us, "I can stay watching television until late" and "I like my jazz, I've got lots of concerts I watch on DVD." A member of staff commented, "[Person using the service] likes everything around [them], [their] chocolates and sweets and then life's good." A hairdresser visited weekly and from our observations people were well groomed and dressed neatly in clean clothes.

People's cultural and religious needs were considered when support plans were being developed. Care records stated whether people held a particular faith and where possible people were supported to practice this. Representatives from the Catholic Church visited people living in the home weekly and there was information in the reception areas about local services for people of other faiths.

Care plans detailed how to communicate with people and whether people wore glasses and/or used hearing aids. Staff were able to describe how they communicated with individuals who were unable to communicate verbally. This included writing things down and also reading body language and facial expressions. From our observations, staff demonstrated a commitment to ensuring people were able to communicate their choices.

Staff spent time chatting to people to build up a rapport and were attuned to people's emotional well-being. A person using the service told us, "[Staff] are caring and kind especially when I'm feeling low. Two nurses have been talking to me this morning because I'm depressed."

People's friends and relatives were welcome to visit at any time and there were no restrictions to the amount of time they could spend at the service. People told us they felt welcome and included in the day to

day life of the home. Relatives told us, "My [family member] has been here seven years. I come here every day" and "We attend the monthly family meetings. [The registered manager] will always chat with us." The staff team had received a number of cards and email compliments from relatives thanking them for the care and kindness shown to their family members.

We saw sensitive personal information was stored securely in locked cabinets. Relatives and people who used the service confirmed their permission was sought before their confidential information was shared with other healthcare and community professionals and we saw this documented in people's care records. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act.

Good

Is the service responsive?

Our findings

Relatives told us, "I've been involved in the care planning from the beginning" and "The staff have done everything possible to accommodate our needs when [my family member] was settling in. They have been very helpful and kind."

There was evidence that people and their relatives were involved in the development of their care plans where this was appropriate. Support planning documentation was comprehensive in range and included information about all aspects of people's care. A photograph of each person using the service was included on the front cover of each set of care records along with a brief overview of people's medical history and allergy status. Further information recorded people's physical, cognitive, medical, social and cultural needs and the objectives of care provision. Where people had specific care needs in relation to diabetes or where catheters and percutaneous endoscopic gastrostomy (PEG) tubes were in place, staff had completed additional care plans, risk assessments and monitoring charts. However, information was not always ordered according to front page indexes and handwritten entries were not always legible and easy to read. Not all care and support plans were signed by people using the service or their representatives and reasons for these omissions were not always clearly explained.

The service was complying with the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss. Each person's initial assessment identified people's preferred names, communication needs, use of hearing aids and/or glasses and provided brief details of the best way to communicate with them.

People's care records contained some information about their life histories, individual preferences and interests. For example, people had specified their music preferences, favourite television programmes, activities they liked to partake in such as reading a newspaper or completing crosswords, food and drink likes and dislikes. Staff demonstrated a good understanding of how people liked to spend their time and were knowledgeable about people's lives, family connections, preferences and daily routines. Staff told us, "Everyone has a history", "We talk about horoscopes and travelling", "[They] have a sister who's very involved" and "[Person using service] likes a glass of wine, likes to bake and loves [their] movies."

The service employed an enthusiastic full-time activities co-ordinator who organised a range of group and one to one activity sessions. A person using the service told us, "I like the coffee mornings and the newspaper discussion group. They have other activities like pudding making on Mondays and arts and crafts". A relative said, "We'd give [the home] six out of 10 for the food and eight out of 10 for everything else. [The activities co-ordinator] gets 12 out of 10, five stars for [them]!" A schedule of weekly activities was advertised on each unit and in the main reception area. On the days we visited, coffee mornings, arts and craft sessions and a birthday party took place. We saw photographs of other events that had taken place over the past 12 months including an International Day celebration, an open day, birthday celebrations, tea parties and barbecues. The service had a children and adults volunteering programme in place and the registered manager told us they hoped to recruit more volunteers to assist with activities in the home, develop music projects and support people to attend community events. A relative suggested, "Wi-Fi needs

to be working for the residents. It's a way for people to be opening up their access to other things."

Staff were kept up to date and informed about issues, concerns and any plan of action in place to address them. Staff attended a daily 'ten at ten' meeting where issues relating to maintenance, meals, activities, staffing levels and visits from health and social care professionals were discussed. Staff recorded the care they provided on daily monitoring sheets and this information was reviewed when staff began their shifts. This meant staff were aware of how people were feeling and were informed about people's changing healthcare needs.

The provider worked closely with clinicians from the Pembridge Palliative Care Centre and sought advice and guidance when needed to ensure people remained comfortable, pain free and supported at the end of their lives. A relative told us, 'I have been involved with end of life plans. I can discuss anything I want with the kind people here." Staff told us that it wasn't always appropriate to discuss people's end of life plans and that they returned to the subject only when they felt people were comfortable discussing these issues. Where plans were in place they provided information about who was to be informed in the event of death and noted people's religion or faith and any end of life preferences. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed by GPs and hospital consultants. (The purpose of a DNACPR decision is to provide immediate guidance to those present on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly). However, where people lacked the capacity to make these decisions for themselves, DNACPR forms were not always recording how decisions were reached and who other than a medical professional had been involved in these discussions.

The service was responsive to concerns and/or complaints raised. The provider had a complaints policy and procedure in place and information on how to make a complaint was on display in the home. One person told us, "They respond to me and sort things out when I talk to them." Relatives were confident the registered manager would investigate any concerns or complaints as soon as they arose. We saw evidence that the registered manager handled complaints quickly and effectively, conducting an investigation and taking disciplinary action if appropriate to do so.

Good

Is the service well-led?

Our findings

The service was well-led. Staff were positive about the service and said that there was an inclusive and supportive working environment with good communication between senior staff and staff on individual units. Staff told us the registered manager was visible, approachable and supportive. Comments included, "I like our manager, she is in control of everything", "She's supportive and helpful" and "You can talk to the manager, she really knows the residents."

The provider was part of the Registered Manager's network which enabled staff to find out what was happening in the care profession, share good practice and keep up-to-date with new legislation and guidelines. The registered manager was keen to develop and improve the service. Staff were able to make suggestions about how the service operated and told us they were confident they would be listened to, taken seriously and any good ideas implemented.

The registered manager was responsive and understood the relevant legal requirements in relation to her role and responsibilities. Leadership in the home was visible at different levels. A regional manager visited the service on a regular basis for meetings with the registered manager and wider staff team. We saw evidence that their visits were business focused with records of discussion points including; care delivery, monitoring of quality and safety, monthly audits, staffing, complaints and actions to be completed.

There were opportunities for career progression, further training and development within the service. For example, train the trainer and champion roles were open to those who demonstrated a genuine interest and aptitude for the roles. Staff were able to give examples of further courses they had attended to develop their knowledge, skills and experience such as dementia awareness and falls prevention courses and most staff had completed health and social care vocational courses at various levels.

The registered manager completed weekly and monthly audits to ensure she maintained a clear oversight of the service and the people using it. Audits addressed safeguarding, complaints, incidents/accidents and falls, pressure wounds and infection control. Audits were shared with regional managers monthly for their oversight. Nurses and senior care assistants also completed daily and weekly medicines audits and shared their findings with the registered manager. This meant any shortfalls in service provision were detected and remedied in a timely manner.

The provider routinely listened to people in order to improve service delivery. Feedback from people using the service, relatives and staff was sought through regular meetings, feedback forms and annual surveys. A relative told us, "[The home] is as good as it can be. [Staff] work well as a team and communicate." Meetings took place monthly for people who used the service; topics discussed included activities, meals on offer and levels of satisfaction. Relatives were invited to attend monthly meetings at the service and meeting dates were clearly posted in the main reception area.

The most recent family, friends and visitors questionnaire returned 27 completed responses. The survey asked a number of questions relating to service delivery. Respondents indicated 100% satisfaction with the

home environment, privacy, and staff communication. The registered manager reviewed this information and produced an overview detailing the findings which was shared and made available around the home. A relative commented, "Before [the service] was run by the NHS, it has improved, for the better."

The registered manager maintained positive relationships with healthcare professionals, service commissioners and representatives from local safeguarding teams. A senior commissioning manager wrote to us saying, 'The Managerial and Clinical Leadership by the current manager is very strong which results in high levels of care and professionalism in the home. The manager provides assurance to the Clinical Commissioning Group in regards to the management of the home, especially with the increasing complexity of clients.'

Dignity champions from Healthwatch Central West London provided positive feedback following their visit to the service in March and June 2017 and stated, 'We found staff to be caring and respectful to the residents.' They made five recommendations relating to meal preparation, community links, volunteering opportunities, scope of activities and preventing social isolation. With the exception of meal preparation, the registered manager confirmed that all recommendations had been implemented and improvements achieved.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily access the most current assessments of the provider's performance.