Kudos Care (UK) Limited

Knightsbridge Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 28 December 2017, 2 and 3 January 2018 and was unannounced.

Our comprehensive inspection on 16, 17 and 18 January 2015 found breaches in legal requirements. These included shortfalls in infection control procedures, unsafe recruitment of staff and a lack of effective quality monitoring processes. An action plan was received and the provider told us these breaches would be met by 31 July 2015.

On 3 and 5 September 2016 we carried out a second comprehensive inspection and found the provider had met the necessary regulations. The rating for the key question, Is the service safe? had improved to at least good. However, further required improvement was needed to the key questions, Is the service effective and well-led? and the overall rating of the home remained Requires Improvement. We made two recommendations to support the provider to improve their quality monitoring processes and the implementation of the Mental Capacity Act 2005 to ensure people were fully protected. We also met with the provider following this inspection. We discussed the fact that this was the second, consecutive time the service had been rated Requires Improvement and to receive assurances that action would be taken to improve the rating of the service to at least Good.

During this inspection on 28 December 2017, 2 and 3 January 2018 we found the recommendations had been acted on and improvements had been made to the key questions, is the service effective and well-led?. The service has been rated Good overall.

Knightsbridge Lodge 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. Knightsbridge Lodge does not provide nursing care and can accommodate 22 older people in one adapted building. At the time of the inspection 19 people were living there.

Accommodation was over two floors and comprised of a single bedroom with window/s, a sink, heating and bedroom furniture. Additional communal and adapted toilets and bathrooms were on each floor. People also had the use of two lounges and a dining room. Outside there was an enclosed garden with seating areas to both sides of the building. A larger, grassed area with flower borders as well as car parking was at the front of the building. The home had wheelchair access and a passenger lift and stairs allowed access to the second floor.

A registered manager was employed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Why the service is rated Good.

There were arrangements for keeping people safe which were consistently adhered to. There was a proactive approach to managing risks, which took into account people's desire to remain independent. An open and transparent culture helped to protect people from abuse and poor care. There was a willingness to learn from mistakes. People's rights were protected. The need for specific support, stemming from people's behaviour was understood and provided. There were systems in place to ensure all equipment, services and the building remained safe. People lived in a clean home where infection control measures were followed. Staff were recruited safely and in enough numbers to meet people's needs. People's medicines were managed safely.

People and their relatives gave consistent positive feedback about the care provided. Staff received relevant training and support to be able to support people's well-being and meet their diverse needs. Care and health needs were assessed, reviewed regularly and referrals were made to other professionals and agencies who could help with these. Where needed people were supported to eat and drink. Any concerns about people's appetites or weight were addressed.

Staff worked closely with other agencies and services when supporting people. 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. People who lacked mental capacity to make their own decisions were protected from decisions which may not be in their best interest. Adaptions were made to the environment to make people's lives easier and safer.

People and their relatives were consistent in their feedback about how kind and compassionate the staff were. Staff took time to explore people's likes, dislikes, preferences and wishes as well as their life history. This meant staff knew people well and could have meaningful conversations with them. People were treated with respect and their dignity and privacy was upheld. Those who mattered to people were welcomed and included into the 'Knightsbridge Lodge family'. People were listened to and communicated with in ways which enabled them to be included and to participate.

People's care was planned with them. Where appropriate family members were consulted with and could speak on behalf of their relative. Care planning took into consideration people's diverse needs as well as their expectations and goals. Care was reviewed and altered in consultation with people. People were provided with information in a way they could understand it.

Arrangements were in place for people and others to raise a complaint and have this listened to and addressed. Managers used complaints and other feedback as an opportunity to reflect on and improve the service provided. Staff worked closely with health care professionals to ensure people had a comfortable and dignified death. People's specific wishes for this time were met. Relatives were provided with the support they needed at their time of loss.

Improvements in how the service was monitored and in how actions were followed up had led to sustained improvements in systems, processes and practices which helped protect people. Staff were committed to the provider's visions and values. These were of a caring service which supported people to live well. Managers valued feedback from people, relatives and staff and used this to make improvements and to inform the decisions made about how the service was run. All necessary regulations were complied with.

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.

Action was taken to reduce risks which may have an impact on people, in such a way that people's independence was promoted.

People were protected from potential abuse and discrimination.

Staff were recruited safely and there were enough staff to meet people's needs.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's needs were assessed and met by staff who had the knowledge and skills to meet these.

People had access to social care and health professionals who could contribute to improving their quality of life and who were involved in protecting their rights when they lacked mental capacity.

People were supported to eat and drink well.

Adaptions to the environment helped to support people's individual needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and supported to be involved in making decisions about their care and treatment irrespective of their diverse needs.

People's dignity, privacy and rights were upheld whatever their personal preferences or beliefs were.

People were supported to be independent and to retain relationships which mattered to them.

Is the service responsive?

Good

The service was responsive.

People received care which was tailored around their personal needs, preferences and abilities. Each person was treated as an individual.

People made choices about what activities they attended and how they wanted to socialise and were supported to participate.

There were arrangements in place for people and others to make a complaint and for this to be listened to and addressed.

People were involved in planning their end of life care and supported to have a comfortable and dignified death.

Is the service well-led?

Good

The service was well led.

Arrangements were in place to monitor and improve the services provided to people.

Managers promoted and supported a positive culture which led to good outcomes for people.

Feedback and suggestions from people, relatives and staff were valued and used to help make improvements to the service.

Knightsbridge Lodge

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 28 December 2017, 2 and 3 January 2018, was unannounced and carried out by one inspector. Prior to the inspection visit we reviewed information we held about the service. All statutory notifications, received since the last inspection on 3 and 5 September 2016, were reviewed. These contained information about incidents and events that had taken place, which the provider must legally inform us about. We used information the provider sent us in the Provider Information Return (PIR) to help plan the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection visit we observed the support being provided to people. We spoke with six people who lived in the home including one relative. We inspected five people's care files which contained pre-admission assessments, care plans, risk assessments and other relevant care records. We reviewed records and documents relating to the care of people who lacked mental capacity; one of which had authorised Deprivation of Liberty Safeguards (DoLS) in place. We spoke with the registered manager, deputy manager, a senior care assistant, two care assistants, a cook and the activities co-ordinator. We also spoke with two practitioners from the NHS Rapid Response Team and sought the views of two other health care professionals. Two representatives of the provider were present throughout the inspection visit and were present at the inspection feedback.

We looked at records pertaining to the management of the home. These included three staff recruitment files, the staff training record, a selection of audits and two policies. We reviewed the maintenance records and various service certificates. We also reviewed complaint records. We attended two staff handover meetings. We visited all areas, inside and outside of the building, which were accessible to people. We read the compliments which had been forwarded to the staff.

Good

Is the service safe?

Our findings

People described how staff helped them to feel safe. For example, one person told us they had experienced falls when they had lived in their own home. They said, "I only have to press my buzzer (call bell) here and they [staff] come." They told us about the actions staff had taken to reduce the risk of them falling again. This person felt very reassured by these. Feedback given by a relative of someone who had stayed at Knightsbridge Lodge included, "[name] realised immediately that they were in safe hands" and that Knightsbridge Lodge was "somewhere [name] felt safe."

Staff were aware of the risks which potentially impacted on people's health and well-being. Risks were assessed and managed. The risk of falling, losing weight and developing pressure ulcers were common to most people at Knightsbridge Lodge. All accidents were recorded and the circumstances of any fall examined. This helped managers determine if the actions already in place were effective in reducing further risk and injury. For example, it had been identified that one person's falls were usually followed by an infection. This had led to staff monitoring for earlier signs of infection so that treatment could be organised quickly. Staff ensured people had access to professionals who assessed people and provided equipment which helped to keep them safe.

Technology was used to help lower risks whenever possible. Sensor mats and infra-red beams were in use and alerted staff to when people attempted to stand or walk. Staff could then attend when support was needed. This technology had been successful in lowering risks for one person but had proven not to be effective in another person's case. This person lived with dementia and had dismantled the equipment. This technology aimed to reduce risks to people without the need for constant staff supervision, which could be perceived as intrusive and restrictive. Staff had resorted to closer observation of the one person as the technology was no longer used.

The condition of people's skin was monitored by the staff. Any concerns were referred to the community nurses for assessment. According to the person's level of risk of developing a pressure ulcer, they provided pressure reducing equipment. People who experienced swallowing difficulties were referred to a speech and language therapist. They assessed the person's ability to swallow and if they were at risk of choking. If required, they advised on how people's food should be provided. The cook told us they were aware of how to prepare textured-modified foods, for example, pureed or fork mashable textures. At the time of the inspection no-one had been assessed as being at risk of choking.

Successful risk management had also resulted from staffs' ability to form trusting and positive relationships with people. This had enabled staff to have conversations with people, about how they could manage their own risks and what support they needed from staff to do this. We observed good relationships in place, also, with people who lived with dementia. In one person's case, when they became distressed, their behaviour altered. They sometimes exhibited behaviour which could be perceived as challenging. The potential for distress and challenging behaviour came when staff needed to help the person with their physical care; washing, dressing or toilet needs. Risks associated with this had been identified and staff knew what caused the person to get distressed and how this could be best avoided. Care records showed that over time, staff

had managed to build up a trusting relationship with this person, which allowed them to deliver the care the person required.
People's rights were upheld and there was zero tolerance of any form of abuse or discrimination towards people. The same was expected of staff in the way they behaved towards each other. The home's Statement of Purpose outlined what the service would ensure people received. It stated people had "the right to receive an anti-discriminatory service which is responsive to your race, religion, culture, language, gender, sexuality, disability and age." The home's policy "Providing non-discriminatory services and respecting equality and diversity" referred to the Equality Act 2010 and how this would be met. The "Safeguarding" policy was in line with the local authority's procedures for protecting people from abuse. These documents supported best practice and underpinned the practices and actions we observed throughout the inspection.

Staff had received training on how to report concerns and senior staff shared relevant information with other professionals in order to protect people from abuse. When staff spoke about people, for example, during staff hand-over and at other times, they referred to them in a respectful way and in a non-judgemental manner. The registered manager and deputy manager adhered to other policies and procedures which helped to protect people from poor or unsafe practice. Staff knew how to report concerns they may have about a colleague's or visiting professional's practice. Staff we spoke with had confidence in the managers to address their concerns correctly. Where needed, significant conversations and disciplinary action had been taken.

Records showed that regular safety checks were made of the environment. Any risks were identified and the actions taken to improve safety were completed and recorded. Maintenance and servicing, by specialist contractors, kept equipment and main systems working safely. For example, the passenger lift, all care, catering and laundry equipment as well as the fire detection system, water and heating systems and electric and gas utilities.

Managers ensured there were enough staff on duty to meet people's needs and to ensure the smooth running of the home. Staff worked in a flexible way to achieve this. Both the registered manager and deputy manager were qualified to deliver care and worked alongside care staff when additional help was required. Robust recruitment processes protected people from those who may not be appropriate. The improvement seen in the recruitment process during the last inspection had been maintained. New staff had been employed and they had brought additional skills and knowledge to the staff team. For example, a new and experienced activity coordinator had been employed.

People were supported to take their medicines. Medicines were administered by staff who had received relevant training. Staffs' on-going competencies in this task were monitored. When administering medicines, staff took the time to answer people's questions and give them explanations. Medicines were stored securely and correctly. People's medicine administration records (MARs) were well maintained. Staff signed the MAR when a person's medicine had been successfully administered indicating the person had taken it. Two signature gaps on one person's MAR were seen to be missing during the inspection. Following investigation by the registered manager it was found that the medicines had been given but that this had been a record keeping error. Staff had been reminded to be more vigilant when signing for medicines administered and when checking the MARs for completion before administering medicines.

All other records and areas of the medicines system, checked by us, showed safe practice and good record keeping to be in place. An audit completed by a visiting pharmacist in May 2017, had praised the staff for maintaining such "excellent systems". The systems seen during this inspection had remained the same since that audit. During the inspection one person was commenced on oxygen. As soon as this was delivered, staff ensured this was administered safely. A safety sign was placed on the person's door alerting people, visitors

and staff to the potential risks associated with the use of oxygen. Medicines for use in end of life care were prescribed by GPs and delivered before they were actually needed. This ensured they were always available when staff or community nurses need them to keep a person comfortable.

Good

Is the service effective?

Our findings

At the last inspection on 3 and 5 September 2016 we recommended the provider seek further advice on the processes that needed to take place to ensure all people were fully protected under the Mental Capacity Act 2005 (MCA). During this inspection we found this had been done and the staff were following correct processes to protect those who lacked mental capacity.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People had been supported to make independent decisions and this was the case for one person who was supported in the least restrictive way to take their medicines. The deputy manager explained that apart from best interest decisions having been made regarding where people lived through Deprivation of Liberty Safeguards (DoLS), no other significant decisions had been made on people's behalf in respect of their care and treatment. This was because at the time of the inspection people were able to make these independently or with support.

We checked whether any conditions on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One application for DoLS had been authorised by the supervisory body (the local county council). This application had not been subject to any conditions. Since the last inspection managers had correctly completed and submitted DoLS applications to the supervisory body for other people. These were yet to be assessed by the supervisory body. When we spoke with staff they understood that people could not be deprived of their liberty unlawfully.

People's needs were assessed prior to them moving in. A relative confirmed that the person's next of kin had been involved in this process. This assessment process helped managers to be sure the person needs could be met at Knightsbridge Lodge. We reviewed one pre-admission assessment. It showed that the person's individual care and health needs had been explored and recorded.

Staff often liaised with health care professionals to ensure they had, for example, the appropriate equipment and medicines ready to meet people's needs once they arrived. During this stage and following admission, where appropriate and relevant, issues relating to personal relationships, religious and cultural beliefs, specific disabilities, sexual needs or sexual identity were explored. This helped staff to further personalise people's care and to meet their diverse needs.

Pathways of care were followed to ensure people received care which followed best practice. This was seen in particular for people who lived with dementia. The staff sought advice from mental health care professionals whose knowledge and practice was in line with best practice as well as nationally and locally agreed strategies. This helped to ensure people received consistent assessment and support to live well

with their dementia. Feedback from one health care professional told us that the home could access more support in relation to care pathways and best practice if they chose to. The managers of the home confirmed they were due to seek further information and training for staff on dementia care.

People received care from staff who held appropriate qualifications and who were supported to update their knowledge and skills. Out of 15 care assistants employed, 13 held nationally recognised qualifications in care, including two of the three additional general assistants. One person told us staff were "good all-rounders" and they said, "They do their job well." All newly recruited staff, whatever their role, completed induction training. This included awareness of the provider's policies and procedures and expectations. The Provider Information Return (PIR) also stated that staff new to care, completed the care certificate. The care certificate is designed to provide training and support, which once completed, enable staff to provide basic and safe care to a recognised standard.

Staff told us they were well supported by their colleagues and managers and their competency was routinely checked. The home's central training record showed there were arrangements in place to ensure staff remained up to date with relevant knowledge and skills. Further training was also planned in end of life care. Managers told us they provided staff with regular opportunities to discuss their training needs and reflect on their practice. The staff we spoke with confirmed this to be the case.

People made choices about what they ate, drank and where they took their meals. People's appetite and weight were monitored so staff could be sure people were eating and drinking enough to maintain their nutritional wellbeing. People not maintaining their weight or not eating and drinking enough were referred to the GP. Support from staff varied from additional encouragement to eat and drink, providing snacks in-between meals to fortifying foods. This involved adding calories to foods by adding for example, extra butter and cream. One person told us they were vegetarian and the food was "quite good". A relative said, "Certainly it's of a good standard." Another person told us they really enjoyed the meals. The cook told us they provided people with two options for lunch, but they also provided alternatives as well.

The dining room was presented in such a way as to enhance people's dining experience. It was warm and tables were attractively laid with table cloths and napkins. Flowers were on each table as well as salt and pepper and a weekly menu. Care had been taken in the choice of tumblers. The registered manager explained these had been specifically chosen with older and frailer people in mind. A dining room dresser faced the open door, giving a reminder to people walking down the corridor, that the room ahead was the dining room. A wipe board was placed on a side table giving more detail, in larger writing, about the day's food choices. People were offered a glass of sherry before their main meal and could have a glass of wine if they wanted one. We observed cold drinks to be available in all three communal rooms and bedrooms. The registered manager said, "You never know when someone maybe thirsty, or a visitor, so it's there if they want it." We also observed staff reminding people to have a drink. Snacks for in-between meals were also available in the lounge as well as fresh fruit.

Staff in the home reported good working relationship with external agencies and health care professionals. When talking about the home's main GP practice the registered manager said, "They bend over backwards; nothing is too much trouble, they really care." One GP from this practice carried out a "planned surgery", at the home, every other week and they were happy to visit in-between if needed. This meant that a review of their patients took place regularly. Other GPs visited as required. The registered manager said, "I have known our GP just to pop in to check that someone is alright." By working together the staff in the home and the visiting GPs did their best to facilitate people's particular wishes. One health care professional commented, that there was "excellent communication" and that staff in the home were "quick to raise and try and solve any issues." Conversations and advanced decisions relating to cardiopulmonary resuscitation

were held with people [or their relatives where appropriate] by their GP. We saw these decisions to be clearly recorded for visiting health professionals, such as paramedics.

During the inspection one person expressed a wish not to be admitted to hospital. The staff therefore asked the GP if they would consider a referral to the NHS Rapid Response Team first. Practitioners from this team, can sometimes, support people's health needs in their own home. This can avoid potentially upsetting and unnecessary admissions to hospital and help meet people's wishes not to be admitted. This person said, "They're [the staff] so good here I trust them implicitly to look after me well, here." However, this person's needs were too complex to be met outside of a hospital setting. Both NHS practitioners and the home staff gave this person accurate and clear information about their condition and supported them to make an informed decision about their treatment. One practitioner said "They're very good here." People were supported to attend hospital appointments and various other health appointments. NHS vision and hearing checks were made for people if they did not attend private services. A Chiropodist (foot care) also visited the home on a regular basis.

The home had been adapted to meet the needs of older people. We saw for example, grip bars, raised toilet seats and easy pull cords in toilets and bathrooms. Some bathrooms had hoist seats to help lower people into the bath. The Provider Information Return (PIR) told us that a new disabled bathroom was to be installed on the first floor. More recently adaptions to the environment had been made to support those who lived with dementia. These had included painting toilet door frames a different colour so people could locate these more easily. Signage around the building was being reviewed for the same reason, to help people better orientate themselves. Other changes had involved starting to remove areas of patterned carpet. The dementia lead explained that this could potentially present itself as a series of holes and steps to be avoided to those who lived with dementia. They told us this increased the risks of falls. This showed that this member of staff had a good understanding of how people who lived with dementia may perceive their surroundings. Outside the garden area had been made more secure so that people who lived with dementia could enjoy the outside safely.

Good

Is the service caring?

Our findings

People told us about how caring the staff were. One person said, "Oh it's beautiful here, they [staff] are wonderful. I'm very happy here". Another person described the place as being "home from home". They said, "They [staff] are all my friends." This person spoke about how "kind" and how "thoughtful" the registered manager was. They said, "He is just lovely" and then described all the staff as being just the same. A relative described the staff as being "very patient" and spoke with us about how the staff had built up a "really good" relationship with their relative. One member of staff said, "I would say the whole staff team are genuinely caring and interested in people's well-being." One health care professional commented, "….all the staff are warm and friendly….it is evident that they really care about their residents and treat them all as individuals." Written feedback comments from a relative included "The whole general atmosphere is happy and homely…. I find all the staff to be respectful, caring and courteous and visitors are always greeted, at any time, with a friendly smile." Another relative had described the care provided by staff as "warm and loving".

A caring culture existed and this was demonstrated through acts of kindness and concern. One example, witnessed by us, involved a person, who had been waiting in hospital all day for a medical procedure only for this to be cancelled late afternoon. Transport to get the person back was potentially not going to be available for another five hours. The registered manager was so upset for the person they dropped everything, cancelled the transport and collected the person themselves. The deputy manager later said, "Yep, that's him [registered manager] all over, he won't put up with people being left and upset like that." Other acts of thoughtfulness included driving people to visit family if the family had no means of getting to the home or picking family members up to visit their relative in the home [with no financial charge attached].

In celebration of one person's 100th Birthday staff had contacted the football team the person had followed since their childhood. In response the team had signed a poster and a card and had forwarded this to the person. The person's reaction to this was described to us as having been "magical". A party with 30 plus guests was held for this person for which staff, including the catering staff, had prepared and helped with in their own time. People had been involved in many festive activities but they had been unable to put up decorations. The deputy manager told us that staff had asked if they could voluntarily return or stay on after work so they could decorate the house once people had gone to bed. They said, "They had wanted to give people a surprise when they woke up in the morning." As a thank you the registered manager had organised take-a-way food to be delivered whilst the staff put up the decorations. The deputy manager told us that no-one would be left to feel "not included" or "unloved" at Christmas. Everyone had therefore had a Christmas present prepared by the staff and Christmas stockings had been hung at the end of everyone's bed.

People had different communication needs which the staff were aware of. One person who lived with dementia was able to converse but not in a way which others could follow. However, staff knew from this person's non-verbal communication and behaviour, their level of well-being. Another person required hearing aids to help them hear and to be able to communicate effectively so staff always made sure these were used. Another person had slurred speech and required staff to be patient in order for them to explain

what it was they wanted to say. We observed different approaches by staff to ensure people felt included and cared for. Some people responded to "banter" and "laughs" and others required a more quiet and soft toned approach.

Care was delivered in a personalised way, meaning it was tailored to people's individual preferences and diverse needs. People were supported to be as independent as possible. Care records recorded what people could achieve independently and what they needed help with. One person told us it was important for them to try and remain as independent as possible. They told us the staff "just knew" exactly when to help them and when not to. Information about people's life history, achievements and other significant events helped staff have meaningful conversations with them. We observed people to be relaxed around the staff. Staff had a casual and familiar approach which remained professional. We observed people being treated with respect and their privacy and dignity upheld at all times. Personal care was delivered behind closed doors at all times and people's personal spaces, their bedrooms, were respected as being just that. We observed staff knocking on bedroom doors before entering, or if the door was open, asking permission to enter before they did so.

People were encouraged to maintain relationships with people that mattered to them and to go out of the home with family and friends if they wanted to. People's right to a private family life was respected and people could receive visitors at any time. Visitors were able to see their friends or relatives wherever the person was happy to receive them. We observed relatives visiting people in their bedrooms for example. One relative told us they enjoyed visiting their relative as they were always made to feel so welcome by the staff. If a person had no family support and at any time required an independent advocate, then this would be organised. Staff had explained to people that it was sometimes necessary to share information about their care and treatment with other professionals and agencies. Consent forms had been signed in relation to this by people or their representatives. Managers were aware that some people required information in different formats, such as large print or audio and this could be arranged.

Information and guidance about people's care and health was recorded accurately. Records were kept secure and safe. All electronically held information was password protected. Staff received training on the importance of confidentiality. We attended two staff hand-over meetings where details about people's care and health were verbally handed over to staff coming on duty. This was done in an office with the door shut so the information remained confidential. Offices which contained sensitive information, which included that pertaining to staff, were keypad protected.

Good

Is the service responsive?

Our findings

People's needs were assessed and their care planned with them. Where people were not able to engage in this process their relatives had opportunities to speak on their behalf. The home's Statement of Purpose stated people had "…the right to be involved in your own care plan and be involved in any formal reviews of your needs, which take place at regular intervals." Care plans were written and provided staff with the guidance they needed to support people in a personalised way. An improvement in this was seen in how this had been included since the last inspection. This meant care plans included people's personal preferences, wishes, likes and dislikes. They were reviewed and updated on a regular basis, but also as necessary and with people where this was possible.

One person's mental health care plan gave staff guidance on how to respond to behaviour which could be perceived as challenging. As staff had got better at understanding what triggered this behaviour, they had also learnt better ways of communicating with the person. Staff had been flexible and they had adapted their care delivery around when the person was able to accept their support. The impact of this had been that the challenging behaviour had significantly decreased. The deputy manager explained the person was now able to experience times of well-being, where before they had struggled to do this. Another person's care plan recorded the actions planned to significantly reduce their moments of distress and anxiety. This person's well-being had been substantially improved through the use of a specific therapy. This had been carefully introduced by the home's dementia lead. This was a good example, of how all the staff had embraced this therapy, had ensured it was used in a consistent manner to promote and support this person's well-being.

People's preferences with regard to activities and how they wanted to socialise were explored with them. The activity coordinator played a fundamental role in promoting and supporting people's well-being. They were experienced in delivering and supporting meaningful activities to people in a care setting. They helped people to recognise and use the skills they retained, to decide on activities which were meaningful to them and explore their aspirations and goals. Activities were designed to be interesting, fun as well as challenging so as to help people gain as sense of achievement. People's participation in any activity was constantly evaluated. Activities were then planned with people's abilities in mind. A simple example of this being, a person with poor eyesight was provided with a large print bingo card.

Some people responded better to activities done on a one to one basis and others to more competitive group activities. People were involved in making decisions about what activities and entertainment would take place. Their knowledge, life experiences and interests were used to enhance other people's lives. For example, one person's religious beliefs and their interest in literature had been explored with them with a view of supporting them to provide an activity they could share with others. The activity coordinator said, "It does not all have to come from me, we [the people and the activity coordinator] can feed off each other." This was a good example, of how an older person's contribution was respected, valued and put to good use to give others new experiences. This approach also helped to give people a sense of purpose and self-worth. One person said, "I thoroughly enjoy what [name of activity coordinator] organises for us."

People were able to raise a complaint or an area of dissatisfaction and have this listened to and addressed. Information about how to make a complaint was seen on notice boards and was seen in the home's Statement of Purpose, which was provided to people on admission. The complaints file contained one complaint the registered manager told us they had received since the last inspection on 3 and 5 September 2016. Records showed that an investigation had taken place, which had included obtaining statements from the staff involved. A final response had been provided to the complainant ten days after receiving the complaint. The provider's complaint policy gives a time frame of 28 days for this. We spoke with another relative of the family who had been aware of the issues that had been raised. They confirmed they were happy that the needs around which the complaint had been made were being met.

People were supported to have a comfortable, dignified and pain-free death. At the time of the inspection no-one was in the last few days of life but staff had recently supported several people who had been. Staff started to explore people's specific end of life wishes, including details of spiritual and cultural preferences soon after admission. This was done so people had opportunities to express their wishes whilst they were well enough to do so and, so that staff were aware of these and could meet them at any time. Records showed that some people had wanted to have these conversations and others had not. However, records showed that advanced end of life care planning was an on-going process, which was added to as and when information was gathered. Some advanced care plans had recorded for example, that people's specific wish was to die at Knightsbridge Lodge and not in hospital and to not receive treatment which prolonged their life.

Staff supported relatives and friends of people at the end of their life. Some staff had specific experience and skills in providing support to the bereaved. An end of life champion's role had recently been introduced. As this role evolved, the member of staff holding this would support best practice in end of life care. All staff had access to training which gave them an awareness of what kind of care and support a person should expect at the end of their life. Most staff had completed this, some being non-care staff. Further and more specific training in end of life care was planned for all care staff.

We reviewed some of the feedback comments, from relatives, who had witnessed their relative receive end of life care and who had also been personally supported at this time. One relative had commented "….staff showed much compassion to us all during [name's] final weeks and we remain grateful that [name] was able to pass away surrounded by people they knew." Another relative commented "… we cannot thank you enough in the way you cared for [name], especially during the last few weeks. It is a great comfort knowing [name] was so well cared for." A general comment made by this relative was "nothing was too much trouble."

Good

Is the service well-led?

Our findings

At the last inspection on 3 and 5 September 2016 we recommended the provider seek further advice on how to ensure improvements made to the quality monitoring systems could be sustained. During this inspection we found this recommendation had been acted on and effective quality monitoring arrangements were in place.

The registered manager audited checks completed by staff, to ensure care was provided in line with the provider's policies and met regulatory requirements: This included audits of care plans, infection control measures and health and safety checks. Once actions needed to improve the quality of the service had been completed, these were signed off by the registered manager. Effective quality monitoring of the service had helped to keep people safe, had led to improvements in practice and the services provided. This is reflected in the improved ratings in the key questions, Is the service effective and well-led? Which have been assessed as good and in the improved overall service rating.

Both the registered manager and deputy manager worked most days in the home. They were both often 'hands on' in delivering care and services so they frequently worked alongside the staff. They were aware of the day to day culture in the home and of the staffs' attitudes, values and behaviour. There were good working relationships in place and staff described both managers as "approachable" and "supportive". We observed good communication between managers and staff, with managers often giving praise and saying thank you. The deputy manager told us they knew the staff well and made themselves available when staff needed to talk with them. There were policies and procedures in place which allowed staff to formally raise concerns and grievances if needed and to have these addressed.

Both managers gave clear direction and communicated their expectations. Managers and staff were committed to the provider's values and visions of a caring, inclusive service which supported people to live well with whatever their disability was. Personalised care, tailored to meet people's individual needs, remained central to achieving this. Feedback from people and relatives was sought to help support this approach, but also to improve the service overall. The activity co-ordinator gathered the wider views of the people through informal conversation. The Provider Information Return (PIR) stated that 'resident' meetings were being encouraged to take place again. There was evidence of a supportive community within Knightsbridge Lodge as events such as a summer fete and bonfire evening had been well attended. These events along with the sale of various items such as marmalade, pickles, Christmas cards and tags had raised valuable amounts of money for the 'residents' amenity fund.

People were supported to be part of the wider community through church events and by visiting the local town's facilities and shops. The home had its own transport which could accommodate wheelchair users. Invitations to events which enabled people at Knightsbridge Lodge to socialise with people living in the wider community were welcomed. Prior to our visit an invitation had been accepted to the local town's senior citizen Christmas party. A comment made to the activity co-ordinator by one person when they were there had highlighted to staff how important it was to support community links. The person had said, "Do you know what was really nice is that I was able to sit and chat with that lady and we realised we came to

music concerts here all the time, way back when we both used to come to dances here."

Longstanding community links were in place with the local church and Salvation Army who visited the home regularly. The activity coordinator told us they were keen to establish new relationships within the more immediate local community. They were due to explore ideas with people, staff and those in the community about the home maybe playing host to a regular community based activity of some sort.

Managers ensured compliance with necessary regulations. This included forwarding appropriate notifications to us and displaying the inspection rating awarded to the home. They kept themselves aware of changes in legislation and best practice by being members of a provider forum and attending various social care and health related conferences and workshops. They took learning back from these in order to influence and change practice and improve the service generally.