

Royal British Legion Industries Ltd

Gavin Astor House Nursing Home

Inspection report

Royal British Legion Industries
Royal British Legion Village
Aylesford
Kent
ME20 7NF

Tel: 01622791056

Website: www.gavinastorhouse.org.uk

Date of inspection visit:
28 March 2018
05 April 2018

Date of publication:
12 June 2018

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 was carried out on 28 March and 5 April 2018. The inspection was unannounced.

Gavin Astor House 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.

Gavin Astor House is a purpose built care home registered to provide accommodation and nursing care to up to 50 adults. The service provides nursing care to adults over age 18 with physical disabilities as well as to older people. Gavin Astor House is owned by the Royal British Legion Industries. The home is situated in grounds within the Royal British Legion village, there is ample parking. All rooms are single with en-suite facilities. There were 42 people living there at the time of our inspection; 40 people on a permanent basis and two people staying for a period of respite.

At the last inspection on 7 and 8 December 2016, the service was rated Requires Improvement. At this inspection the service was rated Good.

At our last inspection in December 2016, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach related to the people's care plans not being updated to ensure they contained the relevant information to inform staff how to meet people's assessed needs, in particular information pertaining to nutrition and hydration. This inspection took place to check that the registered provider had made improvements to meet the regulation. We found that improvements had been made and the breach had been met.

The service had a registered manager in post who had worked for the organisation for a number of years. The registered manager was moving to a new role within the organisation and a new manager had been recruited. At the time of our inspection the new manager was working alongside the registered manager whilst they were in the process of completing the provider's induction. 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.

There were mixed views regarding the deployment of staff. Some people told us their calls bells took a long time to be answered by staff whereas relatives told us they felt there were enough staff. People's needs had been assessed and recorded; the registered manager used an assessment tool to monitor the number of staff required to meet people's assessed needs. Observations and records showed there were enough staff to meet people's needs.

People felt safe and were protected from the potential risk of harm and abuse. Staff understood their responsibilities for safeguarding people and followed the provider's policy and procedure. Potential risks to

people had been assessed and steps were taken to reduce any risks. The premises were well maintained and equipment had been regularly serviced to ensure it was in good working order.

The provider operated safe and robust recruitment and selection procedures to make sure staff were suitable and safe to work with people.

People received their medicines safely as prescribed by their GP. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed regularly. People were protected by the prevention and control of infection where possible, with systems in place to ensure the risks of contamination were minimised. Accidents and incidents were monitored and managed effectively.

People received a personalised service which was responsive to their needs. People and/or their relatives were involved in the development and review of their care plan. Guidance was in place to inform staff of how to meet people's needs whilst encouraging and promoting their independence.

People's nutrition and hydration needs were assessed and recorded. People received food they enjoyed and specific dietary requirements were catered for. Staff worked with health care professionals to ensure people remained as healthy as possible.

People were treated as individuals, their equality, diversity and human rights were promoted and protected.

Staff at all levels were given the training, skills and confidence to meet people's needs. Staff were supported in their role by a member of the management team, this included clinical support and supervision for the registered nurses.

People were encouraged to make their own choices about their lives. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider supported staff's rights and made adaptations to the service to meet people's needs.

Effective systems were in place to enable the provider and the management team to assess, monitor and improve the quality and safety of the service. Records were maintained adequately and kept securely.

Staff respected people's privacy and dignity. Interactions between staff and people were caring and kind. Staff were patient, compassionate and they demonstrated affection and warmth in their discussions with people. Staff knew people well and had knowledge about people's histories, likes and dislikes.

People were offered the opportunity to participate in a range of activities to meet their needs and interests. The views of people and others were sought and acted on. People knew who to speak to if they were unhappy. Complaints were managed in line with the provider's policy; complaints were used as a way to learn and improve the service that was provided to people.

The management team worked in partnership with external organisations to promote best practice and to develop and promote a positive culture between the staff, supporting people that had dementia.

The registered manager and the management team understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken.

Further information is in the detailed findings below.

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.

Staff were effectively deployed to meet people's needs.

People felt safe living at the service. Staff protected people from the risk of harm or abuse and knew how to identify and raise safeguarding concerns.

People received their medicines as prescribed by their GP, by staff that were trained to do so.

People were protected from the risk of infection and cross contamination. The premises were clean and maintained.

Potential risks to people, staff and visitors had been assessed and recorded. Action had been taken to reduce any potential risks.

Is the service effective?

Good ●

The service was effective.

People had access to the food and drink they enjoyed. People's nutrition and hydration were assessed with action taken if additional support was required.

People were supported to remain as healthy as possible with support from health care professionals.

People's needs were assessed and recorded prior to receiving care and support.

Staff received the support, skills and knowledge to fulfil their role to meet people's needs, including their specialist needs.

People were encouraged to make their own choices about everyday decisions. People were asked their consent by staff prior to any care and support tasks being carried out.

Is the service caring?

Good ●

The service was caring.

People received compassionate support from staff that were kind and caring.

Staff protected people's privacy and dignity whilst encouraging people to maintain their independence.

People and/or their relatives were involved in the planning and delivery of their care.

People were supported to maintain relationships with people who mattered to them.

Personal information was stored securely to maintain confidentiality.

Is the service responsive?

Good ●

The service was responsive.

Care plans were person centred and included comprehensive guidance to staff regarding how to meet people's needs.

People's documents were regularly reviewed to ensure staff were following the most up to date guidance.

People were supported and encouraged to participate in a range of activities to meet their needs and interests.

People that were receiving care at the end of their life had been involved in discussions about the care they wanted to receive.

Systems were in place for people and their relatives to raise any concerns or complaints. Complaints had been responded to appropriately as per the provider's policy.

Is the service well-led?

Good ●

The service was well-led.

There was an experienced management team in place who promoted an open culture and kept staff informed about changes within the service.

Systems were in place to monitor the quality of the service that was provided to people. Action was taken to improve the service when suggestions were made.

The registered manager worked in partnership with external organisations to promote best practice and increase staff's knowledge.

The management team had a vision for the service which included refurbishment of the entire service.

Gavin Astor House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 28 March and 5 April 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a nurse with expertise in medicines management and end of life care 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. The expert-by-experience for this inspection had experience in care for older people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We observed staff interactions with people and observed care and support in communal areas. We spoke with 11 people about the care and support they received. We spoke with eight relatives and visitors about their experience of the service. We spoke with eight staff, which included two care assistants, two registered nurses, the clinical lead, the nominated individual, the registered manager and the new manager.

We requested information by email from local authority care managers and commissioners who were health and social care professionals involved in the service, to obtain their feedback and views about the service.

We looked at the provider's records. These included eight people's care records, which included care plans,

health records, risk assessments, daily care records and medicines records. We looked at documentation that related to staff management and recruitment including four staff files. We also looked at a sample of audits, satisfaction surveys, staff rotas, minutes of meetings and policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including staff training records, the training plan and confirmation of the electrical hard wiring test. The information we requested was sent to us in a timely manner.

Is the service safe?

Our findings

People told us they felt safe living at Gavin Astor House Nursing Home, and, with the staff who provided care and support. One person said, "I feel safe the doors are always locked and the carers are always around." Another person said, "I feel safe the staff are very good." A third person said, "I feel safe because when I lived on my own I felt isolated."

Relatives told us they felt their loved one received safe care. One relative said, "I feel he is safe here, he has 24 hour care, there is someone on hand all of the time."

People were protected from the potential risk of harm and abuse, by staff who knew the potential signs of abuse and the action to take if they had any suspicions. Staff told us and records confirmed staff had received training relating to the safeguarding of adults. Staff said they felt confident any concerns they raised would be taken seriously by the registered manager and management team. Staff understood the whistleblowing procedure and knew they could take concerns to agencies outside of the service anonymously. People's personal precious items were protected from the potential risk of theft, with lockable cupboards available within people's bedrooms. People's belongings were inventoried on admission to the service. Some people had chosen to keep the key to their bedroom door and locked the room when they were not in it.

People were protected by safe recruitment procedures. We looked at four recruitment files of staff that had been recruited since the last inspection. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character. These included obtaining suitable references, identity checks, health declaration and completing a Disclosure and Barring Service (DBS) background check. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Staff completed an application form, gave a full employment history, showed proof of identity and had a formal interview as part of their recruitment. Written references from previous employers had been obtained. Records showed the recruitment lead had checked nurses registration was current, and they were on the professional register of practising nurses (NMC). People could be confident recruitment systems were robust and made sure the right staff were recruited to keep people safe.

People told us they felt there were not sufficient staff on duty and calls bells took a long time to be answered. One person said, "Not enough carers we are left sometimes 20 minutes waiting for them after we have made a call." Another person said, "Not enough staff, they don't come quick enough when I push the bell." A third person said, "Sometimes there are too many but sometimes not enough." Whereas a relative said, "I have never had a problem that I couldn't find a member of staff when I need one." The new manager had spoken to staff regarding the importance of answering calls bells in a timely way.

The registered manager told us staffing levels were based on people's assessed needs. The registered manager used an assessment tool to determine the total amount of support hours each person required, this had been reflected in the rotas seen. However, staff spoken with felt there had been staff shortages and

"lots of use of agency", which had affected staff on shift. One staff member talked about how staff had phoned in sick and cover could not be found and how staff were taken off shift when people had hospital appointments as extra staff could not be found. The new manager told us there had been a recent recruitment drive and we were told that all but one vacancy had been offered to prospective staff subject to recruitment checks.

Staff were supported by the activities staff, the management team, housekeeping, maintenance and administration staff. An additional nurse also supported staff as required with assessments, admissions and the monthly medicine delivery. There was an on-call rota in place for emergencies.

At our last inspection in December 2016 we made a recommendation about the placement and recording of people's medicated pain patches. At this inspection we found that action had been taken to ensure the site was rotated in line with the manufacturers' guidance, this was to avoid skin irritation.

People's medicines were managed and administered safely. People received their medicines as prescribed. People told us they received their medicines regularly. Comments included, "Medicines are always on time.", "Medicines come regularly. I can ask for extra pain killers if I need them." We checked medicines against the records within the service and observed the administration of people's medicines. Nurses held the responsibility for administering people's medicines. Nurses including agency nurses completed an induction which included observations of the medicines round, before they were signed off as being competent to administer medicines. Medicines were observed to be administered in a calm and unrushed manner, ensuring people received the support they required. Medicines were stored safely, securely, and at appropriate temperatures, including medicines which required refrigeration. There were suitable arrangements for the storage and recording of medicines which required additional safe storage. Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. Some people were prescribed topical creams and records showed these had been used as prescribed.

Each person had detailed information and written guidance for staff in relation to 'as and when required' (PRN) medicines. The guidance included the reason for administration, the frequency, and the maximum dose that could be given over a set period of time. Relatives told us they felt the staff were responsive to their loved ones' needs. One relative said, "[Loved one] was struggling to swallow paracetamol tablets so the nurse has proactively gone to the doctor to change to liquid." Another relative told us their loved one was unable to tell the staff verbally if they were in pain, however, the staff were able to see from their loved one's facial expressions.

Lessons were learnt and improvements were made when things went wrong. The registered manager told us that following a recent medicine error, all staff were reminded of the medicine policies and procedure and the need to adhere to these. Additional monitoring had also been implemented to minimise the risk of the error reoccurring. Another example, was given when a member of staff had fallen over an electrical wire from a persons' bed. As a result new guidance was produced regarding how any wires from people's beds should be stored.

People were protected from the risk of infection, by the systems and processes that were in place to prevent and control the risk of infection. The provider employed a head of housekeeping who managed a team of housekeeping staff; there were four housekeepers on duty over seven days a week. Each housekeeper had their own cleaning trolley and followed a schedule of cleaning tasks, set by the head of housekeeping. We observed the service was clean and odour free. The head of housekeeping completed infection control audits to ensure best practice guidelines were followed.

Substances hazardous to health were kept securely within a locked cupboard in order to minimise the risk of people using them inappropriately. Staff had knowledge of infection control procedures, and, were observed using personal protective equipment (PPE) such as, gloves and aprons. The laundry was well managed, clean and dirty laundry was kept separated. The service had devices fitted in communal areas to sterilise the air to prevent outbreaks of infectious diseases.

Staff had up to date information to meet people's needs and to reduce risks. Potential risks to people, in their everyday lives, had been identified, such as risks relating to personal care, their health, mobility, regaining confidence and re-learning their daily life skills. Each risk had been assessed in relation to the needs of the person. Measures were in place to reduce risks and guidance was in place for staff to follow about the action they needed to take to protect people from harm. If people required specific equipment a risk assessment had been completed, for example the use of a profiling bed and an air mattress. Risk assessments were kept under constant review by the unit managers and updated accordingly. Members of the management team completed training regarding the completion of risk assessments. General risks relating to people, staff or visitors had been assessed such as, cleaning equipment and fluid (COSHH) and display screen assessments for people using a computer.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. The service had access to maintenance staff each Monday, Wednesday and Friday for routine jobs and they were on call for urgent work. Work was undertaken in a timely way. We looked at servicing and testing records for portable appliances (PAT), profiling beds and hoists, pressure relieving mattresses, lifts and the water supply. All had been serviced within recommended dates and there was a legionella risk assessment. Hot water valves were serviced quarterly, to avoid the risk of scalding. These checks enabled people to live in a safe and adequately maintained environment.

Each person had a personal emergency evacuation plan (PEEP) in place which provided guidance to staff on how to support people in an emergency. The provider had a business continuity plan in place for the event of an emergency such as, extreme weather, utility failure or a flood. An emergency 'fire box' was stored securely in the nurse's station within the entrance hall, along with items such as torches and first aid items. People's safety in the event of a fire had been assessed and recorded.

Accidents and incidents were recorded and monitored on a regular basis. Staff completed an accident form which was then investigated and reviewed by a member of the management team. A monthly analysis of all incidents and accidents were completed by the management team which highlighted any patterns or trends that had developed. The new manager told us they planned to implement a new system where all forms would go to them to view; this would enable the manager to have oversight of all accidents and incidents.

Is the service effective?

Our findings

People told us they enjoyed the food they received. One person said, "I think the food is pretty good and if I don't like it I tell the chef." Another person said, "The food is good, you can always have something different if you don't like what is on the menu." A third person said, "Food is reasonable, we have a take away evening once a month Indian, Chinese or fish and chips."

At our inspection on the 7 and 8 December 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The provider had failed to ensure people who received their nutrition and hydration through percutaneous endoscopic gastrostomy (PEG) did so adequately, and, the recording of people's food and fluid intake was insufficient. A PEG is where specialised food is passed into a person's stomach through a tube. This procedure is used when people are unable to have food orally because of difficulty or inability to swallow. At this inspection, we found that improvements had been made, people had received the right amount of food and fluid to maintain good health, and weights were also checked to verify this. If there were issues that had been identified the person's doctor was contacted. Any concerns were also discussed during the staff handover. This breach has now been met.

People's nutritional needs had been assessed and recorded; these had been reviewed on a regular basis. People who had been assessed to be at a high risk of malnutrition or dehydration had a record of their food and fluid intake. People's weight had been monitored on a regular basis, this was completed in conjunction with a nutritional screening tool.

People were supported to maintain their nutrition and hydration. The provider used an external catering company to manage the kitchen and prepare food and drinks for people. People had a choice of two hot meals for lunch, with the addition of a vegetarian option and a specials board. Meals were freshly prepared and cooked with locally sourced ingredients, and were nutritionally balanced. We observed the lunch service in the dining room, lunch was relaxed with people chatting to one another across the table. The dining room was accessible to all with tables at different heights and table cloths at different lengths to accommodate people's varying needs, such as the use of different wheelchair models. People were offered condiments with their meals. One person said, "I don't have gravy ever but I like my sauces, they know me very well." People were offered a variety of drinks with their meal including, hot, cold and alcoholic.

The catering team were aware of people who had specific dietary requirements such as, a fortified diet and a soft or pureed diet. A copy of any specific eating guidelines, likes, dislikes and allergies was kept in the kitchen. There was a food comments book which was used to record any suggestions or opinions. Records showed people had requested a greater variety of ice cream flavours and the option of hot plates and bowls; this had been actioned by the catering team. The kitchen had scored a five rating (5 is the highest) at the last environmental health visit in April 2017.

A member of the management team carried out an initial assessment with people and/or their relatives prior to them starting to use the service. Initial referrals came through social services or a fast track continuing health care assessment for people who were being discharged from hospital. The providers' pre-

admission assessment took into account the person's care and support needs, communication, eating and drinking, mobility, social needs and expressed sexuality. They included details about how the person wanted to be supported and were written in conjunction with people's families if necessary. For example, one person's assessment recorded that they liked a small drop of vodka before bed. Once the person had moved into the service a further nursing admission checklist was completed which included, allocating a designated nurse to the person, a GP registration form and the completion of the person's medicines records.

People's health was monitored and when it was necessary health care professionals were involved to make sure people remained as healthy as possible. There was a team based within the service which consisted of a clinical lead, registered nurses and care staff, that worked alongside external health care professionals. All appointments with professionals such as doctors, district nurses, physiotherapists, dieticians, speech and language therapists and opticians had been recorded with any outcome. Future appointments had been scheduled and there was evidence that people had regular health checks. The GP visited and supported the service on a regular basis. People had been supported to remain as healthy as possible, and any changes in people's health were acted on quickly.

People who had been assessed as being at high risk of developing skin and tissue damage, had clear guidance for staff to follow to reduce the risk of occurrence. Equipment was available and in use for people such as, pressure relieving mattresses and cushions. Each person had been assessed by the relevant health care professional. A health care professional told us they felt the service was 'very proactive' in relation to the pressure area care.

People received nursing and personal care from staff that had the skills and knowledge to meet their needs. Staff told us they felt they received effective training to meet people's needs. One member of staff said, "training is superb", however they felt there had been a recent lack of training courses provided. The training matrix showed a number of staff had not received the required refresher training in subjects such as, first aid, fire safety and infection control; the new manager told us they were aware of the shortfalls and were in discussions with the training provider to ensure staff received the refresher training they required. Following the inspection the new manager sent through a training plan to ensure all staff had completed their refresher training courses by July 2018.

Staff received training to meet people's specialist needs such as, dementia awareness, wound management and multiple conditions such as, epilepsy, diabetes, stroke, Parkinson's and multiple sclerosis. On the day of our inspection the registered nurses were completing training regarding the verification of death; this had been arranged by the new manager in conjunction with another provider. The clinical lead for the service supported the registered nurses with their continuing professional development training. Registered nurses were supported to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. These courses enabled the registered nurses and staff to feel confident in their role and provide people with the care and support they required.

New staff had undertaken the provider's induction which included training, completion of the Care Certificate and working alongside experienced staff. The Care Certificate includes assessments of course work and observations to ensure staff meet the necessary standards to work safely unsupervised. The provider's mandatory training included; equality and diversity, medicines administration, health and safety, safeguarding adults, moving and handling, infection control and personal care. Care staff were offered the opportunity to complete a formal qualification during their employment. For example, Qualifications and Credit Framework (QCF) in Health and Social Care, this is an accredited qualification.

Staff told us they felt supported in their role by their line manager and the senior management team. Systems were in place to provide support to staff through supervisions and an annual appraisal. Supervision provides opportunities for staff to discuss their performance, development and training needs.

People and staff's protected characteristics, such as their race, religion, sexual orientation or disability, were supported by the provider. There were equality and diversity policies in place for staff to follow, and, staff received training in this subject, this helped staff promote people's equality, diversity and human rights. Nobody we spoke to had been discriminated against because of their protected characteristics at the time of our inspection. Records showed that the senior management team had made adaptations to staffs' working roles and people's environment to ensure people's rights were promoted.

The premises had been adapted and decorated for the people who lived at the service. For example, widened door frames and corridors for different sized wheelchairs. People's bedrooms were personalised with items that had meaning such as photographs or pictures. People were able to access the garden where they were able to sit and spend time alone or with a loved one. Flower planters were arranged at different heights for people to access if they enjoyed gardening.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA 2005, and whether any conditions or authorisations to deprive a person of their liberty were in place. The registered manager, management team and the care staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005, and the Deprivation of Liberty Safeguards (DoLS). All staff had been trained to understand and use these in practice. People's consent was gained by themselves and staff talking through their care and support or by staff offering choices. People had signed their care plan and consented for things such as, personal care tasks, medicine administration and a personal preference form. Records showed when people had been assessed as not having the relevant mental capacity; meetings had been held with appropriate parties to reach a decision in their best interest, considering the least restrictive options. We observed people being asked for their consent before being offered support from the staff with eating and with moving around the service.

At our last inspection in December 2016 we made a recommendation that the registered manager implemented a system to monitor, track and report DoLS applications, authorisations and conditions. At this inspection we found that the registered manager had implemented a tracking system for all DoLS applications. The tracker enabled the management team to see at a glance the status of any applications that had been made, the renewal date and any further comments such as conditions that had been included with the authorisation. Records showed that DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said, "There are no better staff than these, the day staff have an awful lot to do." Another person said, "The staff all have a good sense of humour that is important." A third person said they were, "Very happy with the care, lovely helpful staff, all of them have time for me." A fourth person said, "The male activity leader is the best member of staff."

A relative said they felt Gavin Astor House was a, "Very nice place, you couldn't get better care than [loved one] is getting." A health care professional wrote, 'The staff are always welcoming and respectful of client confidentiality and dignity.'

People told us they were treated with dignity and respect by staff who promoted their independence. One person said they felt, "Quite independent, always wash myself." We observed staff gently encouraging people to eat their meal independently at lunchtime. People told us and we observed staff knocking on people's bedroom doors and waiting for an answer before entering. One person said staff, "Always knock on the door and are quite discreet, they put a towel in the right place during personal care." Another person said staff, "Always knock on the door and very discreet with personal care." Staff gave examples of how they protected people's privacy and dignity whilst offering them care and support. For example, closing doors, covering people up with a towel following personal care, closing the curtains and asking people if they want to be on their own.

Relatives told us they felt the staff treated their loved one with dignity and compassion. One relative said the staff were, "Very discreet and considerate, they take it at [loved one's] pace, very gentle, everything that you would want. Very calm and they know what they are doing." Another relative said, "[Loved one] is hoisted for their shower but they [staff] always explain what they are doing."

Observations between people and staff showed conversations were warm and friendly. Staff spoke discreetly to people when offering support with tasks such as, cutting up the persons' meal at lunchtime. Some people did not use verbal communication to express their needs. Detailed communication plans were in place to guide and inform staff how to promote effective communication, between themselves and the person. We observed a member of staff using verbal and nonverbal communication skills when describing a drink to a person; the member of staff also knelt down to the person's eye level to maintain eye contact and observe the person's facial expressions and gestures.

People and or their relatives were involved in the planning and delivery of their care. One person said, "I can get up when I like and go to bed when I like." People's care plans included clear information and guidance about their individual support needs, their preferences, likes, dislikes and interests. People and their families were encouraged to share information about their life history with staff to help staff get to know about people's backgrounds. A relative said, "I wrote a story about mum's life to help people get to know her and everybody had read it before she got here." Staff knew people well and were observed talking to people about what they had been doing and their family members.

People were supported to maintain as much contact with their friends and family as they wanted. Relatives and visitors told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. There was a kitchenette area within the dining room where visitors were able to access refreshments. People invited their relatives and friends to the planned entertainment. We saw some visitors participated in the external singing on the first day of our inspection and the flower arranging afternoon on the second day of our inspection.

People's confidential records relating to their care were kept secure within the nurses stations, only people who had permission to access the files could. Staff understood the importance of maintaining people's confidentiality through the providers' induction and ongoing training programme.

Is the service responsive?

Our findings

People told us they had access to a range of activities to meet their needs and interests. One person said there were, "Quite a few things going on, day trips to garden centres and the coast." Another person said, "I have a paper delivered daily." A third person said, "A very interesting man comes in and does really interesting talks." A fourth person said, "We've had visits from various creatures including snakes, beetles and spiders."

At our inspection on the 7 and 8 December 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The provider had failed to ensure care plans were in place to meet all aspects of people's needs. The registered manager had implemented a new care plan system; however, not all of the files had been transferred over to the new system. At this inspection, we found that people's care plans were complete and contained the relevant information to meet people's needs. This breach has now been met.

People received a personalised service that was responsive to their needs. Care plans were person centred and contained information about how each person should be supported in all areas of their care and support. People and their relatives told us they were involved in the regular review of their care plan. A health care professional wrote, 'The care plans and other client paperwork are comprehensive and appropriate.' Care plans were detailed and informed staff what the persons' abilities were and the support they required from staff. Care plans contained a detailed medical history and health needs of the person and included details of emergency contact information such as the next of kin, religious beliefs, social history, expressed sexuality and preferred gender of carer. Staff knew about people's needs and their backgrounds and the care and support they required. People's care plans provided consistent and up to date information about each individual.

People's care plans were reviewed on a regular basis, changes were made when their support needs changed, to ensure staff were following up to date guidance. People, if able, were fully involved in the development and review of their care plans. One person said, "They review my care plan regularly." A relative said, "The care plan is being reviewed all the time." People and their relatives took part in formal care review meetings which involved health care professionals. Each person had a named nurse who had responsibility, alongside the unit managers, for ensuring people's care records were reviewed and updated. The unit managers were registered nurses that managed each of the two units.

The provider employed an activities co-ordinator who managed another member of the activities team and the team of volunteers. The service owned an accessible mini bus which was used for trips out into the community. The activities team spent time with people to find out their likes, dislikes and interests. The activities programme was then developed using this information and offered a varied range of activities within the service and out in the local community. A monthly activity planner was given to people and displayed on the notice board. Activities within the service included, pet therapy, visiting musicians, bingo, flower arranging and aromatherapy. Activities out in the community included, trips to the coast, steam railways, lunch out and an annual trip to Buckingham Palace for the 'not forgotten' party. This is an annual

event for the benefit of War Pensioners and service personnel.

The activities co-ordinator was supported by at least one volunteer five days a week. The volunteer's role was supporting people on a one to one basis, spending between 15 minutes and one hour with people. One to one activities included reading with and to people, spending time in the garden, playing games such as, cards or dominos and going for a coffee at the local Hospice over the road. The activities co-ordinator audited people's activities on a weekly basis, this information was used to ensure each person had interacted with people either during an activity or on a one to one basis. The one to one activities reduced the risk of social isolation for people that were cared for in bed. A relative told us the activities team regularly spent time with their loved one on a one to one basis. One person said, "I don't really take part in the activities, one lady comes round the rooms playing her guitar, she is very good." The activities co-ordinator had sourced a local musician who visited each person in their bedroom to play and sing a song of the person's choice.

On the second day of our inspection we observed the flower arranging activity. There were five people taking part, all were chatting, smiling and laughing. The activities co-ordinator showed one person a choice of two vases which they were able to fill with fresh flowers. These vases were then displayed on the dining room tables where people ate their meals. A conversation took place between the group regarding the various methods they had previously used to keep fresh flowers alive for longer. People appeared to enjoy the session and were engaged in conversation throughout. On the first day of our inspection an external singer visited the service to perform in the dining room, there were 16 people who had chosen to attend and some relatives. People were observed singing, waving their arms and smiling.

People and their relatives told us they knew who to speak to if they had any concerns or complaints, they felt staff would listen and take action. Complaints were seen by the registered manager and management team as positive and a way the service provided to people could be improved. One person said, "On the whole everything is good, I can't complaint about anything." A relative told us they had a small "niggle" which was dealt with promptly by the staff team. The provider had a complaints policy which included the procedure which would be followed in the event of a complaint. An accessible information booklet had been provided to people informing them of ways they could give feedback about the service. Records showed that complaints that had been raised had been investigated and responded to as per the provider's policy. Examples of complaints that had been raised included the conduct of a member of staff and a missing item of jewellery. Complaints were audited by the registered manager on a monthly basis. People, their relatives and others could be assured their complaints and feedback would be listened to and acted on.

A communication book was used between care staff, the management team and the housekeeping team, this enabled any areas which required attention to be prioritised. A comments book was used when any concerns or suggestions had been made by people. Records showed that people had raised concerns about items of their clothing going missing. Following this feedback a clothes labelling machine was purchased to reduce the risk of clothing being given to the wrong person.

The management team kept copies of the compliments that staff had received; these were in the form of cards and letters. One card dated March 2018 read, 'I just wanted to thank you for being so kind to [name] and I and making everything smoother and easier settling into Gavin Astor.' Another card from March 2018 read, '[Name] and I would like to thank you all for the very kind and alternative care which mum has received especially in her last weeks.' Another card from March 2018 read, 'With gratitude for all the care and attention you have given to my aunt during her many years in the home, it is very much appreciated.' A letter from February 2018 read, 'The chefs in the kitchen should be proud.' Another card from February 2018 read,

'A very big thank you for the excellent care you gave mum in making her comfortable with the best quality of life she could have in her last difficult year.'

People's end of life care had been discussed with them and/or their relatives and recorded within their care plan. People's wishes had been respected if they had chosen not to discuss things. Some people's care plans recorded specific preferences such as whether they wanted to be buried or cremated. There was a holistic approach to people who were at or nearing to the end of their life. The service worked in partnership with the palliative care team from the local hospice to ensure appropriate pain relief medicine was in place. Records showed a person had requested information regarding funeral plans which had been sourced by the staff team.

Is the service well-led?

Our findings

People and their relatives spoke highly of the registered manager and the management team and felt confident in approaching them. One person said, "I have been introduced to the new manager." A relative said, "I know the new manager and I am perfectly happy to speak to the manager with any concerns." Another relative said when talking about the management team, "They always give me the time when I phone up."

The service had an experienced registered manager in post who had worked at the service for a number of years. The registered manager was changing their position within the organisation and at the time of our inspection a new manager had been recruited and had been in post for six weeks, completing their induction. The nominated individual who was also a senior manager told us the organisation wanted to ensure a transition and handover period between the two managers. The new manager had submitted their application to become the registered manager of the service.

Staff told us they felt there was an open culture between themselves and the management team, and they were asked for their feedback on a regular basis. Staff understood the management structure and who they were accountable to. Staff said they understood their role and responsibilities and said this was also outlined in their job description and contract of employment. There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. For example, equal opportunities policy, capability policy and staff recruitment and selection. Staff knew where to access the information they needed.

The new manager had started to work in partnership with other external companies such as the local safeguarding team, continuing health care team and the local hospice. Staff from Gavin Astor House had recently attended training alongside the staff from the local hospice.

Staff and people were kept informed about people's care needs and about any other issues. The new manager had introduced morning meetings with the heads of departments, this included, the clinical lead, housekeeping, catering and activities. These meetings were used as a way to discuss what had occurred the previous day and anything that was planned for that day. We observed this meeting on the first day of our inspection, topics of discussions included, changes in people's health, new assessment taking place, hospital discharges, staffing absences and planned health visitor visits. Regular team meetings were held so staff could discuss practice and gain some feedback from observations made by the management team. Staff meetings gave staff the opportunity to give their views about the service and to suggest any improvements. Staff handovers between shifts highlighted any changes in people's health and care needs, this ensured staff were aware of any changes in people's health and care needs.

People and their relatives received a regular newsletter. This contained information about activities that had taken place, planned activities, staffing changes and updates about the service in general. People were asked for their feedback about the service they received through regular resident meetings, an annual questionnaire and a comments and suggestion box. People views and comments were listened to and acted

on. For example, someone had commented that the television reception was not good and did not offer a range of channels; as a result satellite TV and a Freeview box was made available. Another comment was made about the redecoration of the persons' bedroom; as a result people were given the option for the redecoration of their bedroom.

The nominated individual had secured funding for the refurbishment of Gavin Astor House. The vision and aim was to create a dementia friendly building. The new manager had been working in partnership with a national dementia care organisation who had been training staff and offering guidance. However, staff feedback to the new manager that they would benefit from training within the service to show how they put these skills into practice. As a result of this feedback the new manager had agreed with the nominated individual for the remainder of the investment to fund the national dementia care organisation team to work within the service alongside staff. The new manager said the senior management team had been "very receptive and supportive" of the decisions that had been made.

The provider had been accredited with the Investors in People award. Investors in People has a set of standards for better people management, including, what it takes to lead, support and manage people well for sustainable results. Staff told us they felt valued in their role within the service and the wider organisation.

Systems were in place to monitor the quality of the service that was being provided to people. The unit managers who were registered nurses undertook daily checks, which were recorded including checks on completion of fluid charts, MAR chart signatures, fridge and room temperatures. A monthly audit report was sent to the clinical commissioning group (CCG) which included information about incidents, deaths, accidents, assessments, medicine errors, care plans in place, complaints and staffing. There was a clinical audit monthly that looked at staffing vacancies, training, meetings, outcome of infection control audit, wound audit, accidents and incidents, complaints and compliments and CQC notifications. These audits generated action plans which were monitored and completed by the management team. Feedback from people, relatives, staff and the audits themselves were used to make changes and improve the service provided to people.

There was a monthly internal audit by the registered manager, which focused on different areas of systems in place, such as recruitment, admissions and care practices. It looked at systems against practices and a copy was sent to the Trustees, nominated individual and heads of department. The board of trustees are a group of volunteers who are responsible for the strategic direction, governance and policy of the organisation. Records showed that shortfalls were identified and followed up the next month to ensure action had been taken. The Trustees visited three monthly and met with senior staff to discuss audits and make observations. The nominated individual visited the service on a weekly basis to meet with the registered manager, discuss any concerns or outstanding actions and to sample documents such as, care plans.

The registered manager, the new manager and the management team had a clear understanding of their role and responsibility to provide quality care and support to people. They understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the hall

way. The rating had not been displayed on the provider's website; however, by the end of the first day of inspection this had been rectified.