Kensington Health Care Limited

Old Charlton House Residential Home

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 12 and 16 August 2016 and was unannounced. The home provides accommodation and personal care for up to 32 people, including people living with dementia or other mental health needs. There were 27 people living at the home when we visited. Accommodation was spread over three floors, connected by two passenger lifts and stairwells. All rooms had en-suite toilet and washing facilities. There was a lounge and a dining room on the ground floor and bathrooms on each of the floors. In addition, the basement contained the kitchen and the laundry room. A garden and patio were accessible to people via level access from the ground floor.

There was an experienced registered manager in place. 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.

People, relatives and healthcare professionals praised the quality of care delivered. Staff were skilled at meeting people's needs in a personalised way. They were suitably trained and supported in their work by the registered manager and deputy manager. They responded promptly when people's needs changed.

Staff sought consent from people before providing care and support. They followed legislation designed to protect people's freedom and knew how to keep people safe in the least restrictive way. They also encouraged people to make choices about every aspect of their lives. People told us they could "please themselves" what they did and how they spent their day. They had access to a wide range of activities, run by staff and volunteers, including level access to the garden.

People were cared for with kindness and compassion. Staff created a calm atmosphere in the home by supporting people in a patient and unhurried way. They supported people to build and maintain relationships. They protected people's privacy and dignity and involved them in planning the care and support they received.

People told us staff were always available to support them and their call bells were answered promptly. Safe recruitment processes were followed to help ensure only suitable staff were employed.

Individual and environmental risks to people were managed appropriately. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. Suitable arrangements were in place for the safe management of medicines; people received their medicines as prescribed and when needed.

People were offered a choice of nutritious meals which were freshly prepared daily at the home. They received appropriate support to eat when needed and were encouraged to drink often.

People were able to access healthcare services when needed. Staff were working with healthcare professionals to develop plans to prevent people being admitted to hospital unnecessarily. There were plans in place to deal with foreseeable emergencies and staff knew what action to take in the event of a fire.

The sole director of the provider's company was actively involved in running the home and there was a development plan in place to further enhance the service. Staff understood, and were committed to delivering, the vision of the director which aimed to provide high quality care in a relaxed, homely environment.

There was an open culture where visitors were welcomed at any time. Strong links with the community had been forged, to the benefit of people living at the home. Staff were happy in their work and this had led to a low level of staff turnover. An appropriate quality assurance system was in place that focused on continuous improvement.

The director sought and acted on feedback from people through the use of questionnaires, meetings and informal discussions. People knew how to complain and any concerns were addressed promptly.

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.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

People felt safe and staff had received training in safeguarding adults. Risks to people were managed appropriately and in a way that helped them retain their independence.

Medicines were managed safely and people received their medicines as prescribed. There were plans in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing care and support. They also followed legislation designed to protect people's freedom.

People received effective care from staff who were suitably trained and supported in their work.

People were offered a variety of nutritious meals and were encouraged to drink often. They were supported to access healthcare services whenever needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They created a calm atmosphere in which people felt relaxed.

Staff supported people to build and maintain relationships. They protected people's privacy and dignity at all times.

People were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. Staff responded promptly when people's needs changed.

People had access to a range of activities run by staff and volunteers.

The director sought and acted on feedback from people to help improve the service.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home. The director had a clear vision to create a happy, relaxed service delivering a high standard of care. Staff understood and were committed to delivering this vision.

There was an open and transparent culture. Positive links had been made with the community. Staff were happy in their work, felt supported by management and worked well as a team.

An effective quality assurance process was in place that focused on continuous improvement. The director was actively involved in running the service and a development plan was in place to further enhance the home.

Old Charlton House Residential 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 12 and 16 August 2016 and was unannounced. It was conducted by two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people living at the home, six friends or family members, a visiting doctor and a visiting specialist nurse. We spoke with the sole director of the provider's company, the registered manager, the deputy manager, five care staff, the cook and the administrator. We looked at care plans and associated records for five people, staff duty records, recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us staff had time to meet their needs and that call bells were answered promptly. One person said, "The staff aren't rushed. When I have a bath, twice a week, they ask if I want to stay there for a bit and come back later." Another person told us, "If I press my bell they come straight away, it's brilliant." A third person said, "I've got a bell in my room, If I press it [staff] come and see what I want; and they come pretty quickly too."

Staffing levels were determined by the registered manager, taking into account the number of people using the service and their needs, together with feedback from staff and people. The registered manager had identified that staff were particularly busy at shift changeover times. To address this, they had adjusted the shift times to provide an overlap between shifts. This allowed staff time to complete records and hand over information to the oncoming shift. They told us this had "really helped" and ensured that staff were "always available to support people". In addition to the set staffing levels, extra staff were brought in to support people when they needed one to one care, for example while receiving end of life care. Staff absence was covered by existing staff working additional hours or by the use of a small number of agency staff, who were familiar with the people at the home and worked alongside regular staff.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The registered manager carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

People felt safe at the home. One person said, "There's nothing that worries me; I'm looked after well." Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to mobilise using their walking frames; they remained close by, in case the person needed additional support, but allowed them to travel at their own speed and retain their independence. One person had fallen in their room on a number of occasions. Staff had recommended that the person move to another room where they might be less prone to fall. The person was aware of the risks, but had declined this offer as they wished to remain in their room; they had also declined the use of a pressure mat to alert staff when they were moving around their room. Staff had respected the person's decisions as they had full capacity to make them. The person did accept the suggestion of an additional support rail in their room and we saw this had been installed.

Other risks were also managed effectively. For example, fall saving equipment, such as walking sticks and frames, were in people's reach at all times and staff encouraged people to use them correctly. Where people had fallen, the person's risk assessment was reviewed and staff went to great lengths to consider any additional measures that could be put in place to protect the person. These included reviewing the layout of their rooms to remove hazards, using equipment to monitor people's movements and referring the person

to fall prevention specialists. The registered manager analysed each incidence of falls across the home to identify any patterns. None had been identified, but they described the action they would take if any trends were detected.

Staff demonstrated an understanding of pressure area care and used a nationally recognised tool to assess individual risks to people. Repositioning charts and preventive equipment, such as pressure relieving cushions and special mattresses were in use. Staff made sure cushions went with the person when they moved around the home or used different chairs, so they were protected at all times.

Risks posed by the environment had been assessed and were being managed appropriately. Additional handrails had been installed to support people in the corridors. Equipment, such as hoists and lifts were serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls and fire exit doors were alarmed so staff would be aware if anyone had left the building without staff support. The temperature of hot water at water outlets was controlled through special valves and maintenance staff monitored these regularly. This helped protect people from the risk of scalding.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines. Staff were suitably trained to administer medicines and had their competence assessed regularly by one of the managers. Medication administration records (MAR) confirmed that people received their medicines as prescribed. Comprehensive information was available to guide staff when administering 'as required' medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way. One person told us, "The staff will always give me pain relief if I need it and I will tell them if I am in pain." An appropriate process was in place to help ensure topical creams were not used beyond their safe 'use by' date.

There were plans in place to deal with foreseeable emergencies. The registered manager had identified safe havens for people if the home had to be evacuated. An emergency bag and file had been prepared containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support they would need if they had to be evacuated. In addition, a 'fire list' was updated daily to record the mobility of each resident that day. This demonstrated that staff took fire safety seriously and recognised that people's mobility changed from day to day.

Staff were aware of the action to take in the event of a fire. Improvements had been made to the fire safety arrangements, following a review by a specialist company. Further improvements were being considered, including the upgrading of the fire alarm system to enable staff to identify the location of a fire more quickly. Fire safety equipment was maintained and tested regularly.

Good

Is the service effective?

Our findings

People told us that staff asked for their consent before supporting them. One person told us "[Staff] don't make me do anything I don't want to." This was confirmed by the care records where people's decisions to decline care were clearly recorded. We also observed staff seeking people's verbal consent before providing them with care or support, such as offering to help them mobilise or to have an assisted wash. A staff member told us, "We can't presume that someone doesn't have the capacity to make a choice for themselves. We always need to get their consent before providing them with care." Another staff member said, "If someone declined care I would encourage, try a different approach, give the person time and space and try again later. If care was still declined I'd seek advice and support from other [staff]."

Staff followed the principles of the Mental Capacity Act 2005 (MCA). 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 take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

We identified two people lacked the capacity to make specific decisions. During the care planning process, managers had made decisions on their behalf and documented why they were in the person's best interests. These included decisions relating to the care and support people received and the administration of their medicines. Family members had also been consulted and their views had been taken into account. Whilst the managers had assessed people's capacity to make the decisions in question, they had not always used the standard two-stage test recommended by the MCA. This was unlikely to have affected the outcome for the two people we identified, but the registered manager took immediate action to improve the way people's capacity was assessed and recorded.

Where people had capacity to make decisions, this was recorded in their care files, which most people had signed to show their agreement with the care and support that was being delivered. For example, a pressure mat had been put in place to alert staff when a person was mobilising independently. The person had agreed to its use in order to keep them safe and had signed a consent form to confirm this. Some people had given authority to a representative to make decisions about their welfare. These are called Lasting Powers of Attorney (LPA). Copies had been taken of people's LPAs to confirm that their representative was entitled to act on their behalf. Records showed staff consulted and took account of the views of the person's representative at all times. For example, do not attempt resuscitation (DNAR) forms had been completed for some people and they and/or their representatives had been consulted about the decision in advance.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS authorisation had been submitted for two people and the registered manager was reviewing whether applications were needed for

other people living at the home. Risk assessments were in place to support the applications made and these were detailed and informative. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. For example, people who had the capacity to operate the electronic door lock had access to a fob which allowed them unrestricted access to come and go as they pleased.

People and their relatives spoke highly about the standard of care delivered. One person told us, "The care is excellent; you can't beat it." Another person said, "Since I've been here, I feel different; a lot brighter." A healthcare professional told us, "Care here is to a high standard. [Old Charlton House] is considered one of the more efficient homes; they're proactive, willing to listen and follow any suggestions we make. [Staff] raise concerns appropriately. People are well looked after and happy; they're involved and there is a good feeling in the home." We observed people looked cared for, in that they were wearing clean clothing that was appropriate for the weather and that their individual personal grooming needs were met such as haircare and nail care.

People's needs were met by staff who were skilled and suitably trained. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. A staff member told us, "The training is brilliant. I'm just doing end of life care at the moment and I've learnt a lot." Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques; and they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the registered manager and the deputy manager on a day to day basis.

People were complementary about the meals provided and from discussions and observations people clearly enjoyed their meals. One person told us "The food is very satisfactory, no complaints." Another person described them as "lovely". People were offered varied and nutritious meals which were freshly prepared daily at the home. A daily lunch menu was on display which consisted of a choice of two main meals. People were encouraged to sit in the dining room for lunch and a meal trolley was brought to their table allowing them to make informed choices about what they wished to eat. This also allowed the person to have choice over the portion size. One person told us that "If I didn't like the choices on offer, [staff] would get me something else; although that's never happened as I always like the food." Lunchtimes were a social event and meal times were relaxed. Staff were on hand to provide assistance and support when required. One person needed full support to eat and this was provided on a one-to-one basis in a patient and supportive way.

Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts.

Advice and support was requested in a timely manner when there were concerns in relation to people's intake or swallowing problems were identified. One person told us, "The only thing I want is white bread and butter but [staff recommend I don't] have this because of my swallow. They will tempt me with other things though." Staff monitored people's weight and took action when people started to lose unplanned weight. Food consistency was appropriate for people requiring pureed diets and the kitchen staff were mindful of the presentation of these to make them look as appetising as possible. Fresh drinks and snacks were readily available and offered throughout the day. The inspection took place on a hot day and we heard staff encouraging people to drink often, so they remained hydrated.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. Staff were working with nurses from the local doctors' surgery to develop 'admission avoidance plans' for each person. These were designed to prevent unnecessary admission to hospital and keep people at the home whenever possible. In the event that admission to hospital could not be avoided, each person had a 'transfer to hospital' form. This provided information about the person's health, medicines, care and communication needs to help medical staff understand more about the person and their needs.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. They described staff as "lovely" and "friendly". One person said of the staff, "There's a nice bit of banter between the staff and the residents. They are very attentive. I'm very impressed and very, very pleased." Another person told us, "All the staff are so kind. I've been spoilt here."

Staff supported people to build friendships and maintain relationships. Friends and family members were made welcome at any time and people could use the telephone to keep in touch with people who were important to them. When family members visited, staff took time to answer any questions they had and, on one occasion, invited them to have lunch with their relative. A family member told us, "The staff are always very approachable and kind." Another family member said, "[Staff] went to endless lengths to settle [my relative] in [when they first moved to the home]."

A family member told us their relative was usually "unsociable" but had formed a close friendship with another person living at the home and "spent time together every day, chatting". At lunchtime, people sat in small groups with like-minded people who they knew and got on with well. This created a positive ambiance which people clearly enjoyed.

All interactions we observed between people and staff were positive, encouraging and friendly. Staff were relaxed, while still being respectful and knew people and their backgrounds well. We observed numerous examples of staff using humour to engage people in conversation. People were gently encouraged to take part in activities and were thanked afterwards for having taken part. One person said, "The staff are so attentive; they're very good. I like it when we have a bit of a natter."

Staff created a calm atmosphere in the home by supporting people in a patient and unhurried way. When people were helped to mobilise, staff allowed them to move at their own pace whilst giving encouragement and reassurance. One person summed this up by saying, "I'm quite happy living here. I don't have to make an effort as I know [staff] well."

People were addressed by their preferred names. For example, one person liked staff to use their first name, whilst another person liked to be addressed as Mrs [name]. Staff naturally used these terms when discussing people and their needs and signs on people's doors referred to the person's preferred name.

People's privacy was protected at all times. One person, who stayed in their room, preferred to leave the door open. This had resulted in other people entering their room uninvited. To avoid this, staff had installed a retractable belt to pull across the doorway. This had provided a visible barrier and had been effective in deterring unwanted visitors.

Confidential information was kept securely and only accessed by those authorised to view it. Some important information was communicated to staff through the discreet use of colour coded signs on people's doors. This helped ensure people were provided with the necessary support in a consistent way.

When staff asked people if they wished to use the bathroom, or suggested they use a tissue to wipe their mouths, they did so quietly and tactfully, so as not to cause any embarrassment to the person.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. Comments in care plans, such as "discussed and agreed with [the person]", showed this process was on-going. Family members told us they were kept up to date with any changes to the health of their relatives. People had each been assigned a key worker. A key worker is a named member of staff who took responsibility for supporting a person and liaising with family members. Key workers held monthly review meetings with people to discuss their care and any changes they wished to make.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their needs. One person said, "I get all the help I need. [Staff] are always there for me and help me with whatever I need."

Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support. For example, a staff member told us, "We have to put toothpaste on [one person's] toothbrush for them. Sometimes they can manage to brush their own teeth, but other times we have to do it for them." Another staff member provided examples of how they supported two people living with dementia in different ways, based on their individual needs and their known preferences. They said, "Although [most people in the home] have dementia, each has a different form. Everyone is an individual and it affects them in different ways; they all have their own needs, which we get to know." Staff also knew which people needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time.

Care plans were comprehensive and covered a wide variety of topics, including: the person's normal daily routine, mobility, medicines, continence, hobbies and personal preferences. However, the 'daily plans of care', which provided advice and guidance to staff on how to support people, did not always support staff to deliver care in a consistent, individualised way. For example, information about people's personal care needs was limited to sentences such as "[The person] needs assistance from staff member with personal hygiene", but did not specify what assistance was needed. We discussed this with the registered manager, who agreed to review the level of detail recorded in people's daily plans of care.

At the beginning of each shift, a 'handover' meeting was held. We observed one of these meetings and heard people's needs being discussed in a professional, caring way. It was evident that the staff knew people well. During the meeting, there was a team discussion about the best way in which they could support a person's emotional and psychological needs, including actions to be taken by specific staff. The meeting also helped ensure people received continuous care and support and that concerns were followed up in a timely way. A staff member told us, "If we find a good way to support a person, we pass on the information to [other staff]." Staff told us they used the records from the meetings to help update themselves about changes to people's needs that had occurred while they were off duty or on holiday.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, and how and where they spent their day. Most people preferred to take their breakfast in their rooms, where they spent most of the morning. People then tended to use the communal areas of the home in the afternoons. However, they told us they could "please themselves" about this or any other matter. One person said, "There are no strict rules and everyone is very pleasant." Comments by one person in response to a survey by the provider included: "We're left to ourselves what we do in the day, which is nice." A staff member confirmed this and said, "We support people to do their own thing in their own time." Another staff member told us, "Sometimes [one person] doesn't like to get up in the morning, so I

will just make sure they are OK, comfortable and have a drink. I will then go back to them later."

Staff responded promptly when people's needs changed. For example, records showed that medical attention had been sought when people were not well or had appeared unusually confused or withdrawn. A staff member told us, "[One person] had a swollen leg [and] arranged for her to have a check-up in hospital; it turned out she had a [serious condition that needed immediate treatment]." Another staff member said, "I will consider that someone may have a urinary tract infection or be suffering from constipation if there is a change in their mental capacity or mood and report this to the manager."

A family member told us their relative had recently moved to the home and had been having difficulty finding their way to the bathroom at night. They said the problem was "solved by leaving a light on in the bathroom". They said, "It's very easy to work with [staff] to solve things." They added that their relative was now "happy and settled".

Some people had diabetes and staff monitored their blood sugar levels in accordance with instructions given by their doctors. Information in people's care plans provided clear guidance to staff about actions to take if blood sugar levels were particularly high or low. Staff were attempting to obtain further information about people's normal blood sugar levels from one of the doctors, to help them identify when they needed to take action.

People had access to a wide range of activities. These were advertised on the home's notice board and people were encouraged to take part. They included discussions about local news, reminiscence through the use of objects from people's past, quizzes and seated exercises. During the inspection we observed a word-guessing game which was well attended with lots of participation from people. Staff told us about a visit from a group that cared for birds of prey. They said, "[One person] didn't ever speak but had a wonderful interaction with a snowy owl; they got a lot out of it."

Staff and volunteers also spent time on a one-to-one basis with people who chose not to engage in group activities. The registered manager told us, "Families tell us what [activities] people used to enjoy, but we find that some people don't want to do the same things they once enjoyed and their interests and abilities may change as they get older. So it's a case of finding out what the person wants to do now. So it's a question finding out what the person wants." Four volunteers had been recruited to help run activities, including one who brought a 'pat dog' to the home on a regular basis. People told us they enjoyed stroking and interacting with the dog as it reminded them of dogs they had owned.

People had free access to the garden and we observed some people using the outside space. They were offered the choice of a seat in the sun or one in the shade. Those in the sun were offered sun hats and sun block to keep them comfortable and protect them from sun burn. Staff were observed to regularly check on people who were sat in the garden to ensure they were not getting too hot and had enough to drink.

The provider sought feedback from people through the use of survey questionnaires. These showed people, their relatives and healthcare professionals were satisfied with the care provided at Old Charlton House. Comments from people were used to improve the service. For example, some people had suggested the introduction of toasted tea cakes and crumpets as snacks in the afternoon and these had been made available. 'Residents meetings' were also used as an opportunity to seek the views of people and family members. One person said, "We get together and think of things we would like, then we call the boss in and say what about this, what about that; and they say 'That's a good idea girls, let's do it'." The director was also planning to hold a garden party to involve people in discussions about the building of a sun room.

People knew how to complain and there was a suitable complaints procedure in place which was advertised on the home's notice board. People and relatives told us the staff and the registered manager were "very approachable" with regard to discussing any concerns. One person said, "I've not made a complaint as I haven't had to." No written complaints had been received during the previous year, but the registered manager told us how they dealt promptly with a verbal concern raised by a person who had not been attended to promptly. They had addressed the issue with the staff member concerned. The matter was resolved in a way that helped prevent a recurrence and to the satisfaction of the person concerned.

Good

Is the service well-led?

Our findings

People enjoyed living at Old Charlton House and felt it was run well by an experienced and competent management team. One person said of the staff, "They all work together very nicely." A family member told us, "Communication is very good and very open."

The sole director of the provider's company had a clear vision of the care they aimed to provide. They told us this was to "provide a happy, relaxed, homely atmosphere where staff give people whatever support is needed; it's about good communication and being friendly; it's their home after all". They said they took pride in providing "very high standards and good quality, while keeping it relaxed". This vision was communicated to staff through the staff handbook, at staff meetings and during supervisions. The registered manager said, "[The vision] underpins everything we do and I promote it whenever I [work with staff]." Our observations showed staff understood this vision, which they demonstrated by creating a relaxed, homely atmosphere.

There was an open and transparent culture within the home. Visitors were welcomed and were able to come and go as they pleased. There were good working relationships with external professionals and the provider notified CQC of all significant events. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when mistakes occurred. There was also a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations.

The registered manager operated an open door policy and we saw staff and people regularly visited their office for a chat. They, and the deputy manager, were visible around the home, interacting with people and staff throughout the day. An 'on-call manager' system was also in place so staff could access advice and guidance out of hours. A staff member told us, "The [on-call managers] always answer their phones and come in if needed."

A regular newsletter was produced to keep people and their families informed of changes or developments to the service. This included action the provider had taken in response to any feedback, together with advice or information about current issues; for example, a recent newsletter talked about the safe use of homely remedies, infection control precautions and reminded people of the provider's gifts policy.

People benefitted from strong links to the local community. These included supporting the local Alzheimer's café which some people attended and for which the chef made cakes. A local college provided volunteers to help serve drinks to people and assist with activities; a primary school sung carols to people at Christmas; and a volunteer regularly brought a 'pat dog' for people to stroke and interact with. The registered manager told us, "[These links] give residents more people to talk to; they get a lot of enjoyment out of the animals and children in particular." People were also supported to continue to practice their faith through ministers from two faith groups that visited the home each month.

Staff enjoyed working at the home and told us they felt valued and supported by management. Comments

from staff members included: "I like working here; there's lots of support"; "If you've got a problem, you can go to [the registered manager]; she's very fair and was supportive when [my child was ill]"; and "It's absolutely fantastic here. If there is a problem, I can go straight to management and things are done." Staff understood their roles and worked well as a team. They told us their views were sought during staff meetings and they "were listened to". Staff satisfaction with their work had contributed to a low level of staff turnover which helped ensure people were cared for by staff who understood their needs.

The registered manager was a member of the local care homes association and belonged to a 'managers' network'. This helped them keep up to date with best practice guidance. They also attended relevant training courses, including a recent a four day course about supporting people living with dementia. They described the learning they had taken away from this and other courses and ways they intended to use it to the benefit of people. For example, they were reviewing the colour schemes in the home to see if these could be improved to help people find their way around it. They said, "I've also spoke with [another registered manager] about it. People living here don't have advanced dementia, so we need to balance the design to make it homely and supportive." The registered manager told us they received appropriate support from the director.

An appropriate quality assurance system was in place that focused on continuous improvement. This included auditing key aspects of the service, such as care planning, the environment, medicines and infection control. Where changes were needed, specific actions were developed and implemented. For example, after identifying concerns relating to insulin injections, the registered manager sought advice and obtained alternative needles that reduced the risk of needle stick injuries. In addition, the director visited the home for several days each month. During these visits, they conducted their own quality review by talking to staff, people and relatives, and completing an assessment of the environment. Records of the visits showed any necessary actions were recorded and acted on in a timely way.

The director took an active role in the running of the home. As well as making all the bedspreads and curtains, they organised annual garden parties and Christmas parties, and cheese and wine evenings every two months for people and their families. The registered manager told us, "I get 100 per cent support. Anything I need, I just ask. [The provider] is happy to invest in anything that will help the staff or give better care."

The provider had a development plan in place to further improve the home. The director told us they completed a "major project" every year, such as replacing en-suite bathrooms and resurfacing the driveway to make it more accessible for wheelchair users. The next projects were to enlarge the laundry and build a sun room to provide additional communal space for people. Planning permission had been obtained for the sun room and the director was considering the best time of year to start the work, so that it caused minimal disruption to people.