Voyage 1 Limited

Kenton House

Inspection report

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Date of inspection visit:
13 December 2016
14 December 2016

Date of publication:
03 February 2017

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 unannounced and took place on the 13 and 14 December 2016.

Kenton Road, is a care home which provides residential and nursing care for up to 23 older adults. People receiving the service lived with profound learning and physical disabilities. Some people living at the service also had additional health conditions such as epilepsy and conditions which meant they were unable to move independently. The home comprises of two floors with its own secure rear garden and is situated in Headley Down. At the time of the inspection seventeen people were using the service.

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

Relatives of those using the service told us their family members were kept safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

The provider used robust recruitment processes to ensure people were protected from the employment of unsuitable staff. Recruitment checks were in place to ensure people were of suitable character and experience to enable them to complete their role.

People were kept safe as the provider ensured sufficient numbers of staff were deployed in order to meet people's needs in a timely fashion. In the event of unplanned staff sickness the provider sought to use existing staff including the registered manager to deliver care to ensure familiarity to those receiving the service.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as large scale staff sickness or accommodation loss due to fire or floods.

People were protected from the unsafe administration of medicines. Nurses were responsible for administering medicines and had received additional training to ensure people's medicines were administered, stored and disposed of correctly. Nurse skills in medicines management were regularly reviewed by managerial staff to ensure they remained competent to administer people's medicines safely.

New staff induction training was followed by a period of time working with experienced colleagues to ensure

they had the skills and confidence required to support people safely.

People were supported by staff who had up the most relevant up to date training available which was regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

Documentation was not always available to show people had been appropriately assessed to ensure they were able to make decisions regarding where they lived and all aspects of the care they received. However best interest meetings were used with family, health and social care professionals involved with people to ensure consent was provided prior to the delivery of all aspects of people's care. People where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions.

This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. The home promoted the use of advocates where people were unable to make key decisions in their life. This is a legal right for people who lack mental capacity and who do not have an appropriate family member of friend to represent their views about health issues and where people wished to live.
The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager showed an understanding of what constituted a deprivation of person's liberty. Appropriate authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted.

People were supported to eat and drink enough to maintain their nutrition and hydration needs. People were able to choose their meal preferences. We saw that people enjoyed what was provided. People's food and drink preferences and eating support required were understood and appropriately provided by staff.

People's health needs were met as the staff and the registered manager had detailed knowledge of the people they were supporting. Staff promptly engaged with healthcare agencies and professionals when required. This was to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff had taken time to develop close relationships with the people they were assisting. Staff understood people's communication needs and used non-verbal communication methods where required to interact with people. These were practically demonstrated by the registered manager and staff.

People received personalised and respectful care from staff who understood their care needs. People had care and support which was delivered by staff using the guidance provided in individualised support plans. Support plans contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. People were encouraged and supported by staff to make choices about their care including how they spent their day within the home or in the community.

Relatives knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. Relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager.

People were supported to participate in activities to enable them to live meaningful lives and prevent them experiencing social isolation. A range of activities were available to people to enrich their daily lives. Staff were motivated to ensure that people were able to participate in a wide range of external activities and

encouraged them to participate in external day trips they knew people would enjoy.

The registered manager was new to their position however had fulfilled their legal requirements by informing the Care Quality Commission (CQC) of notifiable incidents which occurred at the service. Notifiable incidents are those where significant events happened. This allowed the CQC to monitor that appropriate action was taken to keep people safe.

Relatives and staff told us the home was well led and staff told us they felt supported by the registered manager. The registered manager provided strong positive leadership and promoted a culture which focused on providing person-centred care to people within a homely environment. These values were supported by staff and evidenced in practice.

Quality assurance processes were in place to ensure that people, staff, relatives and external health and social care professionals could provide feedback on the quality of the service provided. The provider routinely and regularly monitored the quality of the service being provided in order to drive continuous improvement.

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.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

People were supported by staff who had been subject to a robust recruitment procedure ensuring their suitability to deliver care.

People were supported by sufficient numbers of staff to be able to meet their needs.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

Medicines were administered safely by staff whose competence was assessed by appropriately trained senior staff.

Is the service effective?

Good

The service was effective.

The provider ensured that staff had the relevant training to be able to proactively support people's needs and wishes.

People were appropriately assessed for all aspects of their care and where people were not able to consent to the care and treatment they received consent was sought from the relevant parties involved in people's care.

People were assisted by staff who demonstrated they offered people choice in a way that could be understood and responded to. Staff evidenced that they understood how to support people effectively so their needs were met.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. People who had specific needs surrounding their eating and drinking were provided with the additional support. This was to ensure they were protected from risks associated with eating and drinking and were able to

participate in sociable mealtimes.

Staff understood and recognised people's changing health needs and sought healthcare advice and support for people whenever required.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring in their approach with people supporting them in a kind and sensitive manner.

Staff had developed companionable and friendly relationships with people.

Where possible people were involved in creating and reviewing their own personal support plans to ensure they met their individual needs and preferences.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People were assisted by staff who actively encouraged people to participate in activities to allow them to lead full, active and meaningful lives.

Staff and the registered manager reviewed and updated people's risk assessments on a regular basis and when people's needs had changed. This ensured people continued to receive appropriate care and treatment

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to. The service responded quickly to people's changing needs or wishes.

People's views and opinions were sought and listened to. Appropriate communication methods were used to ensure that people could express their wishes and they were respected.

Is the service well-led?

Good

The service was well led.

The new registered manager was in the process of providing strong leadership and fulfilling the legal requirements of their role. Processes were in place and effective to monitor the quality of the service provided.

Staff were aware of their role and felt supported by the registered manager. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The registered manager promoted a culture which placed the emphasis on creating a homely environment and the promotion of people's wellbeing. Staff knew and supported the registered manager's values in their practice.

The registered manager and provider sought feedback from people, relatives, staff and external health and social care professionals and acted on this. They regularly monitored the quality of the service provided in order to drive continuous improvement.

Kenton House

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 13 and 14 December 2016 and was unannounced. The inspection was conducted by one Inspector and a Specialist Advisor. A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a registered mental health nurse who had experience and knowledge of working with people with learning disabilities as well as extensive background advising on Mental Capacity Act 2005 and Deprivation of Liberty compliance.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We did not request a Provider Information Return (PIR) from this provider prior to the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with, a visiting social care professional, the registered manager, deputy manager, nurse, six members of staff and the activities coordinator. We pathway tracked three people which meant we viewed their support plans, associated daily care records and medication administration records as well as an additional persons night time observations charts. We reviewed six staff recruitment files, staff training records and staff rotas for the dates 14 November 2016 to 14 December 2016, quality assurance audits, policies and procedures relating to the running of the service, accident and incident forms, maintenance records and quality service questionnaires. After the inspection we spoke with the relatives of two people.

Not all the people who lived at the home were able to communicate their views and opinions regarding the care they received. As a result we completed a number of observations throughout the course of the

inspection. These involved observing staff interaction with people as well as a number of meal time observations.

The last inspection of this home was completed on the 10 July 2014 where no concerns were identified.

Good

Is the service safe?

Our findings

Relatives told us their family members were safe because staff were present to support the people who lived at the home. One relative told us, "I'm very happy with that sides of things (family member is safe)", another relative said, "There's always someone in the room with them I would feel quite happy that she (family member) is safe".

People were protected from the risks of abuse because staff understood the signs and the actions they should take if they suspected a person had been abused. This included identifying the signs they would recognise in people who communicated using non-verbal methods and who were unable to verbally express their concerns. Staff had received training in safeguarding adults and were required to repeat this training every 18 months to ensure their knowledge remained current. Staff were able to describe the physical and emotional symptoms people suffering from abuse could exhibit and knew their responsibilities when reporting a safeguarding concern. People knew how to identify the signs of abuse and to report these appropriately to keep people safe.

Risks to people's health and wellbeing had been identified and guidance provided to mitigate the risk of harm to them and other people. All people's care plans included their assessed areas of risk and provided guidelines for staff on the support people required to remain safe. These included risks and information associated with people's mobility and their moving and handling needs. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, a number of people living at the home were unable to mobilise independently and required support from staff to be transferred from their wheelchair to their beds. Information in people's care plans provided guidance for staff about how to assist them during these moving processes to minimise the risk of them experiencing an adverse incident. We observed staff assisting people in a manner which ensured their safety. Records showed people had received the appropriate support in accordance with their risk management plans. Staff knew how to meet people's needs safely.

Accident and incident forms were completed when people and staff were involved in adverse situations in the home. These included people being taken to hospital due to a decline in their health or where a medication error had occurred. When these incidents had occurred they were documented, investigated and measures put in place to minimise the risk of reoccurrence. These incidents were then reviewed by the registered manager and appropriate referrals made to external health care professionals to identify if any additional action could be taken to prevent a reoccurrence of the same incident for people.

Robust recruitment procedures had been completed fully to ensure people were assisted by staff who had been fully assessed as being of suitable character. Staff had also undergone detailed recruitment checks as part of their application process to ensure their suitability and these were documented. These records included evidence of good conduct from most recent previous employers and included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services.

Most staff we spoke with felt there were sufficient numbers of staff to be able to meet people's needs safely. The registered manager assessed that In the event of any staff being unavailable due to last minute sickness people would be assisted by staff who would adapt their shifts to provide additional cover. The registered manager and deputy manager would also be available to deliver care if required which was confirmed by staff we spoke with. One member of staff told us, "Yes, yes, yes, (deputy and registered manager support staff) they are very supportive they help…they will really come and help you if we're short staffed." The provider did not regularly use agency staff to provide care. This ensured familiarity and consistency for people who may be sensitive to changes in their living environment and their daily routine. On occasions when staff were unable to assist with covering last minute sickness people still received the care they required at the time they requested. Staff were able to demonstrate that on these occasions people were still assisted to have their needs met, it would mean that external activities would become internal activities until additional staff were able to assist.

The home was able to quickly adapt to changes in people's needs to ensure that sufficient numbers of staff were available to support them. For example, when one person was admitted to hospital due to illness, the home was able to arrange additional support for them in hospital from the existing staff team. This enabled the person to have a recognisable and known face with them whilst they were away from their familiar supportive environment and to ensure their care needs were met. Records showed that the home regularly operated with the provider's minimum staffing numbers of one nurse and seven care staff during the day with one nurse and two care staff during the night. In addition the provider had additional ancillary staff who assisted in supporting people living in the home, these included a cook, domestic staff and two drivers. The staff team also consisted of an activities coordinator and a physiotherapy assistant who provided physical therapy to aid people's health and wellbeing. People's needs were met by sufficient numbers of suitably deployed staff.

People were protected from harm because there were contingency plans in place in the event of an untoward event such as unforeseen staffing shortages, severe weather events or practical risks associated with fire or flood. To ensure people's safety their support plans included hospital passports. These provided detailed and easily read information for staff and emergency services in the event of providing care in an emergency situation. These included how people communicated, medications and their physical capabilities and were updated when people's needs changed to ensure that they remained current.

People received their medicines safely as arrangements were in place for the safe storage, administration and disposal of medicines. Nurses were responsible for administering people's medicines in the home; they received specific training in medicines management and were required to complete this training annually. Nurses were also in the process of completing annual competency assessments to ensure they could manage and administer people's medicines safely. There were clear arrangements in place to ensure that people were protected from receiving the wrong medicines. Medicines were mostly administered using a monitored dosage system from a blister pack prepared by the providing pharmacy. We could see that medicines were stored, reviewed, documented and disposed of correctly.

For people who were unable to communicate verbally that they required medicines which are to be taken as and when needed, such as painkillers, specific guidance had been created to allow staff to easily recognise the signs of people expressing pain. This included the non-verbal cues such as looking miserable or holding the area of pain. Staff recognised and understood these signs and people were provided with medicines appropriately to meet their needs. People were supported to receive their medicines by nurses who received the appropriate, training, guidance and support in order to be able to safely manage medicines.

Good

Is the service effective?

Our findings

Relatives we spoke with were positive about the ability of staff to meet their family members' care needs. They told us that staff were sufficient skilled and experienced in delivering the care their family members required. One relative told us, "Oh yes definitely no issues there (staff skills and experience), they're marvellous for what they do…they're brilliant." Another relative told us, "I always ask them (staff) about all sorts of things they always seem to know, yes I would quiz them on things just like that and they always give me very satisfactory answers". Relatives told us staff respected their family members' decisions and choices taking all steps available to promote people's independence wherever possible.

People were assisted by staff who received a thorough and effective induction into their role. New staff were required to complete an induction which followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised within the first 12 weeks of their employment. This induction covered a number of areas including staff understanding their new role, working with people in a person centred way, communication, awareness of mental health, dementia and learning disabilities and basic life support. Alongside this training new staff completed the provider's own mandatory training which included allergen awareness in care, equality and diversity, food safety and nutrition awareness for example. Staff told us they were continually updating their training and records confirmed that the registered manager ensured staff completed their required training updates at the timescales the provider had identified as necessary.

The provider also supported all care staff in participating and completing National Vocation Qualification's in Health and Social Care. NVQs are work based qualification which recognises the skills and knowledge a person needs to do their role. Staff induction was then followed by a period of shadowing to ensure they were competent and confident before supporting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their role. This allows new staff to see what is expected of them and ensures their confidence in their ability to complete their role fully.

People were assisted by staff who received guidance and support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. The registered manager said that supervisions were due to occur every eight weeks which was in line with the provider's policy of six supervisions a year. All staff we spoke with said they could and were happy to seek additional guidance and support from their senior members of staff including the registered manager at any time. This process was in place so that staff received regular and consistent support to enable them to conduct their role confidentially and effectively.

The Mental Capacity Act (MCA) 2005 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. Records were not always available which showed people had been subject to a decision specific

MCA assessment to see whether or not they could make a particular decision about their care before action was taken. However we could see when people living at the home required medical interventions to ensure their health was maintained appropriate actions had been taken to ensure the appropriate consent and authority was obtained. Relevant parties such as family and health care professionals were involved in decisions regarding medical interventions and agreed these were in people's best interests where required.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records were not always available to show people had been assessed as lacking capacity to making the decision regarding where they lived or the care they required prior to a DoLS application being made. However we saw best interest meetings had been held with relevant parties to ensure the care provided met people's needs and was the least restrictive option available. It is best practice that providers document fully the MCA assessment process prior to the submission of any DoLS applications. The registered manager was aware of this need and was taking action to rectify as part of the provider's action plan.

Other records available showed when the provider had complied with the requirements of the MCA. When people had been assessed as lacking capacity to make other specific decisions about their care records showed that where required decision specific best interest meetings had been held with people, family members and social care professionals. This involved when people were unable to consent to receiving specific aspects of their care such as medical treatments for example. The registered manager had ensured decision making processes were documented to ensure that any actions taken on people's behalf had been discussed and agreed as appropriate and necessary. Staff were not always able to discuss the principles of the MCA however were able to evidence how they offered people choice during their everyday interactions with people when supporting them. We saw staff offering people choice throughout their day regarding the food and drink they wanted and where and how they wanted to spend their time in the home.

The provider completed a 'Decision Making Profile' for people living in the home which assisted staff by providing guidance as to how to support a person to reach a decision about any aspect of their care. This included how information about decisions should be given, such as using clear simple requests, how to help the person understand the decision to be made such as offering choice at every available opportunity. They also included the best time and worst time for a person to make a decision. For example one decision making profile stated that a person was more able to make a decision in the morning when they were fully awake and alert. These provided clear guidance on how staff could take the right action to make sure people were given every opportunity and support to make decisions for themselves.

The registered manager promoted the use of advocates and Independent Mental Capacity Advocates (IMCA) for people who were unable to make key decisions in their life. Access to IMCAs are a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views. This ensured any large decisions involving medical interventions were made in a person's best interests.

The registered manager and staff showed an understanding of DoLS which was evidenced through the appropriately granted authorities from the local authority. Staff were able to discuss the reasons for people being subject to a DoLS and the actions they would take to ensure they were able to support people in the least restrictive way.

People were supported to have sufficient to eat and drink to maintain their nutrition and hydration needs. We saw and relatives told us that people had a choice of menus and enjoyed the food provided. One relative

told us, "I was up there not long ago and the chef came around with samples of the lunch and held under their (people's) noses…I would have had a job and he knew what they would prefer to eat". The chef had worked at the home for 10 years and prepared a seasonal and variable menu using his knowledge of the food people preferred to create the main and alternative menu choices. People's menu choices included a wide range of food which was nutritionally balanced and visually appealing. Staff supported people to maintain a healthy, balanced diet.

People ate well and were provided with sufficient time to eat their meals at their own pace. For those who required additional support during their meal times we could see individualised guidance provided in support plans was followed by staff. One person's support plan had identified they required support during meal times to manage their risk of choking. This included their food to be presented in a certain way to ensure this risk of choking was managed effectively. This was done and staff ensured this person was eating in accordance with their support plan. Where people did not eat or like the main meal which was on offer people were able to choose alternatives they would prefer. People received the food and drink they required, and requested, in order to meet their nutritional and hydration needs and food preferences.

People were supported to maintain good health and could access health care services when needed. Records showed that when required additional healthcare support for people was requested by staff. We saw that people were referred to speech and language therapists when appropriate, such as when they were at risk of choking. When issues or concerns had been raised about people's health, immediate suitable healthcare professional advice was sought, documented and communicated to staff. This enabled health plans to be followed and for people to receive the care they required to maintain good health.

Specific and clear guidance was provided to support staff on how to support people living with certain conditions, such as epilepsy and diabetes. Support plans provided guidance for staff on the actions to take in order to maintain people's health and wellbeing. One relative told us their family member's epilepsy was being managed effectively which was due to the changes in medicines. These changes had been arranged by the home and had resulted in their family member experiencing less seizures than they had previously. For those living with diabetes guidance was provided on how to best support the persons diet to make sure it met their needs. However it was identified during the inspection that one person's diabetes care plan stated that their blood sugar levels should read between 4mmol and 7mmol however they were routinely registering much higher blood sugar levels. This meant if unfamiliar staff were delivering care they may have taken action by involving health care professionals and taking further action such as more regular testing which can cause discomfort. We could see that when this person's blood sugar levels had reached very high levels they had been reported and an ambulance called appropriately.

This was raised with the registered manger during the inspection who ensured this person's care plan was updated to show a more accurate range for their blood sugar levels enabling staff to take the appropriate action only when necessary without causing additional distress. People were also involved in annual health checks with their GP and annual medication reviews to make sure their health needs were being met.

Good

Is the service caring?

Our findings

People displayed behaviours which indicated they enjoyed living at the home and we could see they experienced friendly and companionable relationships with staff. People indicated that they were happy by displaying relaxed body language, happy facial expressions whilst interacting with staff and participating in activities. Relatives told us that their family members' support was delivered by caring staff. One relative told us, "Oh yes (staff are caring), very much so it's like a big family really." Another relative said, "Another relative said, "Yes (staff are caring), very much a family feeling and I got that from all the carers who came and sat with her (when they were in hospital)".

Staff were knowledgeable about people, their preferences, specific behaviours and their support needs. They were able to tell us about people's favourite activities, their personal care needs and any particular diet they required. All staff in the home took time to engage and listen to people. Conversations were friendly, relaxed and mutually engaging. People were treated with dignity as staff spoke to and communicated with them at a pace which was appropriate to their level and needs. Staff allowed people time to process what was being discussed and gave them time to respond appropriately to ensure people were engaged.

Staff spoke fondly of the people they supported which had allowed personal but professional relationships to develop. The development of these relationships had been assisted by people's care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans had personal information people wanted staff to know about them which allowed staff to have a greater understanding of people's needs and the care they required. Care plans detailed people's non-verbal communication methods which they would use when happy or distressed. For example it was documented in one person's care plan that they would display a particular behaviour when they were unhappy. This person's care plan detailed how staff should respond to offer this person comfort and reassurance. Staff knew people's individual needs and the methods to use to reassure and support people in a way that brought them reassurance.

Staff were able to discuss people's individual needs and we could see that they reflected people's preferences in the way they provided their support. Staff told us how they assisted people to express their views and to make decisions about their day to day support. This included enabling people to have choices about what they would like to eat, wear and what activities they wished to participate in. We saw that people were being offered choices on a daily basis about how and where they wished to spend their time which was respected.

When people were distressed or upset staff knew how to comfort them and offer reassurance. Gentle touch support was used to offer reassurance to people and we saw that staff took the time to engage with people often holding hands and stroking people's arms if they appeared upset or did not wish to engage in interaction. Staff knew the importance of offering this touch to people which was more significant as people could not always verbally communicate their concerns. One member of staff told us, "We like talking to them (people) even if they don't respond, touching and telling them we're here to help, even if they don't respond, if they don't understand you, they can hear someone and feel someone is helping them or guiding

them and caring for them". People were cared for by staff who genuinely cared for their emotional wellbeing and took steps to ensure people were happy.

During the inspection staff were responsive and sensitive to people's individual needs, whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion during all interactions. This included allowing people additional time with the tasks they could complete independently whilst remaining vigilant to their needs. People were provided with personal care with the doors shut and staff knocked on people's doors and waited before entering to support them. When people did not wish to receive care at the initial time offered staff respected people's right to choose and would allow people additional time in their rooms returning later to see if they were happy to receive care at that time. Checks to ensure people were safe and not experiencing a health related concern such as an epileptic seizure during the night were respectful of people's right to privacy and not obtrusive.

Where possible people were encouraged to remain as independent as possible. People had guidance included in their care plans which detailed the actions people wanted to be able to achieve independently. For example one person's care plan stated that staff were to encourage them to eat and drink independently. To enable this specific cutlery which was easier for them to hold and a plate guard was provided at lunch time. Promoting people's independence was confirmed by relatives we spoke with, one told us, "They'll (staff) encourage him to use the big spoon they know how important it is and they're very up on things for him". Staff knew the importance of supporting people to remain independent as much as possible.

Good

Is the service responsive?

Our findings

Relatives told us the service supported their family members to lead interesting and full lives. We saw people enjoyed the activities they were provided with. One relative told us, "Oh my gosh yes they're always going out somewhere and the theatre or the pictures or Basingstoke he (family member) just loves going out they all I mean they all get turns… I think it's fantastic to be honest".

People received consistent personalised care and support. People's care and support they required was set out in a written plan that described what staff needed to do to make sure that personalised care was provided. People living at the home were not able to be actively involved in the planning of their care and support they required. As a result the provider involved health and social care professionals such as IMCAs, social workers and used information gained from previous homes when assessing and documenting the care people needed. As a result care plans included personalised information and guidance required by staff in order to deliver care which met people's preferences and needs. For example care plans included information about people's activities they enjoyed and the routine that they preferred with the delivery of their personal care. Relatives confirmed they were invited to be involved in the planning and reviews of people's care as requested and required.

Relatives were actively involved in reviewing their family member's care and invited to express their views during formal care plan reviews. Care plans were reviewed at least yearly and risk assessments were updated when required to ensure they remained current and provided the most up to date guidance available. These reviews also took place if there was a change in a person's personal circumstances such as a health difficulty or change in their support needs. For example, during the inspection we saw reviews had taken place where there had been changes in people's personal hygiene needs for example. Another person's care plan was reviewed when it was identified they now required two members of staff to safely manage their moving and handling needs. Staff told us that care plans always contained the most up to date information. One member of staff said, "If something changes then it's (care plan) updated so it could be a week a month it's constantly evolving". These reviews ensured staff were provided with the most accurate information required to meet people's needs.

The registered manager and staff were keen to fulfil people's lives by seeking ways to allow people to experience different social and leisure opportunities. All the people in the home were supported to take part in activities and attend social groups. The home had its own transport and two drivers which meant that people were supported to access the community and take part in social activities which were important to them.

People had their preferred leisure time documented in their care plans, this provided staff and the home's activities coordinator with information about how people wished to spend their time. For example one person's care plan stated that they were sociable and enjoyed outings from the home to go shopping and visit places of interest. Another person's care plan stated they liked to participate in activities which included cookery sessions. This information helped prepare people's weekly activity planners. Whilst people had a structured weekly activities timetable available to them these were subject to change on a daily basis.

People were provided with opportunities to change their mind and participate in alternative activities whenever they wished. Staff knew people's preferences and provided people with choice asking people daily what they would like to do.

We saw during the inspection a variety of activities were available to people. These included attending local social groups and events, going to the homes multisensory room and enjoying the soft flooring, soft music and lighting available to them as well as participating in karaoke with staff and taking part in cookery sessions. During the inspection a lively karaoke session was being held where people were listening to staff singing and people were seen to be enjoying this activity. An interactive music session was held at the home by a visiting musical therapist during which people were actively involved in playing musical instruments along with accompanying music. Staff sat with people and encouraged them to participate and it was a fully interactive and engaging session. People were clearly enjoying the music and session which was made available to them. Other internally held activities included a visiting miniature pony and donkey, a local wildlife hospital, belly dances, visiting pantomime and theatre productions.

People were also encouraged to take part in external trips which included bowling, attending the local cinema, sailing on the Solent, visiting Marwell Zoo and a hawk conservatory and going shopping for their own personal affects. People were supported by staff who recognised the importance people becoming and remaining socially active and took positive steps to encourage this social interaction and participation.

Relatives were encouraged to give their views and raise any concerns or complaints. The provider's complaints policy provided information for relatives and staff about how a complaint could be made, the timescales for any response and how to complain to the Care Quality Commission and the Local Government Ombudsman (LGO). The LGO is the final stage for complaints about social care provides. It is a free and independent service that ensures that a fair approach is taken to complaints made. People were provided with handbooks when they moved to the home which gave them details of what actions they could take if they had any concerns and wished to complain.

Relatives we spoke with were confident they could speak to the registered manager to address any concerns however had not had the need to do so. One relative told us, "No I haven't (raised a complaint) and I never had all those years I've just got more and more amazed at them all. I wouldn't have any problem with doing that". Systems were in place so if complaints were received they could be documented, raised to the registered manager, investigated and a suitable response provided. Three formal complaints had been made since the last inspection in July 2014. We could see that each complaint had been dealt with as per the provider's policy.

Good

Is the service well-led?

Our findings

The registered manager promoted a service at Kenton House which was open and supportive to both staff and people living at the home. They sought feedback from people living at the home, relatives, staff and other health and social care professionals to identify ways to improve the service provided. Relatives said they were happy with the quality of the service provided and staff thought the home was well led. A visiting social care professional told us Kenton House was, "amongst the best I work with".

The registered manager had moved to the home in April 2015 and had only become the registered manager approximately four weeks before this inspection. The registered manager had a detailed action plan to manage the results of quality assurance processes at the home. The provider's quality assurance process identified where required there was not always documented assessments in place regarding people's cognition and ability to make a decision. This was identified as an area that required additional work which was documented on the provider's action plan. The registered manager had been prioritising their work and had not had the opportunity to complete all aspects of this action plan prior to this inspection. This work included reviewing all the care plans to ensure all aspects of people's are had been reviewed and action taken where necessary to ensure compliance with the MCA. We could see that action had been taken to identify where the home required improvement and these actions were being completed in order of their priority.

The registered manager was keen to encourage a culture which placed an emphasis on placing people at the centre of everything that was done at the home. The registered manager wanted care delivery at the home to be completely person centred and holistic in its approach. This means care is highly individualised and is provided to meet every aspect of a person's wellbeing, including, body, mind and emotions rather than purely treating people's physical symptoms. The home was described by the registered manager and staff as people's home and everything that staff did was to meet and support people's needs as well as promoting their emotional and physical wellbeing. The registered manager wanted the home to have a friendly and relaxed atmosphere to promote a homely environment. This culture was known and evidenced by staff and relatives. One relative told us, "Well I mean they're so welcoming I've been going up there for year I've always felt it's lovely and clean and everybody you know it's like one big happy family". Another relative said, "Yes it is very much" (friendly atmosphere). All staff we spoke with felt and promoted this family atmosphere in the home with one member of staff told us, "I think so it's a friendly atmosphere, sometimes we are joking, singing and cooking it's like a big family but is why I like to be here"

The registered manager was available to people and staff to offer guidance and support whenever they were required. Staff felt consistent support was given by senior staff and the registered manager. One member of staff told us, "Yes, the new manager is nice we can see her. She's really nice we can say you know. She's nice she's very nice and you know she asks for problems and I can tell her what I want she's open". Another member of staff said, "It is good (management of the home) there has been some changes made and they're good changes…it seems to be working…it's the communication I think it's so open…you can go and approach her and say (registered manager), you know, whatever and she'll say whatever we'll sort it. Approachable".

Not all the staff we spoke with were able to discuss the provider's visions or values which included, staff exhibiting a passion for care and a passion for business, displaying positive energy, staff being given the freedom to succeed, facing up to reality and challenges as they arise and thanking people where deserved. However staff were all able to discuss how the registered manager wanted care to be delivered and the type of atmosphere that the home was to have. This included the value that people's care took priority and was delivered in a completely person centred way. These behaviours and values were not only exhibited by the staff but by the registered manager and other senior staff. A member of staff told us, "It's a good relationship with the manager and deputy manager, they'll tell you if you're doing something wrong and when you're doing something good, they come out, normally the deputy will come out and help with breakfast and meals times", another member of staff said, "The manager and deputy manager work well together they work well with the staff….very supportive". Our observations showed that all staff followed these core values in their interactions with people and responded quickly to people's individual needs. Staff were aware and ensured that people were given every opportunity to fulfil their needs.

Staff were clear about what was expected of them and their roles and responsibilities. The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and effectively. Staff knew where to access the information they needed to enable them to deal with new situations and could seek advice and guidance from other staff and managers.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had ensured notifications about significant events had been reported to the CQC in an appropriate and timely manner in line with CQC guidance. These are required for the CQC to monitor incidents as they occur and to identify and confirm that appropriate action had been, and would, be taken in the future in order to keep people safe and minimise the risk of a reoccurrence or the original incident.

The registered manager sought feedback from people, relatives, staff and health and social care professionals to identify how the service they received could be improved. The provider requested their feedback by a variety of methods which included the use of annual questionnaires. The last survey was completed in September 2016 and people, staff, health and social care professionals and relatives were asked to participate in answering questions. These included questions asking what worked well at the home, any changes they would like to see and how people would describe the care that they received.

A number of responses had been received and spoke positively about the care delivery in the home. Positive comments received including relatives describing the care and support. One relative wrote the home provided, 'Excellent care and supported, very inclusive and to the needs of the residents'. A healthcare professional described what they felt were the strengths of the service, '(the home is) very good, staff extremely helpful...the house is always immaculate…service users always look wonderfully clean, looked after and are always busy doing various activities'.

Staff had mentioned during this process the home needed refurbishing. At the time of the inspection plans were in place for refurbishment which included the extending of a persons living accommodation. People, relatives, external health and social care professionals and staff were given the opportunity to feedback on the quality of the service provided and make suggestions where improvements could be made.

The provider ensured that there were systems in place to monitor the quality of the service people received though the use of regular provider and registered manager audits. The results of these audits were then used to create an action plan. This action plan covered all areas of care delivery and included timescales for

completion and who was responsible for ensuring these actions were completed.

The provider had recently completed a quarterly audit which had looked at whether or not the service was providing, safe, effective, caring, responsive, well led care. To reach a judgement the provider sought evidence to answer questions such as, 'Caring – observations of interaction between staff and service users, mealtimes and conversations'. We could see that this level of care was routinely displayed by staff. The provider had noted there were areas of people's support plans which required updating. This included reviewing people's support plans as well as their health action plans to ensure they remained current. This was in the process of being addressed by the registered manager at the time of the inspection.

Staff were aware of their role to provide high quality care and relatives we spoke with told us this was being delivered and their family members were happy living at Kenton House. One relative told us, Well I think it's absolutely excellent to be honest as I say basically (family member) is happy there I can see he's happy there…if he wasn't happy I can tell". Another relative told us, "I think (the care) it's excellent absolutely excellent. It's a difficult thing they (staff) do and they do it really well. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed and demonstrated when supporting people.