Crown Care IV Limited

Kensington

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Kensington is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Kensington accommodates 41 people in one adapted building, across two floors. There were 29 people using the service at the time of our inspection, including some people living with dementia.

This unannounced comprehensive inspection took place on 19, 24 and 25 January 2018. This meant that neither the provider nor the staff knew we would be visiting the home on the first day of our visit.

Following these visits we attended a meeting at the home with other health and social care organisations and relatives on 5 March 2018 and contacted relatives by telephone.

We last inspected this service in February 2017 and at that time found the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Dignity and Respect. We rated the service as 'requires improvement'. After that inspection the provider wrote to us, setting out the steps they were taking to address the breach. During this inspection we could see the provider had completed their action plan to improve the service; however we found further shortfalls in the delivery of care. The breach had not been met, and the service continues to be rated as 'requires improvement'.

A registered manager was 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.

Whilst the majority of people and relatives we spoke with told us the service was caring, and that staff were kind and patient, some people and relatives described times when staff had not treated people with dignity and respect. We observed that staff were generally friendly and polite, however we saw that one member of staff expressed frustration when speaking with two people who used the service, and that other staff discussed people's personal needs in public. Signage around the building and storage in people's bedrooms did not promote their dignity. We shared this feedback with the provider, and the local authority safeguarding team.

People were supported to be independent and maintain their skills. People were included in decisions about their care, and care records incorporated information about people's choices, preferences and life histories.

People told us the service was safe and described feeling comfortable and well looked after. Two relatives

described observing care which could potentially put people at risk of harm. We immediately fed this back to the provider's regional manager who assured us additional observations had been put in place to monitor the delivery of care.

Processes were in place to reduce the risk of abuse or harm. The registered manager had made referrals to the local authority safeguarding team when required, and any complaints or concerns had been investigated. We found that some identified future actions, such as increased staff supervision, in response to concerns about staff conduct had not been followed up.

People and relative's feedback about staffing was mixed. Some thought the home was well staffed, whilst others told us more staff were required. We saw the home was a relaxed environment, busier times of the day were well managed and people's requests were quickly met. Staff told us they thought staffing was appropriate to the needs of people in the home. Safe recruitment procedures had been followed.

The home was clean, and well maintained. Infection control procedures were well followed. Risks had been well managed, and accidents and incidents monitored for trends.

Medicines had been administered as prescribed, but policies in relation to self-administration and the use of medicines dispensed through patches had not been followed.

People's needs had been assessed, and care plans devised to enable staff to meet those needs. Records were generally thorough, although we saw some examples where important information was missing.

Staff received training designed to equip them for their roles. Refresher training was scheduled so staff skills remained up to date. The provider did not have a policy to ensure staff were competent in modules delivered via E Learning. Staff undertook knowledge checks, but there was no pass mark, and some scores were low. We have set a recommendation about this. Staff told us they were well supported and had regular opportunities for personal development.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Applications had been made for Deprivation of Liberty Safeguards (DoLS), where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied.

Mealtimes were well organised and an enjoyable experience. Tables were well set, and people were made aware of the choices available to them. Choices were not offered in a way which met the needs of people with dementia, but the regional manager advised us this would be something they would look into providing. People's food and fluid intake were well monitored. Where needed referrals were made to health and social care professionals, such as speech and language teams, dietitians, specialist nurses and GPs.

There were a range of activities on offer within the home. Activity staff spent time with people on a one-to-one basis as well as planning group activities. The home had access to a minibus and arranged visits to local landmarks. The provider had introduced a 'Three Wishes' programme, and people had been supported to identify ideas which would they would enjoy. Activity staff worked with care staff to help people achieve these wishes.

Complaints had been well recorded and responded to in line with the provider's policy. The registered manager identified lessons learned from complaints and had introduced changes to reduce the likelihood of future complaints.

The quality assurance system included a range of audits carried out regularly by the manager, regional manager and the provider's quality assurance team. These quality assessments were in-depth, but had not highlighted the shortfalls in care delivery which we found during the inspection.

Feedback about the management team was very positive. People, relatives and staff fed back that the registered manager was approachable and a visible presence in the home.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to Regulation 10: Dignity and Respect and Regulation 17: Good Governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Two relatives told us they had observed staff providing care which could have compromised people's safety.

Investigations into concerns about staff conduct identified ongoing actions to monitor staff performance. We could not find evidence this had been carried out.

Feedback from people and relatives about the staffing levels in the home was mixed. During our inspection we saw there were enough staff to meet people's needs, staff confirmed this. Safe recruitment processes had been followed.

Medicines were administered by trained, competent staff. However, some policies had not always been followed.

The home was clean and well maintained. Steps had been taken to ensure the building and equipment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst care records were generally detailed, we saw some examples where important information about people's needs were missing.

The provider had identified a programme of training for staff and this was well maintained. However, where training was delivered via E Learning the provider had not identified an effective way to ensure staff competency.

Where decisions had been made in people's 'best interests' the Mental Capacity Act 2005 had been followed.

People's feedback was positive about food on offer in the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Most people and relatives told us staff were patient and kind. However, some described times when staff had not treated people with dignity and respect.

We saw staff were generally warm and patient, but observed one occasion when a staff member communicated frustration to a person using the service.

People's privacy was not always promoted, as signage around the home highlighted people's personal needs, and staff discussed people and their needs in communal areas.

People were provided with information about the home, supported to be independent and included within planning meetings about their care.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and detailed information to help staff to provide care which met people's preferences.

The service provided a range of activities planned to meet people's personal choices, which were well received by people who used the service and their relatives. Activity staff worked with people to identify and work towards goals they would like to achieve.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance system was in-depth and covered a range of areas. However it had not highlighted the shortfalls in the delivery of care which we found during our inspection.

People spoke highly of registered manager and described them as approachable. We saw they knew people and their relatives well.

Kensington

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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident had been brought to the attention of the police and local authority. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of how people were safeguarded from abuse. This inspection examined that concern.

This unannounced comprehensive inspection took place on 19, 24 and 25 January 2018. This meant that neither the provider nor the staff knew we would be visiting the home on the first day of our visit.

Following these visits we attended a meeting at the home with other health and social care organisations and relatives on 5 March 2018 and contacted relatives by telephone.

The inspection team consisted of an inspection manager, an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who supported this inspection had experience of nursing homes.

Prior to our inspection we reviewed the information we held about the service including statutory notifications. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used this information to inform the planning of this inspection. We contacted the local Healthwatch service, and spoke with the local authority commissioning and safeguarding teams to gather views of professionals who come into regular contact with

the service. Healthwatch are an independent organisation who listen to people's views about local service to help them to improve. We also spoke with the police.

Not everyone who used the service was able to communicate verbally with us. 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. We spoke with six people who used the service and chatted with them about their views on the service. During the course of the inspection we spoke with 10 relatives, including four relatives who were visiting Kensington during our visits, and a further six relatives who we spoke with over the telephone.

We spoke with the provider's managing director, the provider's regional manager, the registered manager, a registered nurse, six care workers and an activities coordinator. We reviewed a range of documents and records including; eight people's care records in detail, four records of staff employed at the home, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings with people who used the service and a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us Kensington was a safe place to live. One person said, "I've been here a few years now and always felt safe." Another person said, "I feel the home is safe and secure with door locks and coded access and the windows are also secure."

Two relatives told us relatives had been assessed as needing two members of staff to support them with their personal care needs. They told us they had been present when their relative's care had been provided by one staff member only. Staff we spoke with told us they always delivered care as per people's assessed needs, and had never witnessed any staff doing otherwise. We shared the relatives' feedback with the regional manager who held a meeting with all staff to communicate the importance of following safe care. They told us they were introducing further observational checks to ensure people's care plans were adhered to.

The provider had processes in place to safeguard people from abuse. Staff had received training in recognising and responding to any harassment, discrimination or concerns of a safeguarding nature. Staff we spoke with all described appropriate actions they would take if they had any concerns about people's safety or welfare, and they were aware of the provider's safeguarding policy.

Where concerns had been raised, the registered manager had followed the safeguarding policy. They had promptly communicated with relevant organisations, including the CQC and carried out investigations. Investigation reports had identified actions to address any concerns; however, it was unclear as to whether all actions had been completed. We saw two instances where people or relatives had raised concerns over staff conduct. In response the registered manager had immediately held supervision sessions with the staff members involved, to discuss their communication skills, tone of voice and to set expectations. Staff had been required to repeat dignity and respect training. However, whilst the investigation stated the staff would receive 'increased supervision' we could not find any evidence that this had been followed up. There was no record of these issues within subsequent supervision meetings. When repeating dignity and respect training immediately following concerns about their conduct, one staff member had scored only 67%. There was no evidence that this low score had been reviewed by the registered manager or discussed with the staff member. The regional manager told us the process for managing investigations would be reviewed to ensure future actions were recorded and signed off when completed.

During our inspection we observed there were enough staff to meet people's needs safely, however some people and relatives told us about their concerns about staffing levels. At the time of our inspection there were 29 people accommodated at Kensington, residing on two floors of the home. During the day there was a registered nurse on duty, supported by five care workers in the morning, and four care workers in the afternoon. Overnight staffing levels were set at one registered nurse and three care staff. The registered manager usually worked Monday to Friday, and was supported by a deputy manager, two activity coordinators and domestic, laundry and kitchen staff. The registered manager told us these staffing levels had been determined by an assessment of people's needs. We reviewed staffing rotas for the three months prior to our inspection visits. We saw staffing numbers consistently met these assessed levels.

During our inspection we observed there were enough staff to meet people's needs. Busier times of the day, such as mealtimes, were well organised so people received their meal and any support they needed to eat in a timely way. We noted call bells were responded to quickly and any requests from people who used the service were met promptly.

However, people's feedback on staffing levels were varied. Some people and relatives told us there were enough staff on duty, whilst others told us more staff were required. Positive comments included, "Staff are can attend to me in 30 seconds when I press the call button" and "I'm able to press the buzzer and staff respond within a minute if I'm unwell."

Of those who told us more staff were required, one person said, "I often need to go to the toilet after my meal and carers tell me 'can you wait a bit until I move all the other people from the dining room'". A relative commented, "I feel there should be more staff, as service users don't always get immediate attention when they need it."

None of the staff we spoke with raised any concerns about the number of staff on duty. One staff member said, "We can manage fine with the staff we have. It's better now we have that extra member of staff on a morning for the busier time. That really makes a difference." We shared feedback from people and relatives with the provider and the registered manager, who told us they felt there were enough staff to run the home safely and meet people's needs. They advised us they would look into how staff were deployed to ensure their time was maximised to support people.

Suitable pre-employment checks were carried out when new staff were being recruited. These checks included checking a prospective member of staff's identity, employment references and Disclosure and Barring Service (DBS) information. A DBS check supports safe recruitment decisions by providing information to employers about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. Qualified nurse's registrations were checked regularly to ensure they remained in date and that there were no issues with them practicing.

People received their medicines as prescribed, however, we found some occasions where the medicines policy was not being followed. People told us they received their medicines on time and that staff stayed with them whilst they took their medicines. One person told us, "Staff make sure I get my medication twice a day."

Staff responsible for administering medicines had received appropriate training and had their competency assessed. Sufficient information was available to staff about people's individual medicines routines. However, this information wasn't always up-to-date. One person was self-administering some medicines, but their care records stated that this would be done by staff. The risks associated with self-administration, had not been formally assessed. In discussions with the registered manager they told us they would review risks assessments relating to medicines to ensure they were accurate.

Records relating to administered medicines were well kept. They were completed with no gaps. Topical medicines records, such as those for creams or ointments, clearly communicated to staff where they should be applied. However, we noted instructions for medicines dispensed via a patch stated the site where it was placed should be rotated to ensure it was not placed on the same spot for at least 21 days. Within records we viewed staff were only recording whether they had placed the patch on the left or right-hand side. This meant information recorded was insufficiently detailed to ensure the manufacturer's instructions had been followed. The registered manager told us they would discuss this with staff and include these records within audit checks.

Risks to personal safety had been assessed and information was provided to staff in care records about how to mitigate known risks where possible. For example, where people were at risk of falling at night, pressure mats were in place which alerted staff if people got out of bed, so staff could check on them.

Accidents and incidents were well monitored. Staff understood their responsibilities and had completed accidents and incident records promptly after accidents had occurred and with a good level of detail. Action had been taken such as body maps of where injuries had occurred, and reviews of care plans to ensure they were appropriate, to ensure people received the right support following any accidents. Accidents and incidents had been monitored by the registered manager to determine if there were any trends ongoing. Preventative action had been taken where possible, to reduce future accidents, such as making referrals to the GP or falls team where a person had fallen over.

The home was clean, tidy and with no unpleasant smells. People told us the home was well maintained, one person said, "As I am a fussy person, I'm very pleased with the way staff maintain cleanliness in the home and they are around with the hoover every day."

Steps had been taken to ensure the building and any equipment used was safe. Specialist maintenance companies were contracted to ensure the home was meeting the required standards, for example, relating to asbestos and electrics within the home. The call bells and fire alarms were tested weekly. Equipment such as hoists, boilers, emergency lighting and lifts were serviced regularly so they were kept in good working order.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the service provided good quality of care. One relative said, "I rate this home very highly for the treatment of [my relative]." A person who used the service said, "I am bed bound It's difficult to move me around but staff are adequately trained to implement the right strategies to move me when required. They understand the support I need since I've lost the full use of my legs."

People's physical, mental and emotional needs had been assessed, using a range of evidence based assessment tools. Following assessment, care plans detailed to staff how people's needs should be met.

We noticed some variance within records. The majority we viewed were detailed and provided staff with information about how to effectively provide consistent care. For example, where people required equipment to reduce the risk of them developing pressure damage, care plans specified how it should be set, and how frequently staff should check settings to ensure it met the person's needs. We checked two people's mattresses and found they were set correctly.

A small number of care plans provided less specific information. The registered manager ensured these care plans were re-written before the end of our inspection.

The provider used an electronic system for the majority of care records. We reviewed daily records and saw that these were updated in a timely manner and were thorough so they provided a full picture of the care people received. Records included body-maps which evidenced the action staff had taken and future planned care.

Staff had received a training programme designed to provide them with the skills and knowledge to carry out their roles effectively. This included a mixture of both face to face and online training modules. Training was monitored so staff skills stayed up-to-date. We saw staff training in all areas key to safely carrying out their roles had high levels of completion.

Many of the online learning modules included knowledge checks to ensure staff had understood the training materials and could be considered competent. The provider had not set a 'pass mark' for the knowledge checks. The registered manager told us a previous regional manager had stated that any scores of 65% and above could be considered a pass. The training system identified this score as grade D. We saw staff had received low scores in some modules. Half of the staff team received a grade D in 'responding to people who displayed behaviour which may be challenging to staff'. One third had received a D in dignity and respect training. The provider advised us that all staff had attended a full day face to face training session in dignity and respect which had been very well received. They told us competency was assessed through a variety of ways, and that E learning modules did not meet learning styles of some staff.

We recommend that the provider considers best practice in assessing and recording staff competency and incorporates this into their training policy.

New staff undertook induction training. This included reading policies, care records, shadowing experienced staff and completing a training package. The induction had been designed to incorporate the Care Certificate. The Care Certificate is a set of minimum standards for care workers.

Staff told us they were given adequate support and opportunities for development. They attended regular one- to- one supervision sessions, to ensure they had the opportunity to discuss their practice and the needs of the people they supported. Appraisals were held annually, and we saw staff were asked to consider their performance and discuss any training needs. Nursing staff received regular clinical supervision sessions with the manager, and senior nurses from the provider organisation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Each care plan we reviewed had an appropriate and up- to- date mental health risk assessment and care plan which clearly recorded if people had capacity and if a deprivation of liberty safeguard was required.

Where people were assessed as not having capacity to make specific decisions, decisions were made in their 'best interests'. We saw one person was wearing socks on their hands. Staff advised that this was to ensure the person did not pull out a feeding tube which was connected to the person's stomach. We saw the MCA and best interest documentation had been completed in relation to the decision. However, there was no evidence of specialist healthcare input or that it had been considered as to whether using socks in this way was the least restrictive option. The regional manager told us they would engage with specialist nurses and look for a solution which had less impact on the person's dignity.

Staff told us, and observations confirmed that even when people had been assessed as unable to make significant decisions, they were encouraged to make day to day decisions, for example, what clothes they would like to wear or where they would like to spend their time

We saw that people enjoyed a pleasant dining experience. Tables were well presented, laid out with napkins and condiments, and menus. Signs were displayed throughout the dining areas to let people know that other options were available if they did not want any items from the daily menu. People were offered choices at each meal by selecting from the menu in advance. We discussed with the provider that this method did not best suit the needs of people with dementia. Shortly after the inspection we were advised the provider had introduced visual choice for people with dementia, where plates of each option were shown to people. This meant they could see and smell the food and enable people to make decisions based upon their communication needs.

People told us the food at the home was appetising. One person said, "I like the food the home provides, but I don't like the soup. You get a choice of two menus, but wouldn't mind a greater choice of food." Another person said, "I like the food I get in this home." They told us they got migraines from particular types of food

and said, "The staff have responded well to my problems and check the ingredients before offering me food from the menu."

Food was plentiful, with snacks such as fruit platters, biscuit selections and home baking available in between mealtimes. Where people had been identified as at risk of dehydration or malnutrition, additional documentation had been completed to monitor their daily intake. We saw this documentation was well completed. Referrals had been made to dietitians and speech and language teams where necessary. One relative told us, "[My relative] needs special attention when feeding themselves and staff have been very effective by introducing a plate guard to assist them with this. Staff are always on track with everything, one example is making sure that people's weight it monitored weekly."

People continued to be supported to access a full range of health care services and information from external professionals was incorporated into their plans of care.

Requires Improvement

Is the service caring?

Our findings

When we last inspected Kensington in February 2017 we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Dignity and Respect. At that time, we found people's care was not given in a caring or dignified way. One person had described needing more timely support from staff with their toileting needs and a relative told us staff had not consistently ensured their relative was properly dressed so they would be comfortable. We had observed that the dining experience did not promote people's dignity, as a staff member had not taken due care when supporting a person to eat.

Following that inspection, the provider had written to us to explain the actions they were taking to ensure that staff always treated people with respect and dignity. However, at this inspection, we found further concerns in how people were treated. This meant the provider had continued to breach these legal requirements.

In conversation with people and relatives, their views about staff were mixed. Most feedback was very positive. People and relatives described staff as kind. One person said, "Staff are very caring, kind and patient with me and always ask how I am that day before they attend to my requirements. Staff sit and listen to what I have to say. They don't check their watch and rush me along." Another person said, "Staff always listen to me if I have any problems I want to get off my chest." And a third person told us, "I have a favourite carer who looks after me like her own family and kisses me on the cheek every time she sees to me."

Eight of the 10 relatives we spoke with told us they had never had any concerns over how staff interacted with their family member. One relative said, "I've had [my relative] in other homes in the past and this is just a gem in the way staff care and look after people compared to other homes." Relatives described enjoying a joke and 'banter' with them and their relatives. We observed lots of good interactions where staff chatted with people, talking with them about their day. Staff were generally very warm towards people, and we saw them holding one person's hand, and putting their arm around another in a comforting way when people looked upset.

However, two of the six people, and two of the 10 relatives we spoke with told us about times where they felt staff had not treated people with respect. One person told us, "Some staff and carers are good, but some of them become a little impatient with me and don't realise what it's like to be old." They continued, "On the whole some staff are excellent. However, there is a marked difference in the service from one carer to another. I get immediate assistance from some carers whilst others can take up to 15 minutes before they've really understood what I wanted and often become impatient by shouting and showing little empathy for my personal needs." A different person echoed this saying, "Occasionally I've ran into difficulties with carers when I don't respond to their requests straight away. One carer shouted, 'Come on, come on' which I found a little sharp."

One relative told us staff did not listen to their family member or respect their wishes. They told us they had visited at times and saw their relative's personal items and glasses of water were out of their reach, that

some staff would close the door when their relative had requested it stayed open, and had brushed their family member's hair with a brush that had been used for other people. This relative told us their family member had shared with them, "They (staff) have ways of getting their own back if I complain." We shared this feedback with the local authority safeguarding team. We shared this feedback with the registered manager and the provider's regional manager. They were concerned about this information and told us they would discuss issues around dignity and respect in meetings held with people and relatives. Following this feedback the regional manager told us they had arranged additional training in dignity and respect for all staff.

During our inspection we overheard one staff member raised their voice and repeated instructions in a way which seemed to communicate a frustration, when two people taking part in an activity did not understand what they were expected to do. Whilst the people involved did not appear upset by the interaction we considered this tone not suitable to promoting an encouraging and enjoyable atmosphere. We immediately shared our observations this with the registered manager who held a supervision with the staff member to discuss their manner.

People's personal information was not always confidential. During our walk around of the home we saw signs in communal areas which detailed people's names and dietary needs. During the inspection the registered manager removed the signs, and told us all signage would be reviewed to ensure it upheld people's privacy.

Over lunch we saw improvements in the way staff supported people who needed assistance to eat. Following our last inspection, the provider had introduced dining audits where management staff regularly observed the mealtime experience. We saw staff talked with the people they supported and explained what foods they were about to eat. Staff helped people at a relaxed pace, waiting for the person to finish their last mouthful before they offered another. Drinks were regularly offered.

However, whilst staff did talk with the people they were supporting, on the first day of our inspection we found they also held conversations between themselves. Whilst serving people their meals, or supporting them to eat, we saw staff chatted amongst themselves. Some conversations included discussions about people who were in the room, which did not promote their dignity. For example, one staff member nodded at a person using the service and said to another staff member, "He's knackered today." They said about another person, "Just keep pushing the fluids, he's not done too bad today." Whilst we considered that these interactions were made in a concerned way to communicate between staff people's ongoing needs. They did not take into account people's feelings at having their personal needs discussed in public or their right to privacy. We fed this back to the registered manager told us they would discuss this topic during a daily meeting with staff. We observed mealtimes on the second and third day of our inspection and did not observe any further occasions where staff did not uphold people's privacy.

We noted that items related to people's care needs, such as continence products or nutritional supplements were stored in people's rooms. In some instances there was an overstock, which did not show that staff had considered people's dignity or right to their personal space. For example, in one person's room we saw over 200 bottles of nutritional supplement stacked up. We fed this back to the registered manager during the inspection who arranged for them to be moved to storage areas in the home.

Throughout the inspection we spoke with the registered manager about the steps they had taken to address the breach relating to dignity and respect highlighted at the last inspection. They explained that staff had attended face to face training in dignity and respect, which was supported by regular supervisions. Supervision records prompted discussion about staff manner and the way they supported people's dignity

Some staff had been appointed as dignity or dementia champions, tasked with staying up to date with best practice and sharing that with their colleagues. Despite these steps taken by the provider, through observations and discussions with people who used the service it was evident that shortfalls remained in the way people were treated. The registered manager and regional manager were disappointed with our findings, as they told us they had worked hard since our last inspection to address issues with dignity and respect. They told us they would work to reinforce the culture expected within the home, and review supervision and observation practices to enable more opportunities to feedback to staff about their practice.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to be independent wherever they could. We saw staff walking alongside one person in their electric wheelchair. The staff member reassured the person when they were unsure about their controls and talked the person through how to manoeuvre it rather than stepping in and guiding it themselves. The staff member walked alongside the person moving any obstacles out of their way. One person told us, "I still try to be independent and when staff offer assistance I often say to staff, 'I'll try to do this task myself' as I want to remain independent within my own capabilities." Care records reinforced to staff that people should be encouraged to maintain their independence.

Most of the staff had worked at the home for a considerable amount of years. Staff we spoke with clearly knew people very well. They could tell us about people's needs, and the important people or events in people's lives. Staff were proud of working in the home, and all told us they thought Kensington was a very homely, friendly place for people to live. One staff member said, "I genuinely love working here and that in itself helps me to be a better staff member."

Families and relatives could visit the home at any time. All but one of the relatives we spoke with told us they felt welcomed when they visited Kensington. Relatives described building rapport with staff. One told us, "The staff always have time to say hello when we walk in. They'll often offer us a cuppa if they aren't busy. I'm always greeted with a smile."

A range of information continued to be provided and displayed around the home about the service's ethos and what people could expect from living at the home. This included an informative guide to the service, a 'resident charter', details of social activities and events, and a noticeboard dedicated to dignity in care. A 'You said. We did' board was on display which detailed the provider's response to the most recent quality survey.

People and their relatives were supported to express their views about the care provided and the service in general. They were involved in reviews of care and could give their feedback through meetings and surveys. Most of the relatives we spoke with told us they thought the home communicated with them well. Family members told us they home had contacted them whenever staff had noted their relative wasn't feeling themselves, and they were invited to the home regularly to discuss people's care.

The registered manager told us no one was using an advocate at that time, but that advocacy services could be arranged they thought anyone needed this type of service. Information relating to independent advocacy was available on the noticeboard. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

All the people we spoke with, and all but one of the relatives who we spoke with told us they thought the service met their or their relative's individual needs. One person told us, "Staff are quick to respond to my requirements and understand the support I need." Another person said, "I have confidence in staff that they will continue to provide a good service for me."

Care records were detailed and contained information gathered from speaking with people and their relatives about people's life histories. It was clear that people and their loved ones had been involved in the assessment process and when planning how people's care should be provided. Throughout people's care records there was lots of information about people's choices, and preferences. This meant staff had information available about how to provide people with care that met their needs and wishes. The registered manager had supported one relative to write an overview of needs for their family member. This care plan was kept in the person's room so that staff could refer to it whenever they needed to, to deliver person-centred care in line with the person and family member's wishes.

People we spoke with told us their choices were respected. They explained personal care was provided by staff of their preferred gender, and that they were given baths or showers as often as they would like. Care records were kept electronically, and staff told us they had the chance to read everyone's records.

People were able to decide how they wanted to spend their day. Care records stated the times people would usually get up, whether they would like to eat their meals in their room or the dining rooms and what style of clothes they liked to wear. This information was available to enable staff to better respond to the person's needs.

Communication needs had been assessed, and care plans detailed how staff should communicate with people. For example, one person's records said staff should make sure they were facing the person when they were speaking to them, as their hearing was impaired, but they were able to follow conversations through lip reading. Information about people's care choices and about the service were available in large print and if required could be provided in braile and easy read. Easy read is a form of communication where straightforward words and phrases are supported with pictures and symbols.

The service provided end of life care to people with terminal and life limiting illnesses. People had been asked to think about how they would like to be cared for at the end of their lives. This information was available to inform staff of the person's wishes at this important time when people may no longer be able to communicate. The registered manager told us that when they were supporting people at the end of their lives, the home would store medicines in advance of people needing them so they could be accessed quickly if people's health deteriorated. Nurses were trained in delivering medicine through a syringe driver which is a system to deliver a steady flow of medicines and sometimes used in end of life care. Nurse competency in using syringe drivers was checked annually to ensure they had the skills to use the equipment if it was needed.

There were a range of activities held inside and outside of the home. Kensington employed two activities co-ordinators who supported people to take part in arranged group activities as well as spending time with people on a one on one basis. During our inspection we saw people taking part in biscuit decorating, dominos, and a music singalong. Activities records showed that regular activities also included karaoke, quizzes and baking. People and their relatives were positive about the activities on offer. One person said, "There is always something going on." A relative told us, "Activities are good. It's always fresh. Something different every week." The home had links with a number of local churches, and services were held regularly within the home.

Some people and relatives told us they would like to get out of the home more regularly. Staff from the home had access to a minibus and had recently visited a local open-air museum, based around life in the North East at different times in history. They had also arranged trips to the coast. Signs were placed around the home to advertise upcoming visits and relatives were also invited to join their relative. We told us registered manager that some people would like to go out more, they told us they would ensure staff communicated to people about upcoming trips, and told us that as the weather was getting warmer more activities would be planned outside. The home had recently built a raised balcony at the front of the home. This created a comfortable seating area outdoors which we were told was very popular during summer. The registered manager advised us that during the colder months it was not used as much, but that she encouraged staff to continue to offer people the opportunity to wrap up warm and sit outside.

The regional manager told us the provider had introduced a new activities programme called 'Three Wishes'. Activities staff had spent time with each person who used the service to discuss people's hobbies and aspirations, and come up with three wishes that staff would help people to achieve. We saw one person had wanted a Chinese takeaway so a private room had been decorated in a Chinese theme. The person's relatives had been invited to the home, and the person and their family had been served their meal by staff. Another person had said they would like to go for a pint, so activities staff had worked with care staff to ensure the person's physical health needs could be met whilst they accompanied the person to enjoy a few hours in their local pub. The programme was ongoing and staff and the activities coordinator were very enthusiastic about the future wishes they were planning on granting when the weather was warmer, such as for one person who said they would like to eat fish and chips at the seaside.

There was a complaints procedure in place. A log was recorded of formal written complaints, and any minor concerns which had been brought to the attention of the registered manager. We saw that the registered manager had investigated them all, and responded in line with the complaints procedure. There were nine in total received in the year prior to our inspection visit. We saw where appropriate the registered manager had formally investigated complaints, and shared the results with the regional manager. The tone of all communication with people who had made complaint was empathetic and whenever possible the registered manager had identified lessons learned and set action plans to reduce the risk of any incidents causing people to complain happening again.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found shortfalls in delivery of the service which had not been identified and addressed by the provider's internal quality assurance systems.

We could see the provider had taken a number of steps to meet the breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Dignity and Respect which we had set at our last inspection in February 2017. However, during this inspection, feedback from people and relatives, observation of staff practice, improper storage and the way people's personal information was displayed within the home, showed people's dignity was not always upheld.

Some risks relating to medicines had not been mitigated, a small number of care plans did not detail key information about people's needs, and records did not evidence that actions, identified following concerns around staff conduct, had been followed up.

The quality assurance system was in-depth and comprehensive with a schedule of audits and assessments carried out by staff of different designations. The registered manager completed a daily walk around of the home noting areas to address. Medicines systems, health and safety, infection control processes, the kitchen and dining room experiences were audited regularly. However, these had not highlighted the concerns which we found. This meant auditing systems in place had not always driven improvements.

Records showed representatives from the provider visited the home regularly. They monitored management information and performance information such as the number of accidents, incidents, safeguarding issues, number of people with unintended weight loss, complaints and staff disciplinary investigations which were on-going to ensure these were being handled appropriately and to monitor for any trends. This performance information was reported up to board level. During monthly board meetings the quality, standards and indicators related to each of the provider's homes were discussed.

The provider's regional manager carried out monthly quality assessments which included review of care records, observations, and discussions with people who used the service and staff. The provider's quality assurance manager also carried out inspections of the home based around the Care Quality Commissions key lines of enquiry (the areas we look at when we inspect homes) as well as other performance measures. However, whilst we could see that feedback from these quality checks was detailed, and action plans had been created and monitored to address any areas for improvement, these checks had failed to identify the shortfalls in care delivery that we found.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

At the time of our inspection there was a registered manager in place. She had been registered with the Care Quality Commission in November 2016. The registered manager had skills and experience to lead the service. She had worked within adult social care for 15 years, and told us she had been supported by the

provider to continue to broaden her management skills, including attaining a Level 5 diploma in leadership for health and social care. She was present throughout our inspection, and alongside the senior management team, displayed openness and transparency towards the evidence we presented to them and were proactive in their response to our findings. The registered manager, regional manager and nominated individual showed a commitment to making changes and improvements within the home.

Feedback about the leadership of the service was generally very positive. People and all but one of the relatives we talked with, spoke highly of the registered manager. One relative told us, "I've spoken with [the registered manager] on multiple occasions. I've never had to wait to speak to her. She's really approachable. She says, 'My door is always open' and it really is like that. She's always made time if I've ever had anything to talk to her about." The registered manager was a visible presence. She carried out a daily 'walk around' which included speaking with people and staff about how they were feeling. During our inspection we saw the registered manager knew people and their relatives well.

The regional manager told us they visited the home at least once a week and ensured they spent time out of the office, in communal areas during their visits so they could monitor the atmosphere and culture of the home. We saw she knew staff and people by name, and staff we spoke with confirmed that she was approachable. The regional manager told us staff were encouraged to share their views and to raise any concerns if they had any. The provider's whistleblowing policy set out their commitment to protecting staff if they brought to the provider's attention any concerns about the service. Staff were aware of how they could contact the provider if they needed to, and the regional manager told us in addition to the whistleblowing contact details, there were lots of opportunities for staff to approach her directly if they had any information which they wanted to share.

The provider's philosophy of care was to provide a safe, happy and homely environment for people to relax and be cared for. Staff were made aware of the provider's values within their induction, and the principles of person-centred care, treating people with compassion were agenda points within each staff supervision meeting. All of the staff, and most of the people and relatives we spoke with described Kensington in ways which reflected the provider's philosophy. The nominated individual told us the quality assurance system in place across the provider's homes was subject to continuous evaluation and improvement. They showed us a new version of an audit tool which had just been developed by the provider's quality assurance manager which incorporated more metrics to assess the quality of the service. In response to our feedback about shortfalls in the delivery of care the provider told us they would further review their quality tools to consider more ways in which to evaluate the culture and philosophy of the service.

The registered manager told us they were committed to communicating openly with people and their families. They told us that previous meetings for relatives and people who used the service had not always been well attended, so they had introduced changes to make them more of a social occasion, including providing home-made snacks for people and relatives to help themselves to, to encourage a relaxed, welcoming environment.

Feedback had been sought from people who used the service, staff and visiting professionals. Surveys were sent out annually to ask people about their views on a range of aspects of the care which was delivered and the service provided. During our inspection we asked to see the analysis from the most recent survey, carried out in 2017. The provider was unable to show us this, as they advised the member of staff responsible for the collation of the surveys had since left the company. This meant we were unable to view the collective response to see what themes had been fed back to the organisation. We were able to view the 'You said. We did' findings which had been shared with people and relatives following the survey. This document appeared to focus on the specific comments which people left, but detailed the steps the home was taking

to improve further, including discussing privacy and dignity during supervision sessions, introducing a suggestions box and publicising upcoming events more widely.

Staff told us they found the registered manager and the provider to be very supportive and told us they felt valued. Staff meetings were held regularly. These minutes showed that in addition to receiving information about the home, staff were asked to feedback on their views on the service which was provided. Staff told us communication between the management and the different staff teams within the home was good. One staff member said, "We have an excellent team here, from [registered manager] to every one of the carers. We want our home to be the best and we are proud of it. It's like a second home for lots of us. I actually get excited to come to work. I love our residents and we all work together to do the best we can for them."

The registered manager and the provider had built good working relationships with other organisations. We saw evidence that the registered manager had communicated promptly with the local authority, and provided detailed investigations to the safeguarding team where concerns had been raised. The local authority commissioning team had visited the home in November 2017 and their quality assessment report was very positive about the service and care provided. The provider evidenced a commitment to quality improvement by implementing action plans to address minor feedback shared through the quality assessment process. We saw actions had been completed and communicated to the local authority. When people had moved to other homes the home provided their assessments and records to enable a smooth transition to other services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people using the service were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Whilst the provider evidenced that the action plan, in place to address the breach of Regulation 10: Dignity and Respect found at the last inspection, had been completed, issues with dignity and respect remained. Audits and checks on the service were in place but had failed to highlight the shortfalls identified during the inspection. Risks relating to health, welfare and safety had not been mitigated because the provider had not ensured that complete records were in place for each person who used the service. Regulation 17(1)(2)(a)(b)(c)