Kudos Care (UK) Limited

Knightsbridge Lodge

Inspection report

Knightsbridge Green
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 and 5 September 2016 and was unannounced. During our last inspection on 16, 18 and 19 January 2015 we found the provider had not fully protected people against the risk of potential infection, had not fully protected people against staff who may not be suitable and had not established systems and processes that effectively ensured the service was adequately monitored. The provider had forwarded an action plan which told us how they would meet these breaches of regulation. The provider told us these would be met by 30 July 2015. At this inspection we found these areas of regulation had been met although further improvement was needed to ensure the appropriate processes under the Mental Capacity Act were completed at the appropriate times and auditing process was fully completed.

The care home is registered to provide care and accommodation to up to 22 people; predominantly older people. At the time of the inspection there were no vacancies. Each person had a private bedroom with toilet and washing facilities. There were additional bathing and toilet facilities with specialised equipment to help people. Two lounges and a dining room provided people with comfortable, domestic style areas to sit and socialise. The care home had very well maintained gardens which people told us they enjoyed when the weather was good. Work had started to secure these gardens so people who could get confused and disorientated could enjoy these independently. There was ample parking for visitors.

This is a family run business of which the registered manager is a member of the family.
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.

Prior to the inspection we had received information of concern telling us there were not enough staff to meet people's needs. There were also concerns relating to the safety of one person who chose to take a walk outside of the care home and that people were being forced to get up from bed earlier than when they wanted to. We explored all of these concerns during the inspection. We found no evidence to suggest people were being forced to get up and where people were at risk staff had taken action to address this.

Risks to people's health were identified and actions taken to address these. Senior staff fully understood the principles of the Mental Capacity Act 2005 (MCA) and had liaised with external professionals where they had concerns about a person's mental capacity. In some people's cases however, where it would have been appropriate to assess the person's mental capacity and make applications under the Deprivation of Liberty Safeguards (DoLS), this had not been completed. Work to rectify this started at the time of the inspection. We made a recommendation that the provider seek further advice about when applications under the DoLS should be made.

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 protected against risks that may affect them. Environmental risks were identified and managed including risks which may cause the spread of infection.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and improved recruitment practice protected people from the employment of unsuitable staff.

Arrangements were in place to make sure people received their medicines appropriately and safely.

Is the service effective?

Requires Improvement

The service was effective. People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were understood. In some cases however, the correct applications and assessments under the MCA had not been completed. As soon as staff were made aware of this they started to address this. People were supported to make their own decisions as and when they were able to do so. Care was provided to people in the least restrictive way.

People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met by working closely with visiting health care professionals.

Is the service caring?

Good

The service was caring. People were cared for by staff who were

kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Care was delivered as people wanted it delivered.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. Care plans gave detail about people's needs and how they wished these to be met.

People had opportunities to socialise and partake in activities and the staff were trying hard to make these activities more meaningful to people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led. Some improvements in the organisation of what needed to be followed up and acted on by the management staff had been made. However, the auditing system was weak and required some improvement to ensure that where improvements had been made these were sustained and that future shortfalls could be identified and correctly addressed in order to protect people.

People benefited from having management staff in place who genuinely wanted to provide a good service. They communicated well with their staff and supported them to provide this.

The management team were very visible and approachable so people were able to express their views to them. Plans to improve how the views of people, relatives and other visitors were formally sought were being made.

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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 3 and 5 September 2016 and was unannounced.

Prior to the inspection we reviewed all the information we held about the service. This included all statutory notifications received since our last inspection on 16, 18 and 19 January 2015. Statutory notifications are information the provider is legally required to send us about significant events. We reviewed all information of concern received about the service since the last inspection. We reviewed the Provider Information Return (PIR) submitted to the Care Quality Commission on 12 April 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

One inspector carried out the inspection. We spoke with eight people who lived at the care home. We sought their views about the care they received and their ability to have their choices and preferences met. We also spoke with five relatives who gave us their views of the care their relatives received and about the services generally provided. We spoke with six staff including the deputy and manager and registered manager. We reviewed the care records of four people and the medicines records of six people. We spoke with two health care professionals and gained their views of the care delivered to people. We spoke to one regular visitor to the care home. We reviewed three staff recruitment files.

We also reviewed records pertaining to the management of the care home. These included cleaning records, staff rosters, records relating to actions taken in response to medicine errors and medicines management, staff training records, staff meeting records, audits, accident and incident records including falls management and people's social and meaningful activities. We also reviewed the policy and procedure for infection control and management of laundry.

Good

Is the service safe?

Our findings

During our last inspection in January 2015 we found the provider had not fully protected people against the risk of potential infection. Although staff had received infection control training, this had not been delivered in line with the care home's policy and procedures and, these procedures were not entirely relevant to Knightsbridge Lodge. There had been some differences in staffs' understanding of what was expected in practice. This potentially put people at risk of acquiring infections, which could be avoidable through well organised infection control arrangements. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan which told us how they would meet this breach of regulation. During this inspection we found this had been met.

People lived in a clean and fresh environment. One relative told us what they liked about the care home. They said, "I'm fussy and it's clean and never smells." Infection control arrangements were in place and improvements had been made to the relevant policy and procedures. There were two areas, one related to laundry management and the other to the cleaning of some floors where the guidance needed to be clearer to aid consistent practice. This posed a minimum risk to people because other effective arrangements were in place. Also, the cleaning tasks designated to the night staff had not been signed for even though this was expected of them. The registered manager told us these had been carried out because they checked. The management team told us these areas would be addressed immediately after the inspection.

We re-visited the infection control policy and the procedures for cleaning. We spoke with staff about their practices and made observations. The written procedures were now relevant to the care home. For example, a piece of equipment previously stated in the procedures, which would be used for sanitising equipment and which had never been in place in the care home, had been removed from the procedure text. Further amendments had taken place in July 2016 following the purchase of different cleaning products. The management staff had gone through how to use these new products with the staff. One member of staff confirmed that the product stated in the procedure for cleaning commode pans, for example, was being used for this purpose. Other staff were asked about this and the correct practice was being followed.

When it came to cleaning toilet and bathroom floors, staff confirmed they used a product which the registered manager had told us they did not like used. The home's written procedure did not refer to the use of this product (bleach). One member of staff said, "We have always used it". A container of bleach was seen in the cleaning cupboard and we established it had been purchased for staff to use. We discussed this with the registered manager who reiterated, he did not want it used, that it would not be purchased again and staff would use the product stated in the procedures. This choice of product was entirely up to the registered manager but we emphasised the home's written procedures and actual practice needed to be the same.

We also re-viewed the procedures for managing laundry. When we arrived at the care home we saw two piles of laundry on bedroom floors. Staff confirmed and we observed, the laundry being bundled up and carried through the care home to the laundry room. Both of these actions were poor infection control practice. When we spoke with staff about this they were unclear as to what was available to place the laundry in and subsequently transport it to the laundry safely. One member of staff told us there were no

laundry bags so they carried the laundry as it was. They also said, "Wherever I have worked before there have been laundry skips you can wheel around with you," Another told us they bundled it up in the towel that had been used and carried it to the laundry room in that. Another said "There are no laundry skips as such" but there were plastic baskets to use for dirty laundry. The laundry collection procedures stated, "All laundry must always be transported in a laundry bag". It also said, "Laundry bags must not be overfilled". The registered manager told us laundry should not be placed on the floor and confirmed there were plastic baskets for transporting the laundry. We pointed out that the procedures did not make this clear and the registered manager told us this would be addressed.

All staff knew however, if laundry was soiled it must be handled differently and segregated from unsoiled laundry. The procedure said, "All soiled items to go into red bags". These were plastic bags designed to split open in the wash cycle. These were readily available in the care home. This avoided the re-handling of soiled items in order to get them into the washing machine. This practice reduced the risk of spreading infection. Other good arrangements seen in January 2015 remained in place. These included, staff wearing protective aprons and gloves when delivering personal care or food. Colour coded cleaning equipment ensured equipment used to clean the toilets was not used to clean lounges and bedrooms. We saw staff washing their hands and liquid soap and paper towels were in place which all helped to reduce the risks of germs spreading.

During our last inspection we found the provider had not fully protected people against staff who may not be suitable. Robust recruitment practice had not been followed. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan which told us how they would meet this breach of regulation. During this inspection this had been met.

People were protected from staff who may not be suitable because the recruitment practice had improved. The recruitment records showed appropriate checks had been carried out. Clearances from the Disclosure and Barring Service (DBS) had been requested and received prior to staff starting work. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought. When a request for a reference had not been responded to we were told by the management staff they followed this up verbally, this action had not always been recorded. We were told that in the future this action would be recorded.

Prior to the inspection we received information of concern that there were not enough staff to meet people's needs. People told us their needs were met and staff agreed there were enough staff on duty to look after people. We did not find any evidence that suggested people's needs may not be met due to a lack of staff. Staff who cleaned the care home had also received training which enabled them to help, if needed, with personal care. This gave the care home some security in situations where for example care staff went off sick at the last minute. Since the last inspection the staffing had also been adjusted to ensure there were three care staff, instead of two, on duty when the domestic staff went off duty. The kitchen was staffed by two cooks and only if the cooks were unable to cover each other did certain other staff cover the kitchen shift. For example, the activities co-ordinator told us she sometimes covered the kitchen to help out in this situation but only in addition to the designated activity hours. We were also told that where needed the deputy manager and registered manager helped with personal care.

People were kept safe because their risks were identified and action taken to reduce these. One person said, "I'm very pleased to be here. I feel safe here." Accidents and incidents were recorded and monitored. Most accidents consisted of falls and people's care records stated what actions had been taken immediately after a fall. The person's GP or paramedics had usually been involved in checking the person for injury and if

needed, people had received treatment. The support provided by the staff had also been reviewed to ensure it was still relevant; the aim being to reduce the risk of another fall. Sometimes the introduction of or change of equipment had been needed to help the person mobilise safely. In one person's case, following an assessment by a physiotherapist it was apparent the person could no longer mobilise independently so equipment to help move this person had been supplied. Where people went on to have a further fall circumstances leading up to them falling were explored in more detail. Again, the support actions were reviewed and managers looked for trends and patterns in the circumstances leading up to a fall to help them determine what needed to be put into place to help keep the person safe.

We spoke with one person who had previously fallen in their own home and they told us they had "lost confidence". They said staff had been "very nice" to them and had insisted they call for their help but they had not wanted to initially "bother them" and had experienced another fall. They had received hospital treatment and their recovery was still being monitored by health care professionals. When we visited this person they had arranged for a member of staff to help them and their call bell was within reach. Another person had fallen and required hospital treatment. On their return to the care home they had been moved to a downstairs bedroom so staff could monitor them more closely and provide support when it was needed.

There were arrangements in place to help protect people from abuse and any form of discrimination. Staff received training on what constituted abuse, how to recognise it and how to report any concerns. The management staff often took advice from the county council's safeguarding team on how to manage safeguarding concerns and they worked with adult social care professionals to protect people. During the inspection we spoke with the management staff about two cases where safeguarding actions were in place to protect the person. The service's safeguarding policy worked in conjunction with the county's multi-disciplinary safeguarding policy. This meant that the care home appropriately shared safeguarding concerns and information with other professionals and agencies who also had responsibilities to protect people.

Health and safety checks were carried out to ensure the environment remained safe. Health and safety awareness was the responsibility of all staff and they made sure the care home remained tidy and free of obvious risks. They reported concerns they had to the management staff who addressed these. Staff had received health and safety related training and knew, for example, how to manoeuvre people safely. The registered manager and maintenance person carried out more detailed checks to ensure the environment and systems in the care home were safe. Contracts were in place with specialised companies, for example, to check the fire safety systems, call bells and lifting equipment. Prior to the inspection (August 2016) we had received concerns about one person and their safety when they walked outside of the care home's grounds. This person's rights to walk out of the care home had been upheld but staff had also identified risks to their safety when they did this and actions had been put in place to reduce these. The Provider Information Return (PIR) had stated arrangements were to be made in the next 12 months to secure the grounds around the care home. We found this work had already begun in order to provide people, especially those who lived with dementia, the ability to enjoy the very well maintained gardens safely and independently. The care home sat alongside a busy main road which, for some people, posed a risk. This work was being carried out to reduce risks to people and not intended to restrict people.

People's medicines were managed safely. Secure storage was in use and records pertaining to this were well maintained. We observed people being supported to take their medicines safely. Staff who administered medicines received specific training to do this and their on-going competency was monitored.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 (MCA) were understood by the staff however, the required processes which ensure people are protected under the MCA had not always been completed. Where people had been assessed by external health or social care professionals as lacking mental capacity and needing to live in a care home in order to receive the care and treatment they required, staff had correctly applied for Deprivation of Liberty Safeguards (DoLS). It was recognised by the staff that although a person may lack capacity in respect of this decision they may have capacity to make other specific decisions. In some cases where staff had concerns about a person's ability to make specific decisions they had arranged for the person to be appropriately assessed. In one person's case their capacity to make a specific decision had been assessed by an independent assessor. They had assessed the person as having capacity to make specific decisions. Staff however had continued to have concerns about this person's mental abilities and the person's mental capacity was now to be re-viewed by a Consultant.

However, for people who had lived in the care home for a while and had become unable to make specific decisions about their care and accommodation, who were not necessarily refusing care or attempting to leave the building but were nevertheless unable to leave the required processes under the MCA and DoLS had not been completed. After discussion with the management staff they told us there were several people who fell into this category. Work began during the inspection to ensure these people were protected under the MCA and DoLS legislation to receive their care lawfully. We therefore saw mental capacity assessments and DoLS applications being completed.

We recommend the service seek further advice, from an appropriate source, on the processes that need to take place to ensure all people are fully protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Prior to the inspection we received concerns about people being able to walk out of the care home and concerns about their safety when they did this. The registered manager explained one person had not had DoLS authorisations in place and was able to make decisions about where they wanted to go. However, there had been concerns relating to their safety when they had left the care home and the management staff had sought further advice from the person's social worker. The social worker had confirmed the person had the mental capacity to make their own decisions in regard to this and they should not be stopped if they wished to leave the care home. Another person who lived with dementia used to walk out of the care home and staff did escort them to ensure their safety. This person was assessed as requiring more supervision and monitoring and was therefore moved to a more appropriate environment. In these cases the management staff had ensured people's rights and they had taken action to address known risks.

People's consent was sought before staff provided care. Sometimes a balance between a person's desire to remain independent, their reluctance to accept help and their health needs had to be found. Staff worked closely with one person who was frequently reluctant to ask for help and accept help when it was clear they really needed it. The deputy manager explained that staff aimed to support this person to make their own decisions. They also tried to deliver this person's care at times that best suited the person. Staff were aware

care could not be forced upon a person and that not all decisions people made were wise decisions but they had the right nevertheless to make them. Another person was receiving care for a short period of time and their ultimate goal was to return to their own home. Therefore staff were supporting them to achieve this by promoting their independence. People who lived with dementia were also supported to make decisions when they were able.

People we spoke with told us in various ways they felt well looked after. One relative was particularly relieved that their relative had been admitted to the care home. They spoke highly of the staff and the support they gave. They said, "I cannot fault it." Another relative said, "Oh it's lovely, we're happy and [name] is happy." One health care professional said, "Very helpful staff, they communicate well with us and follow our instructions. It's a nice home." Another health care professional said, "I have no concerns about people's care and treatment here." We spoke with one experienced care assistant who had worked in other care homes. They said, "I think the care is a good standard here."

People had access to health care professionals when they required additional health support or medical intervention. Local GPs visited regularly or when needed and community nurses carried out visits on most days to attend to people's health needs. Community nurses, for example, attended to all wound care needs and assessed people's risk of developing pressure ulcers. They organised pressure reducing equipment when it was needed. People's records and the staff confirmed visiting health care professionals often worked together to support people. People's records showed many had a mixture of physical and mental health needs. In one person's case their GP had monitored and supported their physical needs which were exacerbated by what appeared to be psychological stresses. This person had therefore been visited by a Consultant Psychiatrist who reviewed their mental health and the behaviours they were presenting with. In the case of another person the advice and guidance of a mental health community nurse had been incorporated into the person's daily care planning in order to better support their needs.

People's needs were met by staff who received relevant training and support to be able to this. One member of staff said, "We get loads of training" and "[name of deputy manager] is very supportive." When staff started work at the care home they all completed the provider's induction training. This consisted of basic training subjects such as, safe moving and handling, safeguarding people, fire safety, food hygiene, infection control and the Mental Capacity Act. This helped staff carry out their jobs safely. We asked to see the induction record for one new member of staff. The deputy manager explained this member of staff had not completed the induction training yet. They were however an experienced care assistant and had been shown the fire safety systems pertinent to the care home. Another member of staff, employed prior to this member of staff, had completed the provider's induction training and this was recorded on the service's central training record. This member of staff along with three others had completed induction training linked to the care certificate. This came into force in March 2016 and lays down a framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. The training record showed five staff who delivered care held a recognised qualification which gave them the skills to supervise other care staff. Two further staff, not employed as care staff, also held a nationally recognised qualification and had completed training which enabled them to assist with people's personal care if needed. Half the work force had completed training in dementia care. Two members of staff had completed additional training in dementia care which enabled them to support staff when providing care to people who lived with dementia. People benefited from this training because staff knew how to meet their individual needs.

People received support to maintain their nutritional well-being. People had a choice of food each day. The menu for the week was displayed outside the dining room and for example, there were two options at lunch-time. We were told the cook was aware of what people liked and disliked and that they also provided

alternative options on the day. Tables in the dining room were laid with table cloths, napkins and mats to help provide a pleasant eating experience. One person said, "The food is lovely here". A member of the night staff told us one person had been awake during the night and they had made them a cup of tea. Drinks were seen available in the lounge and people's bedrooms and were served in-between meals with biscuits and cake. Some people had specific drinking cups and beakers to help them drink independently.

People's weight was monitored and any concerns relating to this reported to their GP. One person's care records showed the person had gained weight steadily following their admission to the care home and it was now stable. Another person's diet and appetite was monitored because they had diabetes. An appropriate care plan was in place for this giving staff guidance on this area of support. Any concerns staff had in relation to this person's condition they could refer to the community nurses. Another person told us they had been eating well as they enjoyed not having to worry about getting the food and cooking it as they had needed to in their own home.

Good

Is the service caring?

Our findings

People and their relatives had very positive comments to make about the staffs' approach and how caring the service was as a whole. They said, "The staff are very nice", "They're like my family, it's like my own home", "I think Knightsbridge Lodge is one of the nicest homes I have been in. It's so welcoming and homely" and "It's small, homely and you get one to one care [name] is never distressed here. It's superb here; I would die if [name] had to leave here." One other regular visitor to the care home said, "It's a lovely home. I never have any concerns about how people are treated here. If I did I would report these to [name of registered manager]."

Prior to the inspection we received information of concern that people were being forced to get up from bed earlier than when they wanted to. We had also been told that a certain number of people had to be up before the day staff came on duty. We specifically spoke to all of the people who were already up when we arrived at 7am. There were eight people up out of the 22 present. Each person told us they wanted to be up and they had either been helped by the staff or had got themselves up. One person said "I like to get out of bed early, they [staff] help me and I sit in my chair; I may nod off again." Another person said, "I like to be up once I'm awake". One of the night staff said, "I have never been told to get a certain number of people up before the day staff come on duty and anyway it's their [people's] choice if they want to get up or not. They get up when they want to." We spoke to another person who was awake and who had been provided with a cup of tea and who was waiting in bed for staff to help them have a bath. They told us they could get up when they chose to.

People looked relaxed around the staff as conversations were casual and friendly. Staff showed they cared by listening to what people had to say, by offering explanations when required, by supporting people's decisions and choices and by upholding their rights. They were very supportive towards those they cared for. Throughout the inspection it was obvious the staff knew the people they looked after well because they were aware of people's likes, dislikes, routines, preferences and what needed to happen to enable people to feel settled.

People's dignity and privacy was maintained, for example, all personal care was carried out in private. People were supported and advice given when needed in a respectful and private way.

People were able to receive visitors as and when they wished and in private. Visitors told us they felt welcomed when they visited. At the time of the inspection we saw one person go out with a relative.

Good

Is the service responsive?

Our findings

Staff were responsive to people's needs. Prior to admission people's needs were assessed to ensure the care home could meet these. People's preferences, wishes and expectations were explored with them and, if appropriate, with their relatives. Additional information was gathered from social care and health care professionals and from previously completed assessments. On admission risks to people were assessed and all of this information helped staff devise care plans. Care plans recorded what people's needs were, how the person preferred these needs to be met and provided guidance for the care staff. It was the registered manager's expectation that people's care plans were reviewed at least every six months. The deputy manager told us risk assessments and care plans were often reviewed and amended more frequently because people's needs and care altered.

We saw examples of this when we reviewed people's care records. In one person's case their risk assessment and mobility care plan had been reviewed four times in one year and three times the following year. They first presented as a low risk of falling but as time went on their ability to mobilise had deteriorated and they were eventually assessed as a high risk of falls. In response to this increased risk and need for additional support a physiotherapist had been involved and a walking frame provided. When the risk was last reviewed in August 2016 it was assessed that the response to the increased risk had reduced the number of falls and the person had not fallen for three months. The relevant care plan had also been reviewed and adjusted accordingly. The risk of their reduced mobility was also reflected in the risk they then presented in developing pressure ulcers. This risk and the relevant care plans were also reviewed and adjusted. In response pressure reducing equipment had been provided. This person's mental health had also been monitored and when needed, for example, when their mood had been low, staff had responded by involving the NHS mental health team.

Following admission people completed a document called "My Life So Far" and in some records the Alzheimer's Society's document called "This Is Me" was seen. These records gave staff a potted history of the person's life, where they grew up, their work, family history, hobbies and other significant events, dates and information which helped staff to get to know the person a little better. This information helped staff to personalise their conversations with people and the care they provided. The relatives spoken to confirmed they had been very involved in giving staff information to help plan their relatives care. They also confirmed they were involved in reviewing the care provided to their relative. One relative told us their relative had been settled for the last year and there had been very few alterations to their needs or care. Another relative explained that during the planning of their relative's admission they had been able to move in familiar objects from their relative's own home to help them settle in the care home. They told us their relative now considered their bedroom to be part of their own home. The relative was relieved that their relative thoughts this way and the transition from their own home to the care home had been so successful.

People were supported to be involved in social activities and other activities which were meaningful to them. They helped plan these with the activity co-ordinator who was present in the care home Monday to Friday. The activities co-ordinator also helped with other tasks in the care home but told us they made sure they maintained their designated hours for providing activities. We spoke with a small group of people who

told us they enjoyed spending time together in the lounge. They had become supportive of each other and through conversations, sometimes led by the activities co-ordinator, they had found they had things in common and had shared similar experiences in life. This provided stimulation and a sense of community. One relative explained their relative was visually impaired and the fact that the care home was relatively small with the same staff on duty most days who knew them well suited their relative. They also told us their relative received support to join in the activities. The activities co-ordinator had worked at the care home for some time and knew what people liked and disliked. For example, one person who had enjoyed a specific activity throughout their life was not able to physically carry it out anymore. However, they enjoyed the time the activity co-ordinator spent with them doing the activity in front of them. This way there was designated time to talk and the person planned and advised on what the activity co-ordinator was doing. This had subsequently enabled involvement still in something the person enjoyed and a sense of collective achievement when something was produced. Another person had not wanted to join people in an activity or to socialise. In this case staff were aware of the risks of self-isolation. They had found however that when they kept the lounge door open during an activity such as a quiz the person, in a nearby room, would call out the answers. They had continued with this practice and the person had continued to join in from a distance. Staff also used other times with this person, during personal care for example, to have meaningful interactions with them. These included short but designated conversations about their life, past achievements, hobbies and family.

More formalised activities were also planned and enjoyed by people such as a tai-chi group and chair exercise group. The activities co-ordinator told us, as did one person, that people enjoyed this. Comments included "it gets people moving" and "we have a laugh". Various activities took place on a regular basis which involved music. A Salvation Army band visited once a month. Every two weeks, volunteers from a local church led a non-denominational service which was followed by coffee and biscuits together. The care home had a mini bus which was used to take people out to garden centres or to the shops. For example, one person liked to keep some edible treats in their own fridge in their bedroom. If the staff were going shopping for this person they would also take others with them. The activities co-ordinator told us people enjoyed this and they usually stopped for a cup of coffee/tea when out. During the inspection a dog from the Pets At Therapy (PAT) organisation visited. This visit was clearly enjoyed by many people.

Specific times of the year were not always celebrated and if they were they were celebrated in a way people wanted to celebrate them. It was recognised that some times of the year, such as Valentine's Day and Christmas, came with sad memories for some people. For example, people had not wanted to do anything special on Valentine's Day this year but in a separate part of the care home it had been appropriate to set a table for one couple to have a meal together and enjoy a glass of wine. This was a good example of the staff recognising that people's needs differ and responding to these.

The provider had a complaints policy and procedures and people had been given guidance on how to raise a complaint. The registered manager and deputy manager told us they were both available and visible for people to be able to approach them about any complaints, concerns and areas of dissatisfaction. The registered manager explained they liked to deal with any issues people may have straight away in order to get it resolved. They confirmed they had not received any complaints about people's care since the last inspection. They told us one relative had raised frustration at items of clothing such as socks getting lost. The registered manager told us they had organised for name labels to be ordered and had confirmed with the relative that these would be sewn into each item. Another person had complained because a favourite item of clothing had been shrunk in the wash. The registered manager told us they had given an apology had reimbursed the person. We asked one relative how easy they felt able to discuss areas of dissatisfaction or raise a complaint if they needed to they said, "I'm able to talk to the staff about [name's] care and any other concerns I may have at any time. I have absolutely no concerns."

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in January 2015 we found the provider had not established systems and processes that effectively ensured the service was monitored adequately in order to maintain safe and effective compliance with relevant regulations and legislation. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan which told us how they would meet this breach of regulation. During this inspection we found some improvement had been made. A system had been introduced to help the registered manager plan what tasks needed to be completed to ensure compliance with various regulations. It also reminded him when various quality monitoring tasks needed to be completed. The way the quality monitoring was carried out however, did not always help identify shortfalls. There was however regular oversight of the service generally by the provider's representative. They communicated regularly with the registered manager and were well informed of any issues arising in the care home.

We were shown the reminder system and some of the electronic auditing which had been completed, for example a falls audit. The reminders had flagged up two policies which were due for review. The registered manager told us he would now complete these before the end of the month. It also flagged up which staff were due their annual appraisal and when these needed to be done by. Several staff were already recorded as having had their appraisal. The registered manager told us he had realised that he needed to delegate the responsibility of completing some of the quality monitoring checks/ audits to other staff. The plan would be for staff to complete an audit, identify any actions required, action what they could and send the audit with a record of the completed actions to the registered manager. This would enable the work to be spread amongst the senior staff team. The plan would be for the registered manager to then follow up to see if the actions had been met and assess their effectiveness. Some areas of monitoring were already delegated for example, the deputy manager monitored all care records and care planning and they also completed the medicines audit with the registered manager.

The registered manager told us they reviewed people's care records but they did not record this process. They told us if they identified a gap and action was required they verbally handed this over to the staff to action. In March 2016 a review was completed by the registered manager on a person's care record. They told us they had identified some gaps in the records. They told us they had flagged this up verbally with the appropriate staff. There was no evidence to demonstrate that the registered manager had then re-visited the records to see if the required action had been completed. They explained they would have picked this up when they next looked at the person's care file. This potentially would not be for some time as they selected a percentage to look at each time. There was therefore no system in place which recorded the audit contents, recorded what action was needed and to ensure this was re-checked and completed therefore closing the audit loop. The deputy manager explained she regularly checked the care files which, she predominantly completed, so she was aware there were not too many gaps in the records.

We discussed with the registered manager the importance of recording their audits along with the shortfalls they found, what action they had requested to be completed, the date they wanted it completed by and when they re-viewed this and signed it off as completed. This would provide staff with more precise

information about what was required, give them a time frame for completing the actions and demonstrate closure of the audit loop. A good example of the service's system not always being effective was seen in the cleaning records, which the registered manager thought had been completed but had not been for several weeks. It was recognised during the inspection that some alterations had been made to better organise the quality monitoring tasks however, how the audit process was carried out was not robust enough to identify potential non-compliance and ensure all areas of regulation and legislation is met in the future.

We recommend the service take further advice, from an appropriate source, on how to best devise an effective audit system, which would support the management staff to ensure people's safety and ensure compliance with all relevant regulations and legislation going forward.

All people, relatives and staff spoken with told us how helpful the registered manager and deputy manager were. They all felt confident that they could speak to either of them about anything worrying them. One member of staff spoke about the deputy manager and said, "[Name] is very supportive, she will always follow up on my concerns about someone, or will come and check them if I ask." One relative explained how "very supportive and helpful" the registered manager had been in getting their relative admitted to the care home.

The registered manager and deputy manager were present in the care home Monday to Friday but were also available at weekends if needed. They shared an on call rota with one of the provider's representatives. Both wanted people to receive the best care they could provide. The registered manager told us they wanted "A happy, safe home for all." They supported their staff in turn to achieve this. Staff received a handover at the beginning of each shift which updated them with relevant information they needed to support people. During the inspection we observed staff constantly handing relevant information to each other and reporting to the management staff. Staff meetings were held every two or three months, where expectations were communicated, issues relating to work discussed and where staff could put forward suggestions on how people's quality of life could be improved. In the last meeting a discussion had been held about how staff could spend more social time with people. A volunteer from the staff team had been requested to take a lead on organising activities when the activities co-ordinator was not present. There had been no member of staff willing to do this. This had been recognised as an area of staff engagement which required some improvement. Any concerns raised by staff were taken seriously and dealt with. An example of this was discussed with us during the inspection.

The views of people and their relatives had not been formally sought in the last year through the use of questionnaires. The Provider Information Return (PIR) told us the service was planning on improving the questionnaires used in the past; wanting to make questions more specific. It was however obvious during the inspection that in conversation with people and their relatives the management team were open to receiving feedback about the service.