Care Quality Commission

Bupa Care Homes (GL) Limited

The Kensington Care Home

Inspection report

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17 July 2017

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Ratings

Overall rating for this service

Is the service safe?

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 11 and 17 July 2017. The first day of our inspection was unannounced. We informed the home manager we would be returning to complete our visit on 17 July 2017.

Our last inspection took place in February 2016 where we reported improvements had been made and the service was meeting the legal requirements we checked. We indicated that we would require a longer term track record of consistent good practice before we were able to revise ratings for the service.

The Kensington Care Home provides nursing care, respite and accommodation for up to 53 older people. The home is located in a Victorian terraced property, converted and arranged over three floors. All floors have lift access. The provider's website states that it is able to provide specialist dementia staff and 'respectful pro-active care for residents and relatives in their last days of life.'

There were 29 people living in the home at the time of our visit. Occupancy levels were lower than usual due to a planned and extensive home refurbishment programme which began in July 2016.

The home manager informed us that building works (which include room redesign, redecoration throughout, new carpeting, furniture, fixtures and fittings) are likely to continue until September 2017. As a result, people living in the home, visitors and staff are subject to a certain degree of ongoing disruption and disturbance. The home manager told us the home remains open to new admissions during this period.

At the time of our visit, staff working on the two upper floors of the home were providing care and support to elderly frail adults some of whom are living with dementia and other long-term health conditions. People receiving respite care are accommodated on the ground floor. People have their own rooms with en-suite shower facilities and are able to access shared bathroom facilities should they prefer a bath. The home has a spacious open plan reception area, communal seating and dining areas and a large garden.

The home manager in post had begun the application process with the CQC to become the registered manager. 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 and associated Regulations about how the service is run. The home manager was supported in her role by a clinical services manager, a resident experience manager and three unit managers.

People's needs were assessed before they moved into the service and further assessments were conducted once people had moved into the home and were feeling settled. This information was used to develop individual care and support plans that evidenced consultation with people and their relatives.

Risk assessments were carried out and management plans were in place where risks to people and/or

others were identified. Risk assessments were reviewed and updated in line with the provider's policies and procedures.

People were encouraged to mobilise independently or with assistance where this was required. However, staff were not always using recommended techniques when providing people with moving, sitting and standing support.

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

The provider had policies and procedures in place that ensured staff had guidance if they needed to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation to restrict a person's liberty in their best interests. Staff received training in mental health legislation which covered consent and capacity issues.

We observed warm and caring interactions between staff and people living in the home. However, some staff were less skilled at delivering kind and respectful care and not all staff were seeking consent from people before providing them with care and support.

People were provided with opportunities to meet members of the local community, including school children and volunteers. We were told that musical performances, birthday parties and other celebrations took place at various times within the home and outside in the gardens when the weather permitted.

People's comments in relation to the quality of the food provided were mostly positive. However, we observed inconsistencies in the way mealtimes were organised and the way in which people who were unable to eat and drink independently were supported by staff.

People were supported to access GP and other healthcare services. There were procedures in place to respond to people's changing healthcare needs and medical emergencies.

People were supported to discuss their end of life wishes and where appropriate, 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed and reviewed by people's GPs.

Staff recruitment processes were followed ensuring people received their care and support from staff who were suitable for employment at the service. Sufficient numbers of staff were deployed to the service in order to meet people's needs.

Staff completed mandatory training and annual appraisals were taking place. Some staff were not always being supervised on a regular basis and the home manager was aware that some training and supervision was overdue.

Satisfactory processes had been implemented to ensure the safe management, storage and administration of people's prescribed medicines.

People and their relatives were provided with information about how to make a complaint. There were systems in place to investigate and resolve complaints, and where applicable to learn from these incidents.

There were quality assurance systems in place to monitor the quality of the service and seek the views of people and their representatives. These systems were not always identifying, managing and resolving issues we highlighted during the inspection process.

Most of the relatives we spoke with provided positive feedback as to the way care was delivered to their family members and the way in which the home was managed.

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

Not all aspects of the service were safe.

Staff were not always using safe moving and positioning techniques when providing support to people using the service.

At the time of our visit, not all staff had completed or updated safeguarding adults training.

Risk assessments were completed and reviewed in line with the provider's policies and procedures.

The service had systems in place to safely support people with the management of their medicines.

Staffing levels were based on people's needs and adjusted accordingly.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People who required assistance eating and drinking were not always being supported in a consistent and appropriate manner.

Mealtimes were not always taking place in a calm and convivial environment.

Some formal staff supervision sessions were behind schedule and some training had been delayed (due in part to the refurbishment programme and closure of office space).

People had access to health and social care practitioners as required and were supported to attend medical appointments when this was needed.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

We saw examples of staff providing good care. However, we also observed staff providing care and support that required more

thought and greater consideration.

People were able to personalise their living spaces as they wished.

Staff encouraged people to maintain the relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Care records contained a good level of detail about how people wished to be cared for and the type of support they required.

The provider had policies and procedures in place to manage complaints.

People were encouraged to maintain their hobbies and interests.

The provider sought feedback from people using the service, their relatives and friends.

Is the service well-led?

Good

The service was well-led.

The home manager had completed the CQC application process to become the registered manager for the home.

People using the service, relatives and staff were positive about the leadership within the service and the way in which the service was evolving.

The provider had systems in place to monitor the quality of service provision. These systems were identifying and managing some but not all of the issues we found during the inspection process.

New staff roles offered staff opportunities to progress in their chosen careers with remuneration that reflected any increased role responsibility.

Care Quality Commission

The Kensington Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 17 July 2017. The first day of the inspection was unannounced. We informed the home manager we would be returning for a second day. The inspection team consisted of two inspectors on the first day and a single inspector on the final day.

As part of the inspection planning process we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications of incidents reported to CQC and the last inspection report of 22 February 2016 which showed the service was meeting all of the regulations we checked at the time.

We were provided with a tour of the premises before we began our inspection. We spoke with five people using the service and five relatives. Some of the people living at the service have dementia and other complex health conditions meaning we were not always able to gather their views or understand their direct experiences of life within the home. Because of this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We contacted a further three relatives following our inspection to gather their views about the home and the care provided to their family members.

We spoke with three nurses, three members of care staff, a chef, a resident's experience manager, the home manager and a regional director. We observed two lunchtime meals, reviewed how medicines were managed and administered and joined a staff handover meeting. The records we looked at included six people's care plans, medicines records, staff records and records relating to the management of the service. We requested and received further specific information about the service from the management team following our visit and spoke with a further two members of care staff.

We contacted a local authority safeguarding lead, a Clinical Commissioning Group (CCG) clinical quality

manager, two GPs with patients using the service, a CCG nurse responsible for reviewing people's care, a physiotherapist and an occupational therapist for further information and feedback about the service.

Requires Improvement

Is the service safe?

Our findings

People living in the home told us they felt safe. However, some relatives raised concerns about the safety of their family members in relation to staffing levels and care delivery. Whilst the refurbishment programme was nearing its end, some relatives also indicated that building works had caused considerable disruption to the lives of their family members. On the day of our visit, we observed and were told by staff that some aspects of service delivery continue to be affected by issues relating to maintenance and the reorganisation of the home environment.

Staff completed a range of risk assessments in relation to people's nutrition and hydration, personal care support needs, skin care and continence requirements. Further assessments identified people's mobility needs and risk of falls, what action to take when people were unable to use their call bells and the type of assistance required in the event of a fire.

Risk assessments specific to people's health conditions were also in place, for example, where people were at risk of choking or required special diets, aids, equipment and/or adaptations. Assessments provided staff with a sufficient amount of guidance to be able to manage and minimise risks to people living in the home and were reviewed on a regular basis in line with the provider's policies and procedures.

Staff used hoisting equipment to lift and position people when they were unable to do this for themselves. One relative voiced concerns that their family member was poorly positioned in the chair provided for them. We checked the seating arrangements for this person and discussed the issue with the home manager and regional director. We requested and have received an update on this matter from an occupational therapist (OT) who visited this person in May 2017. The OT expressed no concerns and told us staff were responsive and did their best to follow any guidance they provided.

We saw people being encouraged to mobilise independently or with assistance where this was required. However, we observed that staff were not always using recommended techniques when providing people with moving, sitting and standing support. For example; we saw one person being assisted out of their chair using an underarm method, another person being held by the wrist whilst walking and seating positions being corrected for two people without due diligence, a request to proceed or an explanation provided.

We observed a member of staff repositioning a person's upper limbs; who was particularly frail and unable to communicate, with a level of force that was excessive and inconsiderate of their medical condition, potential pain levels, general comfort and well-being. We asked the nurse on duty to comment on the moving and position technique we both observed and were told, "[They] should ask [them] first." We were unsure from this response, whether this staff member possessed the confidence required to challenge and correct poor practice when they witnessed it.

Following our visit, we contacted a physiotherapist (PT) who told us about a project that was taking place in several care homes across Westminster and the Royal Borough of Kensington and Chelsea. The 'pro-active care home pilot' scheme is aimed at reducing the risk of falls amongst people living in care homes. We were

told that staff would be supported to improve and update moving and positioning skills. The PT told us the clinical services manager had been "open and transparent" about shortfalls in this area. A member of care staff had been identified as a 'falls champion' and was currently working jointly with the PT and a pharmacist to identify people at high risk of falls, review people's risk assessments and support other staff to minimise people's risk of falls. The 'falls champion' was enthusiastic about their new role and told us they would be coaching and advising staff on how to use correct and considerate moving and positioning techniques.

People's medicines were managed so that they were protected against the risk of unsafe medicines administration. Medicines were stored and administered safely. People's current medicines were recorded on medicines administration records (MAR) along with their allergy status in order to prevent any inappropriate prescribing. There were individual protocols in place for people prescribed 'as required' medicines (PRN). This meant that staff knew in what circumstances and at what dose, these medicines could be given, such as when people had irregular pain needs or observed changes in mood or sleeping patterns. Medicines records showed that people received their medicines when they needed them and we found no omissions in the recording of this task.

Fridges and storage room temperatures were maintained within the correct parameters and we saw that items requiring refrigeration were stored correctly and clearly marked with the opening date to prevent staff continuing to administer expired items such as eye drops. Medicines were disposed of appropriately and staff appeared knowledgeable about their responsibilities in relation to safe medicines practice. Medicines audits were completed weekly and checked by the unit managers. There was a process in place to learn from any medicine incidents or errors in administration and we saw good evidence of this having taken place in relation to a medicines error that occurred at the point of prescribing.

We asked staff how they managed the care of people who were at risk of developing pressure sores. Staff demonstrated a good knowledge of pressure wound prevention and management and sought appropriate guidance from tissue viability nurses when this was needed. The incidence of pressure wounds acquired within the home was low. A nurse told us, "We have enough training, we are using air mattresses, repositioning, checking hydration and good nutrition, making sure hygiene is good and applying creams." Turning charts were completed by staff as per guidelines and where this formed part of an agreed care plan. Body mapping charts and wound records were in use and provided adequate information in relation to the ongoing status of people's skin integrity. Nearly all of the permanent nurses employed in the service (94.1%) had completed training in pressure wound care and management. Continence care training had also recently been delivered to nurses and care staff.

Not all staff had completed or refreshed their training in relation to safeguarding vulnerable adults. We checked whether staff were aware of their responsibilities in this area and asked them how safeguarding related to their particular roles. A nurse told us, "Safeguarding is about the protection of people who are vulnerable." They were able to explain what they would do if they saw people being treated unfairly and told us, "I would talk to [the member of staff], talk to the manager and request training." Some staff were not always able to remember when they had last attended either face to face safeguarding training or completed e-learning modules and one member of staff told us they found it difficult to navigate e-learning systems. We checked care staff's understanding of how to keep people safe from the risk of abuse. They were able to give examples of the types of abuse people may be at risk of and knew what action to take if they had concerns including using the provider's whistleblowing policy.

The provider had up to date safeguarding policies and procedures in place, maintained a record of safeguarding incidents and collaborated with the local authority and other external agencies where this was

required. We have received three safeguarding notifications since our last inspection took place in February 2016. These were and in one case, continue to be investigated appropriately.

Steps had been undertaken to help ensure staff were safe to work with people living in the home. We looked at six staff records and saw that appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) and copies of other relevant documentation, including proof of identity, character references and employment contracts/job descriptions were also kept on file. The home manager told us there was a recruitment programme in place so that new staff were employed to cover any vacancies and ensure enough staff were on duty to meet people's needs at all times.

A relative acknowledged that there had been improvements to the service but expressed concerns about the number of staff on duty and the safety of people using the service. Another relative told us they had previously had concerns around night time staffing levels. Most of the staff we spoke with told us and records confirmed that staffing levels were sufficient to meet the needs of the current number of people living in the home. The home manager told us that staffing numbers had increased since our last inspection and would increase further as new people came to live in the home. There were arrangements in place to provide one to one support for people where this formed part of an agreed care package.

Records showed that procedures were in place to ensure the premises were safe and that people, visitors and staff were not exposed to unnecessary risks. There was a seven day cover maintenance team on duty to ensure the home was safe and the provider able to respond to any issues or emergencies in a timely manner. One relative described the head of the maintenance team as "fabulous" and always "very helpful." Fire alarms were tested on a weekly basis and staff were aware of fire evacuation procedures. Fire equipment had been serviced appropriately.

Construction staff working on the refurbishments endeavoured to keep corridors and exits free from obstacles but the nature of their work meant that at times the home was short of appropriate storage space for hoists, laundry bins and other furniture. One person commented, "I would have thought it would be easier to move people out, but the workman are very good." Contractors we met on site were polite and professional and mindful of the needs of people living in the home. We observed them knocking on doors and making their apologies for any disturbance caused.

The home was clean and free from odours. Staff had access to personal protective equipment such as disposable gloves and aprons to prevent the spread of infections. We saw these items being used during our visit. Staff told us and records confirmed they had recently updated infection control training.

Requires Improvement

Is the service effective?

Our findings

People were able to eat their meals in communal dining room areas and in their own rooms. Where people were unable to eat and drink independently, staff were required to provide people with appropriate support and encouragement.

We observed two lunchtime meals on the top floor of the home. We saw examples of kind, compassionate and caring support being offered to people at mealtimes, where staff spoke gently to people, gave them plenty of time, were seated at the same level and able to converse in an appropriate fashion.

However, we also observed two people receiving support from staff who stood in front and beside them making engagement difficult. At one time we saw a member of staff with their arm around a person's neck and shoulders standing and spooning food into their mouth in a hurried manner, each spoonful proceeded by a wipe with a tissue, with little conversation or explanation offered as to what was being done. When this person was half way through their soup dish the member of staff left the room and returned a while later to continue the task. Once the soup was finished, the main course was started and completed in a similar manner.

Surplus tables waiting to be deployed to other areas of the home meant the dining space felt cluttered and presented a potential hazard to people with mobility issues. Tables were not set out in advance meaning people were required to wait seated at the table whilst this task was completed. We observed two people had fallen asleep by the time their meals were served. Two different radio channels were audible in the room and a member of domestic staff continued with their cleaning tasks using aerosol products just beyond the dining area. We observed that people seated in wheelchairs, found it difficult to reach their food and drink without spillages.

The home manager has since informed us that this situation has been addressed and rectified. We were told that tables were specifically designed to accommodate wheelchairs and that staff have now been shown how this can be achieved. Tablecloths have also been changed to allow people improved access to tables. We will check seating arrangements are satisfactory during our next visit to the home.

Food was delivered in a heated trolley from the kitchen on the ground floor. On the second day of our visit we noted that when asked, staff were unsure of what was on the menu that day. When staff did find out this information, they explained to people it was "soup, chicken or fish." There was little explanation as to what was in the soup or how the chicken was prepared or what type of fish was being served until this was supplied by the chef and a menu sheet located. We observed that people were not always able to remember what meal they had ordered and menu cards were not available on tables or elsewhere. Staff were not aware that showing people the food choices on offer may have prompted memory or at least allowed people to make their choices there and then.

We discussed these issues with the chef and the home manager and were told about plans for the future which included new menu cards with real time photographic illustrations and the planned refurbishment

and eventual re-opening of an impressive conservatory structure leading on to a garden area where people would be able to enjoy a more comfortable dining experience.

People who were able to provide feedback about the quality of the food made positive comments with one person telling us, "The food is excellent" although we did hear another person stating that the soup was not to their liking. We tasted the food on both days of our inspection and in our opinion, the quality, quantity and temperature of the food served was good. However, in terms of temperature, this may not have been the case for people who were served both a starter and a main course dish at the same time. Halal and other specific diets were catered for. A good selection of drinks were available and offered to people during the meal and throughout the day. The home was displaying a food rating score of 4 (good) awarded by the Foods Standard Authority in March 2017.

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

The home manager was aware of the need to assess people's capacity when important decisions were required and there was some doubt as to their ability to fully understand the choices available to them. Care plans recorded relevant capacity assessments and these had been signed and dated appropriately. Some people were supported by their own legal representatives and we saw evidence of best interests meetings taking place where people lacked capacity to make their own decisions about the care and support they received. Appropriate applications were undertaken for people living in the home and submitted to the relevant agencies. We are aware the provider continues to experience some significant delays in the assessment of applications by local authority representatives due to a backlog of cases. The provider has been advised that social workers are currently prioritising urgent referrals.

Care records showed people were supported to access the appropriate healthcare professionals to meet their needs. People could choose to remain with their own GPs (if agreed geographical boundaries permitted) or see a GP commissioned by the service. One person told us, "My GP has visited me several times; I'm very well looked after." People could arrange to see a visiting chiropodist for a fee. The home manager told us referrals were made (where this was required) to appropriate NHS podiatry teams for people with specific health issues such as diabetes. NHS physiotherapists visited people in the home and we saw one person using the garden facilities for their own private physiotherapy session. Some people were supported to attend medical appointments by relatives whilst others received this support from staff.

There is an expectation that CQC regulated providers ensure induction programmes for new staff meet the requirements of the national standard of good practice. New staff completed an induction which included elements of the Skills for Care common induction standards which have now been replaced by the Care Certificate. New staff were required to complete training in areas such as, equality and diversity, dementia awareness, health and safety and infection control. Post induction, staff were required to complete ongoing job specific training such as, mental health legislation, basic food hygiene, emergency first aid and managing behaviours that challenge. We looked at training compliance data and saw that over 85% of staff had completed training in mental health legislation, food safety and dementia awareness.

We reviewed staff appraisal records which included quartile supervision sections. The home manager told us that these were a work in progress and that supervision for some staff was a little behind schedule.

People told us they thought staff were good at their jobs. One person told us, "Everything is professionally done. I can't think of anything to criticise." The home manager told us that some training had been cancelled due to the building works and would be re-scheduled for a later date. Nurses told us they had opportunities to update their knowledge through additional training sessions arranged by the provider.

Requires Improvement

Is the service caring?

Our findings

People living at the service, family members and healthcare professionals told us that most of the staff were caring, supportive and kind.

We observed examples of good interaction between staff and people living in the home. For example; we observed a member of staff knocking on people's doors and asking permission to enter; greeting people warmly by name, asking if they wanted their curtains pulled, lights on or off, flower vases moved and checking if people had everything they needed.

This staff member offered people a cup of tea and then asked if they required more milk and drinks were placed within people's reach. As we continued down the corridor, people were asked if they wanted their TV on or off or on a different channel. One person commented, "[Member of staff] is a lovely lady," and another person told us, "I like it here, this lady is nice to me." This staff member acknowledged that the present call bell system was not working properly on the ground floor due to maintenance work and reassured us they checked on people on a regular basis during routine tasks and planned welfare checks.

However, we also observed examples of care that required improvement. We heard staff referring to the support they provided during mealtimes to people who were unable to eat and drink independently as "feeding" and "people get fed."

On two occasions, we observed a member of staff abruptly adjusting a person's clothing without first informing them of what they were going to do or asking permission to do so. Whilst we acknowledge this member of staff may have had good intentions, these actions lacked an understanding of the principles of dignity and respect.

We also observed four members of staff attending to one person who was calling out for help and who had a history of confusion and anxiety. This person's room was small and the ratio of attending staff appeared excessive and could potentially have caused this person more distress.

Some, but not all staff were informed about people's lives and the things that were important to them. We asked a nurse to tell us something about the life histories of the people they were caring for. They told us they knew very little about people's backgrounds as they had only been working on this particular floor for the past month and said they would need to look in people's care records in order to find out about the people they were supporting. Another member of staff we spoke with was able to tell us about people's health status but very little about their life histories or the people that were important to them. This lack of knowledge about people's individual lives, preferences and daily routines may have made it difficult for staff to deliver care in a person-centred manner.

We discussed some of the above observations with the home manager at the time of our inspection. She assured us there were plans in place to address these issues. She told us about a project that was being designed in conjunction with a local adult learning centre to support staff with a clearer understanding of

the benefits of positive language use. We will request an update from the home manager in relation to this learning and the impact it is having on people using the service and staff, in due course.

Care records showed that people were consulted about how they wished to be supported. Where appropriate, relatives and representatives were involved in people's care decisions and told us they received feedback about any changes to the health and well-being of their family members.

Staff understood people's needs in regards to their culture, gender and sexual orientation. Staff spoke positively about same sex relationships and married couples and promoted these relationships where this was possible. A healthcare professional told us staff had been very supportive and one particular nurse was "really charming" when providing care to a married couple living in the home. Care records showed that staff supported people to practice their religion and people were able to attend religious services in the local area.

People had their own rooms and were free to decorate them as they pleased. Refurbished rooms had a modern feel and were clean, decorated in a range of colours, carpeted and contained a set of matching cupboards, desk and drawers if people required these. People were encouraged to personalise their rooms with their own framed pictures and photographs, throws, cushions and furniture (space permitting).

Talks were in progress to create a dementia friendly environment on designated floors. We saw evidence that discussions had taken place between an Admiral Nurse and staff in January 2017 with these objectives in mind. (Admiral Nurses work alongside people with dementia, relatives and healthcare providers to provide support, expert guidance and practical solutions). These specific design features had not yet been incorporated on floors where people were presently living with dementia.

Where appropriate, people's preferences and choices as to how they wished to manage the end of their lives were communicated, recorded and kept under review. Appropriate, 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed and reviewed by people's GPs. (The purpose of a DNACPR decision is to provide immediate guidance to those present on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly). Where people lacked the capacity to make these decisions for themselves family members had been involved. DNACPR forms recorded the names and relationship status of family members and any other representatives involved in these discussions and decisions. However, we noted that one form we looked at did not include these details.

The service was not currently taking part in any accreditation scheme such as the Gold Standards Framework (GSF). The GSF provides training to all those providing end of life care to ensure better lives for people and recognized standards of care. We did not see any reference to end of life training in the training compliance data provided to us. The home manager acknowledged that end of life training needed to be more robust. We heard concerns from a medical professional in relation to end of life medicines administration and a lack of appropriate training in this area for nursing staff. The provider informed us that the home received regular visits from the palliative care team.

Relatives, friends and representatives were free to visit people whenever they wanted to. We observed relatives being welcomed warmly by staff and were told that family members were encouraged to participate in activities and meal times.

One person told us they were visited by a dog and its owner "every Monday, absolutely adorable and a cat comes every Friday." Photographic evidence showed that people responded well to these visits.

Good

Is the service responsive?

Our findings

People we spoke with told us they knew how to make a complaint and to whom. One person remarked, "Come back in 20 years and maybe I'll have a complaint." Another person told us, "I have a completely trouble free life here." A relative told us, "I felt the previous management weren't responsive but that has changed since [the home manager] came here; there has been an uplift in attitudes."

The service had a complaints policy. Complaints were mostly informal and relatives told us they felt comfortable speaking directly with the management team about any concerns they may have. There was a suggestion box in the reception area but we did not see any comment cards available for people to complete and put in the box.

We have received two formal complaints since the last inspection took place in February 2016 and followed these up with the home manager at the time of our visit to see what action had been taken. Where concerns were known, the home manager had addressed and responded to these appropriately. The staff team had received a number of cards and email compliments from relatives thanking them for the care and dedication shown to their family members.

Initial assessments had been completed and were used to design a package of care for people ensuring their needs could be met by staff at the service. Care records contained details of the level of support people required and included contact details for GPs, family members and other relevant people involved in their lives.

Staff were able to respond to people's changing healthcare needs because care plans were well organised, easy to navigate, up to date and had been reviewed in line with the provider's policies and procedures. People's health and well-being was reviewed on a regular basis by GPs and other healthcare practitioners responsible for this undertaking. A nurse responsible for reviewing the continuing care needs of two people living in the home told us communication between the provider and their team could be improved but reported no other concerns as to how people's changing healthcare needs were responded to.

Care plans provided a good level of detail about how individual people liked to be supported with tasks such as their daily personal care needs. Information as to whether people preferred to be supported by a male or female member of staff was clearly recorded. There was further information on how staff could promote good communication, for example; one person's support plan stated that they should be assisted to clean their glasses and put in their hearing aids each day. One relative told us their family member required more support with their hearing aids. We have passed on this information to the home manager.

We saw examples of people's preferences being used to guide the care and support provided to people. For example, one person's support plan stated that they liked to have their lunch in front of the television tuned to the Wimbledon tennis tournament. This person's relative told us they had recently made an unplanned visit to the home and were pleased to have found their family member having lunch and watching the tennis.

Entries in people's activity logs provided information as to how people were using their time. We were told people spent time in the garden, visited the local cinema for special dementia friendly film screenings, played ball games and took part in exercise sessions. People who spent a lot of time in their rooms were supported to maintain their hobbies and interests. For example; one person was assisted to grow and water houseplants and other people enjoyed having their nails painted, reading newspapers, listening to specific radio programmes and watching their favourite television programmes.

The service had an activities coordinator who was employed to organise leisure and social events. We were told by the home manager that activities were taking place but not as often as she would like due to the continuing building works. This was in part compensated for by the home's extensive and well maintained, landscaped garden and recent good weather.

The garden had been well thought out and provided plenty of separate seating areas, sensory planting, wind chimes, a gazebo tent for providing shade, a smoking area and a wide range of plants, shrubs and flowers. On the second day of our visit, we saw people enjoying tea and refreshments in the garden. Some people had received small bouquets of lavender put together by the gardener and staff. People told us they were enjoying themselves. The home manager told us the garden was often used for parties and family gatherings. The gardener told us they would like to see the facilities used more often.

A relative told us, "The activities lady was wonderful in helping with the party I arranged for my [family member's] birthday. My [family member] can socialise, when I come in I find everything done beautifully, I am so glad that BUPA has respect for my [family member]. I sat with [the chef] before the party and planned the food, they go out of their way to do things." One person living in the home told us, "This is a very happy place with a lovely garden."

Good

Is the service well-led?

Our findings

Relatives told us, "[The home manager] is the best manager in seven years" and "We find the manager and the staff here amazing. Another relative told us, "I like [the home manager]. I think she sincerely wants to make the home a better place. Staff don't get it right all the time but they are trying. Some staff are fantastic."

The home manager had been in post since April 2016 and submitted an application to CQC in May 2017 to become the registered manager for the service. She told us she had been a trustee for the Older Personal Advocacy Alliance (OPAAL), a steering group member of Islington Healthwatch and a Samaritan. She also informed us she was a Person First Dementia second qualified coach and had completed recent training programmes in areas such as ageing and the life course, dementia care, death and dying.

People's comments about the quality of the service were taken into consideration and used to measure service quality. The provider published the results of a resident's survey in December 2016. Of the five people who had completed the survey, 80% said they were 'happy and content' and 100% said they were 'treated as individuals.'

We found the home manager to be responsive and aware of the responsibilities of her role. She was visible and accessible within the service during our visit and enthusiastic about plans for the future and new ways of working. She had initiated discussions with various healthcare and education/learning providers with a view to improving service delivery. Staff told us the home manager was supportive and that senior team members provided good leadership.

Staff from across all departments attended a daily 'ten at eleven' meeting where issues relating to maintenance, staffing levels, visits from health and social care professionals, new arrivals and departures were discussed. This meant staff were kept up to date and informed about issues, concerns and any plan of action in place to address them.

The home manager told us the clinical services manager carried out daily checks on each floor and spent time discussing any concerns and/or questions raised by nursing and care staff relating to clinical practice. The home manager told us these discussions allowed staff to work as a team to problem solve and share best practice. More in-depth clinical meetings took place weekly.

The home manager told us that unit managers attended regular meetings. We saw from meeting minutes dated 20/03/2017 that topics such as people's health and well-being needs, clinical training, infection control, pay and contracts had been discussed. However, meetings for the wider care staff team were not always taking place on a regular basis. One member of staff we spoke with thought meetings for care staff should happen more often in order to bring the team together, discuss concerns and exchange ideas about working practice. The home manager told us that at present, room space prevented them from holding large group meetings but these would recommence as soon as this was possible.

A relative told us, "BUPA needs to improve job incentives." The home manager told us that significant changes had taken place within the staffing structure since we last visited the home in February 2016. This included the creation and appointment of a clinical services manager, a resident's experience manager, unit managers and senior care team leaders. The aim of the re-structuring was to provide a strong management team and provide staff with more opportunities to progress in their chosen careers. A remuneration package had been designed to match the increased responsibility and leadership qualities these new roles required.

The provider had systems in place to monitor the quality of service provision and carried out a range of monthly home reviews and quarterly monitoring visits to the service. The last visit had taken place in July 2017 and we saw the report for this. The home manager was expected to respond to the report to demonstrate how any shortfalls had been addressed.

The home manager produced a monthly set of metrics designed to track and measure the outcome of care delivery. Data was collected and recorded in relation to pressure wounds, nutrition and weight loss, completed GP reviews, medicines, safeguarding and hospital admissions. This information was used as part of a wider review process to monitor and improve the quality of service delivery.

We saw a range of audits were completed in order to monitor the service and address any shortfalls and areas for development. These included medicines audits, fire safety and equipment checks.

Quality monitoring systems were identifying and managing some but not all of the issues we found during the inspection process. The home manager has written to us ahead of the publication of this report to say what action they have taken in response to feedback we provided at the time of our visit. She assured us that the management team will continue to implement, imbed and review safe care practice and procedures to ensure that care and support is consistent and promotes a positive experience for people living in the home.

We are aware that during what has been a challenging period of change and restructuring (both in terms of the home environment and the staff team), the home manager has been working hard to improve care standards within the home. A relative told us, "It's a well-run home but far from perfect."