Kentwood House Ltd

Kentwood House

Inspection report

Darenth Road South
Darenth
Dartford
Kent
DA2 7QT

Tel: 01322279771

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 28 March 2017 and was unannounced. We returned on 7 April 2017 to complete the inspection.

The home provides accommodation, nursing and personal care for up to 32 older people, some of whom may be living with dementia. The nursing and care was provided in an environment designed to meet people's longer term needs. Accommodation was provided over two floors with a passenger lift available for moving between floors. There were 20 people living at the home at the time of our inspection.

A registered manager was employed at this home. 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.

At our last inspection 27 May 2016, we gave the home an overall rating of, 'requires improvement' and ratings of requires improvement in the responsive and well led domains. Although we did not find any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found that the registered manager needed to make improvements. Complaints had not been formally recorded and regular audits of the quality of the home were not taking place.

At this inspection, there had been some improvements, but we found other areas that breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Health and Social Care Act 2008 (Registration) Regulations 2009. The fire risk assessment did not identify any additional protections needed for people who may not be able to evacuate the premises quickly. For example, personal emergency evacuation plans and horizontal evacuations. We have referred this to the fire service. Incidents and accidents were recorded and checked by the registered manager, but the actions that could be taken to prevent the incidents reoccurring had not been recorded. The registered manager and provider had not reported incidents of potential harm to the local authority or CQC.

Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. However, reportable incidents had not been appropriately reported and investigated and the potential risk from legionella had not been fully assessed. We have made a recommendation about this.

There were a range of policies in place governing how the home should be run, but these were not kept updated. We have made a recommendation about this.

The provider and registered manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the home had

been tested and well maintained. However, the emergency policy was not specific to the home. We have made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care were generic and did not cover individual elements of their care. We have made a recommendation about this.

Staff received support and supervision and a range of training that related to the needs of the people they were caring for. Nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council (NMC). However, the registered manager had not ensured that additional training had been provided for challenging behaviour. We have made a recommendation about this.

The registered manager was also the provider and had maintained responsibility for the delivery of the nursing and care within the home. However, they had delegated the responsibility for the overall operation of the home. The delegated person, needed to broaden their knowledge and experience of running the home to enable them to better understand their duties and responsibilities. We have made a recommendation about this.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely.

Nursing staff assessed people's needs and planned people's care. The risk of providing care was assessed and the steps to be taken to minimise them were understood by staff. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the home. This included checking nurse's professional registration.

The registered manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. A robust agency back up system was in place. The provider had a system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively and the registered manager provided nurses with clinical training and development.

We observed staff that were welcoming and friendly. People and their relatives described staff as friendly and compassionate. Activities were available to keep people active. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained they were listened to and the registered manager made changes or suggested solutions that people were happy with.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we have told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risk assessments and policies needed to be reviewed to ensure they were up to date with current practice.

Safeguarding concerns and incidents were not always reported appropriately.

There were safe recruitment procedures and sufficient staff to meet people's needs.

Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk.

The premises and equipment were maintained to protect people from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act and Deprivation of Liberty Safeguards were not fully understood by managers.

Staff received supervision, an induction and core training, but staff did not get the additional training they needed.

Staff delivered care based on people's assessed needs.

Staff encouraged people to eat and drink enough.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

Staff protected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments. Information about people was updated.

Activities were available based on people's needs.

People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and others running the home did not always fully understand their legal responsibilities.

Policies were not always updated.

Audits took place to monitor and review the risks that may present themselves.

The registered manager promoted person centred values within the home. People were asked their views about the quality of all aspects of the care they received.

Kentwood House

Detailed findings

Background to this inspection

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

This inspection took place on 28 March 2017 and was unannounced. We returned on 7 April 2017 to complete the inspection. The inspection team consisted of one inspector and an expert by experience. The expert-by-experience had a background in caring for elderly people.

Before the inspection, we had been contacted by a whistleblower. They had shared concerns they had about the home in relation to staffing levels, the application of the mental capacity act and general standards of care. We could not corroborate their concerns at this inspection. We also looked at previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us by law.

People who were living with dementia were not able to verbally communicate their views with us or answer our direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas.

During the course of this inspection, we covered every area of the home, speaking with people, their relatives, observing activities and how staff interacted with people, at different times of the day. We spoke with six people and three relatives about their experience of the home. We spoke with eight staff including the registered manager, the provider, two nurses, two carers, the cook and the activities co-ordinator. During the inspection, we spoke with a visiting community mental health nurse. We sought the views of the local authority contracts team.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at seven people's care files, five staff record files. The staff training programme, the staff rota and medicine records.

Requires Improvement

Is the service safe?

Our findings

Some people in the home could speak to us about their experiences. Other people living with dementia were not always able to verbally tell us how safe they felt. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. One person said, "I do feel safe yes, the staff make me feel safe and also the security is very good and the doors are locked." Another person said, "Yes very safe, they [staff] help me with everything I have nothing to say, they aren't rude, and the girls are lovely." And, "The staff are really helpful you know."

People were relaxed and comfortable with staff when care was delivered. People smiled when staff spoke with them.

Relatives said, "Oh yes, the level of care is outstanding, staff talk to Mum and all sorts, that's really important for us." "Mum had several falls [in another home] before, I feel very safe that Mum is here and staff here to support her". And, "Yes, I think there is enough staff and what is most important is that Mum is alright and healthy."

People with mobility or cognitive problems were not always protected by the emergency evacuation procedures practiced by staff. Staff received training in how to respond to emergencies and fire practice drills were in operation. However, people did not have current personal emergency evacuation plans (PEEP's). PEEP's are individualised assessments of people's evacuation need and direct staff in how each person needs to be supported to evacuate in an emergency. This meant that there was a potential risk that people would not be protected from harm should there be a fire in the home.

There was a lack of clarity about the fire procedure staff practiced as it did not take into account current guidance around horizontal evacuation and the additional protections people required. (Horizontal evacuation ensures that people who cannot be easily evacuated are moved by staff to safe zones that have enhanced fire protection.) Without the additional protections of horizontal evacuation procedures people with more complex needs or who were cared for in bed would remain in their bedrooms or in the communal areas behind a fire door until help arrived. This meant that the registered manager had not taken account of the latest published guidance about enhanced fire protected zones there were a number of people living in the home who may be at risk if they were not evacuated by staff in the event of a fire. We have passed this information onto the fire service.

The risk from fire were not adequately mitigated by the procedures in place within the home. This was a breach of Regulation 12 (1) (2) (a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from potential abuse by staff trained in how to safeguard adults. Nursing staff understood their professional duty to safeguard people. The provider had a policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking

place. Staff explained to us their understanding of keeping people safe. This meant that if people were at risk staff understood how to protect them.

Risk assessments and care plans were in place for people with behaviours that may cause harm to themselves or others. This included guidance for staff about managing behaviours, set up in conjunction with people's GP and community mental health nurses. However, people were not always protected from preventable harm. Incidents that occurred in the home were fully recorded, but lessons learnt investigations and actions to be taken to prevent them happening again were not taking place. The registered manager was not checking for patterns of risk or ensuring that incidents were notified to the safeguarding authority or CQC. For example, there had been 13 recordable incidents over a five month period. Some of these incidents were about events that caused harm. In one instance a person had received a gash to their head when being hoisted. In another instance a person had injured their knee when they slipped out of their wheelchair when they tried to stand up. These incidents had not been appropriately investigated and reported to the local authority by the registered manager.

We spoke to the provider about this and they told us that they had introduced a new system for recording, investigating and learning from reported incidents. However, the new system did not include a robust process for ensuring staff understood what preventative actions should be taken after incidents had occurred or guidance for reporting incidents appropriately to relevant external bodies. The provider told us they would add these areas to the form.

Incidents that affected the health, safety and welfare of people using the home were not being thoroughly investigated or reported internally or externally. This was a breach of Regulation 12 (1) (2) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were maintained to protect people's safety. There were adaptations within the premises and externally like ramps to reduce the risk of people falling or tripping. Hoist were available for emergencies and for the safe delivery of people's care. For example, if people fell or where people needed a hoist to assist them to move from bed to chair. Other environmental matters were monitored to protect people's health and wellbeing. Firefighting equipment and systems were tested, as were hoist, the lift and gas systems, there was also an annual legionella water test. The management team kept records of checks they made so that these areas could be audited. However, the provider did not have a full legionella risk assessment in place to underpin the reasons they were carrying out water test and to assess the plumbing systems for overall potential risk of waterborne illnesses happening.

We recommended the provider researches guidance published by the health and safety executive in relation to the management of legionella in care home settings.

The provider had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. The registered manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. However, the policies were not adequately completed to ensure they were specific to the home.

We recommended the provider seeks advice and guidance from a specialist in relation the levels of information their policies should contain and how this should be presented in the home.

People received their medicines safely from staff who had received specialist training in this area. The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. We observed the safe administration of medicines. Medicines were stored

safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

Medicines were correctly booked in to the home by nurses and this was done in line with the service procedures and policy. Nurses administered medicines as prescribed by other health and social care professionals. For example, medicines specific to end of life care were well managed. 'As and when' required medicines (PRN) were administered in line with the PRN policies and procedure. This ensured the medicines were available to administer safely to people as prescribed and required.

Staffing levels were planned to meet people's needs. In addition to the registered manager, who was also the nursing clinical lead, there was a registered nurse and five staff available to deliver care during the day. At night there was a registered nurse and two staff available. The rota showed that time was given between shifts for staff to hand over. Staff we spoke with confirmed handovers took place. People told us that staff responded to nurse call bells in a timely way and they told us there were enough staff. Staffing levels were consistent and staff were on hand to meet people's needs. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. People told us they did not have to wait long for staff to arrive when they asked for assistance. One person said, "I cannot fault the staff, they answer it [call bell] within the time they have, but they are very fast". Another person told us, "Plenty of staff yes and they all look like they know what they are doing". Staffing deployment was based on an analysis of the levels of care people needed. Staff prioritised answering nurse call bell alarms and people confirmed to us they did not have to wait long for staff to assist them. There were enough staff available to walk with people using their walking frames if they were at risks of falls.

The provider's recruitment policy was followed by the registered manager. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (DBS) records. This highlighted any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Before employment, all applicants for posts at this home were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the registered manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

The registered manager had ensured that individual care risks had been assessed and safe working practices were followed by staff. Risk assessments considered the levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough.

Requires Improvement

Is the service effective?

Our findings

Some people in the home could speak to us about their experiences. Other people living with dementia were not always able to verbally tell us how about their experiences. However, people communicated with us, either by us observing how they responded to staff when care was delivered, or by talking to us about things that were important to them. One person said, "They [staff] are definitely good at their jobs." "Of course they [staff] are good with their jobs otherwise I would not be here."

About the food offered people said, "They don't need my help to cook, the chef is very good here, I must say." And, "I can feed myself no problem at all, I have access to food and drinks whenever I want, I cannot have fish and chips on Friday so instead they give me mash potato and baked fish, and I really enjoy that." "I am quite fussy to eat but I enjoy the food here."

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Discussions in people's best interest with close family members and people's GP's had been carried out and an assessment made in line with the mental capacity act 2005. Four people had DoLS in place that had been approved by the local authority supervisory body and there were 13 DoLS applications waiting for approval by the local authority supervisory body. This indicated that the registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. However, care plans did not consistently show how the registered manager responded in people's best interest. For example, if people had been assessed as lacking capacity to make certain specific decisions, it was not clear what individual decisions the person could make and what decisions needed to be made by others in their best interest. This meant that staff did not get a full understanding of people's abilities and choice for all decisions.

Staff told us that the on line training they received about the MCA and DoLS gave them a basic knowledge. However, they told us they would get a better understanding of their responsibilities if they could ask questions which was not possible from the on line training. We discussed this with the registered manager and they told us they had already started looking for a training provider who could deliver face to face training for staff in the MCA and DoLS. This would enable staff to clarify their learning about this subject.

We recommended the provider seeks advice and guidance about the application of the mental capacity act 2005.

Training was not always planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, wound care and gained knowledge of other conditions people may have such as diabetes and dementia. New staff inductions followed nationally recognised standards in social care. For example, the new care certificate. The training and induction provided to staff ensured that they had the core skills to deliver care and support to people. However, staff had recently been caring for a person with behaviours that may challenge. We noted that the registered manager had provided guidance to staff in how to respond to these behaviours, but had not sought to provide any additional training. This meant that staff did not have an underpinning knowledge of how to safely manage and respond to challenging behaviours.

We recommended the provider seeks advice about specialised training.

Nurses informed us that they had received appropriate training to carry out their roles. This included statutory mandatory training, infection prevention and control, First aid and moving and handling people. The first aid training had provided them with information on how to manage/support people who may be bleeding or choking. One nurse gave us detailed information about the revalidation process with the nursing and midwifery council (NMC) showing a good understanding of the purpose and process. They told us that the registered manager would mentor them through the revalidation process to maintain their skills and NMC registration.

Training provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Staff understood people's needs, followed people's care plan and were trained for their roles. Relatives spoke highly of the staff. A relative said, "Staff must be well trained in order to work here, and the reason why we chose this place is because they keep me informed at all times." "I don't have any doubts the staff well trained, they are also doing a very good job."

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. The cook met with people to discuss their food preferences. People were complimentary about the food and told us there were always choices of meals. Nutrition assessment tools were completed every month for each person and actions were taken to support people to stay healthy if they were considered to be at risk. For example, in cases were the person's body mass index (BMI) had dropped, the catering team were informed and they provided fortified food for the person.

The care plans were detailed to support people's wellbeing and enable staff to record progress. For example, where people were moved using a hoist, the sling size and type was recorded. Also, regular monitoring assisted people to maintain a healthy weight. People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. People had benefited from appropriately losing weight or gaining weight within published body mass index [BMI]

guidance.

Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

People's physical health and mental wellbeing was protected by staff who were qualified and trained to meet these needs. Registered nurses were available to meet people's health needs. Community nurses protected people's mental health.

A community nurse said, "I would complement the staff, they follow my recommendations and guidance." People's health was protected by proper health assessments and the involvement of health and social care professionals. A GP visited the home, and people had access to occupational therapist and other specialist services. Staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. Staff were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers).

Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisals were planned. Supervisions were planned in advance by the registered manager and were fully recorded. Staff told us that in meetings or at supervisions they could bring up any concerns they had. Staff said they found supervisions useful and that it helped them improve their performance. Staff confirmed they were receiving supervision and that they were able to discuss any concerns they had regarding care and welfare issues for people living at the home.

People's health needs were met and where they required the support of healthcare professionals, this was provided. People accessed support from the chiropodist, the GP, the community nurse and a community psychiatric nurse. Records showed that people, with consent, had received the flu vaccination and other health checks carried out by community nurses, such as blood pressure checks. This protected people's health and wellbeing.

Good

Is the service caring?

Our findings

Some people were able to give us their views about the home. Other people living with dementia were not always able to verbally tell us about their experiences of the home. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a caring staff team.

The staff were very caring, compassionate and kind towards people. They knew people's names, were polite to people and gave people time to make choices, for example about what they liked to drink.

People described their care positively. People said, "They [staff] have a good attitude, they know if I need a shower, so they just do it, it is like a routine, I enjoy it down here." And, "Their [staff] attitude is very positive and they are very caring, they know I don't like to leave my bedroom, so they often come here and ask me if everything is ok or if I need something."

Relatives said, "Couldn't ask for better staff, their attitude is always positive and they always want to help Mum."

Staff were committed to delivering compassionate care. A staff member said, "I always try and make people happy, I enjoy giving care and the people here thank me." Staff described how people changed their routines each day and how staff supported this. For example, with the times they required support with bathing and showering.

Staff were polite and cheerful. They took the time to understand how dementia or other conditions affected people. They got to know people as individuals, so that people felt comfortable with staff they knew well. Staff were aware of people's preferences when providing care, for example, if they liked a cushion in their chair or their preferred name.

People's care records contained detailed information about people's likes and dislikes. Staff built good relationships with the people they cared for. Staff told us that as a team they promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. Staff spoke to people and supported them in a caring and thoughtful way.

Staff ensured a lively, jovial atmosphere. They listened to people, answering questions and took an interest in what people were saying. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures like a gentle touch, smiles and nods). People responded well to the quality of their engagement with staff.

People said they felt at home and included. Comments included, "Very good, everyone treats me really well and I get very good care here, I feel like the staff are also my family." And, "I have been in different places before that were shocking, but this one is just like being born again." A relative said, "Well yes, they do ask us." [Our views]. Some people could recall being asked their views and others remembered the manager

asking if everything was okay. The registered manager, played a key role in meeting and greeting relatives, assisting nurses and staff with care and moreover making sure that people were happy and comfortable.

Staff provided care in a compassionate and friendly way. People were able to access information about the time, date, year and weather forecast. Displayed photographs of events and parties held at the home highlighted a friendly family atmosphere within the home. People had made choices about what they did and where they sat. One person was particularly fond of and requesting to sit looking out over the gardens and staff made sure the person conformable. Staff spent time talking with people. Staff listened to a people as they spoke. People were able to personalise their bedrooms as they wished. One person said, "I asked to personalise my room and the response was positive."

Staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff. People said, "They knock my door, and they speak softly with me." "Yes, they respect my privacy and dignity, they also knock."

People had choices in relation to their care. People indicated that, where appropriate, staff encouraged them to do things for themselves and stay independent. Staff closed curtains and bedroom doors before giving personal care to protect people's privacy. People told us that staff were good at respecting their privacy and dignity. Staff understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this. Access to information about people was restricted to staff.

Staff operated a key worker system. Each member of staff was key worker for three or four people. (This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their care). They took responsibility for ensuring that people for whom they were key worker had sufficient toiletries, clothes and other supplies and liaised with their families if necessary. This enabled people to build relationships and trust with familiar staff.

Good

Is the service responsive?

Our findings

Some people were able to give us their views about the home. People living with dementia were not always able to verbally tell us about their experiences of the home. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described the home as responsive.

People said, "They do listen to me of course." "They just ask me if everything is ok you know as normal." "They just ask how things are going, if everything is ok and stuff like that."

Relatives told us that the staff and registered manager were responsive and communicated with them well. One relative said, "When I asked for changes it was done accordingly." Another relative said, "There has been an absolute transformation in mum's health and wellbeing, she had bad falls before but now lots better, very pleased with care."

At our last inspection on 27 May 2016, we noted that improvement was required in the handling of complaints. The provider had reviewed their complaints reporting system since our last inspection so that formal complaints would be investigated and responded to in line with the provider's policy. However, there were no new complaints, which meant that we were unable to check the new system.

People told us that in their experience the registered manager promoted a culture that enabled them to openly raise concerns or make suggestions about changes they would like. People were confident they could raise a compliant if they needed to. One person said, "Staff listen to everyone here, they are pleasant to be around with." This increased their involvement in the running of the home. There was a policy about dealing with complaints that the staff and the registered manager followed. Information about how to make complaints was displayed in the home for people to see.

Referrals had been made to GPs and other external professionals seeking advice from them when required. Staff kept good records of when they liaised with healthcare professions to make sure people received prompt care and treatment to meet their physical and mental health needs. A community nurse said, "The nurses make prompt referrals to our service and the records they keep assist me to make assessments of people's mental health needs."

People's health and wellbeing was protected by in depth care planning. The care plans were well written. They focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. Registered nurses had received training in skin integrity. They also had support from District nurses via GPs when requested. Information about people's life histories was in place, telling others who people were and about their lives and loves. Knowing about people's histories, hobbies and former life before they needed care could assist staff to help people to live fulfilled lives, especially if they were living with memory loss, dementia or chronic illness.

People received care from staff who knew their needs, their individual likes and dislikes and their life stories,

interests and preferences. People's needs had been fully assessed and care plans had been developed. Before people moved into the home an assessment of their needs had been completed to confirm that the nursing or residential service was suited to the person's needs. Each person had their health and care needs assessed. Risk identified in each area had an associated care plan which listed interventions to be implemented to address the risks.

Care plans were kept under review to ensure people care needs were up to date. Changes in people's needs had been responded to appropriately and actioned to keep people safer. Care plans and risks assessments evidenced monthly reviews. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care.

People had opportunities to take part in activities and mental stimulation. On the first day of the inspection there was some disruption to the activities programme due to staff sickness. However, activities included arts and crafts, discussion groups, bingo and one to one sessions for people. Records showed that the activities people participated in were monitored so that everyone was included at some stage in one to one sessions. This reduced isolation for people who preferred not to engage in group activities. The activities co-ordinator clearly enjoyed their role. The coordinator was flexible in their approach trying to include as many people as they could to join in the activities she organised.

Requires Improvement

Is the service well-led?

Our findings

Feedback about the management of the home was positive. People said, "Well, put it this way, I have no problems here and I don't have to wait for anything, my meals are always good". "No complaints at all." Relatives said, "Very good staff and managers, they actually care about everything here, but the home needs refurbishment."

At our last inspection on 27 May 2016, we noted that improvement was required in the levels of quality and risk audits taking place.

At this inspection, we found improvements in the quality auditing processes. For example, care plans were reviewed and medicines were regularly audited. Other audits taking place included environmental checks, equipment checks, monthly health and safety audits and infection control audits. However, from our discussions with the registered manager and the delegated person they were not clear about how to fully meet their risk management and quality audit responsibilities. For example, on the first day of our inspection we asked the provider to properly secure or remove an extension lead that had been fitted across the main stairs. When we returned for the second day of the inspection, the extension remained in place as seen on day one of the inspection. Also, the registered manager and the delegated person relied heavily on an external organisation to provide their policies and procedures. The policies we viewed had not been updated since 2010 and whilst many of them were still relevant, others should have been reviewed to maintain their relevance to current legislation, such as the updates to the Care Act 2014.

We recommended the provider seeks advice and guidance to promote their understanding of the legislative requirements placed upon them.

The registered manager and the delegated person were not proactive in ensuring safeguarding concerns were reported and investigated. They did not fully understand when they should report and discuss safeguarding issues with the local authority safeguarding team. We found two recorded incidents where people had been harmed whilst care was being delivered. Between 22 December 2016 and 4 January 2017 there had been five incidents of aggressive or challenging behaviours towards others by one person living with dementia. These had not been reported to the local safeguarding team for investigation. The registered manager and the delegated person had not fully understood their responsibilities around meeting their legal obligations by sending notifications to CQC about events within the home.

Failure to notify the Commission of reportable incidents was a breach of Regulation 18 (1) (2) (e) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager often worked side by side with staff delivering care. This meant they knew people and their needs well. The registered manager and others in charge oversaw the management of the home. People told us they knew the registered manager and often saw and spoke to them. The registered manager was a qualified and experienced nurse in managing care for older people. They had continued their professional development and nursing and midwifery council registration.

General risk assessments affecting everybody in the home were recorded and monitored by the registered manager. There was a five star food hygiene rating displayed from the last food hygiene inspection from 2016.

The registered manager reviewed the quality and performance of the home's staff. They checked that risk assessments, care plans and other systems in the home were reviewed and up to date. All of the areas of risk in the home were covered.

Staff told us they felt supported by their registered manager. There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings. These meeting were recorded and shared. Staff said, "The registered manager promotes good team work." And, "This is a good team, we care for people like a family." Information about how staff could blow the whistle was understood by staff. Staff told about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings and handover meetings. Staff felt that they could speak up at meetings and that the registered manager listened to them.

Maintenance repairs were carried out safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing.

People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people.

Twenty people had given feedback about the home since October 2016. The results of the feedback surveys/questionnaires had been analysed by the provider. Information about people's comments and opinions of the home, plus the providers responses were made available to people and their relatives. Where people had been asked for a change in their care, the provider had acted on this. For example, one person had asked if they could move to a different room and this had happened. This showed that the provider listened to feedback and that people could influence decisions the provider had made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) (e). Incidents were not being notified to the Commission without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b). The risks from fire were not adequately mitigated by the procedures and control measures in place within the home. Incidents that affected the health, safety and welfare of people using the service were not being thoroughly investigated or reported internally or externally.