Wessex Care Limited

Kimberly West & East Care Centres

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on the 11 and 13 December 2018 and was unannounced. This was the first inspection for Kimberly West & East Care Centres since it registered. Kimberly West & East Care Centres are 'care homes'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is two nursing homes on one site. Kimberly West opened first in November 2017 and Kimberly East opened in November 2018. Both homes accommodate 27 people over three floors. The services share some facilities such as a kitchen, garden and laundry. At the time of our inspection there were 25 people living in Kimberly West and 26 people living in Kimberly East. Both homes provided 'intermediate care'. Kimberly East had seven rooms for people to use following a discharge from hospital. This gave people the opportunity to regain their independence before returning home, for example after planned surgery. Kimberly West had eight rooms for people to use as a 'step up' from home. These rooms were for people who required additional support or care but not necessarily needing to go into hospital. A short stay in 'intermediate care' could help them to regain confidence following a fall, or have additional support following illness.

There was a registered manager in post. 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.

Recruitment procedures were safe with the required pre-employment checks consistently completed. New staff had an induction and then an on-going programme of training to make sure skills and knowledge were kept up to date. Staff were supported by the management. They were able to have supervision meetings to discuss any concerns and identify any further training needed.

People were supported and cared for by sufficient numbers of staff. Staff knew how to keep people safe and had received safeguarding training. Staff we spoke with had good knowledge of the different types of abuse and how to report any concerns.

People's individual risks had been assessed and suitable care management plans put into place to reduce risks. Risk assessments were reviewed regularly by nursing staff.

People had their medicines as prescribed. There were safe systems in place for the safe storage and administration of medicines. The service used an electronic medicines management system which helped to reduce the risk of errors.

All areas of Kimberly West & East Care Centres were clean and free of odours. Cleaning schedules were in

place and staff followed good infection prevention and control practice. There were supplies of personal protective equipment available and we observed staff use it appropriately.

The premises were purpose built and had been fitted with up to date equipment to meet people's needs such as ceiling tracking hoists. CCTV cameras were installed in all areas and the provider had policies in place to protect people's privacy.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The polices and systems in the service supported this practice.

People told us and we observed that staff were kind and caring. Dignity was promoted by all staff and people were treated with respect. There was a friendly atmosphere at the service and visitors were welcome with no restrictions.

People had sufficient food and drinks. Mealtimes were unhurried and a social event. Staff sat down with people to offer them support where needed.

People had their own personalised care plan which recorded their needs and gave staff guidance on how to provide care. They were regularly reviewed by the nursing team. The service was in the process of moving to an electronic system of care planning to improve their recording.

We have made one recommendation about people's monitoring records.

People's health needs were being met. Where appropriate, a timely referral had been made to various healthcare professionals. People staying in 'intermediate care' were supported by a multi-disciplinary team which included a nurse practitioner and therapists.

People had been given the opportunity to record their end of life wishes. The service had supported people at the end of their lives with assistance from healthcare professionals.

People could follow their interests and join in planned activities. There were welfare assistants who led on activity provision in the service and supported people's well-being. People were supported to access their local community. Where people were not able to get out the provider organised services to come in such as hairdressing and chiropody.

There were regular meetings for people, relatives and staff and minutes were kept. People's feedback was sought and encouraged. There were suggestion boxes in the foyers where people and relatives could leave comments, anonymously if they wished.

Systems were in place to monitor quality and safety. Where needed, action was taken to make improvements. The provider actively looked to continually improve the service. Complaints were recorded and responded to within the provider's set timescales.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely.

Staff were recruited safely and there were sufficient staff to meet people's needs.

Staff knew how to safeguard people from harm and how to report any concerns.

Risks to people's health and well-being had been identified and measures were in place to make sure people were safe.

The service was clean with no odours noted. We observed the staff followed effective infection prevention and control good practice.

Is the service effective?

Good

The service was effective.

People's needs were continually assessed, and referrals were made to healthcare professionals where needed.

Food was a good quality, people had choice and the support they needed to eat and drink sufficiently.

Staff were trained and supported by the provider and registered manager. They had opportunity for formal supervision to discuss any concerns.

The environment was purpose built and had up to date technology and systems to support people with disabilities.

People were supported by staff who worked within the principles of the MCA.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring. Privacy and dignity were promoted by all staff.

People were involved in their care, independence was promoted.

People could have visitors without restrictions. We observed relatives having a meal with their family.

Is the service responsive?

Good

The service was responsive.

People's care needs were being met. Care and support plans were personalised and reviewed monthly.

Activities were available and varied. People were encouraged to be involved and given support from staff if needed.

Complaints were recorded and managed.

End of life care had been provided and people were supported to make decisions about what they wanted at the end of their lives.

Is the service well-led?

Good

The service was well-led.

People's views and feedback were regularly sought. There was opportunity for people to voice their opinions in a variety of ways.

Community links were established.

Team meetings were held regularly; staff felt supported and were encouraged to develop their skills and knowledge.

Quality assurance systems were in place. The provider looked to continuously improve the service and worked in partnership with various agencies.

Kimberly West & East Care Centres

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 13 December 2018 and was unannounced. It was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. For this service, their experience was older people.

Before our inspection visit, we reviewed the information we held about the service. We looked at information within the statutory notifications the provider had sent to us. A statutory notification is information about important events, which the provider is required to send us by law. We also reviewed information the provider had sent us in the provider information return (PIR). This is information the provider sends us annually to give us key information about the service, what the service does well and the improvements they plan to make.

During our inspection we spoke with 10 people, three relatives, 10 members of staff, one healthcare professional, the registered manager and the operations director. We looked at 10 care plans, six recruitment files, medicines administration records, health and safety records and reviewed records relating to the management of the service. Following our site visit we contacted a further 14 healthcare professionals. We also spoke with the founding director and business director on the telephone to obtain further information.

Good

Is the service safe?

Our findings

People told us they felt safe at Kimberly West & East. Comments included, "I am very safe here it is a marvellous place", "I do feel safe here, it is very nice, nothing has gone missing" and "I do feel safe here, I have had no trouble from other residents." One relative told us, "This is a very safe place for [Relative] to be cared for."

The service was clean throughout and there were no unpleasant odours. People told us their rooms were cleaned regularly. One person told us, "This home is kept very clean, they [staff] are always cleaning and vacuuming." One relative told us, "The home and the equipment are kept very clean here." We observed domestic staff following cleaning schedules during our inspection. Staff used personal protective equipment appropriately and had plenty of supplies to use. The sluice rooms had been fitted with modern machinery to make sure equipment could be cleaned thoroughly.

Staff used a digital medicine management system (EMAR). The operations director told us EMAR promoted more accurate medicines administration records and reconciliation. For example, if a person's dose was not administered, the system automatically prompted staff with an alert. This made sure people received their medicines as prescribed. There were safe systems in place to check people's medicines into the service, quantities of medicines were recorded on the EMAR. One person told us, "Generally I get my pills and medicines when I should."

Medicines were kept in appropriate medicine trolleys which were stored safely. Medicines not in use were stored in a clinical room. The temperatures of the storage rooms had not been recorded in Kimberly East on the first day of the inspection. This was brought to the attention of the head of care and records were in place for the second day. Records for the temperatures of the medicines rooms in Kimberly West demonstrated the temperature was often over 25 degrees. Medicines are required to be stored below 25 degrees to make sure they are effective. We raised this with the provider who took action to reduce the temperature of the medicines storage rooms. Temperatures of medicine fridges were recorded daily and those reviewed were within acceptable limits.

Individual protocols for the use of 'when required' (PRN) medicines were available on the EMAR system. The system required a reason to be entered as to why the PRN medicine was required and later prompted the nurse to record if the medicine had been effective. Prescribed topical medicines, such as creams and lotions were applied by care assistants and following confirmation by the registered nurse, administration was recorded on EMAR.

We observed staff administering medicines and found their practice was safe. Staff we observed showed an awareness of the needs of the people they administered medicines to. Staff we spoke with confirmed they had received training and a competency assessment regarding the use of the EMAR system. A 'medication profile' was available for each person, which detailed how best to support them in taking their medicines. It also gave staff guidance on what approaches might be tried to encourage people to take their medicines.

Recruitment was managed safely and carried out by the business director. Personnel files were stored at the provider's head office which was nearby. We found all the pre-employment checks had been completed. All staff had references from previous employers and a check with the Disclosure and Barring Service (DBS). A DBS check allows employers to make safer recruitment decisions and prevent unsuitable staff from working with people.

Systems were in place to safeguard people from abuse and avoidable harm. Staff had received training on safeguarding people and were aware of signs of abuse. Staff we spoke with could tell us how they would report abuse and were confident the appropriate action would be taken. Staff understood what whistle-blowing was and told us how they would report their concerns if they had any. Whistle-blowing is when staff alert the home or outside agencies when they are concerned about wrongdoing. The provider reported appropriately to the local safeguarding authority and took appropriate action when required to keep people safe.

Individual risks to people had been identified and assessed. To mitigate the risks there were risk management plans in place with safety measures for staff to follow. Risk management plans covered areas such as falls and moving and handling. Some people had been assessed as being at risk of developing pressure ulcers due to reduced mobility or a loss of weight. The service had taken action to reduce the risk by providing air mattresses. We saw the air mattresses automatically adjusted to the correct inflation pressure for the persons weight. Where people had been assessed as requiring bed rails; these were in place. The care plan contained guidance for staff on the safe use of bed rails. Where people had been assessed as being at risk of choking we saw appropriate measures in place to reduce the risks. The service made sure people had been referred to speech and language therapists (SALT). Any recommendations made by them were being followed.

People had a personal emergency evacuation plan in place to support staff to evacuate them from the building in the event of an emergency. People's individual needs and guidance on how best to support them were recorded. Emergency equipment was available to assist staff to transfer people safely.

Accidents and incidents were recorded in full and action taken to prevent reoccurrence. The registered manager reviewed accidents and incidents monthly to identify any patterns. Incidents were shared with staff at staff handover meetings, so any learning or guidance could be discussed.

There were sufficient staff available and we observed people had support at the time they needed it. Comments from people about staff noted that they always appeared busy, however they recognised that staff did not rush them when providing support. Staff told us they felt there were enough staff on duty to meet people's needs. The provider used a dependency tool to guide them on staffing levels. In the provider's PIR they told us, 'Staffing levels are reviewed and adjusted where necessary, our staffing levels are flexible in order to meet the needs of our residents'. The operations director told us the senior management team met weekly to discuss staffing levels. Changes to rotas could be made responsively to ensure people were supported by safe staffing levels.

Fire records reviewed indicated that fire safety checks were completed regularly, and fire safety equipment was maintained at the recommended schedules. The home was fitted with an automatic fire extinguishing and smoke extraction system. A fire risk assessment had been carried out annually and the last was dated 1st November 2018. There were no major risks identified and the assessor added the comment, 'These premises have been built incorporating the highest standard in respect of fire safety measures. Management procedures are robust'.

The provider had put into place a system of maintenance checks to make sure all areas were regularly maintained. For example, all lifting equipment would be checked six monthly. The sluicing equipment would be checked six monthly. Kimberly East had only been open for one month at the time of our inspection so records for maintenance checks were limited. Kimberly West records demonstrated all checks had taken place.

Good

Is the service effective?

Our findings

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 service was working within the principles of the MCA. Capacity had been assessed, where people had been assessed as lacking capacity this was recorded in people's care plans. Staff used the principles of the best interests process to act on people's behalf where appropriate.

Staff had been trained on the MCA and understood how it applied to their work. The operations director told us the most recent training the management had attended had provided the team with a "light bulb" moment. They said whilst they understood the MCA, the training had given them ideas of how to improve their systems. The provider was in the process of updating records around the MCA process. This would better evidence the best interest decision making process and who had been involved.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Whilst the service had applied for a number of DoLS authorisations, the local authority had only granted one so far. The remainder were waiting for the local authority to assess. We checked that the service was meeting the conditions on the one authorisation granted, we found they were.

Prior to moving into the service, a member of the management team would visit people to assess their needs. This was called a pre-admission assessment. For people who were using the intermediate care service the pre-admission assessment could be completed by a healthcare professional. The operations director told us they or the registered manager would review this assessment and make sure they were happy with the information. If needed they would contact the hospital or the GP for more information before they agreed to offer a place to people. This is called a 'trusted assessor' scheme and is an initiative to reduce delays for people ready for discharge from hospital.

People had their healthcare needs met by healthcare professionals. Where needed referrals were made to professionals such as local GP's, tissue viability nurses and mental health teams. People told us they could see the GP when they needed to. One person said, "If I need a GP, I see one that visits this home." There was a team of healthcare professionals allocated to regularly support people using the 'intermediate care' service. This included physiotherapists, occupational therapists and a nurse practitioner. There were weekly multi-disciplinary team meetings where the intermediate care team would meet and discuss people's progress. Staff from the service were included in these meetings so they could work with healthcare professionals to provide the right care and support. One healthcare professional told us, 'The staff and managers were always helpful and responsive to our requests for bloods or observation monitoring. They would always find out any queries or clarify any required information'.

People were being supported by a staff team that were trained and had the appropriate skills. One person

said, "The Staff are well trained to look after me." Another person told us, "The staff seem well trained and able to help me when I need it." Staff had access to a variety of training. The provider used online learning, face to face sessions and a local training provider to make sure staff received training they required. Records demonstrated that staff received training in topics such as moving and handling, dementia, pressure area care and record keeping. A registered nurse told us they felt they received good support from the provider to enable them to carry out their role. They told us they had been provided with clinical skills training such as catheterisation and using syringe drivers.

Staff new to the service received an 'orientation' which was the provider's induction. This had to be completed before they were able to work unsupervised. 'Orientation' included training, time to read care plans and shadowing more experienced members of staff. One member of staff told us, "I have found the induction supportive, I have been shadowing [member of staff], I have not felt pressurised at all." The provider had a six-month probation period for all new staff which could be extended if needed. In the provider's PIR they said, 'We have a 6-month probation period which can be extended should that staff member not feel ready or we in management feel they are not ready and continue to require a high level of supervision and support'.

The service had a number of 'champions' amongst the staff team. For example, there was a dementia 'champion' and a dignity 'champion'. These roles were appointed to staff who had a keen interest in the topic and were able and willing to share their knowledge with other staff. They were provided with additional training in the topic and had access to literature and publications on the specific area. There were also link nurses for tissue viability and end of life. These were identified nursing staff who had been upskilled in specific areas to link with the specialists in the local area. They met regularly with specialists to identify good practice and discuss people's needs with the aim of prevention. For example, if a person's skin was causing concern the link tissue viability nurse would liaise with the lead tissue viability nurse specialist in the local area. The specialist would give guidance on care and support to aim to prevent the development of a pressure ulcer.

Staff had regular supervision which is a process where staff meet with a supervisor to discuss any concerns and identify any training needs. Staff we spoke with told us they found this process useful and valued the opportunity to discuss their work. One member of staff said, "I have regular supervision and find I can say what I need to say. I find the manager supportive." The provider's PIR stated, 'We have a low staff turnover which we believe to be down to good support through staff supervision, appraisals and team meetings'.

People told us they enjoyed the food. Comments included, "The food is very good here, there is always a choice", "No complaints about the food it is very nice", "I can get a snack if I want one like a sandwich" and "The food is smashing here, no complaints at all." We observed that snacks and drinks were available in communal areas. People told us they could have drinks when they wanted. Comments included, "Drinks can be asked for at any time here" and "Drinks are always available here - tea, coffee or cold drinks." One relative said, "[Relative] likes the food and they will make her something special if she wants it. Drinks are available all the time as required."

People were provided with sufficient food and drink. If people required specialist diets this was catered for, for example if people required a diabetic option or a soft diet this was provided. The chef told us they would cook alternatives to the menu if people wanted specific food. We reviewed the menus on offer and saw that there was a choice provided at all meals. This included a choice of main meal, potato options and vegetables.

People could have the support they needed to eat and drink. We observed mealtimes and saw they were

unhurried and social events. Staff sat down with people to offer support where needed. There were aids available for people to promote their independence when eating such as a plate guard. When used this aid can support people to continue to eat themselves. We observed staff providing support that was kind and caring. One person who required support to eat was supported by a member of staff who sat next to them. The member of staff told the person what was on each forkful of food and gave gentle encouragement to eat. The person wanted to hold the member of staff's hand, the member of staff gently squeezed the person's hand to let them know they were there. The person appreciated this gesture.

The premises were purpose built to accommodate people who may have a range of physical health needs and disabilities. All rooms were en-suite and had ceiling tracking hoists. Ceiling tracking hoists were available all through the building which meant the service could support people with reduced mobility to access all areas. Doors and corridors were wide enough for a profiling bed to move about with ease. A profiling bed is a large electronic bed designed to be used for people who are frail or disabled. The lift was big enough to accommodate a profiling bed which again helped people who were less mobile access all areas of the service.

Both homes had spa facilities available on the ground floors. This included a large assisted jacuzzi bath which people could be hoisted into. There were hairdressing salons in both homes where people could have their hair done or treatments such as manicures and hand massages. The spa facilities were fitted to offer a sensory experience with coloured lighting available and various music and sounds. Communal areas were available to people and their relatives. There were small lounges on each floor where people could meet with their relatives privately. There were kitchen areas in the lounges where people and visitors could make hot and cold drinks.

CCTV cameras were installed throughout the homes. There were cameras internally and externally including people's rooms. At the time of our inspection cameras in people's rooms were not switched on. The provider had obtained people's consent to record daily life with the aim of safeguarding and keeping people secure. The technology being used was of a very high quality and the provider had robust security procedures in place to protect people's privacy.

A communal garden was available at the rear of the property which had various seating areas. The garden was all on one level and easily accessible for wheelchairs. At the time of our inspection there was still building work being finished primarily in a section of the garden and outside the front entrance. This building work did not pose a safety risk to people living at the service. Once completed there would be more garden space available to people and underground parking.

Good

Is the service caring?

Our findings

People and their relatives told us all the staff at Kimberly West & East Care Centres were kind and caring. Comments included, "Staff are very caring and supportive towards me", "Staff are caring when they support me", "They [staff] are very good and caring in my observation" and "The staff are very kind and respectful towards me."

People told us the staff promoted their privacy and dignity. One person told us, "Staff always protect my dignity and the other residents here." One relative told us, "Staff always knock before entering my [relative]'s room." We observed staff knocking on people's doors before entering and making sure doors were closed when providing personal care. Staff we spoke with gave us examples of how they promoted privacy and dignity. Examples included, making sure people were covered with a towel when receiving personal care and using the person's preferred name. One person told us "The Staff do treat me with respect, they use my first name." People's information was kept secure, only authorised staff had access to personal records. We observed a handover between staff during our inspection and saw it was held in a private room.

People were supported by staff that had time to offer care at a pace that suited them. One person told us, "The staff here are very good to me when I need them, they never rush me when they are dealing with me." Another person said, "The staff are very busy, but they do their best, I am not rushed at all." One relative told us, "The staff are very nice here, they have time for [relative], and [relative] is never rushed." People were being supported by a stable staff team. One healthcare professional told us, "The care the residents receive is good and consistent."

If people became anxious or distressed, staff responded appropriately. We observed one person who was anxious about something that was important to them. Their anxiety resulted in them shouting at the staff. Staff remained calm and respectful. They talked the person through their anxieties trying to reduce their concerns. This approach helped the person to calm down.

People staying in 'intermediate care' had short term care plans which were written to promote independence. They were called 'enablement plans' and described what they were able to do for themselves and how they could be supported to achieve this. Goals were set by therapists with the aim of supporting the person to move back to their own homes within a timeframe. Staff supporting people staying in 'intermediate care' promoted independence. One person told us, "The staff encourage me to be independent." This culture of promoting independence was not confined to people staying in 'intermediate care'. We found the staff followed this approach with everyone. One member of staff told us, "Everyone is an individual, anything is possible for them." Another member of staff said, "I love it here, I love working with people and promoting their independence."

People were involved in their care as much as possible. People told us staff asked their consent before carrying out care tasks. One person said, "The staff seek my consent always." Another person told us, "I was involved in my care plan" and told us how they had been involved in making decisions about their care. People had a choice of the gender of their care worker. Where people only required a specific gender, this

was recorded in their care plan. We saw that some people had stated they preferred a female carer only for their personal care. We asked staff if they knew who had requested a female carer, they were able to tell us.

There was a key worker system in place. This was a system where a member of staff was allocated to work closely with an identified person. The operations director told us they believed this system helped to give people a "sense of belonging". People could request a member of staff to be their key worker or a match was made based on personality. It was hoped this would encourage a good working relationship. Key workers had a variety of responsibilities, such as making sure people had what they needed and helping to keep rooms as people wanted them.

People's cultural needs were identified and respected. People's cultural beliefs were recorded in their care plans and people were supported to attend religious services where appropriate. One member of staff told us they organised to read biblical text with one person as they enjoyed this. National festivals were celebrated by people and staff where they wanted to such as Easter and Christmas. The service used 'This is me' leaflets to record people's life story information. This gave staff background information about people, their lives so far and informed them about key events in their lives such as weddings, birth of children and places people had lived. 'This is me' leaflets recorded others that were important to people such as spouses and family members.

People were supported to maintain relationships that were important. Relatives and friends were welcomed at any time, there was no restriction on visiting times. During our inspection we observed relatives visiting to take people out, to have lunch with their relative or to join in an activity. Snacks and drinks were on offer to all visitors at no charge. There were details of a local advocacy service available. An advocate is someone who can speak up independently for a person if they need them to.

There was a welcoming and friendly atmosphere at the service. We observed relaxed interactions between people and staff that demonstrated staff knew people well. One person told us, "I am always treated well here." Another person said, "The atmosphere is very good here." A relative told us, "It is very friendly here, everyone chats to my [relative] when they see her." The service had received many compliments about the care they gave.

Good

Is the service responsive?

Our findings

People's needs had been assessed and were identified in their care plans. People had their own personalised care plan that gave staff guidance on how to meet their needs and provide support. Those seen covered areas such as personal hygiene, mobility, skin condition, eating and drinking, continence, sleeping and breathing. They had been reviewed at least monthly and updated when necessary.

Where people had specific health needs such as wound care, individual care plans were in place to promote healing. Records were available detailing the assessment of the wound, treatment to be given, progress and evaluation. Photographs were included to monitor the progress of the healing. People's consent for the photograph had been obtained. Other health needs had a specific care plan such as diabetes or epilepsy. These plans gave the staff additional guidance on how best to support people.

Whilst the care plans contained the action needed to support the person such as re-positioning we found the monitoring records were not always completed in full. For example, there were gaps in the monitoring records of a person who required repositioning every four hours. We could not be sure they had been repositioned at the required times. Another person required 1.5 litres of fluid a day. Records indicated that this was not always being either achieved or recorded. We discussed this with the operations director during our inspection. They agreed that staff had not always documented their actions clearly. They added that evidence of repositioning was sometimes evident in other records, such as 'comfort checks'. In addition some of the people who had care plans stating a frequency of repositioning were able to move around in bed unaided, but this was not recorded. They stated that those who had plans stating they needed encouragement to drink 1.5L per day were often able to do this themselves. The service was in the process of moving all records to a digital records system. It was hoped the move to a digital system would improve record keeping. For nursing staff to monitor staff intervention it would require accessing a number of different records. This was time consuming.

We recommend the service seeks advice and guidance from a reputable source about how best to record all monitoring interventions so that an overview of care given can be easily accessed and monitored.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had assessed people's individual needs and recorded them in the care plan. Where people required specific support to communicate this had been recorded. For example, people who required a hearing aid had this recorded in their communication care plan. We saw one person who was registered blind, had specific guidance for staff. Their communication care plan identified that staff needed to identify themselves every time they entered the person's room. The operations director told us they could provide information in various formats such as large font or by audio, so people could listen instead of reading. The registered manager told us people could have a 'talking newspaper' or an audio book.

People were able to take part in activities. There were welfare assistants employed who told us they enjoyed

providing group and individual activities at the service. Comments from people included, "I do participate in the activities, we get animals and pottery making events", "I do enjoy the activities, it's something to do to keep me occupied" and "When I want to I can get involved in activities." People could choose to spend time in their rooms. The welfare assistants told us they would visit people on an individual basis and provide activities 1-1. One person told us, "I prefer my own company and make cards in my room." The service provided daily newspapers for anyone to pick up and read.

Activities were planned by an activities co-ordinator who worked at another of the provider's homes in Salisbury. The welfare assistants told us they helped to plan the activities as they knew what people liked and wanted. The plan could be changed or adapted to meet people's needs on the day. We saw the range of activities on offer included crafts, exercises, trips out into the local community and musical activities. All staff had received training in activity provision by a local charity. In the provider PIR it stated, 'An activity coaching programme has helped our staff understand the importance of meaningful activity and the provision of it. They can further build on the wonderful relationship they have with the residents and their families'.

A relationship had been established with a local parent and toddler group. Children visited every week with parents to do activities with people. This had been a success with both people and the children enjoying the time spent together. A healthcare professional told us, "Kimberly West invites the local children's nursery to join in activities with the residents. This has a very positive impact on their well-being." One member of staff told us, "This has been such a success for the people involved. For [person] the change in them is noticeable. They enjoy singing with the children, they carry on singing when the children leave. It helps them to engage with their own grandchildren."

Activities were evaluated monthly by the welfare assistants. They kept records of who had attended activities and how much they engaged in the activity and enjoyment levels. This meant the service could re-book successful entertainers or activities for people knowing they enjoyed them.

The service had provided end of life care. Staff had received training on end of life care. Staff we spoke with told us this was useful and good training to help them provide palliative care. Where end of life care had been provided the staff liaised with healthcare professionals to make sure people were comfortable. People had been given the opportunity to record their wishes for the end of their lives, which covered a range of information such as who they would like present and where they wanted to be at the end of their lives. People had also had conversations with their GP about putting in place do not attempt resuscitation forms. We saw the reasons for this discussion had been recorded by the GP.

The provider had a complaints policy which was available to people. People told us they knew how to complain. One person told us, "I have no problems but if I did I would speak to the nurse or the manager." One relative told us, "I have raised concerns, but they have been dealt with promptly." Complaints received had been logged and records kept. The provider carried out thorough investigations before writing responses to the complainants. If people were not satisfied with how the service dealt with complaints, there was information available of who to contact.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. 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. The registered manager was supported by two heads of care. One head of care was responsible for the care in each home, whilst the registered manager worked across both homes.

People and relatives thought the service was well managed. Comments included, "The home is well managed, it runs very well no problems", "I do think this care home is well managed, very good indeed" and "The service does seem very well managed in the short time [relative] has been here. The management do listen and act on my concerns about [relative]." One healthcare professional told us, "The head of care is so good, they are amazing. They have good communication skills, they know exactly what is going on and they are very friendly."

We observed the registered manager and operations director interacting with people and staff and it was evident they were approachable. They knew all the people and visiting relatives and were able to offer support to people when needed. The registered manager helped to serve lunch and led the staff handover. This meant they were up to date with people's needs. There was an open and inclusive culture at the service. Staff we spoke with told us the management were supportive and open to listen to their views. One member of staff told us, "I like working for this company, I like their ethos of looking after people and staff. They always listen to us."

The values of the service were available to all in various literature at the service. The provider's PIR stated, 'Having clear vision, values and strategy are key. We actively involve the staff in reviewing and creating our vision and values, the theme for 2018 is Empowerment'. The provider was a family run business that aimed to provide care in a small family orientated service. Staff we spoke with were aware of the ethos of the service and all enjoyed working for the provider. People told us they were being supported by staff who enjoyed their work. Comment's included, "The staff are happy here, they get on well together", "Staff are always cheerful, they get on well with each other and the residents" and "Staff are hard-working and seem happy to me, always laughing with us and each other." Staff also spoke about a good teamwork. One member of staff told us, "I work in the best team, we are here for each other and help each other. There is good communication amongst us." Another member of staff told us, "My colleagues are like family, we all get on so well."

Feedback from people and their relatives was regularly sought. There was a suggestions box in the front foyers of the homes where people could leave comments. This could be done anonymously if people wished. The service sent out surveys to people and relatives and used an external company to independently monitor the quality of the service. All feedback was collated and analysed, and changes made to improve the service where possible. The operations director told us that following the recent surveys it was noted that people and their relatives felt communication could be improved. To help improve

communication the service had started using 'crib' sheets for the staff. 'Crib' sheets were a daily handover sheet which had up to date needs recorded for people. All members of staff had a 'crib' sheet for the people they were supporting on a specific day.

In addition, to help communication with relatives the service had identified which relatives required what level of communication. The heads of care then either emailed relatives weekly, or monthly with an update to keep them better informed. Some relatives had preferred a phone call, so heads of care made sure they phoned relatives with an update. The operations director felt this had improved communication.

People could attend a 'residents meeting'. These were held quarterly through the year to discuss a range of topics. Minutes were kept and relatives were also invited. Records demonstrated that topics discussed at meetings included activities, use of the spa facilities and staffing. People could access a range of services sourced for them if they were unable to easily access the local community. For example, the provider used a local hairdresser who visited the service every week, there was a visiting chiropodist and various visiting clergy.

Continuous improvement was important to the provider. The operations director told us they welcomed feedback from any visitor to the service. They told us they strived to continually improve the service in any way needed. Systems were in place to regularly monitor the quality and safety at the service. The provider employed an external health and safety auditor to annually audit all areas of health and safety. The registered manager regularly completed audits for care related topics such pressure ulcers, non-pressure wounds and weights. Where improvement was needed this was shared with the team. Medicines were audited by the external pharmacist who had recently completed a full medicines audit. No concerns were identified.

Staff were supported to develop internally. Staff were given time and support to gain a work-based qualification to support their learning and development. One member of staff said, "The provider is very supportive and very good to us, they support staff to study. They even organised English studies to help staff develop." In the provider PIR it stated the service was trying different ways to support staff and secure staff retention. It stated, 'We are constantly thinking outside of the box to improve and secure staff retention by offering child care vouchers, discounts at local gyms, free exercise classes, flexible working hours and Salisbury gift card bonus vouchers'.

Partnership working was important to the provider. Links had been established with the local authority and the local Clinical Commissioning Group (CCG). Staff worked with a range of healthcare professionals who regularly visited the service. The founding director of Wessex Care was the elected chair of a local initiative called the Wiltshire Care Partnership (WCP). This initiative had been set up to support local providers of adult social care services by being a channel of communication. WCP enabled all members to share information and best practice and support each other on a local level. WCP had held conferences and workshops which staff from Kimberly West & East Care Centres could attend.