Hallmark Care Homes (SW19) Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 27 and 28 July 2016. This was the first inspection of this service under this provider. We undertook a comprehensive inspection of the service on 9 and 19 June 2015 under the previous provider when we rated the service as 'Requires Improvement'. We imposed a warning notice for safe care and treatment and a requirement notice for good governance. We undertook a focussed inspection on 14 September 2015 to check compliance with the warning notice. We found the provider was meeting the regulation we looked at, but we did not amend our rating as we wanted to see consistent improvements at the service.

Hallmark Care Homes (SW19) Limited, also known as Kew House, provides accommodation and personal and nursing care for up to 81 older people. The service operates over three communities. Each community occupies a floor of the home. Oak community on the ground floor provides personal care and support. Cedar community on the first floor provides support to people living with dementia, and Maple community on the second floor provides nursing care. At the time of our inspection 70 people were using the service.

A registered manager was in post. They had been at the service since December 2015 and were registered when the service was re-registered in July 2016. 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.

On the whole there were sufficient staff on duty to meet people's needs. Staff were aware of the support people required and provided them with this promptly. Staff were aware of their responsibilities to care for people, including to safeguard them from harm and to work in accordance with the Mental Capacity Act 2005. Staff received the training they required to undertake their role. Staff reported that they felt well supported by their management team, however, we found that staff had not received supervision at the frequency stipulated in the provider's policy.

People's care and support needs were assessed, and on the whole detailed care plans were produced informing staff how to meet these needs. We saw that this considered a range of support needs including in relation to people's physical health, psychological health and social needs. The majority of people had care plans in place outlining their wishes in regards to end of life care. However, we identified that this was not in place for all people and did not always take into account pain management. People were able to access healthcare professionals when needed, and staff liaised with specialists for advice when needed.

Staff were aware of the risks to people's safety, and management plans were in place to minimise and manage those risks. The risks were reviewed regularly to identify if they had changed and if people needed additional support. We saw that appropriate action had been taken to reduce the risks of people falling and developing pressure ulcers at the service. Staff also monitored people's food and fluid intake for those at risk of becoming malnourished or dehydrated.

There were positive and caring interactions between staff and people using the service. Many of the people at the service considered the staff as "friends". We observed staff engaging people in conversations and a number of different activities. There was a comprehensive lifestyle (activities) programme in place and people were able to choose what activities they participated in and how they spent their time. The staff had organised for people to interact with the local community through links with local schools and via the 'pre med' project. This involved students prior to starting their medical degrees undertaking work experience at the service.

People's privacy and dignity was maintained. Staff were aware of people's individual preferences and supported them with any cultural or religious needs they had.

The provider obtained feedback from people and their relatives to inform service provision, and to identify where improvements may be required. We saw that a process was in place to monitor and respond to any complaints received. Staff were also asked for their opinions and encouraged to express their views. The staff were working with the provider's regional dementia lead to implement the provider's dementia strategy. This included supporting people and their relatives to further understand what dementia is and how this may impact on the people living on the dementia community. The registered manager had also started a "good care" workshop to further obtain information from relatives about what good care means to them, so that it could be used to improve service provision.

The registered manager and the senior management team regularly reviewed the quality of service provision through a programme of audits and review of key performance data. A thorough action plan was in place outlining what steps were planned to address all areas identified as requiring improvement.

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. There were sufficient staff on duty to meet people's needs, and we observed people receiving prompt support from staff. Staff were aware of their responsibility to safeguard people from harm. Any concerns about people's safety were discussed with the management team and local authority safeguarding team as required.

Staff regularly assessed and reviewed the risks to people's safety, and we saw that appropriate procedures were in place to minimise and manage those risks.

An electronic system was in place for medicines management. People received their medicines as prescribed, and appropriate processes were in place to obtain, store, administer, record and dispose of medicines.

Is the service effective?

Requires Improvement

Some aspects of the service was not effective. There were processes in place to ensure staff were supported and supervised, however, these were not consistently adhered to.

Staff were able to access a range of training courses to ensure they had up to date knowledge and skills to support people. Staff were aware of and adhered to their responsibilities under the Mental Capacity Act 2005.

People were supported with their health needs, and staff liaised with healthcare professionals if they needed any additional advice. Mealtimes were a social occasion, and staff provided people with any support they needed. Staff ensured people's dietary requirements were met, and protected them from the risk of dehydration or malnutrition.

Is the service caring?

Good

The service was caring. Staff were friendly, polite and patient when speaking with people. They were aware of people's communication needs, and spoke with them in a way they understood. Staff involved people in decisions, and respected their choices.

People's privacy was respected, and their dignity maintained. Staff supported people with their individual needs, including in relation to their culture and religion.

Staff had discussed with the majority of people, and their relatives, their end of life wishes, so that staff were aware of how the person wished to be cared for.

Is the service responsive?

Good

The service was responsive. Detailed assessment and care planning processes were in place to identify people's needs and how they wished to be supported. This included in relation to the physical health, psychological health and social needs.

There was a comprehensive lifestyle programme in place. As much as possible people were able to continue with the same interests they had prior to moving to the service.

A complaints process was in place, and the complaints received had been investigated and responded to.

Is the service well-led?

Good

The service was well-led. The registered manager had added stability to the service. Staff felt able to approach the registered manager, and that their views and opinions were listened to. There were staff recognition processes in place to acknowledge their contributions at the service.

There were processes to obtain the views of people and their relatives, and these were used to improve the service.

Audits, key service data and feedback mechanisms were used to identify where improvements were required and we saw that an action plan was in place to continuously develop the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 July 2016 and was unannounced. An inspector, an inspection manager, and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Although this was completed by a previous provider, the parent organisation remained the same and the report is about the same care home, management, people using the service and staff.

During the inspection we spoke with 13 people, five relatives, twelve staff and a healthcare professional. We reviewed eight people's care records and five staff records. We undertook general observations on each floor, including during dinner and lunchtimes. We used the short observational framework for inspection (SOFI) on the dementia community during the evening. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff handover from day staff to night staff. We reviewed medicines management arrangements and shadowed the lunchtime medicines round on the residential floor. We looked at other management records including those in relation to incidents, complaints and audits.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. Comments included, "I couldn't be safer", "[The staff] keep an eye out so you feel a lot more safe", and "I'm looked after very well. We're amply supervised."

Staff were aware of their responsibilities to safeguard people from harm. Staff were able to describe to us signs and symptoms of possible abuse, and they were aware of the reporting procedures they were required to follow if they had any concerns. We saw that where staff noticed bruising on people during personal care that the required paperwork was completed and staff investigated how the bruising had occurred. Information was included in people's care records for those who bruised easily, and how staff should support them to reduce the risk of harm. The registered manager had informed the local authority safeguarding team about any signs of possible abuse, including in relation to the development of pressure ulcers at grade three and above. The registered manager liaised with the safeguarding team and implemented advice given to further protect people from harm.

Staff assessed the risks to people's safety, and regularly reviewed these risks to establish whether they had changed or increased. This included the risk of malnutrition, choking, development of pressure ulcers, risks associated with moving and handling, and the risk of falls. Management plans were developed to support people to manage and minimise these risks. Where required, equipment was made available to lower the risk to people's safety, including hoists, rollator frames and walking sticks. We observed staff regularly reminding people to use their frames and sticks when mobilising around the home to reduce the risk of them falling.

Where people needed bed rails to reduce the risk of them falling from beds, appropriate risk assessments were carried out and recorded. People's capacity to make decisions about bedrails was also recorded and where possible they were involved in decisions about bedrails. Staff made sure appropriate management plans were in place where people had bed rails to mitigate the risks associated with these. When it was not appropriate for people to have bed rails in place, we saw that people were provided with low level beds, and crash mats either side of the bed to reduce the risk of injury if they fell. Some people also had sensor mats in place which alerted staff if they got up at night, so staff could support them as necessary. The registered manager tracked the numbers of falls at the service to identify any patterns. They had identified that one person had started to regularly fall. Since having a low level bed in place, the number of falls they experienced had reduced.

Staff were aware of their responsibility to report and document incidents that occurred at the service. These detailed what occurred and how the person was supported at the time of the incident, and action taken to prevent future incidents. We saw that incident forms were completed appropriately including in regards to episodes of behaviour that challenged staff, bruising and skin tears.

Risk assessments were also in place to identify the risk to people in the event of a fire and what support people required to respond to a fire alarm. Personal evacuation plans were in place for each person and detailed what support they required to evacuate the building in the event of a fire, including the number of

staff and equipment needed.

There were sufficient staff on duty to meet people's needs, and staff confirmed there were sufficient numbers of staff to enable them to undertake their duties and spend time with people. People also felt there were sufficient staff around. One person told us, "[The staff] put their head round and ask are you alright?" Another person said in regards to whether there were enough staff, "Oh yes there are a lot of people around." We observed that staff were available and responded to people's requests promptly. We observed call bell alarms were answered promptly and on the whole people told us they received the support they required from staff. However, two people told us that when they needed support from two staff and required the use of hoisting equipment there were delays in getting the support they needed. We spoke with the registered manager about this concern who told us they were in the process of purchasing additional hoisting equipment which should hopefully reduce the delays, and they would continue to monitor this. On the whole we observed that staff were allocated in appropriate numbers on each community to ensure people received support when they required. However, we observed in the evening on the dementia community that there was a period of time when no staff were available in the communal lounge, and there was the risk of people displaying behaviour that challenged staff and others. We spoke with the registered manager about this and they said they would look at the deployment of staff during these times.

The numbers of staff on duty were based on the level of support people required and their dependency levels. Staff rotas were organised so that the appropriate numbers were on shift, and staff sickness, annual leave and training requirements were accounted for. Additional staff were on shift to support people that required escorts to hospital appointments, those receiving end of life care and where the registered manager felt a person required one to one support to ensure their safety. Staff told us that staffing numbers were organised so additional support was available between 7am and 8am to help with the morning routine and support people with their personal care.

Safe recruitment practices were in place to ensure appropriate staff were employed who had the knowledge, skills and attitude to support people. People were involved in the recruitment process and were involved in selecting the right people to work at the service. They were asked for their opinions about potential candidates and who they would like to support them. We saw that appropriate checks were undertaken to ensure staff were eligible to work in the UK, and had the appropriate knowledge and experience. Criminal records checks were also undertaken to ensure staff were safe and suitable to work at the service.

People received their medicines as prescribed. One person told us in regards to their medicines, "Yes [the staff] sort me out. I take it every day without fail." Medicines were appropriately and securely stored in temperature controlled rooms or in fridges. The provider used an electronic management system for medicines. Records about the receipt, stock balance, administration and disposal of medicines were all held electronically. The system informed staff what medicines were to be given and when. The system alerted staff if a medicine had not been given at the time prescribed. It also enabled the recording of medicines when these were given, on electronic medicine administration records (MARs) and kept an account of stock control. Where people did not take their medicines for various reasons, appropriate coding was used to describe the reason why. We observed medicines being given and saw that these were provided in line with people's prescription. We also checked how controlled medicines were being managed and we saw that they were being administered with appropriate records being kept. There were arrangements for the disposal of medicines, including the disposal of controlled medicines.

Staff requested medicines reviews and liaised with the person's GP if they had any concerns about people's medicines. For example, one person had been identified as having difficulty swallowing tablets and staff had

organised for the person to have their medicines changed to liquid form.

Audits were carried out to monitor the management of medicines. The electronic system gave an automatic balance of medicines in stock so it was easy to keep an audit trail.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff who did not always receive regular supervision. Staff told us they felt well supported by their managers, however, there was mixed feedback from staff about supervision arrangements. The provider's expectation was for staff to receive supervision every six to eight weeks. However, this had not been adhered to. Some people had received supervision focussing on different topics including moisture lesions, bed rail safety, care planning and completion of care documentation. A supervision tracker was in place for the registered manager to review compliance with staff supervision, and from this tracker we saw that staff were not receiving their supervision as frequently as required. The registered manager told us they were aware of the current shortfall and that adherence with supervision requirements was "work in progress". We saw that dates had been scheduled to ensure that staff received the supervision and support they required to undertake their roles. Nevertheless, at the time of our inspection the provider had not adhered to their own procedures. We spoke with the registered manager about this who informed us they would ensure all staff received adequate supervision to undertake their role.

Staff had the knowledge and skills to undertake their duties and meet people's needs. New staff spoken with confirmed they had received an induction when they started working in the home. They said the management team made sure staff received training and were assessed as safe before they were allowed to care for people. As part of the induction, staff who had not completed the Care Certificate in previous jobs were given the opportunity to complete this training. Staff told us there were lots of training available. They were offered a range of training courses and they could request to attend additional courses if there was a specific training they wished to receive. We saw there was a programme of e-learning training considered mandatory by the provider which staff were given the time to complete. A dedicated staff member regularly reviewed staff's compliance with this training, and informed the registered manager if staff were not compliant with their training requirements so this could be followed up. In addition to the e-learning, staff participated in classroom training on a variety of topics, including first aid, infection control, assisting with eating and drinking, care planning, moving and handling, fire safety, medicines administration, tissue viability, and continence care. The staff team were due to receive training on the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards, and safeguarding. Unfortunately this training had to be rearranged and was due to take place a couple of weeks after our inspection.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of their responsibilities under the Mental Capacity Act 2005 and adhered to these. They were also aware of who had capacity to make decisions, and who had varying capacity. Staff involved people in all decisions they were able to participate in. One staff member told us they "respect [the person's] decision at the time." If a person did not have the capacity to make a decision a best interests' meeting was held, with input from staff, people's relatives and other professionals as required. People's care records outlined if a person had a lasting power of attorney in place, and they were involved in decision making processes.

The registered manager had applied for authorisations under DoLS to ensure for everyone who was deprived of their liberty the staff had legal authorisation to do so. Since the registered manager had been in post they had reviewed all DoLS authorisations to ensure they had been reviewed and were in date.

Mealtimes were a pleasant and enjoyable experience for people who used the service. We observed many people eating meals with friends they had made when they moved into the home and mealtimes for many were a social occasion. People were able to choose where they wanted to eat, and we saw there were a variety of dining areas on each of the communities.

People told us they liked the food. One person said, "It's very nice, very good." A choice of meals were available. A daily menu was presented on the tables for people to choose from. For people that were unable to read the menus, staff plated the different options available and showed people what was available so they could make an informed choice. One person said, "The food's very nice – we're very lucky."

Staff were aware of who had special dietary requirements and the chef confirmed that this was communicated with them, so that people received meals that met their needs. People we spoke with also confirmed that they received meals that met their dietary requirements. This included providing people with soft or pureed meals if they were at risk of choking due to swallowing difficulties. People who required assistance from staff at mealtimes received this. We saw the support provided was at a pace dictated by the person and the staff were able to dedicate their time and attention to supporting the person. The catering team had undertaken a review of meals, to ensure a balanced and nutritious diet was made available to people.

Drinks were available throughout the day. People were able to help themselves to hot and cold drinks on each community and in the café area on the ground floor. Staff assessed the risks to each person making hot drinks, and if it was unsafe or they were unable to make drinks for themselves staff made these available for them. We observed staff regularly offering people drinks, and people we visited in their rooms had drinks available.

Staff supported people to maintain good health and to access healthcare services. We observed during handover staff discussing people's health needs and they were prompt to contact specialist healthcare professionals where they needed additional advice. For example, in relation to continence needs and skin integrity. People's care records outlined any physical health diagnoses and what support they needed with these, for example if they were diabetic. Staff were aware of the signs and symptoms that a person was experiencing high or low blood sugar and how to support the person if this occurred. A physiotherapist regularly visited the service and many people we spoke with said they were able to access this service.

Staff liaised with relevant healthcare professionals to support people with pressure ulcers and moisture lesions. They followed advice regarding dressing of wounds, and what continence products to use where impacting on the sore. We saw from people's care records that staff reviewed and commented on people's

skin integrity daily. The staff we spoke with were aware of the signs of a person's skin breaking down, and any signs of redness were discussed with the nursing team and documented in the person's care records.

There was a regular GP who visited the service to attend to any primary care needs people had and to undertake health and medicine reviews. They confirmed that overall people's healthcare needs were appropriately monitored by the home's staff and referrals were made appropriately for them to see people. When they offered advice this was followed by staff to help treat people. A dentist and a chiropodist also visited the service. People confirmed that they were able to have their toe nails cared for, and staff organised for them to visit the opticians. Staff liaised with community mental health teams, community psychiatric nurses and psychiatrists involved in people's care. They requested assistance and advice in regards to behavioural changes and if they felt a medicine review was required. During the inspection we observed a physiotherapist helping people with their mobility. One person was able to tell us of the progress they had made with their mobility since coming to the home.

Good

Is the service caring?

Our findings

One relative told us, "The care assistants are the key to good care. They work fantastically hard." People said all the staff were "very friendly", and one person said, "on the whole [the staff] are terrific." Another person told us, "[The staff] are kind and they are always around to offer a helping hand."

During our observations we saw staff interacting with people in a polite and friendly manner, and treating them with dignity and respect. We saw that staff knew the people they were caring for and used their preferred name. We also observed that people knew the staff caring for them, and engaged with them in everyday conversations. One person told us they saw the staff as "friends". The night staff we spoke with on the dementia community said their supper time gave them a good opportunity to meet with people and have a conversation about how their day had been.

During most of our observations we saw staff engaging people in conversations or undertaking activities. Staff orientated people to time and reminded them of key events during the day, such as mealtimes. Staff informed people and asked for their permission before moving them in their wheelchairs, and kept people updated as to what support was being provided to ensure people were involved and support was in line with their wishes.

Staff offered people support but respected their decision if they wanted to do a task themselves, even if this meant it took longer to complete the task. Staff also respected how people wished to undertake tasks. For example, we observed one person ate their dinner with their hands and whilst staff reminded them about the cutlery they respected the person's preference.

People were able to spend their day how they liked. One person said, "I decide what I wear, I decide whether I want to go out or if I just want to sit here in the café." We observed people freely accessing different areas of the service and choosing where and how they would like to spend their day. Some people chose to stay in bed because of their frail condition and we saw staff respected this. This fed into the 'Kew House promise' which stated "we promise to respect the choices the residents make every day."

Information was included in people's care records about how to communicate with each person to ensure they understood what was being said, and how to involve people in choices about their care. Some people found it difficult to process lots of information in one go and therefore staff were informed to use short sentences and to only offer two choices at a time. Information was provided to staff about those individuals who did not vocalise their needs and wants. For example, one person's care record stated they tended to not ask for a drink, and therefore staff were to regularly offer this to the person to protect them from the risk of dehydration. Information was also included in people's care records about how people's communication had changed, particularly for people with a diagnosis of dementia.

People were supported with their cultural and religious needs. Some people at the service spoke more than one language and English was not their first language. For some people their diagnosis of dementia had started to affect their ability to speak English. Within the staff team there were staff who spoke the same

languages as the people at the service. We observed staff speaking French and Spanish with different individuals. Staff told us through discussions with people they had started to learn key words and phrases in the person's preferred language to aid communication. People were supported to practice their religion. This included supporting some people to access church at the weekends, and organising for religious leaders to visit people at the service.

People were well presented and in clean clothes. There was a hairdresser on site which staff were able to access, as well as a spa therapy room. People were able to book in for manicures and massages. Some people had recently had their nails manicured and they were pleased with how they looked. One person told us, "[The therapist] gives me a massage for my neck and shoulders and it's very relieving." Another person said, "They do a very good job with my nails. I get my hair done when I want it." Staff were prompt to support people with their continence needs, and ensure they were dressed appropriately to maintain their dignity. People confirmed that staff respected their privacy. One person said, "If you want to be left alone, you can be. They let you have the quiet time by yourself without interrupting." A person's relative told us, "There is a lot of privacy, they knock and doors are always closed if they are helping her with her personal care. There is respect for her privacy."

Staff supported people with end of life decisions. Most people in the home had 'Do not attempt cardio-pulmonary resuscitation' (DNAR) forms in their care records. The DNAR forms were appropriately completed by the GP, with people or their relatives involved as required. These had been kept under review and prominently displayed in people's care records should they be needed in an emergency.

People who had been identified with end of life care needs had medicines that are normally used in end of life care to alleviate symptoms, should these be needed. Staff had discussed people's needs with their doctor and other healthcare professionals as needed. Nursing staff told us they were familiar with meeting people's end of life care needs and were supported by the clinical manager of the home and external palliative care nurses.

The care records of some people showed that end of life care was discussed with them or their relatives when they were first admitted to the home or during their stay. Where end of life care plans had been completed, they described people's wishes including where and how they wanted to be cared for. Out of the records we looked at, two people did not have detailed information about end of life care. We discussed this with the registered manager who confirmed staff were in the process of updating the care records as this had also been identified through the care records audits that had been carried out.

Good

Is the service responsive?

Our findings

One person said, "The staff are very good – they help me." Another person said, "I'm a bit lucky. I need help getting dressed. They help me to the shower and help to clean me. I do what I can and I tell them what I can't manage."

People's needs were assessed by the registered manager or a senior member of staff prior to them being offered a place in the home. We saw copies of the assessments on people's care records. Once admitted to the home, people's preferences, likes and dislikes were established and their needs were comprehensively re-assessed so care plans could be drawn up to address how their needs would be met. We also noted from signatures we saw on care records and from feedback we received from people and their relatives, that they were involved in developing care plans. These were reviewed monthly or more often if people's needs had changed.

Care plans addressed people's physical, psychological and social needs, and on the whole were clear and detailed the action staff needed to take to meet people's needs. This included identifying how many staff were required to support with personal care, and what equipment people required to aid moving and handling, pressure ulcer care and any continence aids they required. Staff were able to describe to us signs that a person's health may be deteriorating or if they needed additional support. This included signs that a person may have an infection, and they told us of the action they would take to ensure the person received the support and treatment they required.

We found that where three people were prescribed strong pain killers to manage their pain there were no care plans in place to describe the action staff needed to take to manage the pain and to evaluate if the action taken was effective in managing the pain. Pain assessment charts were available in people's care records, however, we did not see these being consistently used. We saw two of the people who were on these pain killers and noted they were not in pain and they appeared to be comfortable. MARs charts also showed people received their pain killers as prescribed. We discussed this with the registered manager and the staff and they agreed they needed to have appropriate care plans and to use the pain chart to demonstrate they were managing people's pain appropriately.

Staff confirmed there was effective communication between shifts to ensure staff were up to date with people's current needs and to ensure continuity of care. We observed this occurring during handover. A member of staff from the day and night shift visually checked on each person during handover to ensure they were safe and well. There was also a group discussion with all staff coming on duty about each person. This included reflecting on their mood, their eating and drinking habits and whether there was any additional support people required.

Staff were aware of their responsibilities to provide people with ongoing support. This included checking on people at night at the frequency appropriate for the person, regularly repositioning people and monitoring their food and fluid intake. The repositioning, food and fluid charts we viewed were completed correctly and showed that people received the support they required in line with instructions in their care plans.

The staff were in the process of implementing the provider's 'dementia strategy' with support from their regional dementia lead. Through this strategy the staff were holding education sessions with relatives and people who lived on the residential and nursing floors so they could learn more about dementia and what it was like living with dementia. This enabled them to further understand what some of the people on the dementia community were experiencing. The regional dementia lead was also working with the staff team to look at the environment and identify where improvements were required to make it easier for people with dementia to navigate around the service.

People were encouraged to participate in activities. However, staff were respectful of a person's decision not to participate if they did not wish to. The member of staff leading on activities kept a track of which activities people participated in. If they noticed that a person had not engaged in any activities at the service or in the community for a number of days they allocated a member of staff or volunteer to spend some time with them. This was to protect them from social isolation and to identify if there was anything they wanted to do that was not yet available at the home. People told us, "There's a lot to do," and another person said, "You can find plenty to do." The staff member leading on activities was called the "Lifestyle team leader". They told us the focus at Kew House was on lifestyle rather than just activities, and as much as possible enabling people to continue with the lifestyle they had prior to moving into Kew House. For example, if they regularly attended church staff supported them to continue to do so. We also heard that if people were no longer able to attend their groups in the community because of health reasons, the staff ensured they could participate in that activity at the service. For example, they had introduced a bridge club. We also saw that leisure activities were available at the service, including a cinema with a rolling programme of films, a spa and a library.

People on the different communities often supported each other through the lifestyle programme. For example, people on the residential community were making sensory cushions for people on the dementia community. We also heard that one person on the residential community held cooking groups on the dementia community. In response to feedback from people the service had purchased a minibus, which enabled people to engage in more activities in the community. Staff also supported people to give back to the community. For example, some people had been making blankets and staff supported them to donate these blankets to local hospital wards.

As part of the activities programme the service had a project called "wish star". This enabled people to tell staff what their hopes and wishes were, and the staff, as much as possible, supported people to attain those wishes. For example, one person used to regularly attend Royal Ascot horse racing with their husband but had been unable to attend in recent years. Staff organised for the person to be chauffeured to the races and enjoy a day at the races with their family.

The service liaised with local community groups. This included a number of schools. Students came to sing for people, and to sit and engage with them. People were also invited to attend one of the school's Christmas performances. The service was also involved in a 'pre-med project' in which students prior to starting a medical degree were able to come to the service to obtain work experience, attend the doctors rounds and engage in activities with people to learn more about supporting people with dementia and those who had nursing needs.

The provider had a procedure they called 'How to give us negative feedback'. This was in essence the complaints procedure as it had details about how to give negative feedback (complain). It also contained the stages of how the negative feedback would be addressed and the last stage appropriately described how a complaint can be referred to the Local Government Ombudsman or the Parliamentary and Health Services Ombudsman where people's care was funded by the NHS. However, there was a possibility that

people would not know and understand that this procedure was what they could use to make a formal complaint, as it did not use language familiar to people and their relatives about making complaints, and it is supposed to be used primarily by them.

People and their relatives had made complaints where they needed to. One person said, "I can speak to [the staff] about anything." Where people had complained, these had been appropriately investigated and responded to. A record of all complaints received and responses made were kept in a folder. These were monitored by the registered manager and more senior staff for any patterns so appropriate action could be taken to avoid similar complaints from arising.

Good

Is the service well-led?

Our findings

One person told us, "There's good management here – they listen." Another person said, "The manager's door is always open. If there is anything that could be done better I can just have a chat." A third person said, "[The registered manager] and I have a very good relationship, she's a lovely person."

There was a clear management structure in place with leadership at all levels and within each department. Staff felt all levels of management were "hands on" and approachable. The registered manager was regularly supported by the provider's regional director. In addition the governance director and regional care specialist provided support to the service, in areas such as the clinical aspects of the care of people and monitoring the quality of service provision. The regional care specialist offered additional support to the service's management team through clinical supervision and discussions about any complex clinical concerns.

Staff we spoke with were pleased with the way the home was being managed and with the fact there was a permanent manager at the home and who has brought stability in the way the home was operating. They said they could speak with the manager about anything and knew that their concerns would be taken seriously and addressed. The registered manager arranged monthly general staff meetings so staff were kept informed of developments, changes and events within the home and the organisation and also for them to contribute and share ideas about the running of the service. There were specific meetings on each community when issues arose that needed to be discussed within the staff team on that community. Staff confirmed the range of meetings that were arranged in the home and said they could contribute to these if they needed to.

Staff told us that communication at the service was "important and effective". They felt able to freely express their opinions to the management team. One staff member said, "[The registered manager] listens. She's done really well in sorting out the staffing issues." Another staff member told us the registered manager was "approachable" and "she always gets back to you" when they raised any concerns or needed support.

Daily meetings were arranged by the registered manager at 10am every weekday with the heads of department to discuss any events happening in the home, identify any problems or issues so these could be addressed appropriately to ensure the smooth running of the home.

A centralised electronic system was used to monitor service provision and key performance data. This meant all levels of management were able to access the information and monitor what action the staff were taking to address any areas requiring improvement. At the time of our inspection the registered manager had addressed the staffing concerns. Staff told us previously there were inconsistencies in the staffing numbers and much last minute staff sickness. They told us in recent months staffing levels had improved and there was consistency and reliability within the staff team. People and their relatives also commented on the improvement in the staffing establishment, and the reduction in the use of agency staff.

At the time of our inspection there were a number of new staff employed, particularly nursing staff. All the

staff we spoke with said there was good team working and a lot of work had been done to develop a close working relationship within the staff team.

A staff survey was carried out annually to gather staff's views about the service. A copy of the results following the survey in May 2016 was provided to us. It showed that most staff were aware of the vision of the home and knew how to contribute to it. The weakest area in the survey was around being recognised for their contribution and achievements. During the inspection we saw that the provider had taken note of this.

There were a variety of staff recognition schemes in place. This included the 'Hallmark awards'. This was an initiative by the provider which gave the opportunity for staff's individual contributions to be recognised by them. This covered a number of categories including care assistant of the year and nurse of the year. Nominations were made by people using the service, their relatives and staffing colleagues. 280 nominations had been made in regards to the staff at Kew House, and five Kew House staff had been named as finalists. In addition, the registered manager acknowledged staff's contributions through ad hoc staff recognition cards and thank you cards. The registered manager organised for an ice cream van to come to the service during the hot weather for staff and people to access free of charge, and distributed sweet treats to the staff as a thank you for their hard work. The registered manager was also able to organise for staff to use the spa at the service as a thank you for the work they had undertaken.

The provider had a number of measures to monitor the quality of the service. There was a clinical governance tool that consisted of a range of audits in key areas such as medicines management, catering, health and safety and care planning. Most of the audits were carried out monthly by the registered manager or delegated to heads of department. The audits were then validated by the regional clinical care specialist. They also carried out some audits. For example, we saw them carrying out an audit on care plans during the inspection. In addition to these audits, the regional director also carried out a senior manager's audit.

The provider had arrangements to get people's and relative's views about the quality of the service. An annual survey of people or their relatives was carried out through the Your Care Rating Survey. This is a survey that is organised by a national organisation specialist in polling people's views on behalf of care providers. Each care service is then given an Overall Performance Rating (OPR) and four theme scores. Kew House scored 777 out of a maximum of 1000 at the last survey which was carried out in August and September 2015. This meant there were a number of areas that needed improvement. This was acknowledged by the registered manager and they showed us their plan to address the shortfalls. The home had one action plan which included all the areas that had been identified for improvements through audits, surveys of people, relatives and staff as well as lessons to be learnt that had been identified from complaints, investigations and other types of feedback. This was reviewed and kept up to date by the registered manager.

We saw evidence that quarterly relatives meetings were held and monthly meetings for people who used the service. These meetings gave people and relatives the opportunity to contribute their views about the service.

The registered manager had introduced a 'good care' workshop. This was an open session where the registered manager discussed with staff what good care looked like, and also offered relatives the opportunity to attend to express what they felt good care was. The registered manager informed us that often the discussions focussed around the details that made a big difference to people's experiences. For example, for people that wore glasses. Ensuring that they always had their glasses with them, but also making sure that the glasses were regularly cleaned.

The registered manager was aware of their Care Quality Commission registration requirements, including the submission of statutory notifications about key events that occurred at the service. At the time of the inspection the registered manager had not submitted all notifications regarding authorisation to deprive people of their liberty, however, this had been received by the time this report was written.