C. & P. Limited

Kimberley Residential Home

Inspection report

40 Mickleburgh Hill
Herne Bay
Kent
CT6 6DT

Tel: 01227374568
Website: www.kimberley-care.com

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection was carried out on 2 and 3 February 2016 and was unannounced.

Kimberley Residential Home provides accommodation for up to 36 older people who need support with their personal care, some people are living with dementia. Accommodation is arranged over two floors. A lift is available to assist people to get to the upper floor. The service has 26 single bedrooms and 5 double bedrooms, which people can choose to share. There were 32 people living at the service at the time of our inspection.

A registered manager was leading the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider's recruitment procedures were not being followed. Information about the character and conduct of staff in their previous employment had not been checked to make sure staff did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were supported to provide good quality care and support. Staff had completed most of the training they needed to provide safe and effective care to people. Some staff held recognised qualifications in care. Staff met regularly with the registered manager to discuss their role and practice and any concerns they had.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations have to be applied for if people, who lack capacity, are at risk of being deprived of their liberty. Arrangements were in place to check if people at risk of being deprived of their liberty and apply to the supervisory body for a DoLS authorisation when necessary.

People's needs had not been consistently assessed to identify the care they required. This did not impact on people as staff recognised changes in their needs and provided the care they required in the way they preferred. Care and support was planned with people and reviewed to keep people safe and support them to be as independent as possible.

People's capacity to make decisions was not always assessed. This did not impact on people because staff made decisions in people's best interests with people who knew them well. Consent to care had been obtained from people. People were supported to make decisions and choices. The requirements of the Mental Capacity Act 2005 (MCA) had been met.

People were treated with dignity and respect at all times. One person's relative had commented, 'Staff are aware of [person's name] as an individual and always accommodate their funny little ways'.

The registered manager provided leadership to the staff and had oversight of the service. Staff were motivated and felt supported by the registered manager. The registered manager and staff shared a clear vision of the aims of the service. Staff told us the registered manager was approachable and they were confident to raise any concerns they had with them.

There were enough staff, who knew people well, to meet their needs at all times. The needs of the people had been considered when deciding how many staff were required on each shift. Staff were clear about their roles and responsibilities and worked as a team to meet people's needs.

Staff knew the signs of possible abuse and were confident to raise concerns they had with the registered manager or the local authority safeguarding team. Plans were in place to keep people safe in an emergency.

People received the medicines they needed to keep them safe and well. Action was taken to identify changes in people's health, including regular health checks. People were supported by staff to receive the care they needed to keep them as safe and well as possible.

People were supported to participate in a wide variety of activities that they enjoyed, including day to day household tasks. Possible risks to people had been identified and were managed to keep people as safe as possible, without restricting them.

People told us they liked the food at the service. They were offered a balanced diet that met their individual needs. A wide range of foods were on offer to people each day and they were provided with frequent drinks to make sure they were hydrated.

People and their representatives were confident to raise concerns and complaints they had about the service with the registered manager and provider.

The registered manager and deputy worked with people and staff and checked that the quality of the care was to the standard they required. Any shortfalls found were addressed quickly to prevent them from happening again. People and their representatives were asked about their experiences of the care and these were used to improve the service.

Accurate records were kept about the care and support people received and about the day to day running of the service. These provided staff with the information they needed to provide safe and consistent care to people.

The quality of the care was regularly assessed. People and their relatives were asked for their feedback about the quality of the service they received. Everyone said it was 'good' or 'excellent'.

We made recommendations to improve practice in relation to effective recruitment processes and consistently assessing people's capacity to make decisions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people had been identified and action had been taken to keep people safe and well.

Staff knew how to keep people safe when there was an emergency or if people were at risk of abuse.

There were enough staff who knew people well, to provide the support people needed at all times.

Recruitment checks on staff had not been followed up to make sure staff were of good character.

People were given the medicines they needed.

Is the service effective?

Good

The service was effective.

People's capacity to make decisions was not always assessed. However, staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff offered everyone choices.

Plans were in place to make sure staff developed the skills they required to provide the care people needed.

People received food and drinks they liked to help keep them as healthy as possible.

People were supported to have regular health checks and to attend healthcare appointments.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

People were given privacy and were treated with dignity and

respect.

People were supported to remain independent.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs and care plans were not always up to date. Staff recognised changes in people's needs quickly and provided the care they required.

People and their families were involved in planning their care and people received their care in the way they preferred.

People were involved in the running of the service. They enjoyed the wide variety of activities.

Systems were in place to resolve any concerns people had to their satisfaction.

Is the service well-led?

Good

The service was well-led.

There was a clear set of aims at the service including supporting people to remain as independent as possible.

Staff were motivated and led by the registered manager. They had clear roles and were responsible and accountable for their actions.

Checks were completed on the quality of care people received. People, their relatives and staff shared their experiences of the service.

Records about the care people received were not always kept, for example, decisions made in people's best interests. This was an area for improvement.

Kimberley Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 February 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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. We also looked at notifications we had received from the registered manager. Notifications are information we receive from the service when significant events happen, like a death or a serious injury.

During our inspection we spoke with six people living at Kimberley Residential Home, the registered manager, the registered provider, staff, people's relatives and two visiting health care professionals. We visited people's bedrooms, with their permission; we looked at care records and associated risk assessments for six people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We used the Short Observational Framework for Inspection (SOFI) because most of the people receiving care at the service had dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at medicines records and observed people receiving their medicines.

We last inspected Kimberley Residential Home in July 2014. At that time we found that the registered provider and registered manager were complying with the regulations.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe at Kimberley Residential Home. One person's relative told us said, "I can't speak highly enough of the staff. They have the time and dedication to provide the care people need". Another person's relative told us they were confident their relative was safe at the service and felt confident to go away on holiday without worrying about their relative. A third person's relative told us the staff were visible and engaged with people and their relative's quality of life had improved since they began using the service. All of the people who responded to the provider's annual quality assurance survey said that they felt safe at the service.

The provider's recruitment procedures were not always being followed. We looked at the recruitment records for four staff working at the service and one staff member who was due to start working at the service shortly after our inspection Information had been obtained about most staff's employment history, including gaps in employment. However, dates of employment and reasons for any gaps in employment had not been obtained for two of the four staff working at the service, so they could be checked.. Information about staff's conduct in last employment had been obtained. A reference had been received from a previous employer of one staff member that needed further investigation and clarity. This had not been followed up with the previous employer to make sure that the staff member did not pose a risk to people using the service.

Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Preliminary checks had been completed for all new staff. One check had advised the provider to wait for the outcome of the full DBS before making employment decisions, so to be aware that there may be an issue to consider. This had not been recognised by the registered manager. The registered manager took immediate action to protect people and to obtain the missing information during our inspection.

Information about candidate's physical and mental health had been requested and checked. Checks on the identity of staff had been completed. Processes were in operation to dismiss staff whose practice did not reach the required level and to refer staff who posed a risk to vulnerable people to the DBS.

We would recommend that the provider review their recruitment procedures to ensure they are effective and all the relevant checks are completed on staff before they work alone with people.

People received consistent care, when they needed it, from staff who knew them well. Consideration had been given to peoples' needs and the skills of the staff when deciding how many staff to deploy at different times of the day and when assessing the needs of people who wanted to use the service. Catering staff were employed so care staff could concentrate on caring for people. All the staff we spoke with said they were not rushed and had time to spend with people.

Staff shifts were planned in advance and staff knew when they would be working. Cover for staff sickness

and holidays was usually provided by other team members. Staff came in early or left late to make sure that people got the support they needed. Agency staff occasionally covered shortfalls and worked alongside experienced staff to provide consistent care to people. An on call system was in place and management cover was provided at the weekends and in the evenings, so staff had support when they needed it.

There were policies and processes in place to keep people safe, these were known and understood by staff. People told us if they were concerned about anything they would talk to the registered manager or provider. Staff knew the signs of possible abuse, such as changes in peoples' behaviour. They were confident to raise any concerns with the registered manager, deputy manager or the local authority safeguarding team. Staff told us they were confident the registered manager would deal with any concerns they raised.

Risks to people had been assessed and guidance was provided to staff about how to keep people safe while maintaining their independence. Moving and handling risk assessments had been completed and guidance was provided to staff about how to move people safely. People were encouraged and supported to remain as independent as they could be.

Risks to peoples' skin, such as the development of pressure ulcers, had been assessed. Action had been taken to minimise the risks and no one had sore skin at the time of our inspection. People were moved regularly to take the pressure off high risk areas of their skin. Special equipment, such as cushions and mattresses were provided to keep people's skin healthy, we observed these being used. Staff checked the mattresses to make sure they were on the right setting and people had the maximum benefit from them.

Accidents and incidents involving people were recorded. The registered manager reviewed accidents to check if the care people received could be changed or advice sought to keep them safe. People had been referred to health care professionals for support and advice when they had fallen. The support and advice was used to plan the care they received.

Staff were informed of changes in the way risks to people were managed during the handover at the beginning of each shift. Changes in the support that people needed were also recorded in their records so staff could catch up on changes following leave or days off.

Plans were in place to evacuate people in the event of an emergency and staff knew what action to take to keep people safe. Equipment was in place to support people evacuate safely and training was arranged to train staff to use it effectively. Staff were confident to contact the registered manager and provider for support in an emergency.

The building was secure and the identity of people was checked before they entered. Internal doors were not locked and people moved freely around the service and were not restricted. Fire and environmental risk assessments had been completed and action taken to keep people safe.

A call bell system was fitted in peoples' bedrooms. We observed that staff responded quickly when the bells rang. Staff regularly checked on people who were unable to call for assistance, to offer them support if it was required. Staff were present in communal areas with people and worked as a team to make sure people were safe. Checks were carried out regularly on people during the night. One person's relative had commented in the annual quality assurance survey, 'Staff always know where [my relative] is without having to look for her'.

There was enough space and furniture to allow people to spend time with each other or alone when they wanted to. Furniture was of a domestic nature and the service was comfortable and homely. People were

able to bring personal items with them into the service and these were on display in their bedrooms. One person's relative told us, "[My relative] has a lovely room, which they have personalised with their bits and pieces".

People were protected from the risks of unsafe management of medicines, including systems for ordering, checking, disposal and administration of prescribed medicines, including creams. Medicines were stored securely and were well organised. People received their medicines at the time advised by their doctor.

Some people were prescribed medicines 'when required' (PRN), such as pain relief and for symptom relief. Guidance had not been provided to staff about how to manage each person's PRN medicines. This did not impact on people as most people were able to tell staff when they needed their medicine. Staff knew the signs that other people required their PRN medicines and gave them when needed. A pain relief assessment process was available to staff but was not in use to make sure that people always had their pain relief when they needed it.

Staff had a good understanding of safe medicine management. They were knowledgeable and able to explain the action they would take to manage medicines safely. Action had been taken promptly to check that people had received their medicines if records were not completed correctly. Staff were able to obtain support with medicines from the pharmacy and the local Clinical Commissioning Group Medicines Management team. Staff's policy was, 'If in doubt, check'.

Good

Is the service effective?

Our findings

People were supported to make choices, such as when they got up, when they went to bed and what they wore. People chose how they spent their time and who they spent it with. During our inspection people were offered choices and staff responded consistently to the choices they made. Most people were able to chat to staff and tell them how they preferred their care and support provided. Staff knew everyone well. People's capacity to make decisions had not always been assessed to make sure people were supported to be involved in making decisions.

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 so that they can 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.

Staff had received training in relation to the MCA and supported people to make straightforward day to day decisions. The registered manager had a lack of understanding of their role to assess people's capacity to make complex decisions and there had been occasions when relatives had been asked to consent rather than asking the person first. The registered manager had the skills and abilities to communicate with people and knew them well enough to assess their capacity to make a decision related to their care at the service. The provider and the registered manager had recognised they lacked awareness about their role relating to the MCA and had booked further training.

People with capacity had been supported to make complex decisions, such as using rails on their bed to prevent them from falling out, and had signed to confirm their agreement to their care. Other people were unable to make complex decisions about the care they received and needed other people to make these decisions in their best interests. The registered manager had been involved in making best interests decisions with people's relatives and health care professionals. One person's relative told us they had been asked by mental health care professionals to be involved in making a best interest decision about their relative's treatment. The registered manager had also been involved in making the decision.

The registered manager told us some people who used bedrails to keep them safe in bed lacked the capacity to consent to their use. People's representatives had given their consent for the bedrails to be used and signed consent forms. Records of people's capacity assessments and the decisions making process had not been kept to demonstrate that people lacked capacity, the reasons for the decisions and who had been involved in making them.

Everyone living at the service was able to make straightforward decisions, such as what they wanted to eat or drink and shared these with staff. Staff assumed people had capacity, respected the decisions people made and understood what people were telling them. We observed staff supporting people to make decisions and respecting the decisions they made.

We would recommend that the provider seek advice and guidance from a reputable source about ways to assess people's capacity to make decisions and about recording decisions made in their best interests.

The registered manager was aware of their responsibilities under DoLS. The risks of people who lacked capacity being deprived of their liberty had been assessed some time ago but had not been reviewed to check if people remained at risk. The registered manager told us the people continued to lack capacity and remained at risk of being deprived of their liberty. When the registered manager identified that people may be at risk of being deprived of their liberty, applications had been made to their local authority for standard DoLS authorisations. People were waiting to be assessed by their local authority. No one living at the service was currently subject to a DoLS authorisation.

Staff had received an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities, including shadowing more experienced staff. The competence of new staff had been checked by the registered manager and deputy manager and staff did not work alone with people until they had completed training, including how to move people safely. The registered manager had looked into the Care Certificate, an identified set of standards that social care workers adhere to in their daily working life.

Most staff had completed the training they needed to perform their duties, including moving and handling training, health and safety and fire safety. Some staff had also completed special training to support people's individual care needs including diabetes care and mouth care. The registered manager had identified that staff were not attending training as required and there were gaps in staffs' training. Lunch was now being provided at training sessions as an incentive for staff to attend and was being monitored by the registered manager. A training plan was in place to address the gaps in staffs' training. Staff worked together as a team, monitored by the registered manager, and did not complete tasks they were not competent to perform. We observed staff providing the care and support people needed, including using equipment to move people, safely in the way they preferred. Some staff had acquired level 2 or 3 qualifications in social care.

One person's relative told us they thought the staff at the service had the skills and the patience to provide the care and support their relative needed. Another person's relative told us that some staff had completed training to support their relative to receive treatment at the service rather than travelling a long distance to hospital, which caused them distress.

Staff told us they felt supported by the registered manager to deliver safe and effective care. One staff member told us, "The manager and deputy manager have been very supportive to me. They are understanding and supportive to the staff team". Staff met with their supervisor regularly to talk about their role and people's care and support. They told us they were able to raise any concerns they had about people with the registered manager and deputy manager quickly as they were always available and worked alongside them. Staff practice, as well as people's needs, was discussed with staff throughout the shift to make sure they were supported to provide effective care.

When the registered manager identified that staff's practice needed to improve they put a development plan into operation with the staff member and met with them often to check their progress. Staff had a yearly

appraisal.

People were supported to maintain good health and care was provided to meet their health care needs. Community nurses visited some people to provide treatment for short term illnesses. Other health care professionals, including a chiropodist visited regularly. Visiting health care professionals told us that staff contacted them without delay if they had concerns about people's health and followed the advice and guidance they were given to keep people as well as possible.

People were supported by staff or people who knew them well to attend health care appointments, including emergency visits to hospital or outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service.

Meals times were pleasant, social occasions at Kimberley Residential Home and people enjoyed their meals in a social environment. There was a relaxed atmosphere in the dining room. Some people chatted to other people sat at their table.

People told us they had enough to eat and drink. One person said, "The meals are really nice. I like them very much and I'm not an easy person to please". Portion sizes varied dependant on the person's appetite. Food and drinks were offered regularly throughout the day and were available if people wanted them during the night. Snacks were offered between meals, such as tea and biscuits, which people enjoyed. Staff offered people drinks often to make sure they did not become dehydrated.

People told us they liked the food at the service. One person told us, "I enjoyed the lunch immensely; I'd give it 9/10. The sweet was very good too". We observed people eating the meals and snacks they were offered. The chef spoke to people about the menus regularly and included suggestions that people made. When people lost weight they were quickly referred to their GP for support and advice. Their advice had been put into action and people had gained weight.

People's relatives had meals with them on special occasions such as Christmas dinner. They told us they really enjoyed this time with their relatives. Some people needed support at mealtimes. People were supported at their own pace by staff who had the time to spend with them. Relatives, who wanted to, assisted their relatives at meal times and enjoyed the time they spent together.

Meals were planned to meet people's needs and preferences, including vegetarian. People told us staff knew their preferences. One person told us, "The food is excellent, they listen to me and give me what I want". People who were at risk of losing weight were offered food fortified with extra calories and had put on weight. Other people required a low sugar diet and were offered the same foods as everyone else but made with sweetener rather than sugar.

Menus were balanced and included fresh fruit and vegetables. All meals were homemade, including pies and cakes. Communication between care staff and catering staff was good so that catering staff were aware of any changes in people's needs.

Good

Is the service caring?

Our findings

All the people we spoke with told us the staff were kind and caring. One person told us, "The staff are all lovely, kind, thoughtful and have the patience of saints. They are all very nice to me". One person's relatives told us, "Nothing is too much trouble for the staff". Another person's relative said, "It's only been a few weeks but I think [my relative] is getting excellent care". A third person's relative told us staff had made their relative comfortable at their end of their life and had given them the best care they could. One person had commented to their relative about the staff, "If the queen had someone to bath her, these staff would be good enough".

Staff knew about people's preferences, likes, dislikes and interests. People and their families were encouraged to share information about their life history with staff to help staff get to know them and provide their care in the way they preferred. Information was available for staff to refer to in people's care plans. Staff knew people well, including how they liked things done. People were called by their preferred names.

People were not isolated and were supported to sit with people they could talk to and who had things in common with them. Many people chose to sit in the same seats each day. Staff visited people who chose to stay in their bedrooms regularly and stayed with them if they required support or reassurance. Staff knew people's routines including the response they expected from certain questions or requests. These were provided consistently through the inspection by staff and that reassured people.

Staff showed genuine affection for people and people responded in a similar way. Staff quickly recognised when people were becoming anxious and spent time talking and reassuring them. They also used touch, such as holding people's hands or placing their hand gently on their arm or shoulder to offer comfort and reassurance. One person's relative told us that their relative often worried about their family and they were pleased that staff contacted them on occasions to speak to their relative and reassure them.

People told us staff treated them with respect. One person told us they had not had any lunch and were hungry. Staff asked the person what they wanted to eat and gave them the pudding they requested. Staff knew that the person often forgot what they had eaten and provided them with extra food at their request. The person had three puddings on one day of our inspection.

People were treated with dignity at all times and received the individual support and attention they needed. Staff offered them assistance discreetly without being intrusive. They explained to people about the care they would receive before it was provided. For example, staff supported one person to stand and offered them encouragement when they thought they could not stand. Staff said, 'ready, steady, stand' as they helped the person.

People had privacy. People and their relatives told us that staff asked people if they wanted their bedroom door open or closed when they were in their bedroom and respected people's choices. Staff knocked on doors before entering bedrooms and bathrooms. People had privacy when they washed and dressed and staff only stayed with them at their request.

The philosophy of care at Kimberley Residential Home was to support people to maintain their independence. Staff knew what each person was able to do for themselves and supported them to retain their independence in all areas of their life. We observed people being encouraged and supported to remain independent during the inspection.

People's relatives were able to visit whenever they wanted. One person's relative told us they visited daily and were always told about their relative's mood and other important information before they saw their relative. People's relatives were able to continue to provide their relative with support at the service, such as at mealtimes. People's relatives told us that this was important to them.

Personal, confidential information about people and their needs was kept safe and secure. Staff received information about how to maintain people's confidentiality. Staff told us at the time of the inspection that people who needed support were supported by their families, solicitor or their care manager, and no one had needed to access any advocacy services.

Good

Is the service responsive?

Our findings

People had been involved in planning their care, with their relatives when necessary. Most people were able to tell staff how they liked their care provided and told us that staff did as they requested. Staff knew what people were able to do for themselves and encouraged and supported them to continue to do this. People's relatives told us staff contacted them quickly about any changes in their relative's needs.

Before people were offered a service at Kimberley Residential Home their needs were assessed with them and their relatives, to make sure the staff could provide all the care they required. One person's relatives told us, "They cared about my relative as a person". People and their relatives were also invited to visit the service before deciding if they wanted to move in. People's relatives told us staff had been welcoming and helpful when they were considering supporting their relative to move into the service. One person's relative told us they have visited unannounced and had been welcomed by the registered manager who had "explained everything to them".

Further assessments of people's needs, along with discussions about how they liked their care and support provided were completed to find out what they could do for themselves and what support they needed from staff to keep them safe and healthy. Assessments had not been consistently reviewed to identify changes in people's needs; however, staff knew about the changes in the care and support people needed to keep them safe. People's relatives told us that staff quickly identified changes in their relatives needs and took action to meet those needs.

Care plans had not been regularly reviewed to make sure they remained up to date and provided current guidance to staff about all areas of people's care and support. This did not impact on the care people received as staff knew people well and were providing the care they needed. During our inspection the registered manager began to ensure that assessments and care plans were up to date. This was an area for improvement.

People's care plans contained information about how they preferred their care to be provided and their choices and preferences. Staff described to us the way that people preferred their care to be provided, including the support they required. People who were able confirmed that staff were correct. Staff knew the equipment people used to move safely around the service and when they may need extra support. We observed people being encouraged to use their equipment safely.

Handover meetings between shifts were held and communication books were used to record any changes. Records of health care professionals input and recommendations were maintained so staff could refer to them when they returned from leave or days off.

People had enough to do during the day. Activities coordinators provided a variety of activities each day, in groups or with people on their own. On one day of our inspection a new coordinator was working alongside an experienced coordinator to get to know people and the activities they enjoyed. At the time of our inspection coordinators were developing activity plans for each person, including their likes, interest and

activities they enjoyed to help all staff support people to participate in activities they enjoyed.

The activities offered each day were planned and flexible to meet people's wishes. If people did not want to participate in the activities offered, staff knew the activities people enjoyed and offered these as alternatives. Activities offered included house hold tasks such as sorting and folding laundry and baking including making jam tarts and sausage rolls. This gave people the opportunity to use skills they had had for many years and be involved in the day to day operations of the service.

People participated in group and individual activities with staff dependant on their preference and support needs. Staff spent time each day with people who chose to stay in their bedrooms to make sure they were not isolated. This reduced this risk of people becoming lonely or anxious.

People and their relatives told us they were confident to make complaints about the service. A process to receive and respond to complaints was in place. Information about how to make a complaint was available to people and their representatives. The registered manager and staff supported people and their representatives to raise concerns or make complaints about the service. Staff recognised when concerns were raised about the service and took action. People and their representatives told us they raised concerns they had with the staff or the registered manager and action was taken to address their concerns quickly. One person's relative told us, "I have no complaints about anything. The staff do the best they can".

Good

Is the service well-led?

Our findings

A registered manager was working at the service and was supported by a deputy manager. They knew all the people and staff well. Staff told us they felt supported by the registered manager and deputy manager. They were confident to raise any concerns they had and told us if the registered manager and deputy manager were not on site they were 'always at the end of the phone'. They told us the registered manager and deputy manager visited the home if staff needed additional support. Staff were motivated and enjoyed working at the service.

The registered manager had a clear vision of the quality of service she required staff to provide and how it should be delivered. The philosophy of care at the service was clear and understood by all staff. Staff knew the aims of the service and shared the registered manager's vision of good quality care and people were supported in ways that suited them best.

Values including privacy, dignity, and respect underpinned the service provided to people each day. Staff knew their roles and were accountable and responsible for the service they provided. The registered manager was looking to implement keyworker and task delegation systems to develop staffs' accountability and responsibility. A keyworker is a member of staff who is allocated to take the lead in co-ordinating someone's care.

Staff worked together as a team to support each other and to provide the best care they could to people. One staff member told us they felt valued as a team member and received positive feedback from their colleagues as well as the registered manager. The registered manager had contacted experts for advice and guidance about the best way to meet peoples' needs and keep them as safe as possible, such as the Lead Clinical Nurse Specialist for Older People and the local Fire and Rescue service.

The registered manager and deputy manager were present in communal areas of the service during our inspection and showed leadership and support to staff. Staff and people's relatives told us the registered manager and deputy manager were approachable and available to discuss any concerns they had.

People and their representatives were involved in the day to day running of the service. Systems were in place to obtain their views, including annual quality assurance questionnaires. The 2015 survey showed that people and their relatives were happy with the service they received. Their comments included, 'I have at last been able to relax about my mum's situation since she came to accept Kimberley as her home', and 'Thank you, all staff at Kimberley for giving mum a whole new lease of life and giving me peace of mind'.

Staff had opportunities to tell the registered manager their views about the quality of the service and make suggestions about changes and developments, including staff meetings and supervision meetings. Staff were involved in the development of the service and their views were valued.

The registered manager had the required oversight and scrutiny to support the service. They monitored and challenged staff practice to make sure people received a good standard of care. Regular checks were

completed on all areas of the care staff provided to people during the day and at night, including observations of staffs' practice. Any concerns found were addressed with staff at the time. These checks were not recorded so that staffs' continued development could not be monitored. This was an area for improvement.

A new system had been put in place the week before our inspection to make sure that the provider received information weekly about all areas of the service. The purpose of the system was to highlight any risks or shortfalls and take prompt action to address them.

There was good communication between staff. Processes were in place, such as handovers to share important information between staff and the management team. Up to date records in respect of each person's care and support were not consistently maintained, such records of best interest decisions. This was an area fro improvement.

The registered manager had sent notifications to CQC when they were required. Notifications are information we receive from the service when significant events happened at the service, such as a when people died