Potensial Limited

Kensington Hall

Inspection report

Front Street
South Hetton
County Durham
DH6 2TG

Tel: 01915170101
Website: www.potensial.co.uk

Date of inspection visit:
01 June 2016
02 June 2016

Date of publication:
05 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 June 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Kensington Hall on 30 September 2014, at which time the service was compliant with all regulatory standards.

Kensington Hall is a residential home in South Hetton, County Durham, providing accommodation and personal care for up to 13 people living with a range of learning disabilities. There were 11 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were clean and well maintained.

People who used the service, their relatives and a range of external professionals all expressed confidence in the ability of staff to protect people from harm.

Staff we spoke with displayed a good knowledge of safeguarding principles and how to look out for signs of abuse. They were clear about their responsibilities should they have any concerns.

We saw there were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks, to reduce the risk of unsuitable people working with people who may be vulnerable.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

All areas of the building including people's rooms, bathrooms and communal areas were clean, with infection control risks well managed and appropriately resourced.

Individualised risk assessments were in place to manage the risks people faced. These assessments and associated care plans were reviewed regularly and included advice from healthcare professionals to keep people safe.

Visiting professionals had confidence in the experience and knowledge of staff, citing a range of examples

where they ensured people's healthcare needs were met. There was prompt and regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Staff were trained in areas specific to meeting people's changing needs, for example dementia awareness and communication training, and were also trained in areas the provider considered mandatory, such as safeguarding, health and safety, moving and handling and dignity.

Staff were supported through well-planned regular supervision and appraisal processes as well as 'hands-on' from management when required.

We saw people had choices at each meal and were involved in planning the menu. We saw people who required help to eat were supported patiently and people with specialised diets had their needs met.

Each room had an en suite shower room, whilst the rest of the building was well maintained, with bright spacious corridors and ample communal and outdoor space.

Group activities were varied and well planned, coordinated by a new member of staff with relevant experience. Improvements were planned to ensure people who could not choose to engage in group activities had alternative, meaningful options.

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. The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming and relaxed. People who used the service, relatives and external stakeholders told us staff were caring and compassionate and we saw numerous instances of compassionate and fun interactions.

Person-centred care plans were in place and contained comprehensive information about people's likes, dislikes and life histories. We saw regular reviews took place, ensuring people who used the service, relatives and healthcare professionals were involved.

A range of group activities took place along with individualised activities for people, based on their own goals and aspirations.

The service had built and maintained good community links.

Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and spoke positively about their approachability, flexibility and knowledge of people who used the

service.

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.

Risks to people were assessed and relevant care plans were in place with instructions regarding how to reduce these risks. People's changing circumstances and input from healthcare professionals was accurately documented in these care plans.

There were safe and effective systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Staff were appropriately trained and there were sufficient safeguards in place.

Pre-employment checks of staff reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff received training specific to the changing needs of people, for example dementia awareness training and communication training, as well as a range of training the provider considered mandatory.

People's nutritional and hydration needs were consistently met and people contributed to menu planning through regular meetings and other feedback. Staff had incorporated advice from the Food Standards Agency into meal preparation.

The registered manager displayed a good understanding of mental capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives consistently described staff as caring and compassionate and the service to be homely. External stakeholders provided positive feedback

about staff interactions with people and we observed numerous interactions which supported these opinions.

Staff communicated well with people with varying needs and ensured people were supported to make decisions and feel independent.

Care plans were written with the involvement of people who used the service and their relatives to ensure they were involved in the planning of their care.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and contained comprehensive information about people's likes, dislikes and personal histories. We saw these details were incorporated into people's care.

Staff liaised regularly and promptly with healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

The service had in place a range of activities in place. They had also recently introduced a 'wishing well' scheme, whereby people could put forward the wishes and aspirations they would like to realise. We saw examples of these aspirations being met.

Is the service well-led?

Good

The service was well-led.

We found the culture to be focussed on person-centred care, with individual members of staff aware of their own responsibilities and passionate about delivering good quality care.

Quality assurance and auditing systems were effective and ensured the registered manager and other staff were accountable for all aspects of care.

People who used the service, their relatives, staff and external professionals we spoke with were complimentary about the knowledge and approachability of the registered manager.

Kensington Hall

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.

We visited the service on 1 and 2 June 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking to people and observing people in the communal areas of the home. We spoke with five people who used the service and one visiting relative of a person who used the service. We spoke with six members of staff: the area manager, the registered manager and four care staff. Following the inspection we spoke with a further three relatives of people who used the service.

During the inspection visit we looked at five people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. No concerns were raised regarding the service by these professionals. We spoke with three external healthcare professionals who also raised no concerns about the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service consistently told us they felt safe, whilst relatives we spoke with had no concerns regarding people's safety. One person who used the service told us, "I'm happy and safe, yes." One relative described staff as, "Careful and they look after [Person's name] – we have never had any concerns about their safety," whilst one healthcare professional told us, "People are well looked after – I often pop in unannounced and there are never any concerns." We also observed people who were unable to tell us about their care acting in a calm, familiar and trusting fashion with various members of staff throughout our inspection. This demonstrated that people who used the service felt safe.

The registered manager and all staff we spoke with understood their safeguarding responsibilities. Staff had been trained to have a practical understanding of safeguarding and were able to describe potential sources of risks, types of abuse and what they would do should they have concerns.

We saw the storage, administration and disposal of medicines was in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). For example, we looked at records for people who needed certain medicines 'when required'. We saw the registered provider had in place clear instructions regarding when these medicines should be offered and we saw, when they were administered, staff had recorded a clear rationale on the back of the Medication Administration Record (MAR). This demonstrated staff had the necessary information to know how and when to administer 'when required' medicines. This was corroborated by feedback from a consultant psychiatrist, who commented on the registered provider's careful use of 'when required' medicines.

We saw a recent audit by the pharmacy used by the service had confirmed systems in place for the administration of medicines were appropriate and safe. We saw regular medicines audits were undertaken by the registered manager. Staff had been trained to safely administer medicines and had their competence assessed at least annually.

We saw the treatment room was tidy and kept locked. Medicines were housed in a locked trolley and locked fridge. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits and the controlled drugs cabinet was locked and secured to the wall. Nobody was using controlled drugs at the time of our inspection. MARs we reviewed contained no errors and people's medication profiles contained their photograph, allergy information, contact details for GPs and people's preferences regarding how they would like to take their medicine. This demonstrated people were not put at risk through the unsafe management of medicines.

We found there were sufficient staff on duty to meet the needs of people who used the service, with two care staff and one manager on shift during the day and two care staff working nightshift. We saw when the registered manager was due to be away from the service, for example at a conference, an additional member of staff was resourced to ensure people received the same level of support. People who used the service, relatives and staff all felt there were sufficient staff to meet people's needs. This meant people using the service were not put at risk due to understaffing.

We reviewed four staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw the registered manager kept a record of when these checks were made and renewed them every three years. We also saw the registered manager had asked for at least two references, which they then verified. They also ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We saw risks were managed and reduced through an initial assessment then ongoing review, with the involvement of healthcare professionals where necessary. For example, we saw one person had hurt themselves with a razor whilst shaving. We saw the incident had been clearly recorded, discussed with the person and relatives, and amendments to the relevant care plans and risk assessment had been made.

We found all areas of the building, including people's bedrooms and communal areas, to be clean, bright and free from odours. We noted a recent inspection from the infection control team had identified areas of improvement with regard to the storage of cleaning equipment and found this had been implemented. People who used the service and their relatives commented on the cleanliness of the service and we noted it was generally clean. One external professional told us, "It always smells nice and clean." This meant people were protected against the risk of infections.

We saw a maintenance file was used regularly to record any faults with fixtures or fittings and that these faults were promptly logged with the registered provider, who arranged for one of two handymen to resolve the problem. All staff we spoke with confirmed they found the process to be effective and we found the building to be in a good state of repair.

We saw the registered manager, area manager and other staff were all accountable for undertaking regular environmental checks of the building and reporting concerns. We saw Portable Appliance Testing (PAT) had been recently undertaken, whilst emergency systems such as the call bell system and emergency lighting were tested regularly. We saw fire extinguishers/equipment had been serviced and window restrictors were regularly checked as part of the environmental audits. We saw shower heads had been regularly disinfected and descaled to protect against the risk of water-borne infections such as legionella. We also saw water temperature checks had been undertaken regularly to protect people against the risk of burns. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were acted on and documented in a manner that allowed for easy analysis to identify any trends and patterns.

With regard to potential emergencies, we saw there was an easily accessible emergency box containing personalised emergency evacuation plans (PEEPs), which detailed people's mobility and communicative needs. The box also contained emergency contact numbers, a torch and provisions. We saw the box and contents were reviewed monthly. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

We found people who used the service received effective care and support from staff who were well trained and supported. People who used the service were complimentary about care staff, stating, "They are very good at what they do," and, "They help me a lot." When we spoke with healthcare professionals they expressed confidence in the abilities of staff, stating, "The staff and the manager have a good knowledge of people's needs" and, "They manage a range of behaviours really well."

Staff training was well managed, with staff receiving reminders when they were due to refresh training courses. We saw the registered manager kept a training matrix with these dates on as well as displaying an updated wall chart to remind staff. Staff were trained in a range of areas the registered provider considered mandatory, such as safeguarding, food hygiene, first aid, infection control and moving and handling. We also saw specific training had been sourced when people's needs changed. For example, all staff had recently undergone dementia awareness training, whilst two members of staff had undergone Communication and Interaction training, a course designed to improve staff ability at communicating with people living with dementia. We saw one person at the service was living with dementia and, when we spoke with external healthcare professionals, they told us there was a proactive approach to training to ensure staff were ready to meet people's needs.

We saw examples of people receiving care from a range of healthcare professionals and experiencing good quality of life outcomes through the prompt and effective liaison with these professionals by the registered manager and other staff. For example, one person who used the service had previously suffered significant anxieties and behaved in ways that had challenged when living elsewhere. We saw these instances had decreased at Kensington Hall over the past three years. One social care professional told us, "[Person's] quality of life has definitely improved – staff are well experienced in dealing with those kinds of behaviours and supported [Person]." We also saw praise from a healthcare professional regarding the ability of staff to have successfully implemented a positive behavioural care plan to help reduce the person's anxieties and associated behaviours.

External professionals we spoke with confirmed staff successfully and consistently incorporated advice into people's care planning and delivery. One relative told us, "When it was needed they got the specialists in right away." When we reviewed care files we found this to be the case, with advice included from, for example, community matrons and GPs, behavioural specialists and social workers. We saw people were supported to access health care services such as GP visits, dentist appointments, optician appointments and chiropody services.

Staff confirmed they had regular supervision and appraisal meetings and we saw evidence of this in personnel files, along with a wall planner that scheduled these meetings and set a theme for each one, for example safeguarding or infection control. We saw evidence of regular staff meetings, at which topics such as safeguarding, dignity and infection control were discussed with staff.

With regard to nutrition we saw there was a varied menu with options at every meal. We saw people's

choices were sought at residents' meetings and incorporated into menu planning where possible, for example one person suggested kippers and these were put on the menu. Staff took turns preparing food and displayed a good knowledge of people's dietary needs, for example people who required a softened diet or had diabetes. People who used the service told us they enjoyed the food and confirmed they had a range of choices at each meal. Where people required support to eat we saw this was done with patience and in a dignified manner.

We also saw the registered manager had utilised recent training on 'Dementia Eating and Drinking' to wider effect. Part of the training involved experiencing being fed with a metal spoon and how this could sometimes feel unpalatable if great care was not taken by the person supporting the person eating. Since the training, all people have a choice of metal or thickened plastic cutlery and we saw people choosing different cutlery types during our inspection.

We saw recent advice following a Food Standards Agency (FSA) inspection had been incorporated into meal preparations, with a digital thermometer being used to determine the temperature of meat before serving. We observed the kitchen to be clean, tidy and maintained via a cleaning rota that incorporated support from people who used the service to complete tasks such as washing and drying up.

We saw people were regularly weighed to protect against the risk of malnutrition through the use of a screening tool which identified when people were at risk of malnutrition.

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. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises, we found all rooms had en suite facilities and all rooms we inspected were spacious and bright. The registered manager also showed us plans to adapt an unused bathroom into a wet room. The building was generally well-lit and with wide corridors, meaning people who required assistance to move about the home were not restricted by the design of the building.

Good

Is the service caring?

Our findings

When we asked about the atmosphere and culture of the service, one relative told us, "It's just like being part of another family." Another said, "They know my name and always welcome me with a cup of tea." People who used the service told us they were happy, with one person stating, "I have been here for years – I am at home." External professionals consistently told us the service had a, "Homely feel," with one stating, "It's a fabulous, lovely little home," and another, "I visit regularly – it's a nice little home and the staff are good."

We observed staff interacting with people in a patient, encouraging and warm manner. Likewise, we saw people behaving with staff in a way that demonstrated they were confident in the relationships they had built with staff. We observed people telling jokes with staff and staff reciprocating.

Recent compliments provided by visiting external professionals on 'service feedback forms' supported these views, with one visitor stating, "Interaction/engagement was very positive and there is genuine affection between service user and staff." Another visitor stated, "The quality of interaction between staff and residents was of a very high standard with genuine warmth and empathy." This demonstrated staff had consistently cared for people in a manner that was compassionate and appropriately affectionate.

With regard to people's dignity, we observed staff adjusting their communication style to meet the needs of different people, for example squatting down to speak at eye level with one person in a wheelchair, and using hand gestures to help communication with another person. Two members of staff had recently been trained in Communication and Interaction training. This was aimed at giving staff a greater awareness of empathising with the needs of people before speaking to them, for example, body positioning, speaking more slowly or pausing for a longer duration after asking a question. We found patience in communications and interactions to be a theme of how staff interacted with people. For example, we observed one person being asked if they would like to be weighed, with the member of staff making it clear it was their choice. The member of staff spoke and adjusted their style to respond in kind to the person's humorous comment. One professional told us, "They are patient with people and that comes from a good understanding of their needs," and we found this to be the case during our inspection.

We found people who used the service were encouraged and supported to maintain relationships meaningful to them. For example, one person had a taxi arranged for them to visit a relative regularly, whilst other people kept in touch with relatives via telephone. We saw there were no restrictions regarding visiting times.

People were supported to be as independent as they wanted to be. One social care professional told us, "They are good at encouraging independence – for some people that might be holding a sandwich and for some people it might be going shopping - they understand each person's need." During our inspection we saw people supported to go shopping, do their own errands and take part in activities meaningful to them. One person we spoke with confirmed they enjoyed spending time with their keyworker and that they helped each other to clean their room together. We saw one person had completed a course on maintaining their own wellbeing whilst attending a day centre and proudly displayed this on their wall. This demonstrated

the registered manager had successfully ensured people maintained the independence they valued.

We saw rooms were highly personalised and also decorated in varying styles to meet the preferences of people who used the service. For example, one person had butterfly motifs and other wall art, whilst another person preferred a range of film posters.

We found care plans to contain good levels of information regarding people's preferences and wishes and, where people were able to consent to their care and treatment, they had done so. When we spoke with staff they knew about people's individual needs and preferences.

The registered manager displayed a good understanding of advocacy and ensured relatives were involved with individual decisions regarding people's care.

We saw people's personal sensitive information was securely stored in locked cabinets, in line with the confidentiality policy.

Professionals we spoke with stated they had been impressed by the registered manager's ability to ensure people could be sensitively supported as they reached the end of their lives. Where people could not make their own decisions, family members we spoke with were similarly clear that the registered manager involved them in ensuring people's end of life plans were appropriate to their preferences and in their best interests. Nobody was receiving end of life care during our inspection but we saw detailed end of life planning in people's care files.

Good

Is the service responsive?

Our findings

One visiting professional told us, "They plan things in a person-centred way," and we found this to be the case. One person we spoke with showed us a range of crafts they had been working on and told us they, "Loved it – I'm always doing something." We saw there was a good level of person-centred information in care files, which had been incorporated into people's care planning, for example their individual likes, dislikes, and the things that were important to them. Person-centred care means ensuring all aspects of care planning have regard to people's individual wishes, needs, preferences and life history.

We saw each care plan contained a detail pre-assessment of people's needs, which was then developed into individual, goal-orientated care plans. For example, we saw one person regretted the fact they had not had as full a formal education as they would have liked. We saw they had been offered the opportunity to complete courses in English and Maths at a local day centre and decided on their individual goal as, "To achieve my certificates from the English course." We saw they had regularly attended the course and achieved qualifications in English and Mathematics, and were now planning further studies. We saw this activity had also been incorporated into a Wellness Recovery Action Plan for the person, who had previously suffered anxieties and outbursts. We saw that person-centred care had been successfully delivered to ensure the person not only achieved goals important to them, but that also they enjoyed a better quality of life. We saw they had also developed a strong bond with another person who attended the courses and now proudly displayed their certificates on the wall. This demonstrated the benefits of social interaction for the person, who had previously suffered from social isolation.

The registered provider used a range of documentation to ensure people's individual needs and preferences were accurately recorded, for example a 'Listen to Me' document, which set out details about the persons' likes, dislikes and how they like to be spoken with. Where one person was now living with dementia we saw staff had used the 'This is Me' document to ensure their needs were accurately documented. 'This is Me' is a document produced by the Alzheimer's Society that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.

We reviewed activities provision at the home and found it was similarly person-centred. There were group activities for people who wanted to join in, such as bowling, day trips, crafts and barbecues. There were also person-specific activities, which were suggested at the regular residents' meetings. For example, one person had a love of dogs and spent time petting a dog soft toy. Staff recently suggested the visit of a dog and we saw all people who used the service had enjoyed the visit. We saw the person who had a particular love of dogs had photographs of the day in their room and they smiled when we asked them about the visit. This demonstrated that staff took people's likes, dislikes and wishes seriously and ensured they were met where possible and celebrated.

The registered manager had recently introduced a formal approach to meeting people's aspirations, called the 'Wishing Well'. This was a painted mural on a wall where staff or people who used the service could post ideas on sticky notes about what wishes they wanted the service to help them achieve. Whilst the system was relatively new we saw it had already had a beneficial impact on people. For example, one person who

used the service stated their wish was to drive a 53-seater bus. We saw the registered manager had contacted a local bus operator, found they had a vintage 53-seater bus and arranged for the person to sit at the wheel. We saw the person had enjoyed the day and, again, the pictures were displayed in the hallway as a means of celebrating the day.

Care files were well-ordered and easy to follow for care staff and visiting professionals. Each contained people's photograph and details of each person's keyworker. We saw care plans were reviewed regularly and people confirmed to us they were involved in the review process, as did relatives we spoke with.

We saw, where people's health needs changed, this was identified and people were supported by staff who liaised regularly and effectively with a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. One relative told us, "[Person's] needs have changed enormously but they have been with [Person] at every stage," and, "The always get in touch if there are any changes – they do involve the family." External healthcare professionals we spoke with were similarly confident in the responsiveness of individual staff members, with one telling us, "They are quick to respond," and another, "They changed their approach when [Person's] needs changed."

We saw evidence of staff flexibly and proactively considering people's needs to ensure they achieved good health and wellbeing outcomes. For example, one person wanted to go on holiday to Skegness but required daily visits from the district nurse to manager their insulin injections. We saw staff had liaised with district nurses to ensure their colleagues in the Skegness area could meet the person's needs whilst they were on holiday there.

Surveys of people who used the service, staff and relatives were used as a means of routinely gathering more information about the service. We looked at the most recent surveys and saw all respondents were happy with the level of care provided, the support from management and the safety of the service. We noted the only area of concern was activities provision, with three out of nine staff members and one person who used the service out of eight describing activities as 'poor'. We noted these surveys had been completed over six months ago and, when we reviewed activities provision, found it to be person-centred and informed by people's needs and wishes.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas and was also available in easy-read format. People we spoke with and their relatives knew how to make a complaint and who to approach, as per the registered provider's policy. With regard to compliments we saw there had been many and they were recorded in a diary which gave a handwritten overview of the compliment. The registered manager agreed there may be more systematic ways of recording and analysing compliments from external sources, for example to share best practice, and we saw they had started to trial this with 'service feedback forms'.

With regard to the potential transition to other services, we saw each person had a Hospital Passport and an emergency health plan in place. A Hospital Passport details people's communicative, medical and mobility requirements should they need to go into hospital. An emergency health care plan is a detailed plan that outlines a person's needs to assists healthcare professionals in the event of an emergency.

Good

Is the service well-led?

Our findings

The registered manager had been in post for ten years and had extensive experience of caring for people with learning disabilities. People who used the service, their relatives, and members of staff all expressed confidence in the registered manager's abilities and their level of 'hands-on' involvement in the running of the service. We found the registered manager to have a detailed knowledge of all people who used the service and that they had formed strong bonds with them. Relatives consistently told us the registered manager communicated with them regularly and that they were made aware of any changes. One healthcare professional told us, "[Registered manager] is quick to respond and has a really good handle on everything."

Staff told us, "The manager always supports us," and, "We have enough time to do the job because everyone takes responsibility." We found the registered manager had successfully maintained a culture where staff took individual responsibility seriously and ensured they and others were accountable for making sure people received a good quality of care. We found the registered manager had successfully balanced the need to instil high levels of accountability and scrutiny with a culture that celebrated people's individuality. One example of this was the Resident Recognition Scheme, whereby individual managers could share good news/success stories with the rest of the registered provider's organisation via a newsletter. We saw the registered manager had engaged with this process and championed and celebrated people's individual achievements more widely than just in the home. This showed the registered manager had ensured people achieved good quality, person-centred outcomes and was keen to share examples of best practice.

The registered manager and other staff undertook a range of audits on a monthly basis, including medicines audits, health and safety and infection control. In addition to this auditing each keyworker completed a monthly check of the care plan documentation relating to the person they supported. We also saw staff were responsible for a 'daily walk around', where any identified faults or concerns could be identified and reported.

We saw the area manager visited the service at least monthly and we saw they also demonstrated a good knowledge of people's needs and had developed a good rapport with the people they interacted with. We saw they had completed monthly audits of the registered manager's own quality assurance work and conducted their own 'walk around' inspection of the service. We saw these regular checks had led to specific improvements in service provision, such as identifying where a member of staff had missed a due date for refresher training.

We saw the director of operations visited the service annually and undertook their own observations. Where recommendations were made, we saw the registered manager had incorporated these into the Service Development Plan and actioned them in line with planned dates. This demonstrated people who used the service were supported by a robust quality assurance system that ensured systems and staff were accountable.

We saw good relationships had been formed with the community, for example a community centre and

various day centres. We saw the registered manager had successfully built new relationships with external providers such as a college to ensure people's needs could be flexibly met.

We saw the registered manager had signed up to the Social Care Commitment and had ensured that all staff had completed this. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks. Examples of staff 'I will' statements included, "I will always take responsibility for the things I do or don't do," and, "I will communicate in an effective way to promote the wellbeing of people who need care and support." We saw these pledges were measured by regular meetings with the manager, who ensured evidence was provided to meet the pledges, such as appropriate training or qualifications, or knowledge of people's changing care plans.

We saw the registered provider ran an internal awards scheme and that the registered manager had put forward the team at Kensington Hall, specifically to recognise the impact of a person-centred approach to one person's needs. This helped to demonstrate that the registered manager and staff shared a common understanding of how to successfully provide person-centred care.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided and we found the registered manager had ensured records regarding people's care were accurate and up to date. We also saw a good degree of organisation of key information in the office, such as guidance regarding best practice from the local authority, safeguarding information and information regarding the Mental Capacity Act 2005 (MCA).

The area manager and registered manager were able to clearly articulate their implementation of person-centred care and their vision for service improvements and we noted these were in line with the information provided to CQC in the Provider Information Return (PIR).