Kensington Health Care Limited

Old Charlton House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Old Charlton House is a residential care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and personal care for up to 32 people. At the time of the inspection there were 28 people living at the home.

People's experience of using this service:
People's needs were met in a personalised way by knowledgeable staff who were kind and caring. They supported people to lead happy, fulfilled lives.
Individual and environmental risks were managed appropriately, and people were protected from avoidable harm.
People received their medicines as prescribed and infection control risks were managed effectively.
There were enough staff to meet people's needs and recruitment processes helped ensure only suitable staff were employed.
People's rights were upheld. They were empowered to make their own choices and decisions and involved in the development of their care plans.
People knew how to raise concerns. They had confidence in the registered manager and told us they would recommend the service to others.
A quality assurance system was in place to continually assess, monitor and improve the service.

The service met the characteristics of Good in all areas. More information is in the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection:
The service was rated Good overall at the last full comprehensive inspection, the report for which was published in October 2016.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

Follow up:
There is no required follow up to this inspection. We will continue to monitor all information received about the service to understand any risks that may arise and to ensure the next inspection is scheduled accordingly.

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Old Charlton House Residential Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Old Charlton House is a care home registered to accommodate up to 32 people who need support with personal care. Accommodation is spread over three floors. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from:
10 people who used the service, six relatives of people who used the service, two healthcare professionals who had regular contact with the service, a social care professional from the local authority and a trainer from a training provider that supported staff development. We also spoke with the registered manager, the deputy manager, the head of care, five members of care staff, two housekeepers, the cook, the administrator and the maintenance person. We viewed six people's care records and records of accidents, incidents and complaints, together with audits and quality assurance reports.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Staffing and recruitment:
• People had mixed views about the staffing levels. Some felt staff responded promptly to requests for assistance; their comment included: "Someone comes pretty quickly" and "You don't have to wait at all". However, other people felt there were not always enough staff to meet their needs. Two people reported delays in being supported to use the bathroom, which occasionally caused them anxiety and a visitor told us staff were not always sufficiently visible in communal areas to support people. During the inspection, we found there were enough staff deployed and people were attended to promptly.
• The registered manager told us staffing levels were calculated according to people's needs, although they were unable to demonstrate that they took a systematic approach to setting staffing levels. They did not assess people's levels of dependency or use the data available from the call bell system to analyse response times.
• We discussed this with the registered manager who told us they would explore ways to take a more structured approach to setting staffing levels and would ask the call bell provider to help them to extract and analyse the available data. This would help ensure that enough staff were available to consistently meet people's needs throughout the day.
• The provider had robust recruitment procedures in place. Records confirmed these were followed fully to help ensure only suitable staff were employed.

Preventing and controlling infection:
• All areas of the home were clean and staff completed regular cleaning in accordance with set schedules. One person told us, "Staff are always cleaning."
• Infection risks had been assessed and appropriate action taken to reduce the risk, although these had not been documented, as recommended in guidance issued by the Department of Health. We discussed this with the registered manager who to undertook to ensure these were completed as soon as possible.
• Staff had been trained in infection control techniques. They had access to personal protective equipment, including disposable gloves and aprons, and used these whenever needed.
• During a recent outbreak of infection, staff increased the frequency of cleaning and isolated people who were affected to their rooms. This, together with other appropriate precautions, helped contain the outbreak and led to it being cleared up within 72 hours.

Systems and processes to safeguard people from the risk of abuse:
• Appropriate systems were in place to protect people from the risk of abuse. People told us they felt safe at Old Charlton House; for example, one person said, "I feel hugely safe, I've got no worries at all."
• Staff knew how to prevent, identify and report allegations of abuse. They gave examples of how they were alert to potential signs of abuse and how they had reported concerns in the past. The safeguarding training for one member of staff was out of date, but this was addressed during the inspection.

• Records confirmed that all safeguarding concerns had been reported and investigated thoroughly, in liaison with the local authority's safeguarding team.

Using medicines safely:
• Appropriate arrangements were in place for obtaining, storing, administering, recording and disposing of medicines safely and in accordance with best practice guidance.
• Senior care staff had been trained to administer medicines and had been assessed as competent to do so safely. One staff member's competency had not been assessed, but this was addressed during the inspection.
• Medicine administration records confirmed that people had received their medicines and topical creams as prescribed. There was clear information about 'as required' medicines and when these should be offered, together with prominent information about people taking blood-thinning medicines and the risks posed by these.

Assessing risk, safety monitoring and management:
• People's care plans contained detailed risk assessments linked to people's support needs, including their skin integrity, nutrition and hydration. These explained the action staff should take to promote people's safety and ensure their needs were met.
• People were involved in risk taking decisions. For example, one person had chosen to continue helping with household chores, even though this put them at increased risk of falls. Another person and their relative had been involved in discussions about the benefit of bed rails and had decided to opt for an alternative solution to protect them if they fell out of bed.
• Environmental risks, including fire safety risks, were assessed, monitored and reviewed regularly. All staff had recently taken part in an evacuation drill to help prepare them for such an eventuality.

Learning lessons when things go wrong:
• Incidents and accidents were monitored closely and reviewed regularly to identify any learning which would help to prevent a reoccurrence. For example, following an equipment failure, a more robust checking system was implemented, and all equipment had been labelled with weight limits to reduce the risk of further failures. A person who had slipped out of a chair was given a specially adapted chair to reduce the risk of them slipping out. In addition, people who had experienced falls in their rooms were encouraged to move to ground floor rooms where they could be monitored and supported more effectively.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they wished to receive.

• People told us staff delivered care and support in line with best practice guidelines; for example, two staff were always used to operate mobile hoists. Staff had also started using nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition and took action to help achieve positive outcomes for people identified as at high risk.
• Staff had put together an innovative "hypo box" containing sugar-based products to support people who experienced a sudden drop in their blood-sugar levels (hypoglycaemia).
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed. Pressure-activated mats, linked to the call bell system, were used to alert staff when people moved to unsafe positions.

Staff support: induction, training, skills and experience:
• People and family members told us staff were highly competent; for example, one person said of the staff, "The know what they're doing." A family member told us, "I can leave [my relative] in the full knowledge she's cared for. They [staff] are brilliant. She's so well cared for."
• Staff completed a range of training to meet people's needs, which was refreshed and updated regularly. New staff completed a comprehensive induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff.
• Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• Experienced staff competed regular refresher training to help ensure their knowledge remained up to date. They were also supported to gain vocational qualifications in health and social care.
• Staff told us they felt supported in their roles by the registered manager and senior staff. Comments from staff included: "I can go the [registered] manager any time" and "I feel appreciated and valued, definitely, and the [registered] manager always says 'thank you'."
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with them, discuss their training needs, identify any concerns, and offer support. Yearly appraisals were also completed, to assess the performance of staff.

Ensuring consent to care and treatment in line with law and guidance:
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.
• Where people did not have capacity to make decisions, staff had consulted with those close to the person and had made decisions in the best interests of the person. Clear records of these decisions were maintained, together with copies of any legal authorities that family members had obtained to allow them to take decisions on behalf of their relatives.
• Where people had capacity to provide consent, we saw they had signed their care records to confirm their agreement with the proposed plan of care.
• Staff were aware of the need to ensure people were supported to make their own decisions and understood how to apply the principles of the MCA. They were aware of what decisions people were able to make independently and where they may need further support to do so.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA and found they were. DoLS authorisations had been made when needed. Staff were not always clear about which people were subject to DoLS authorisations, but the registered manager took immediate action to clarify this for staff.

Supporting people to eat and drink enough to maintain a balanced diet:
• People praised the quality of the meals and told us their dietary needs were assessed and met well; for example, one person said, "I can't complain about the food, it's lovely. They work hard to make nutritious meals."
• Where people needed a special diet or required soft or pureed food, we found this was provided consistently. One person preferred to eat with their fingers and the cook described how they adapted meals to suit this preference.
• People were offered regular snacks between meals. They could also choose alternatives if they did not want any of the menu options for the day.
• Staff monitored the amount people ate and acted if people started to lose unplanned weight. For example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• A choice of drinks was available and accessible to people throughout the day and we heard staff encouraging people to drink often.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:
• People told us they usually received all the support they needed at the time they needed it.
• We observed people being supported in a safe way when staff assisted them to move. When talking to people living with dementia, staff faced people, used short simple questions and gave them time to respond.
• People were supported to access other healthcare services when needed. One person told us, "You say you want a doctor and they try to get one on that day."
• Care records confirmed that people were regularly seen by doctors, specialist nurses and chiropodists. A healthcare professional told us, "Staff are very knowledgeable and active. They call us appropriately and always follow our advice."
• When people were admitted to hospital, staff followed the principles of the 'red bag initiative'. This is a local scheme aimed at ensuring essential information, medicines and personal effects are sent with the person to help ensure their needs are known and met.

Adapting service, design, decoration to meet people's needs:
• People told us they were happy with the design and layout of the home. Comments included: "It's like a five star hotel", "The feel of the place is lovely, it's homely" and "It's a lovely environment and it's safe here".
• Some adaptations had been made to the home to meet the needs of older people with reduced mobility. For example, two passenger lifts gave access to upper floors, corridors were well-lit and bathrooms had non-slip flooring fitted. A new carpet had been fitted in the dining room which was plain and demonstrated an understanding of the needs of people living with dementia.
• The registered manager told us they intended to complete an audit of the whole home, using a nationally recognised tool, to help identify further enhancements that could make the environment even more supportive of the people living there.
• There was an ongoing re-decoration programme in place and a clear system to help ensure any maintenance issues were resolved promptly.
• People had level access to a garden area which we were told they enjoyed using in warmer weather. This included raised flower beds for people who wished to garden.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
People told us they liked living at Old Charlton House and spoke positively about staff and the care provided. Comments from people included: "The staff are lovely, they go the extra mile. They are kind and caring and fun. [Most] have been here a long time, that says a lot", "They are charming people and they take great care of you" and "I feel that I'm part of a community here".
• We observed people were treated with kindness and compassion. People were dressed appropriately for the weather and in clothes that were clean and co-ordinated. Staff spoke respectfully to people and supported them in a good-humoured way, making sure they were always comfortable.
• People were supported in a patient and caring way; for example, when helping people to mobilise, staff went at the person's pace and asked where they would like to go. One person told us, "I'm at an age when my legs don't do what I want them to do. [The staff] are very patient with me. They don't rush me."
• When we spoke with staff, they demonstrated an extensive knowledge of people's individual needs, preferences, backgrounds and interests.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home. Staff recognised people's diverse needs and there were policies in place that highlighted the importance of treating people as individuals.
• Staff gave examples of how they treated people according to their individual wishes, preferences and lifestyle choices.

Supporting people to express their views and be involved in making decisions about their care:
• People and their relatives were involved in the planning of their care as much as possible. A family member told us, "They [staff] talked it all through with me. I think it's good that they involve the family."
• Staff ensured that relatives and others who were important to people were kept updated with any changes to the person's care where appropriate. One person had asked that their family were not informed and confirmed that staff respected this.

Respecting and promoting people's privacy, dignity and independence:
• People were encouraged to do as much as they could for themselves. For example, one person told us, "I need physical care. I can't dress myself, but they [staff] let me be as independent as I can be." A family member said of the staff, "They encourage [my relative] to do as much for herself as she can when she's getting in and out of the wheelchair."
• Other people had been given special plates and cutlery to make it easier for them to eat independently. A further person had been given a special, reclining commode, which enabled them to continue to meet their own personal care needs.
• Some people told us they preferred a staff member of a particular gender to support them with personal

care and said this was respected.
• Staff protected people's privacy. We saw people were asked discreetly if they needed help with anything and tasks were carried out in a dignified manner.
• Staff described how they protected people's dignity when supporting them with personal care. This included listening to people, respecting their choices and closing doors and curtains when providing personal care. One person said of the staff, "They shut the door if they have to do anything in the bathroom and they knock the door before they come in." Another person said of the staff, "They respect my preference for being supported to dress in my room rather than the bathroom."

Good

Is the service responsive?

Our findings

The service was responsive.
Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People told us their needs were fully met, in a highly personalised way. Comments from people included: "[It is] absolutely brilliant care. I can't say that highly enough" and "I love it. The care's excellent, the food's good and I like the freedom they give me". Family members echoed these views, included one who told us staff demonstrated a clear understanding of their relatives needs in the way they interacted with them, by holding their hand and introducing themselves.
• Staff supported people to lead happy, fulfilled lives by exploring and supporting people to develop 'goals and aspirations'. For one person, these included a wish to continue singing and we heard staff encouraging them to sing throughout the inspection. Another person wanted to feel a sense of purpose by doing household chores. They told us, "I help out quite a lot. I like to, it's good therapy for me, I enjoy it."
• Care plans had been developed for each person. These provided sufficient information to enable staff to provide support in a personalised way.
• People's daily care records usually confirmed that care and support had been delivered in line with people's needs, wishes and preferences. However, for people with catheters, their records did not show that they had received appropriate support. (A catheter is a tube inserted into the bladder to drain urine to an external bag). We discussed this with the deputy manager and by the end of the inspection a new recording system had been introduced to enable staff to confirm that they had met people's needs appropriately and consistently.
• Care plans were reviewed regularly and changes were made promptly when needed. A family member confirmed this and said, "[My relative] had a care plan review last week. It was very thorough about her medical history, but it was also about her needs and aspirations."
• Staff also responded promptly to changes in people's needs. They recognised that some people's mobility varied from day to day and were able to assess and accommodate people's needs effectively.
• A clear plan was in place to support a person who could behave in a way that put themselves and others at risk. Although sedatives had been prescribed on an 'as required' basis, staff were clear that they should try to support the person with distraction and reassurance before resorting to sedatives. Records showed these interventions were usually effective.
• People's communication needs were met. Most information was available to people in accessible, picture-based formats with large print and staff used white boards when needed to aid communication with people. Flash cards containing large pictures and words were also used to help people express choices and preferences.
• People were empowered to make their own decisions and choices, including when they got up and went to bed, when and what they ate and how they spent their day. A staff member told us how they had supported one person to stay up until 5.00am one day as they did not want to go to bed earlier. They said, "It was her choice. This is her home and we make sure she gets what she wants."

• Staff described how they supported people living with dementia to make choices, for example by offering a limited number of options and by interpreting the facial expressions and body language of people who were no longer able to communicate verbally.
• People had access to a wide range of activities. These included games, quizzes, music, dancing and visits by animals, including a pat dog. A 'magic table' had also been installed. This is a novel system that produces interactive light animations to simulate experiences for people to interact with, such as rustling leaves and fish in a tank. We were told that two people in particular used this a lot.
• The activities were tailored to people's individual interests and needs. For example, a person with impaired sight who enjoyed jigsaws had been given a puzzle with large pieces; and a person living with dementia had been given items relating to their previous employment for them to interact with. Other people enjoyed gardening, so a greenhouse and raised planting beds had been installed to enable them to do this.

End of life care and support:
• Staff had extensive experience of delivering end of life care. Most had completed relevant training and further training was planned for the coming year. All staff expressed a commitment to supporting people to have a comfortable, dignified and pain-free death. During the inspection, a visiting healthcare professional confirmed that one person's end of life care was "being taken care of well" by staff.
• People's end of life wishes and preferences were recorded in their care plans and included guidance to staff about maintaining the person's comfort. Staff told us they had developed positive links with palliative care specialists at a local hospice, who they could contact for advice at any time.

Improving care quality in response to complaints or concerns:
• There was an accessible complaints procedure in place and people told us they would speak with a manager if they had any concerns. A family member told us they felt listened to and said of the management, "They try to resolve any problems." Another family member told us a complaint they made had been resolved promptly and to their satisfaction.
• The registered manager described how they used learning from complaints to help drive improvement within the service and gave examples of when they had done so.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
• People and their relatives spoke positively about the management of the service. Comments included: "I really do like [the registered manager], she's excellent. She's really compassionate and understanding and she's hands on" and "[The registered manager] is lovely. She spares time to talk to you. If you've got a problem, it's properly dealt with. Ask her anything, she's on the ball. She does the job properly".
• The provider promoted a positive culture aimed at delivering high quality, person-centred care. A family member commented on this and said, "You can tell it is [well-led] because of the staff; they don't tolerate bad staff." Everyone we spoke with told us they would recommend the home to others; comments included: "I would definitely recommend it. I would rate it five stars" and "You won't find better than this".
• Staff demonstrated a shared commitment to providing the best possible care to people and to maintaining the good reputation of the home. They worked flexibly to ensure all task were completed; for example, on the first day of the inspection a senior staff member was working as a cleaner for a few hours to cover absence. We were told managers also covered shifts, including in the laundry and worked as care staff when there were shortages.
• The registered manager demonstrated an open and transparent approach to their role. Where people had come to harm, relevant people were informed, in line with the duty of candour requirements and CQC were notified of all significant events. The home's previous rating was displayed in the entrance lobby and on the provider's website.
• Visitors could visit at any time, were made welcome and were able to help themselves to drinks to make them feel at home. A relative told us, "The staff are friendly. They welcome me when I come here. I feel like I'm part of the family."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a clear management structure in place, consisting of the provider's representative, the registered manager, the deputy manager and the head of care. Staff understood their roles and communicated well between themselves to help ensure people's needs were met; this included through a dedicated, secure, online forum to keep staff up to date with any changes.
• There was a quality assurance process in place, consisting of a range of regular audits. Audits had been effective in identifying and bringing about improvement. For example, they had led to improvements in the availability of infection control equipment.
• All issues identified during the inspection were responded to promptly. Following the inspection, the registered manager told us the quality assurance systems would be further enhanced to make them more

robust.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Staff felt listened to and spoke positively about the management. Comments from staff included: "We can go to [the managers] at any time, they are always accessible", "[The registered manager] is supportive, they communicate well and sort out anything we need" and "It's the best place I've ever worked. I feel appreciated and [the managers] always say thank you".
• The provider operated a scheme to reward staff who performed well and went the extra mile to support people. One staff member told us this made them feel "valued and appreciated".
• The provider consulted people in a range of ways; these included regular quality assurance surveys and one-to-one discussions with people.

Continuous learning and improving care:
• The registered manager analysed all forms of feedback from people and used the findings to monitor and improve the service. This had led to new games tables being provided and menus being adapted to meet people's preferences.
• A recent review of the risk assessment process had led to the introduction of additional measures to manage health and safety risks posed by equipment.

Working in partnership with others:
• Staff had developed links to other resources in the community to support people's needs and preferences. These included healthcare services and voluntary support organisations.
• Further links that benefited people included an association with a local primary school, whose children visited regularly to interact with people. A family member praised this initiative and said, "[The children] bring books to read to people. [My relative] adores the children."
• Other links had been developed with local churches, whose ministers visited regularly to meet people; health and social care students from a local college who interacted with people as part of their learning and development; and other pupils who had arranged to interview a person about their wartime experiences.