Rockdale Housing Association

Rockdale House

Inspection report

Rockdale Lodge
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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

Rockdale House is situated near Sevenoaks town centre and is managed and run by the Rockdale Housing Association. It provides accommodation and personal care for up to 50 older people, in 48 permanent rooms and two short-stay rooms. There were 48 people living in the home during our inspection who needed some support with personal care and a few people who may have or develop dementia. All were able to express themselves verbally. The inspection was carried out on 12 and 13 January 2016 by two inspectors. It was an unannounced inspection.

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

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

There was a system to record and monitor accidents and incidents to identify how the risks of recurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were safe recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

All fire protection equipment was serviced and maintained.

People's bedrooms were personalised to reflect their individual tastes and personalities.

Staff knew each person well and understood how to meet their support needs. People told us, "All the staff here got to know me well and I know them too" and, "They [the staff] understand me."

Staff received essential training and had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and an annual appraisal. This ensured they were supporting people to the expected standards.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There was a system to submit appropriate applications to restrict people's freedom considering least restrictive options as per the Mental Capacity Act 2005

requirements.

Staff sought and obtained people's consent before they helped them.

The service provided meals that were in sufficient quantity and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions.
Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.
People were satisfied about how their care and treatment was delivered. Relatives told us, "The staff are very attentive, they are always ready to help" and, "This place is definitely caring, I would recommend it without hesitation."
People were involved in their day to day care. People's care plans were reviewed with their participation and relatives were invited to contribute.
Clear information about the service, the facilities, and how to complain was provided to people and visitors.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

People were promptly referred to healthcare professionals when needed. Personal records included people's individual plans of care, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People's individual assessments and care plans were reviewed monthly with their participation and updated when their needs changed.

People were involved in the planning of activities and told us they were satisfied with the activities provided.

The service took account of people's feedback, comments and suggestions. People's views were sought and acted on. The registered manager analysed the results of satisfaction surveys and acted upon them. Staff told us they felt valued under the registered manager's leadership.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. The registered manager kept up to date with any changes in legislation that may affect the service and carried out audits to identify how the service could improve. They acted on the results of these audits and made necessary changes to improve the quality of the service and care.

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.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Safe recruitment procedures were followed in practice. Medicines were administered safely.

The environment was secure and well maintained.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained and had a good knowledge of each person and of how to meet their specific support needs.

The registered manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink. People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to

do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

People were consulted about and involved in their care and treatment.

Is the service responsive?

Good

The service was responsive.

Staff were attentive to people's individual needs and requirements.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focussed on people. The registered manager operated an 'open door 'policy, welcoming people and staff's suggestions for improvement.

The staff felt supported and valued under the registered manager's leadership.

There was a robust system of quality assurance in place. The registered manager carried out audits and analysed them to identify where improvements could be made. Action was promptly taken to implement improvements.

Rockdale House

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 checked 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 was carried out on 12 and 13 January 2016 and was unannounced. The inspection team consisted of two inspectors.

The provider had completed a Provider Information Return (PIR) prior to our inspection. This is a form provided by CQC that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we looked at this information, and looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We reviewed our previous inspection reports. We spoke with two local authority case manager who oversaw people's care in the home. We obtained their feedback about their experience of the service.

We looked at six sets of records which included those related to people's care, medicines, staff management and quality of the service, and eight staff recruitment files. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out. We sampled the services' policies and procedures.

We spoke with 12 people who lived in the service and seven of their relatives to gather their feedback. We also spoke with the registered manager, the deputy manager, six members of care staff, the cook and one member of the housekeeping staff.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "We are in security here", "I am in very good hands" and, "That's the beauty about living here, I feel safe all the time." A relative told us, "The level of safety is the reason why our mother has chosen to come and live here where there is always staff at hand; there is plenty of staff here."

Staff had received appropriate training and guidance concerning how to identify abuse and potential abuse. Staff's training in the safeguarding of adults was up to date. They knew how to respond and report internally and externally if they had any concerns. The current safeguarding policy had been updated in July 2014 and reflected the policy and guidance provided by the local authority. This was fully accessible by staff and contained all the necessary guidance and procedure for staff to follow. Information about the whistle blowing policy was included in the staff handbook. Staff we spoke with understood their responsibility to report anything they were concerned about at the service. When concerns had been raised by a staff member, the registered manager had taken appropriate steps to address the issues. This had included reporting the concerns to relevant external agencies. Staff expressed confidence that managers would act on their concerns. One member of staff said, "We know what we have to do if we have concerns and we know they will be responded to".

There was sufficient staff on duty to care for people and respond to their needs at all times. Rotas indicated a sufficient number of staff was in attendance on both day and night shifts, and at weekends. Before people came into the service, the registered manager completed an assessment to ensure they could provide staffing that was sufficient to meet people's needs. Regular reviews were undertaken to assess the level of need of the people who lived in the service to ensure that the number of staff deployed was appropriate to meet their needs. Such reviews had been completed at least once a year and up to three times a year for the previous four years. Staffing numbers had been increased in response to a person's increased mobility needs and a senior care worker post had been created to supplement staff shifts in the afternoon.

The staff we spoke with told us there were enough staff to care in the way people needed and at times they preferred. Staff confirmed that they would cover shifts in case of short term sickness and steps would be taken to provide sufficient cover as and when required. There were 48 members of staff deployed at the time of our inspection. Seven volunteers were supporting the service. We observed staff were available to help people at various times depending on their wishes. People we spoke with confirmed that call bells were answered in a timely manner and staff were available to support them when needed. They told us, "When I need them [the staff] to come, It only takes them a couple of minutes and they are there" and, "They don't hang about, they come quick when I call."

Staff files were checked to ensure that suitable recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. When staff had restrictions on their rights to work in the UK such as visas with certain conditions this was

monitored appropriately. References had been taken up before staff were appointed and we saw that references were obtained from the most recent employer where possible.

Information about the home's disciplinary procedures was outlined in the staff handbook. The handbook provided clear guidance concerning the standards that staff were expected to uphold while working at the service. Disciplinary procedures were followed and action was taken appropriately by the registered manager when any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. These were updated as required when people's needs had changed. Appropriate risk assessments were carried out which contained clear control measures to reduce the risks. The staff were aware of the risks that related to each person and knew how to put guidance into practice. For example, a person who had visual impairment and who took their own medicines was at risk of selecting an incorrect dosage. The staff prepared their medicines for them. A person who was at risk of falls was accompanied by staff and was provided with a wheelchair for long distances. All the people whose skin was at risk of becoming damaged were provided with pressure relieving equipment. We saw that staff helped people to move around safely and that people had the aids they needed within easy reach.

The premises were safe for people because the service, the fittings and equipment were regularly checked and serviced. Safety checks had been carried out throughout the service and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, water temperature, Legionella testing, service logs relevant to the lift, appliances and fire protection equipment. Portable appliance testing was regularly carried out to check the safety of electrical equipment.

Staff were familiar with the procedures for evacuating the home in case of a fire and there was appropriate signage about exits and fire protection equipment throughout the service. People had individual personal emergency evacuation plans in place which detailed what assistance they would require if it was necessary to evacuate the home. There were detailed plans in place concerning how the service would manage an emergency. This included information about alternative accommodation if it was necessary to evacuate the building. Information was included in the plan concerning how the home would manage an outbreak of disease. Staff knew where this information was located and understood how they should respond to a range of different emergencies including fire.

There was a system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. The service employed two maintenance staff who were able to attend to any repairs that were required within the home. The building was well maintained and cleaned to a high standard. A log was maintained of any repairs that needed to be made and staff were able to note if any repair needed immediate attention. The registered manager monitored the completion of repairs that were dealt with in a timely manner. There were plans in place to carry out a rolling programme of improvements such as re-decorating particular areas of the premises.

Accidents and incidents were reported when they occurred and the manager maintained an overview concerning accidents within the service. There was an effective recording system that ensured relevant information about accidents and incidents was considered and analysed without delay. This ensured that hazards were identified and actions were taken to reduce future risks of these recurring. For example, a bath mat had been provided for a person who had previously slipped in the bath.

Medicines were managed appropriately within the home in order to ensure that people received their medicines as prescribed. There was a clear medicines policy in place. This included information about how to report and manage any medicines errors that had occurred. Staff were aware of their duty to report any errors and sought medical advice when required. Regular checks were made by the deputy manager of the home to ensure that medicines were properly stored and managed. Stock levels were managed appropriately and there was a sufficient supply of medicines available. Medicines that were no longer needed were routinely returned to the prescribing pharmacy. The medicines trolleys were clean and organised.

Medicines administration records (MAR) were completed appropriately. Medicines records included a photograph of the person as well as information about any allergies they may have to particular medicines. Information was included in the MAR sheets concerning the protocol for administering 'as and when' required medicines such as homely remedies. There were risk assessments in place that clearly detailed how people should be supported to take their medicines safely. For example, if a person needed staff support in order to take their medicines this was documented. The competence of staff who administered medicines was regularly checked by the deputy manager to ensure that best practice was maintained to keep people safe.

Systems were in place to ensure that infection control was properly managed within the home. There was an infection control lead for the service who took responsibility for ensuring that risks from infection were minimised. There was an ample supply of personal protective equipment available and we saw that staff used this appropriately. Alcohol hand gel was readily available throughout the service. Staff were knowledgeable concerning the steps that they would need take in case of an outbreak of infectious disease at the home. For example, they were aware that they may need to isolate people in their rooms in case of an outbreak and they would need to carry out additional cleaning. There was an infection control policy in place that was fully accessible to staff.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. One person said, "All the staff are very efficient." Another person said, "The staff seem to be well trained, they know what they are doing." A relative said, "They know how to manage situations and reassure our relative when she has memory loss." Each person had a named keyworker. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need.

Staff knew how to communicate with each person. Staff were bending down so people who were seated could see them at eye level. Several people had a hearing impairment and needed time to understand what was said; staff respected people's pace to ensure effectual communication. There was an ample supply of hearing aids in the service. One senior care worker was the lead in communication and ensured that staff checked all hearing aids regularly so people could hear effectively. A voluntary organisation came to the service regularly to service hearing aids. One person with visual impairment was allocated a room next to the lift and within short distance of a kitchenette so they would find their way around more effectively. A person had acquired two pairs of new glasses and their name had been engraved onto them to ensure they would not get mislaid. People had individual telephone lines in their bedroom if they wished and some people had their own wireless access to the internet. People were able to use a computer in a communal area, which was equipped with 'skype' to enable them to see and talk to their relatives and friends. Staff helped people connect with the device. One member of staff told us, "It is so important for our residents to maintain regular communication with their families and there are so many ways nowadays they can do this; we often help people make sense of their mobile phones."

Staff handed over information about people's care to the next staff shift three times a day. We observed a handover where staff demonstrated effectual knowledge when discussing how to give people the individual care they needed. The care of each person who lived in the service was discussed appropriately and any changes in their support were noted by staff. Information about incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, moods, behaviour and appetite was shared by staff appropriately. Care plans were updated to reflect any significant changes, such as reviews of their prescribed medicines. Senior staff used a system of computerised notes to record any changes and all care workers referred to the system throughout the day. There were two computers in the care workers' office, one in the reception area, and two were in the managers' offices. An additional system was in place to record people's appointments in a dedicated calendar. This system of communication ensured effective continuity of care.

Staff had appropriate training and experience to support people with their individual needs. New staff had an induction before they started working at the service. This included shadowing experienced staff until they could demonstrate to senior staff that they were competent to work on their own. Induction periods were extended when necessary. The registered manager was introducing elements of the 'Care Certificate' as part of staff induction and was considering incorporating it entirely. The 'Care Certificate' was introduced in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff were provided with a handbook that

contained summaries of the service's policies, and comprehensive information about the code of conduct and standards the provider expected them to maintain.

Staff were supported to gain qualifications and study for a diploma in health and social care. They were supported by an external assessor who monitored their progress. A newly recruited member of staff told us, "As soon as my post was confirmed I was offered to enrol for the diploma at Level two and was told I will be supported to go for the diploma at level three after that." Senior care workers were supported to study and obtain diplomas at level five. This meant that staff were able to develop their skills and knowledge as they received effective support and encouragement.

Staff received essential training and we saw that staff were booked for refresher courses to update and maintain their knowledge. There was an effective system in place to alert when refresher courses were due and this was followed up by the deputy manager. Essential training was provided within five weeks of staff starting work. The staff we spoke with were positive about the range of training courses available to them. Staff had the opportunity to receive further training specific to the needs of the people they supported, such as dementia care awareness, mental health, anxiety and depression, pressure area care, epilepsy, diabetes and end of life care. Some members of staff took the lead in a particular area and had developed their knowledge so they could share it with staff. For example there were leads in mental health, infection control, dietary needs and care planning. The registered manager had also created a post of residential social worker.

The registered manager and deputy manager monitored staff skills and competence regularly to make sure they maintained best practice and were working to the expected standards. This included observations of how staff cared for people. The registered manager carried out unannounced spot checks that included night shifts to ensure good practice was maintained.

One to one supervision sessions for staff were carried out three times a year in accordance with the service's supervision policy. At one of these supervisions, an annual appraisal of staff performance and standards of practice was also carried out. Any difficulties experienced by staff were discussed at supervision to identify the support they needed. A member of staff told us how they had been supported in their role when they had experienced particular difficulties. They told us, "I got really good support that saw me through a difficult period." This system ensured that staff were appropriately supported and clear about how to care effectively for people.

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 are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the registered manager who demonstrated an appropriate knowledge of updated legislation and a good understanding of the processes to follow. No one was subject to DoLS at the time of our inspection. There was a system in place to assess people's mental capacity and hold meetings in people's best interest. This system had been used effectively, for example in regard to a person who experienced some memory loss who wished to go

shopping unaccompanied. Attention had been paid to the person's right to make informed decision and a positive risk assessment had been carried out. This ensured people's rights to make their own decisions were respected and promoted when applicable.

Staff sought and obtained people's consent before they helped them. One relative told us, "The staff are always polite and always check my mother is in agreement about anything." When people declined their wishes were respected and staff checked again a short while later to make sure people had not changed their mind. One person told us how they had declined to get up and had asked to get their breakfast in bed. This had been accommodated. People or their legal representatives when appropriate signed their care plans to evidence their agreement.

Cooked breakfasts were offered as an alternative to continental breakfast. We observed lunch being provided in the dining areas and in people's bedrooms. The meal was freshly cooked, well presented and looked appetising. It was hot and promptly served, well balanced and in sufficient amount. People were offered a choice of two main courses and were able to have second helpings if they wished. A relative told us, "Our mother's appetite has improved since she has come to live here; the meals are lovely; she enjoys them very much." There were two dining rooms, one of which welcomed people who needed help and encouragement with eating and drinking. Some people with sight impairment required pureed food or food cut in small pieces and this was implemented effectively. People told us, "The meals are always very nice", "They know what I like and what I don't like", "We could get wine with our meal if we wanted, anything we like, really" and, "I like my food and the food here is very tasty."

People were consulted when menus were planned four weeks in advance and specific requests were taken into account. An annual food survey indicated that people wished to have 'more curry' and as a result this dish had become a regular occurrence. There was clear updated documentation displayed in the kitchen about people's allergies, dietary restrictions, preferences and birthdays. Although there were two main courses on the menu, people could have an alternative such as an omelette if they changed their mind on the day.

There was a kitchenette on each floor that included a toaster, a microwave oven, a refrigerator, and ample supplies of tea, coffee, milk and biscuits for people to use. Home-made cakes, biscuits and fresh fruit were served from trolleys four times a day and people were encouraged to have hot or cold drinks throughout the day. In the evening, people were offered a range of options that included home-made soup and bread rolls, omelettes, sandwiches and jacket potatoes with a variety of fillings.

Staff monitored and recorded people's intake of food and fluids when their appetite declined or when they appeared dehydrated. This had been implemented for a person whose health had declined and who approached the end of their life. People's weight and 'body mass index' was monitored monthly and people were referred to health professionals such as a GP and a dietician when substantial changes of weight were noted. Fortified diets were provided appropriately.

People's wellbeing was promoted by regular visits from healthcare professionals. These were appropriately recorded and any resulting guidance was updated in people's care plans. For example, referrals to district nurses were made when people had pressure areas or diabetes, and physiotherapists when people came back from a period of hospitalisation. A chiropodist visited every six weeks to provide treatment. An optician visited when required and people were accompanied to a local dentist upon request. Vaccination against influenza was carried out when people had provided their consent. Records about people's health needs were kept and information was effectively communicated to staff so effective follow up was carried out. This ensured that staff responded effectively when people's health needs changed.

The premises had been built in 2013 and were designed to meet the needs of the people who lived at the service. En-suite bedrooms were accommodated over five floors and were spacious and personalised. There were ten bathrooms, two wet rooms, a treatment room, a phone room and a hairdresser's salon for people to use. Corridors were wide with handrails to ensure people could walk independently. People were encouraged to socialise on different floors and were escorted by staff in the lift when needed. On each floor there was a main lounge and sitting areas where people could relax in. There were many comfortable chairs and foot stools, current magazines and books in a suitable format for people with visual impairment. Communal space included a courtyard where people could spend time if they wished. The decoration was bland and there was a lack of pictures or photographs on the walls in communal areas. We discussed this with the registered manager who had planned to discuss this with the provider and introduce new colour schemes and a display of pictures relevant to people's history. This was part of their improvement plan.

Good

Is the service caring?

Our findings

People told us they were very satisfied with the way staff cared for them. All their comments were very positive. They said, "I love it here because the staff are ever so nice", "The staff are like friends", "This feels like home away from home". Relatives told us, "The staff are very attentive, they are always ready to help" and, "This place is definitely caring, I would recommend it without hesitation." A local authority case manager who oversaw people's care in the service told us, "The staff are very kind and knowledgeable."

We spent time in the communal areas and observed how people and staff interacted. There was a calm and homely atmosphere where people were encouraged to chat and staff stopped to listen to people and respond in a compassionate manner. Staff spent one to one time with people to offer companionship and sat with people in the lounges to engaged them in conversation. They checked whether people who chose to remain in their bedrooms were comfortable and occupied. There were frequent friendly and appropriately humorous interactions between staff and people, whom staff addressed respectfully by their preferred names. Staff smiled to people and displayed a respectful attitude towards them. During handovers staff talked about people respectfully.

All staff cared for people's wellbeing and paid attention to what mattered to them. They were attentive to people's needs and adjusted their pace to people's pace. Staff were proud of the 'small touches' that they provided for people who lived at the home. For example, staff responsible for processing laundry would hand-wash cashmere garments for people at the home. We observed staff escort people safely through corridors and into the lift and explain to them what they were doing. At mealtimes, staff talked with people and asked questions such as, "Are you OK for the next fork?", "How is that going down?." One member of staff was kneeling next to a person to encourage them to eat. Another was complimenting a person on their recent hair-do. The registered manager interrupted a meeting in their office to go to a person who needed escorting and help them. A person whose birthday was being celebrated told us, "I got lovely birthday cards from my family and also from the staff because they are like my family."

Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Staff cared for people in a way that showed they knew each person well. They referred to people's points of reference, for example a member of staff was talking about dance with a person who used to be a dancer. Staff were aware of a person's history and knew for example that they used to be a squash champion. Therefore staff were aware of people's history and individuality.

All staff knocked on people's bedroom doors, announced themselves and waited before entering. Bedroom doors were left open or closed at people's request and staff checked regularly on people's wellbeing. Each person's wellbeing was checked discreetly by staff every hour at night time. Care plans included instructions for staff to follow when helping people with their personal needs. People were assisted discreetly with their personal care needs in a way that respected their dignity. People were able to spend private time in quiet areas when they chose to and were escorted by staff when needed.

The staff promoted independence and encouraged people to do as much as possible for themselves.

People followed their preferred routine and washed, dressed and undressed themselves when they were able to do so. The deputy manager told us, "We aim to improve our residents' independence; often it is a question of them regaining confidence." At mealtimes, staff encouraged people to eat independently. A member of staff was praising a person who ate more than usual saying, "You have managed all this by yourself, it is a pleasure to see you eat so well." People were able and encouraged to go out and spend time with their family and socialise outside the service. Three motorised chairs were available for any person who wished to go to the shops. Staff escorted people to town if they felt they needed support to do so.

Clear information about the home and its facilities was provided to people and their relatives. This included a booklet 'Welcome to Rockdale House' which contained information about the provider, a summary of their statement of purpose, the staff and the facilities, and how to complain. There was a website that was user-friendly and which provided information including a calendar of events. There was a board that displayed photographs and names of each member of staff in the reception area so people and visitors could identify staff effectively. There was another board that indicated at a glance who was in and who was out of the premises to inform staff and visitors.

People were involved in their day to day care. People's care plans and risk assessments were reviewed monthly to ensure they remained appropriate to meet people's needs and requirements. People were involved if they chose and their relatives were invited to participate in the reviews with people's consent. People we spoke with knew who their key workers were and told us they would not hesitate to talk with them about any wish they had in relation to their care.

The staff knew how to care for people at the end of their lives. People were asked about their wishes about resuscitation and other relevant details that were important to them. People's families were involved with their consent to discuss end of life care when appropriate. All wishes regarding end of life care were recorded in their files and the staff were aware of this. People had a pain management plan when appropriate and the staff followed guidance from the local hospice palliative team who visited the service as required. Staff remained with people and sat with them if they wished when they approached the end of their life.

Good

Is the service responsive?

Our findings

People and their relatives told us the staff responded very well to their needs. They told us, "All the staff here got to know me well and I know them too", "I love having my hair done at the salon on the premises" and, "They [the staff] understand me." A local authority case manager who oversaw a person's care in the service told us, "Residents are treated as individuals in this home."

Each person's needs had been assessed before they moved into the service in respect to their day-time and night-time care. These initial assessments of care needs informed individualised care plans about each aspect of people's care. These informed care plans were developed gradually and included a personal profile, their likes and dislikes, needs and relevant risk assessments. Before people came to live in the service, they were encouraged to visit, come for a hot drink or a meal, and stay a night or for a period of respite to help them make an informed choice.

Attention was paid to what was important to people. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. People's specific requirements were clearly outlined in their care plan and people confirmed that staff were aware of these and fulfilled their wishes. Wishes included when and where people preferred to eat, their individual choice of food, routine, activities and outings. A person who liked to listen to classical music had been provided with music tapes and earphones. Another person preferred to wear trousers and staff had helped them make a relevant purchase. A person liked to be ready for bed at a precise time; they told us, "The staff know this is what I like to do." Key workers were allocated to people taking account of common hobbies and interests. A key worker had organised the watching of tennis matches with 'Wimbledon cream tea' for a person who was interested in tennis. One staff member told us, "The residents do what they like and make us aware of what they want."

Care plans and risk assessments were reviewed monthly by people and their key workers, or as soon as people's needs changed. They were updated to reflect any changes to provide continuity of their care and support. They were examined by the registered manager or deputy manager after each review to ensure they remained accurate and fit for purpose. A person had a fall and the documentation relating to their care had been updated to reflect any possible risks of recurrence.

Staff attitude was positive and promoted improvement of people's physical and psychological health. A person of an advanced age who came to live in the service had experienced a loss of confidence following a fall at home and did not alert the staff when they felt anxious. The staff had encouraged the person to talk with the staff when needed so they could escort them and alleviate her anxiety. Two people were feeling anxious about using the lift and staff took them up and down until they felt confident to use it on their own. One person who failed to take their medicines at home now was taking their medicines regularly. Another person who had remained in a hospital for an extended period of time before coming into the service had made a full recovery and had regained their skills and independence. A relative told us, "My relative's health and mood have improved ten folds since she came here."

Referrals to healthcare professionals such as G.P. and specialist nurses were made without delay. Their

guidance was recorded and acted on in practice. For example, a person who had displayed a change in behaviour had been referred to their GP to detect any possible signs of infection. Another person whose skin was at risk had been referred to a specialist nurse to protect a pressure area and pressure relieving aids had been provided. Therefore people could be confident that staff would respond to their needs if they became unwell.

People's bedrooms reflected their personality, preference and taste. They contained articles of furniture from their previous home, and picture rails to hang framed photographs and paintings. People were offered the option of having a memory box by their bedroom door although this had been declined by people. One person had wished to have their photograph displayed on their front door and this had been implemented.

A range of daily activities was available. There was an activity coordinator three days a week and designated staff provided the activities the rest of the week. All the people we spoke with told us they were satisfied with the activities provided. One person said, "We are never bored, there is always something to take part in." People were consulted about their preferred activities and were involved in the planning of the activities programme. The activities coordinator told us, "I consult everyone about what type of activities they would like and present them with options; people really enjoy quizzes, they asked to have bingo sessions and knitting so this was introduced, we now have a knitting club going." One person was playing a computer game in the activities room, another was completing crosswords puzzles, and the activities coordinator was involving each person who sat in the lounge in a game. The activities coordinator offered art therapy to a person who chose to remain in their room and had provided colouring books. They told us how a person who was unable to knit chose to concentrate on rolling balls of wool instead. Activities included scrabble, listening to music, singing, light exercise, art and craft, reading aloud, jigsaw puzzles and reminiscence sessions. External activities were provided such as visits from a magician, singers, performing dogs, and a 'Pat dogs and small pets' service. Events such as the Chinese new year and the Queen's birthday had been celebrated with people sewing bunting and having take-away food.

Outings were organised and people had taken part in a boating trip and a lunch in a restaurant, shopping trips, and regular visits to a garden centre. People went to see films and theatre shows, went to the centre of town for shopping or a meal out. Families were encouraged to visit or take their loved ones out whenever they wished. These measures helped reduce people's social isolation.

People's feedback was sought about every aspect of the service and their suggestions were welcome. Residents and relatives 'meetings were held every two months and these were appropriately documented. At the last resident meeting, some people said that they disliked the white bread used in the service, and as a result the bread had been changed. Another person had expressed the wish to have seedless jam and this had been provided. Annual satisfaction questionnaires were provided to people and their relatives. These enquired about how people felt towards each aspect of the service and appraised their level of satisfaction. The registered manager audited the completed questionnaires and identified what worked particularly well and which areas could be improved. Following the last survey, the registered manager had written an action plan and had ensured that action was taken to improve the service. For example, a quarterly meeting with relatives had been set up; a display of staff photographs had been organised; a new post of senior care worker had been created to supplement afternoon staff shifts; menus had been reviewed for more variety; a trolley had been purchased to help people move furniture and their belongings into the service. The registered manager told us, "We need to listen to what residents tell us, this is their home and it is important we get it right." There was a comments and suggestions box that people and staff could use which was emptied every week by the registered manager.

People were aware of how to make a complaint. The procedures to follow should people wish to complain

were clearly displayed in the service and included in the 'Welcome booklet'. The registered manager and deputy manager were visible within the service and people knew who they were. One person said, "They are lovely, I can always talk to them." Another person told us, "I just know the manager would rescue me if I have any problem." Three complaints had been lodged with the service in the last twelve months and they had been addressed in line with the service's complaint policy. All had been resolved to a satisfactory outcome. This meant that people could be confident that their complaints were responded to.

Good

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People knew the management team who spent time with them every day. The registered manager was visible in the service and took time to talk with each person on one floor every day. A person told us, "You can tell she really cares for us." A relative said, "We are impressed with the manager, she is very efficient and very caring." A local authority case manager who oversaw a person's care in the service told us, "This home is well managed; there is a good person-centred culture in the home."

Staff praised the management team for their approach and support. They said they could come to the registered manager or the deputy manager for advice or help. All the staff we spoke with said they felt the registered manager was "Very good at her job", "Efficient". One member of staff said, "The registered manager is firm when she needs to be, and she is chatty and friendly too."

All of the staff we spoke with told us that they felt valued working in the home and that they were encouraged to be involved in the way the service was run. They told us that the registered manager held an 'open door' policy and were encouraged to come and share their views or discuss any problems they may have.

The registered manager was open and transparent. The registered manager consistently notified the Care Quality Commission of any significant events that affected people or the service, as per legal requirements. The registered manager regularly researched relevant websites such as 'Skills for Care London and South East' and took guidance from the National Skills Academy for Social Care, and the National Institute for Care Excellence (NICE). They subscribed to magazines dedicated to nursing and residential care. They attended regular local forums where they met other care home managers to share their knowledge and discuss practice issues. They attended a Housing association Benchmarking group every two months. This ensured that the registered manager kept informed with latest developments in the delivery of health and social care in order to improve their service.

There was a robust system of quality governance to monitor and improve the quality of the service. Quality assurance checks included regular audits that were carried out by the management team to monitor all documentation, policies updates, complaints, health and safety, incidents and medicines. An annual audit on infection control was carried out by the housekeeping team leader. Annual satisfaction surveys were analysed to identify how the service could improve and action was taken as a result. Staff attendance at training, their supervision and performance were monitored and disciplinary procedures were activated when necessary. Unannounced spot checks took place periodically by the registered manager to check staff upheld good standards of practice. The board of trustees visited the service every month and carried out their own inspection. Twice a month, the registered manager scrutinised each of the five floors to check levels of cleanliness and repairs that may be needed. Maintenance job sheets were checked by a maintenance officer who reported to a finance and maintenance manager. The job sheets were checked by the registered manager to ensure action had been taken. When one person had reported faulty hinges, a job sheet had been created and the repair had been carried out.

A Care and Selection Committee which was a sub-group of the board (the provider) visited the service to monitor admissions and carry out a monthly audit of different aspects of the service and spoke with people. They reported their findings to the registered manager. No significant shortfalls had been identified to date. The registered manager met with the provider quarterly to discuss the progress of the service.

The policies in place were specific to the service and were easy to read so staff could apply them in practice. Staff were able to access the policies through an internal computerised system. We sampled policies on professional boundaries, mental capacity, care planning, medicines, safeguarding, complaints and DoLS. All had been reviewed annually, updated when necessary and reflected changes in legislation.

The registered manager learned from mistakes and ensured improvements were carried out. For example, they had purchased a package from an external provider in regard to care planning and rotas, which had proved not to be effective. As a result, the registered manager had abandoned this option and had created a bespoke system instead that suited the service requirements. The registered manager had introduced a system of 'walky-talkies' to improve inter-communication between staff across the floors.

The registered manager spoke to us about their philosophy of care for the service. They said, "We want our residents to be safe, comfortable, happy and able to achieve their aims such as regaining confidence, maintaining their independence and looking outwards." From what people and the staff told us and from our observations, the staff took action to make sure these values and principles were applied in practice.

Regular team meetings took place, such as senior care workers meetings, and health and safety and maintenance meetings every quarter. Every two months, the registered manager or team leaders met with the housekeeping staff. The deputy manager met with care staff twice yearly. Staff were encouraged to contribute to the agenda and their suggestions were listened to and considered. For example, staff had suggested a different way to plan staff rotas, specific leave over Christmas, a shelter to accommodate staff who smoked, and a certain colour of uniforms. These suggestions had been considered and most of them had been implemented. One member of staff told us how they had brought a minor concern to the registered manager and how this had been remedied straight away.

The registered manager encouraged links with the community. People had access to transport through a service of volunteers; the local library and the local church vicar visited the service. A choir created by local school children visited the service and performed for people. The service enjoyed a good relationship with local GP surgeries and district nurses.

All records were easily accessible, well organised, completed, reviewed regularly, updated appropriately and fit for purpose. They were archived and disposed of safely as per legal requirements.