Rochester Care Home Limited

Rochester Care Home

Inspection report

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Date of inspection visit:
31 January 2017
01 February 2017

Date of publication:
28 February 2017

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

We inspected the service on 31 January and 1 February 2017. The first day of our inspection was an unannounced inspection while the second day was announced.

Rochester Care Home is divided into two distinct service provisions. One area provides care and support for up to 56 older people who require accommodation and personal care. This area for older people was further sub divided into four separate wings namely, Bishop Obo, Bishop Gundulf, King John and King Henry. The other area of the service called The Napier Unit provides respite care for up to eight people with physical and learning disabilities combined with additional complex needs. People who use Napier Unit service are aged 16+. The service is provided during evenings, weekends and bank holidays. The bedrooms in the Napier Unit are equipped with modern aids and adaptations. Rochester Care Home is a large service with ample communal space and gardens. At the time of our inspection, 53 people lived in Rochester Care Home for older people.

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

At the previous inspection on 8 and 10 June 2016, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was in relation to the provider failing to adequately implement healthcare professional's guidance in response to peoples' changing needs. The provider sent us an action plan telling us what steps they would be taking to remedy the breach in Regulations we had identified.

We also made three recommendations to assist the provider to make improvements to the service provided. These recommendations were in relation to the provider seeking further guidance on how to put together a risk assessment that would meets people's needs; the provider to seek further guidance on the deployment of staff in order to adequately meet people's needs, and the provider to seek guidance from a reputable source about Dementia Care practice in care homes.

At this inspection we found improvements had been made.

People's care plans contained information about their personal preferences and focussed on individual needs. Care plans had been reviewed and updated. Risk assessments were in place to identify and reduce risks that may be involved when meeting people's needs such as physical disabilities, and behaviours that challenge.

People were provided with a nutritious and a variety of food and drinks. The cook prepared meals to meet people's specialist dietary needs. We found staff recorded what people had to eat and drink in the daily

records.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and the service complied with these requirements.

People were protected against the risk of abuse. People told us they felt safe. Staff recognised the signs of abuse or neglect and what to look out for. Both the registered manager and staff understood their role and responsibilities to report any concerns and were confident in doing so.

Staff supported people with health care appointments and visits from health care professionals. The staff recorded the outcome of these visits. Care plans were being amended to show any changes and staff spoken with knew what care and support people were having.

Safe medicines management processes were in place and people received their medicines as prescribed.

Staff encouraged people to undertake activities and supported them to become more independent. Staff spent time engaging people in conversations, and spoke to them politely and respectfully. The records of activities that people took part in did not always reflect all activities the person had participated in. We made a recommendation about this.

There were sufficient staff with a mix of skills on duty to support people with their needs. Staff were recruited using procedures designed to protect people from unsuitable staff. Staff had the knowledge and skills to meet people's needs, and attended regular training courses. Staff were supported by their manager and felt able to raise any concerns they had or suggestions to improve the service to people.

Staff meetings took place on a regular basis. Minutes were taken and any actions required were recorded and acted on. People's feedback was sought and used to improve the care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

The registered manager and provider regularly assessed and monitored the quality of care to ensure standards were met and maintained. Where there were shortfalls, the registered manager had immediately put plans in place to rectify these. The registered manager understood the requirements of their registration with the Commission.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were effective recruitment procedures and practices in place.

There were enough staff employed to ensure people received the care they needed and in a safe way.

Risks to people's safety and welfare were assessed and effectively managed.

The provider had taken necessary steps to protect people from abuse.

Medicines were safely stored and administered to people.

Is the service effective?

Good

The service was effective.

Members of staff were appropriately supported. Staff supervision and annual appraisals were carried out.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about

their care.

The staff in the service were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

Staff had responded to people's needs quickly and appropriately whenever there were changes in people's need.

People's needs were fully assessed with them before they moved to the service to make sure that the staff could meet their needs.

Care plans had been updated.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The service had an open and approachable management team.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There were systems in place to monitor and improve the quality of the service provided.

Rochester Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 31 January and 1 February 2017. The first day of the inspection was unannounced and the second day was announced. The inspection team consisted of one inspector, a specialist advisor whose background was in professional social care and two experts by experience who had a background of working with and caring for older people.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place in the service, which the manager is required to tell us by law. We also looked at information we had received from the public and the local authority. We used all this information to decide which areas to focus on during our inspection.

Not all of the people at Rochester Care Home were able to tell us about their experiences. Therefore, we spent time observing the care in communal areas. We observed how staff communicated with people so that we could understand people's experiences.

We spoke with 16 people and ten relatives at the time of the visit. We spoke with a local doctor and two social care professionals that visited during the inspection. We spoke with the operational manager, the registered manager, the deputy manager of Napier Unit, one senior carer, eight care staff, the administrator and the cook. We observed staff interactions with people and observed care and support in communal areas.

We looked at records kept by the service. These included five people's records, which included care assessments and plans, risk assessments and daily records. We looked at records that included a sample of audits, meeting minutes, policies and procedures. We also looked around the premises and the outside spaces available to people.

Good

Is the service safe?

Our findings

People told us they felt safe receiving care from the staff at the service. They told us they had no cause for concern regarding their safety or the manner in which they were treated by staff. People said, "I do not feel unsafe here. They are all alright here. No one shouts at me"; "Yes, It is lovely here. Everyone is well educated, they know what is going on"; "I like it here, they look after me and help me out. Yes, I do feel safe"; "I do feel very safe here and I like it", and "Yes I do, the doors are locked and there is someone here all the time".

Relatives said, "Yes, the carers are taking good care of my Mum. I like the security as no one can open the front door and just walk in. Also, most importantly my Mum feels safe here"; "It has a nice feel here, the staff are mostly friendly and I know she feels safe here, she has told me. I feel it is safe to leave her here"; "Yes, it is okay here. They (staff) are gentle with her and it is safe, that is the main thing I worried about, but I am happy with the levels of safety"; "Yes, absolutely this is probably the best care home we found so far", and "They (staff) all seem very good and patient".

At our inspection on 8 and 10 June 2016, we recommended that the provider seeks guidance on how to put together a risk assessment that would meet people's needs, and the provider seeks guidance on the deployment of staff to adequately meet people's needs. At this inspection we found that appropriate risk assessments were in place, and staffing numbers had increased.

Staff told us that they had received safeguarding training at induction and staff training records we saw supported this. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The service had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

People were protected from avoidable harm. Staff had a good understanding of people's individual behaviour patterns. Records provided staff with detailed information about people's needs. Through speaking with staff, we found they knew people well, and could inform us of how to deal with difficult situations such as behaviours that challenge staff in meeting people's needs. As well as having a good understanding of people's difficult behaviours, staff had also identified other risks relating to people's care needs. People were being supported in accordance with their risk management plans. People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety.

Staff maintained records of each person's incidents or referrals, so any trends in health and behaviour could be recognised and addressed. These were then reviewed by the registered manager and action plans and reviews were documented plus any follow up action such as calling a GP. Body maps were completed when injuries were sustained.

At the previous inspection the registered manager told us that the four separate wings namely, Bishop Obo, Bishop Gundulf, King John and King Henry for older people had seven staff on duty in the morning, seven staff on duty in the afternoon and four staff on duty at night. A recommendation was made at that time did not reflect the number of staff required to adequately meet people's needs. At this inspection the registered manager said she was working on a ratio of eight staff on duty in the morning, eight staff on duty in the afternoon and four staff on duty at night. The staff rotas showed that in addition to the care staff there were domestic staff, kitchen staff, the maintenance man and two volunteers that assisted with activities.

The registered manager told us that the Rochester Care Home roster and the Napier Unit roster was based on the needs of people. There was a care home staffing calculator to work out how many staff were required to meet the needs of the people at the home. Each person had an individual assessment carried out to determine what level of dependency they were. These were high, medium, low or self-caring. One person said, "Yes, I see the same faces all the time". Relatives said, "There are a lot of carers to look after her", and "I do not know much about staff levels but usually when I am around you get the same carers around. However, some days I have been here you do not always see a carer as they are busy"; "Not always enough staff. Staff are always running around after someone. There could be a couple more (staff), the lounge only really has one (staff) during the day because the other one is helping in the rooms", and "They treat her well and her needs are usually met. You wait around to get things done; they are short staffed quite a bit". People when asked if their needs were met promptly said "They treat me well Yes", "They are very slow. They are always so busy, and "They seem very quick and there are a lot of people around. They do things when I ask them". We observed that there were short periods of time in the afternoon when there were no staff visible in different lounge areas.

Safe recruitment processes were in place. Appropriate checks were undertaken and enhanced. Disclosure and Barring Service (DBS) checks had been completed. The DBS ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks were undertaken. Staff we spoke with confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them. The provider had a disciplinary procedure and other policies relating to staff employment.

People were protected from the risks associated with the management of medicines. People were given their medicines in private to ensure confidentiality and appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed trained staff members administering people's medicines during lunchtime medicine round. The staff member checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely. Staff discreetly observed people taking their medicines to ensure that they had taken them.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the

person they were prescribed for. No medicines needed to be disposed of for the Napier Unit as this unit only dealt with the medicines that people brought into the unit from home. Accurate documentation and safe procedures were being followed for medicines that were not taken. The registered manager conducted a monthly audit of the medicine used and medication administration records This demonstrated that the provider ensured medicines were kept safe.

Personal Emergency Evacuation Plan (PEEP) was in place for all the people at the service. This is an individual plan for each person which gives staff and others the information about how they would need assisting to evacuate in an emergency. The registered manager also had agreement with venue locally where people could be evacuated too. The information was kept in a bag near the front entrance of the service. These are updated when people came into or left the service; they are also checked each month to make sure they are up to date.

There was a plan staff would use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

Good

Is the service effective?

Our findings

People told us that they thought the staff were trained and able to meet their care needs. "One person said, "I think they are trained quite well". Feedback from people was positive. People said, "I think they do, yes. They help me out with things I may need help with. I do most things myself but sometimes I cannot bend and they help me do my shoes and socks"; "They do help me and I am happy with their help"; "They (staff) do know what they are doing and they assist me well"; "There is a doctor that comes here, you can see, when you need to". Relatives said, "There is a doctor that comes here every week, I will get a call when she does see the doctor", and "They phone me if there are any problems". People commented about the food saying, "It is good, marvellous they make it well"; "I really enjoy it", and "Really tasty, I always get enough to eat". Relatives said, "It looks good, decent size. She eats well, I think they get a choice of two different things and they can pick whatever they want"; "It is all okay, not wonderful but you get quite a bit. There could be more choice if you do not really like something. You get a choice of a main meal or the alternative is usually salad. They could offer an alternative hot meal", and "Looks really nice, Mum always eats it all up and they get cake in the afternoon".

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed; the statutory principles underpinning the MCA and related this to people that were subject to DoLS. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Staff said that they always asked for people's consent before carrying out personal care tasks or offering support. They said that if people declined their support that this was people's right and they respected their decision. We heard staff asking if people wanted to have support to eat. Staff acted on people's responses and respected people's wishes if they declined support.

People were supported to have their nutritional needs met. People told us that the food was nutritious and of the required standard for their needs. All who could specify said that there was a choice, and always sufficient food. Meal times for people were flexible. People who required support to eat their meals were discreetly supported by staff in a manner which was respectful and dignified. The care and support during lunchtime was at the eye level of the person staff were supporting. Mealtimes were not hurried which promoted dignity and respect. People were served different sized portions according to their wishes, and

people were asked if they would like more. People were supported to have cold and hot drinks when they wanted them. When we spoke with the cook before the lunch time meal we saw that a choice had been offered at each mealtime. The tea time choices varied each day.

The cook was fully aware of people's dietary requirements and any preferences. They had a dry wipe board which informed them of any person who was diabetic and the requirements they needed to ensure they did not take too much sugar. The cook told us that they did not do any special cakes or desserts for people with diabetes. They would ensure they used recipes appropriate for all people and also a sugar alternative was used where needed. They said this worked well and people with diabetes did not feel they could not have the same as anyone else.

The kitchen served both the residential and respite units. The kitchen was well stocked and included a variety of fresh fruit and vegetables. Food was prepared in a suitably hygienic environment and we saw that good practice was followed in relation to the safe preparation of food. Food was appropriately stored and staff were aware of good food hygiene practices. People's weights were regularly monitored to identify any weight gain or loss that could have indicated a health concern.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians.

Malnutrition Universal Screening Tool (MUST) assessments were completed and reviewed on a regular basis in many cases monthly. This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese and it also includes management guidelines which can be used to develop a care plan. This was increased when there were any changes in people's condition. The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the service regularly.

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained sugar free diets for people with diabetes and repositioned people who were cared for in bed and on end of life care on a regular basis to minimise the risk of pressure ulcers developing.

The residential unit of the service provided end of life care, the registered manager told us that this was a person's home for the rest of their life when they moved in, if that was their choice. People who required end of life care were referred to specialist nurses who worked with the staff to ensure people remained comfortable.

Staff had received induction training, which provided them with essential information about their duties and job roles. The registered manager told us that any new staff would shadow experienced staff, and not work on their own until assessed as competent to do so.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support older people and respite unit staff had required skills and experience of supporting people with learning disabilities and autism. Some staff had completed vocational qualifications in health and social care. These

are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene.

Staff were being supported through individual one to one supervision meetings and appraisals. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We were told that an annual appraisal was carried out with all staff. Staff confirmed that supervision and annual appraisals were taking place. A member of staff also confirmed training needs were discussed as part of supervision and she could ask for training that would be of benefit to her in her role.

Good

Is the service caring?

Our findings

People and their families we spoke with were satisfied with the quality of care they received and they found staff caring and respectful. People described the staff as very caring and flexible. People said, "They (staff) are very nice and listen when they can"; "I like it. It has a nice lot here and a happy lot too"; "I am treated okay and they are kind yes"; "They (staff) are a smiley lot", and "They (staff) are very busy but they do try and make time for you".

Relatives said, "Very pleasant but very busy keeping track of so many people. If I ask them anything they will stop and talk to you. They are good at noticing anything that is not quite right"; "They seem very on the ball, if you ask them anything they will usually know what is going on"; "They (staff) seem very kind and she has two carers she really likes. They are so lovely to her, everyone seems to be really friendly"; "They (staff) are nice. There are a couple who do not say much but they smile and are helpful"; "It has a nice feel. The staff are usually smiling and they make the residents laugh. That is nice to see. They seem to know them well", and "It is okay. They welcome you and they seem to know the residents well. It is nice when they do have the time to sit and chat. They hold their hands and pat their arms and show they care"

We spent time observing how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. Staff checked on people's welfare when they preferred to remain in their bedroom or not to take part in the activities.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen. People said if they needed to ring the bell for support, staff responded. One person said, "If I use it they do answer really quickly". Another person said, "Yes, every time I have pressed it someone has come along".

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans.

Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. This showed that people's choices were respected by staff.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. People were assisted with their personal care needs in a way that respected their dignity. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. Staff covered people with blankets when necessary to preserve their dignity. People said, "Yeah, they make you feel special", and Yes, always talk to me with respect".

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the service. People's rights and choices about end of life care were respected and this delivered compassionately.

People, their families and the Community Nursing Teams were heavily involved in the planning of end of life care. This ensured that people were supported to stay as pain free as possible and remained comfortable.

Information about people was kept securely in the office and in locked cabinets with access restricted to senior staff. When staff completed paperwork they kept this confidential.

Good

Is the service responsive?

Our findings

Staff told us that people received care or treatment when they needed it. People felt confident to make a complaint if they needed to. People told us they would speak to the manager. Relatives said, "They are always happy to see you and greet you with a smile", and "Yes, they always say hello, how are you. If I have any questions I can go to the office".

At the previous inspection on 8 and 10 June 2016, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was in relation to the provider failing to adequately implement healthcare professional's guidance in response to peoples' changing needs. The provider sent us an action plan telling us what steps they would be taking to remedy the breach in Regulations we had identified. At this inspection we checked they had implemented the changes.

There was evidence that people's needs were assessed prior to admission and continually throughout their stay at the service. The registered manager undertook thorough assessments of people's needs before accepting them and a structured introduction took place. Each person had an initial referral which included a full case history, as well as a pre-admission assessment. The assessment covered all medical history, any challenging behaviour, and care needed to manage and safely support the person's needs. The assessment was used to determine whether or not the service could meet the person's needs, and if any specialised tools would be required. For example, if a hoist or moving equipment was required. This meant that people's needs were assessed in detail to ensure their needs could be met at the home.

Each person's detailed assessment, which highlighted their needs, could be seen to have led to a range of care plans being developed. We found from our discussions with staff and individuals that the care plans enabled staff to meet their needs in both the residential and respite units. People signed consent forms for the provision of support, as well as how the support was to be delivered and recorded, which showed their involvement.

Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. However, for one person whose needs had changed this was not clearly shown in the records. On the second day of the visit this issue had been addressed. The registered manager told us that the person centred care plans were continuing to be improved. We saw evidence of this in the care plans we looked at.

People had regular one to one sessions with their key worker in both the residential and respite units to discuss their care and how the person feels about the home. A keyworker is someone who co-ordinates all aspects of a person's care at the home. These sessions were documented in the person's support plan and agreed by them. Therefore, people were given appropriate information about their support at the home, and were given an opportunity to discuss and make changes to their support plans.

The provider contacted other services that might be able to support them with meeting people's mental and physical health needs. This included the local authority's community learning disabilities team and the

mental health team. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. We spoke with the doctor that visited during the inspection and she commented positively about the service and felt there was good communication between the staff and the doctor's surgery. This showed that each person had a professional's input into their care on a regular basis.

There was a recommendation made in the last report that the registered manager seeks guidance from a reputable source about dementia care practice in care homes. The registered manager told us that they were able to access the Medway Dementia Support Team if advice and support were needed

People in the residential unit were able to express their individuality. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items to which they could relate based on their choice.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the service. Relatives comments included, "My Mother has been looked after very well"; "All in all the staff have been fantastic with the care they have given to my Aunt"; "A 1st class service"; "All is well with the care home and carers", and "Could not ask for a better place. My husband is very happy here. The staff are always happy, cheerful and willing to do whatever is asked of them".

There was also available a compliments log that people could write in, and recent comments seen included, "This is a happy place, very welcoming and comfortable"; "Staff on scene very efficient and caring"; "Supportive and helpful staff"; Made to feel welcome, given all information required. Professional team"; "How nice the staff are here", and "How friendly the staff are when visitors arrive".

Organised activities took place daily, delivered by staff, or volunteers or there were activities provided by external entertainers and specialist activities providers. Staff were allocated to activities planning and roles. A weekly activity programme was on display that included board games, movie afternoon, reminiscence time, memory box activities, arts and crafts. The company also purchased monthly CD's from a specialist activity provider. The CD's provided talks about different subjects of interest that could then be discussed. External providers visited the service and provided for example, Tai Chi sessions, music for health, and informative talks. There were group activities and one to one sessions for people who preferred or who remained in their room. We noted that people cared for in bed were offered activities in their rooms. There was a weekly activities timetable displayed on the notice board and people confirmed that activities were promoted regularly based on individual's wishes.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. People said, "Yes, they do listen to me. If I have concerns and they are too busy I stop the manager as she

goes by. She always has time to talk. I do not really have any worries"; "Whoever is there at the time. They are nice people and they want to talk to you, and "I would talk to the manager if I needed to. I have not had any problems. Relatives said, "I would discuss it with the management"; "The manageress. I have spoken to her a few times, I think she would do whatever she can to help"; "Staff will come back to you. They remember if you ask if you can have a chat, or the manager has an 'open door' policy. We were told that when we started here and she does. We asked to see her about something and got time with her straight away. The residents seem to know they can chat with anyone if they have a worry", and "I would talk with the staff first and then the manager. She is quite new and very 'on it'. They listen to residents. I have seen them come back to them when it is not so busy and remind them they wanted to talk".

Good

Is the service well-led?

Our findings

People and relatives gave us positive comments about the service. People said, "They talk to you and make sure they understand what you are trying to tell them", and "We have a chat about things". Relatives said, "We have meetings and talk about the food and what we do and any changes we would like. They then try to make those changes, but sometimes it does not happen", and "They do keep an eye on you and it is always very clean and tidy".

Our observation indicated that people knew who the registered manager was, they felt confident and comfortable to approach her and we observed people chatting with the registered manager in a relaxed and comfortable manner.

The service had a clear management structure in place led by an effective registered manager who understood the aims of the service. The management team included two deputy managers and senior care staff and encouraged a culture of openness and transparency as stated in their statement of purpose. The organisations philosophy included 'Person centred care, highly trained staff, social life and leisure, a pleasant environment and food - we understand the importance of a balanced, nutritional diet, but also making mealtimes a sociable and enjoyable occasion'. We found that staff understood and adhered to these values. Staff told us that the management team was very approachable. A member of staff said that she enjoyed her role and the registered manager was supportive, she could always ask her for advice. Staff were confident that any issues they raised would be dealt with promptly.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to. Staff told us the morale was good and that they were kept informed about matters that affected the service. They told us that team meetings took place regularly and that they were encouraged to share their views. They found that suggestions were warmly welcomed and used, to assist them constantly review and improve the service.

Communication within the service was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the service. Staff told us there was good communication between staff and the management team.

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the service. The registered manager told us they were well supported by the operations manager who provided all the resources necessary to ensure the effective operation of the service. The operations manager visited the service every month to support both managers.

We found that the provider had systems in place for monitoring the service, which the registered manager fully implemented. They completed monthly audits of all aspects of the service, such as medicine, care plans, nutrition and learning and development for staff. They used these audits to review the service. Audits

routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.