Kent County Council

Gravesham Place Integrated Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 July 2016 and was unannounced. Gravesham Place Integrated Care Centre is run by Kent County Council, and is split in four distinct units in one building owned by the NHS. They provide short term respite and an assessment and enablement service for a period of three weeks to six weeks, before discharging people to the community with a domiciliary care package to suit their needs. 'Diamond' Unit accommodates people living with mild effects of dementia; 'Topaz' Unit, and 'Opal' Unit accommodate older people; 'Emerald' Unit accommodates people with low nursing needs. Each unit accommodates up to 20 people. There were 60 people living in Gravesham Place Integrated Care Centre on the days of our 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 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. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were 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.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect. People were able to spend private time in quiet areas when they chose to.

Staff were well supported in their role; they received all essential training and regular one to one supervision sessions.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them.

People's mental capacity was assessed when necessary about particular decisions. When necessary,

meetings were held to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

The meals that were provided were in sufficient quantity and met people's dietary needs and choices. People were complimentary about the food they received.

People's individual assessments and care plans were reviewed at several stages during their stay in the service or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff focused on enabling people and promoted their independence before they returned to their homes.

People were involved in the planning of activities that responded to their individual needs. People and relatives' feedback was actively sought at meetings and through satisfaction surveys. Action was taken as a result to improve their experience of the service.

Staff told us they felt valued by the new registered manager and they had confidence in her leadership. The registered manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service.

There was a thorough system of monitoring checks and audits to identify any improvements that needed to be made. The management team acted on the results of these checks 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. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to make decisions and were asked to consent to their care and treatment. Where they were unable to make their own decisions the principles of the Mental capacity Act 2005 were followed to protect their rights.

The registered manager had submitted appropriate applications in regard to the Deprivation of Liberty Safeguards and had considered the least restrictive options.

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 and treated them with kindness, compassion and respect.

Staff focused on enabling people; they promoted people's independence and encouraged them to gain or regain skills before they returned home.

People's privacy and dignity was respected by staff.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People or their legal representatives were invited to be involved with care planning at the beginning and at the end of their stay, and with reviews in between. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments. There was a daily activities programme that was inclusive, flexible and suitable for people who lived with dementia.

People's views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted an open and positive culture which focussed on empowering people. Emphasis was placed by the management team on continuous improvement of the service.

Staff had confidence in the registered manager's style of leadership.

The registered manager sought feedback from people, their representatives and staff about the overall quality of the service. They welcomed suggestions for improvement and acted on these.

Gravesham Place Integrated Care Centre

Detailed findings

Background to this inspection

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

This inspection was carried out on 13 and 14 July 2016 and was unannounced. The inspection team consisted of four inspectors and an expert by experience. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people and those who live with dementia.

The provider had completed a Provider Information Return (PIR) prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered the PIR 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 looked at 12 sets of records across the four units which included those related to people's care and medicines. 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 reviewed documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 12 people who lived in the service and four of their relatives to gather their feedback. People were able to converse with us.

We spoke with the registered manager, three team leaders, two nurses, four care workers, and a facilities manager. We also spoke with two local authority case managers, who referred people to the service and

who had monitored their progress. We obtained feedback about their experience of the service.

At our last inspection on 30 August 2013 no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "I do feel safe; I have felt more confident here than in hospital", "Everybody seems friendly, no problems here" and, "I feel safe, there is no nastiness here."

There was a sufficient number of staff to meet people's needs in a safe way. There were 120 staff employed in the service including 5 nurses. The staff included care workers, a 'pathway team leader' and 'pathway coordinators' (who supported staff in more complex cases), an occupational therapy pathway coordinator who supported two occupational therapists, and one physiotherapist. The registered manager oversaw all care and nursing staff. Sixteen team leaders managed the day-to-day running of each of the units and were overseen by the senior team leader. The team leaders deployed staff across the four units. Staffing rotas indicated sufficient numbers of care and nursing staff were deployed during the day, at nigh time and at weekends. A nurse told us, "Compared to other environments where I have worked, staffing levels are excellent here." People told us, "There are plenty of staff around at all times, this is reassuring so I know there is help always available."

The registered manager reviewed staffing levels regularly using a dependency tool that took account of people's specific needs including mobility, continence and mental state. Additional staff had been deployed when necessary, such when people had needed help to eat; one to one support when they displayed behaviours that challenged, and constant attendance when they were unwell. The registered manager had deployed two additional night staff on each unit and two senior care workers to meet people's needs. People's requests for help were responded to without delay.

Staff who worked in the service knew how to recognise signs of abuse and understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. All care and nursing staff had received training in the safeguarding of vulnerable adults. There was a detailed safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. Staff were made aware of the whistleblowing procedure during their induction and staff we spoke with expressed confidence that concerns would be raised.

The premises were safe for people because the equipment that was used by staff to help people bathe and move around, the lift, fittings and all fire protection apparatus were regularly checked and serviced. All aspects of housekeeping, maintenance and repairs were addressed by a facilities management company contracted by the provider. There was an effective system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. The registered manager attended regular meetings with the facilities manager and the National Health Trust (NHS) who owned the building, and kept copies of the checks that were carried out. Services and safety checks were appropriately documented, scheduled, up to date and monitored effectively until completion. For breakages and failures arising in the service, a prioritising system for any urgent matters affecting patient welfare, such as a faulty call bell or lift, ensured these were addressed within 4 hours. All staff had access to a 24 hour facilities helpline.

Systems were in place to ensure the service was secure and people were safe. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they needed or wished to leave the premises. The facilities manager showed us the programme of fire lectures for all staff that was scheduled through the year. There was a recent fire risk assessment that had been carried out by the NHS. As a result, some fire doors were being upgraded. There were weekly fire safety checks on each unit, which showed referrals had been made to the facilities management company when any shortfalls had been identified. Staff had received appropriate training in fire safety and were familiar with the steps to be taken in case of a fire. There was appropriate signage about fire exits and fire protection equipment throughout the service. Detailed plans were in place concerning how the service would manage an emergency. This included information about alternative locations to use in case of an evacuation. People had individual personal emergency evacuation plans in their files and also placed in a fire register which was easily accessible to emergency services. These were updated appropriately and detailed the level of assistance people would require if it was necessary to evacuate the service.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Appropriate logs were completed by any staff, counter signed by team leaders who determined the course of action to follow. The registered manager audited these logs to identify possible trends or patterns. Action was taken to minimise risks of falls, such as the provision of staff visual checks, bed rails and medicines reviews. As a result of such audits, a person was provided with a bed that could be lowered; several people were provided with 'crash mats' that enabled them sliding onto the floor rather than falling. A person's routine had been altered with their consent to increase a frequency of toileting, hence reducing their need to get up at night and possibly fall.

Risk assessments were centred on the needs of the individual and were reviewed on the third, fourth or fifth week of their stay, or sooner when people needs changed. Staff were aware of the risks that related to each person. Each risk assessment included clear measures instructing staff about how to keep people as safe as possible, taking into account people's individual circumstances and preferences. Staff applied these measures in practice, for example following specific instruction for repositioning a person in bed when their skin may be at risk, for keeping a person who smoked tobacco safe, or for people who had a cardiac condition, epilepsy, Parkinson's disease or a history of strokes. One person had a nutrition risk assessment as they were depressed and staff had anticipated that their appetite may reduce as a result. Staff helped people move around safely and checked that people had the equipment and aids they needed within easy reach.

All aspects of people's medicines were managed safely and people had their medicines at the time they were due to be taken. Systems for ordering, stock control and returns of medicines were orderly and easy to follow. There was an effective system to ensure stocks did not run out. People who came for respite were required to bring in adequate supplies of medicines. The nurses and team leaders who administered people's medicines completed the medicines administration records (MARs) appropriately including nutritional supplements and medicines to be taken 'as required', such as pain relievers. MAR folders included hospital discharge reports so staff would be informed of any updates regarding people's medicines reviews. Staff also completed separate administration charts for topical creams. Although systems were mirrored between all units, in one unit body maps were not completed for the application of topical creams. We discussed this with the registered manager and this was remedied immediately. The medicines policy was clear and followed by staff. All nurses and team leaders administering medicines had undergone competency checks.

All medicines were stored safely. Medicines trolleys and clinical rooms were locked securely when not in use. Medicines requiring refrigeration were stored in a dedicated fridge. The temperature of the fridge and the

room in which it was located was monitored daily to ensure the safety of medicines they contained. Monthly audits of medicines were carried out to ensure the safe and effective management of medicines which include a drug error audit. When errors had been identified, measures had been put in place to prevent recurrence. Monthly audits of medicines were carried out by nurses and team leaders and reported to the registered manager. There were additional external audits conducted by the provider's medicines supplier. As a result of a recent audit, the medicines policy and procedures were kept in each of the medicines rooms and people's photographs in their medicines records had been dated.

The home was clean, tidy, well presented and pleasant smelling. People were complimentary about the domestic staff. People told us, "The place is very clean" and, "They are always cleaning and it is always looking nice." In each area of the home there were sterilising gel available and hand washing facilities. Housekeeping staff were employed by the facilities management company and one housekeeper and one domestic person were posted on each unit. They undertook the cleaning of bedrooms, bathrooms, corridors and maintained the kitchen as well as flushing all water outlets daily. There was an infection control policy in place that provided clear guidance for staff concerning the steps they should take to protect people from the risk of infection. The staff were knowledgeable of the policy, wore appropriate personal protection equipment and followed good hand hygiene practice. Infection control audits were carried out by an infection control lead in each unit that included daily visual checks of each bedroom, a hand hygiene audit and cleaning audits of equipment including wheelchairs. There was external auditing of cleaning standards and a policy for monthly internal infection control audits. The last audit was carried out in June 2016 and had led to the 'decluttering' of identified areas. Cleaning schedules were appropriately documented to monitor the cleanliness of the service.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. 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. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Disciplinary procedures were followed and action was taken appropriately by the registered manager when any staff behaved outside their code of conduct. The service's disciplinary procedure had been followed in relation to concerns about the practice of a particular staff member.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "The staff seem good at their jobs", "The staff are very professional" and, "They can sense if you are OK or not."

Staff received essential training to enable them to carry out their roles effectively. New staff received a thorough induction that incorporated the Care Certificate in their six months' probation period. This certificate was launched 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. Each of the 16 team leaders held a speciality in one of the 15 modules included in the Care Certificate and supported staff with their expertise. Essential training included first aid, infection control, manual handling, safeguarding, mental capacity and enablement specific to the service. There were six dementia champions across the service and two dignity champions in each unit. There was an effective system to record and monitor staff training and highlight when refresher courses were due. All staff were up to date with their essential training and were scheduled for refresher courses.

Additional training that was relevant to people who lived in the service was offered and delivered to staff. This included training in positive communication, enhanced safeguarding, diabetes awareness, end of life skills, stroke, and cancers in older people. All staff including housekeeping staff had attended training on dementia awareness. All staff on one unit had attended 'Ladder to the Moon' workshops, which supports social care organisations developing creative and innovative activities. This training was scheduled to extend to the other units.

Staff were encouraged to gain qualifications and progress their careers through the service. The registered manager told us, "We always aim to recruit candidates who already have a Level 2 diploma in health and social care, although we have put two new recruits who did not have these qualifications through the programme as they had the appropriate skills and experience." Staff were encouraged to progress through their studies and attain higher qualifications; a senior team leader was studying for a level 5 diploma.

Staff received one to one supervision sessions every six to eight weeks at which their training needs were discussed. The service managed the nurses except in their clinical supervision which was provided by a NHS Matron. Each member of staff had an action plan in regard to their professional development. They were scheduled for an annual appraisal of their performance.

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). 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. An appropriate application to restrict a person's freedom had been submitted to the DoLS office for a person who had bed rails after the registered manager had considered the least restrictive options to keep the person safe while in bed. The CQC had been appropriately notified when DoLS applications had been authorised.

Staff were trained in the principles of the MCA and the DoLS and were able to tell us of the main principles of the MCA, however three care workers could not recall the knowledge acquired during their e-learning training. We discussed this with the registered manager who took effective action on the day of our inspection. This action included a new schedule for care staff to attend further face to face training; posters explaining the nature of the DoLS and summarising the five key principles of the MCA being printed and displayed for staff; and the senior staff being instructed to discuss the principles of the MCA and DoLS with staff in their one to one supervision sessions.

Assessments of people's mental capacity were carried out when necessary. When people did not have the mental capacity to make certain decisions, such as agreeing their care planning or in respect to the administration of their medicines, meetings were held with appropriate parties to decide the best way forward in their best interest. People's legal representatives had been invited to attend reviews of people's care plans and had been requested to sign on people's behalf when appropriate. Staff sought consent from people before they helped them move around, before they helped them with personal care, when they invited them to take part in activities and when they were helped with their meals.

There was an effective system of communication between staff to ensure continuity of care. Staff handed over information about people's care to the staff on the next shift three times a day. Information about new admissions, achievements of particular goals, referrals to healthcare professionals, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. Follow up action was taken from one staff shift to another to provide effective continuity of care.

People told us they were very satisfied with the standards of meals. They told us, "The food's brilliant; portions are certainly big enough, hot enough and look good" and, "The food is good; if I didn't like the menu they would try and give me something else." The meals were provided by the facilities management company commissioned by the provider. All the residents and relatives we spoke with told us meals were good and reported that requested alternatives were catered for. A person who was vegetarian told us they were always served appropriate food. Menu of the day was posted on notice board and people made their choice in the morning, assisted by staff. Staff described dishes to people and showed them plated meals to check this is what they wanted. The meals looked appetising and were served hot. People were supported by staff with eating and drinking when they needed encouragement. A person who needed soft diet was assisted by staff to ensure they ate safely. In one nursing unit, different coloured plates were used to stimulate interest for people living with dementia.

People were weighed upon admission, on discharge, and in between. Fluctuations of weight were noted and food and fluid intake was appropriately recorded when necessary and examined twice a day by the nurses and team leaders. People were referred to the GP or a speech and language therapist (SALT) when necessary without delay, and their recommendations were followed in practice, such as helping them sit in a particular position when eating.

People's wellbeing was promoted by regular support from healthcare professionals. As the service was adjacent to the local NHS Community Hospital, a wide range of healthcare professionals were available to assist. These included dieticians, a SALT team, GPs, consultants, occupational therapists and physiotherapists, a hearing clinic, diabetic screening clinic, a dentist, and a minor injuries unit. The

registered manager told us how they had built a good rapport with the hospital and was able to gain their support when necessary. For example, when a person had a fall, they had been able to have an X-ray in the same building and promptly with a minimum of disruption. A person told us, "The response to getting a specialist to see my legs was excellent; I asked yesterday and someone is coming to see me today." A NHS 'Hospital at home' team supported people in the three units that did not provide nursing care, when they came from hospital. When people were discharged from the service after three weeks or longer depending on their circumstances, a domiciliary care agency owned by the provider came to assess their needs and take over their care in the community. This model of care responded effectively to people's changes of needs.

The accommodation was suitable to meet people's needs. It was spacious, comfortable and welcoming. There was ample provision of quiet spaces such where people and their visitors could sit and relax. Out of eight lounges, four were kept as quiet rooms without television or radio. All areas were wheelchairs accessible and seating furniture was welcoming and comfortable. Each unit had two bathrooms, a lounge / dining room, an activities room, a medical room, 20 spacious bedrooms with en-suite facilities, a sluice room, a kitchen and three toilet facilities. The corridors were wide and equipped with a banister rail to help people move around. The communal lounges were wide open and decorated in bright colours. There was an enclosed garden area with comfortable garden furniture for people to relax in.

We noted a lack of signage to help people be oriented within the service, other than fire exits, especially as they were staying for a few weeks only and may not have time to familiarise themselves fully with their surroundings. The registered manager showed us a project that was led by three members of staff who were looking at how to improve the environment and signage in the service. As a result, a notice board displaying staff photos with their names and role and a pictorial menu were in progress; bedrooms doors had been ordered in different colours that looked like front doors displaying people's names with their consent; a safe kitchen had been ordered for people living with dementia to use safely. A programme to replace floor coverings and upgrade televisions and music provision in all the units was scheduled to take place. There was a five year plan to change the environment that included the re-decoration of each corridor in different colours, a new internal shop and a garden shed. In the meantime, people and relatives were able to place a photograph or any other keepsake on bedroom doors to help people find their rooms.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "Staff do have time to pop in for a chat", "The staff are nice people, no trouble at all", "Nothing is too much trouble for them", "The staff are wonderful" and, "There is a caring atmosphere here." A relative told us that staff were "lovely" towards their loved one.

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. The staff approach was kind and compassionate. When a person did not wish to participate in a group activity, a member of staff stayed with them and engaged in a conversation that kept the person occupied and interested. Some members of staff were spontaneously singing with people and we frequently heard people laughing with staff. The atmosphere was relaxed and staff were not rushed when they helped people. Staff were vigilant about people's changes of needs and sensitive to their moods, checking on people's wellbeing while respecting their space and privacy.

People were assisted discreetly with their personal care and bathing needs in a way that respected their dignity. Staff told us people could have a bath or a shower "as often as they want" and that staff were "very discreet, very respectful, they leave me to it but are there as soon as I call to help me get out and get dry and covered." Two people told us, "I get a bath every week and I enjoy it, they don't hurry me" and, "I can get a bath every day if I ask, no problem."

Staff knew how to communicate with each person. Staff were lowering their position so people who were seated could see them at eye level. They used people's correct and preferred names, and spoke clearly. They showed interest in people's response and interacted positively with them. When people had hearing or sight impairment, their communication care plans indicated how best to talk with them and be understood. Staff followed these instructions in practice. During group activities, staff made sure these were inclusive as they enunciated carefully for people to make sure they heard and understood.

Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. The importance of maintaining confidentiality was raised and discussed at each staff supervision. All staff had received training in data protection and information governance. People were given the choice of having their doors open or closed; People's records were kept securely to maintain confidentiality. When appropriate, independent mental health advocates (IMCAs) had been enlisted to help represent people's views at best interest meetings, for example when a person had needed their voice and wishes to be heard more clearly by their family, about returning to their home.

Staff encouraged people to do as much as possible for themselves as enablement was the primary aim of the service. A member of staff told us, "We encourage, step back, give the power back to them and it is wonderful to see what they can achieve." People stayed in the service only a few weeks while their progress in their recovery and needs were assessed. This was followed by a return to their own homes with an

appropriate care package to support them remain as independent as possible in the community. A person was recovering from a fracture and received physiotherapy treatment. Their home had been assessed by an occupational therapist to ensure the environment was safe. They told us, "I have been here for three weeks and I am going home next week, I can't wait, it has been wonderful to be able to get better here and I will also get a care worker coming to me every day so I feel more confident than I have been for a long time." People followed their preferred routine, for example some people chose to have a late breakfast, remain in their bedrooms, or stay in bed. Staff presented options to people so they could make informed decisions, such as what they liked to eat or to do, to promote their independence.

The service paid attention to the promotion of equality and diversity, and to their emotional and spiritual needs. A person of Sikhish faith had wished to listen to an audio tape of prayers throughout the day and staff had respected their wishes. A survey on spiritual needs had been carried out in March 2016 as a local vicar had offered to come in and meet any spiritual needs that people may have. The survey covered a range of needs such as communion, group services, one to one sessions and any palliative needs. As a result, fortnightly group religious services had been scheduled. People's families and visitors were welcomed at any time. A person told us, "My daughter visits when she can and she is made to feel very welcome."

Clear information about the service and its facilities was provided to people and their relatives. There was a booklet titled "Gravesham Place Service Information" that detailed the service's model of care and statement of purpose, individual information booklets that welcome people in their unit, and how to make a complaint to the provider. There were large notice boards in lounges that displayed the team leaders, staff and housekeeper on duty and the menu. Another large notice board in the main corridors displayed the hospital radio programme, hairdressers visiting times, the minutes of the last residents meeting and the date of the next one. It also displayed the minutes of the last amenity meeting about forthcoming fundraising occasions and themed events.

People were involved in their day to day care as their needs and wishes were assessed before and upon admission to the service. A member of staff told us, "All our care plans are 'client' led', this means they lead the way, we set the goals with them." They were consulted at each review of their care plans to appraise how they viewed their progress. Social workers sat with people and talked with them about their options available and explained how care packages would operate when they returned home.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their needs. They told us, "The staff have carried out an assessment with me", "I do feel involved in my care" and, "The staff do know me well, what I like and what I don't like."

People's needs had been assessed before they moved into the service to check whether the service could accommodate these needs. These assessments gave a clear account of people's needs in relation to their medicines, communication, breathing, nutrition, continence, skin integrity, sleeping pattern and mobility. They were person centred and noted people's hobbies and interests, the goals they wanted to achieve and special requirements. A local authority case manager who had referred a person to the service told us, "This is a perfect place for people to recuperate and get back on their feet, the care is very person-centred and the staff know how to encourage people to achieve their goals and improve their chance of success when they return home."

Information about people's needs and any particular risks was included in an initial care plan that was completed within 24 hours when people moved into the service. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. Staff knew how to respond to individual needs such as a person's episodes of chest pain or shortness of breath. Another person with a raised blood pressure had a particular protocol of measures in their care plan should they experience headache or noise bleed, and staff were aware of the steps to follow. All people who lived in the service had been risk assessed in respect of accessing terraces and balconies.

People's care plans reflected their current needs as these were regularly reviewed over the course of their stay. People's progress and discharge plans were discussed at weekly multi-disciplinary meetings attended by the registered manager, local authority case managers (social workers), physiotherapist as well as 'care navigators' and care workers from the affiliated domiciliary care agency. When warranted, other professionals such as a doctor, a community nurse, a speech and language therapist and a community physiotherapist were also invited to attend. People or their legal representatives were involved in their care planning and in the discussions about the next stage of their recovery. A relative told us, "We do feel involved with mum's care plan" and, "There is a social worker who keeps us updated, and, "We are waiting for a permanent placement and we are part of the process."

People's likes, dislikes and preferences were taken into account. Staff enquired with people what they liked, disliked, and recorded a summary of their life history. There were records of people's happy memories, where they had gone during past vacations, and of preferences about all aspects of their routine, activities and food. These were taken into account, for example a person had fish served to them instead of meat; another person told the staff they used to sew and knit although they had not done so for many years. Staff had provided them with a knitting kit and sat with them while they recollected their skills. One person supported a particular football club and staff had selected a song that related to their football club and encouraged the person to lead a sing along. We asked members of staff to tell us about people's preferences

and they were aware of these.

People could be confident that staff paid attention to their individuality and to any special requirements they may have. We were told of several instances where staff went beyond the scope of their duties to meet people' individual wishes. A person had stayed in the service because their health had declined and they approached the end of their life; the registered manager had provided recliner chairs to enable their family to remain with them at all times. When a person who remained in bed wished to join an activity performance on a different floor, staff had transported their bed out of the building and back in again to access the event. A special meal had been organised for a person who was a national from a foreign country and their family. Domestic pet foxes had been brought in on a lead to visit a person who missed them.

Staff placed emphasis on the promotion of good health. The purpose of the service aimed to enable people to gain or regain their maximum independence after illness or injury; to offer planned and urgent respite care for individuals and their carers; and to facilitate hospital discharge where people's home required adaptations or equipment, or when a long term placement was delayed due to a waiting list. During these transitional periods, staff focused on stabilising or improving people's physical and mental health. One person told us, "When I came here I was so down and thought I was 'done for' and would have to go to a nursing home, but they got me back on my feet and soon I will go back to my own home with some of their help and be 'me' again, it is so wonderful."

A range of daily activities that were suitable for older people and people who lived with dementia was available. Staff provided these activities daily and we observed these being provided. Themed days were planned three months in advance and included celebrations and buffets or special meals on David's day, Mother's day, St Patrick's day and bank holidays. Activities were flexible as staff presented options to people each day and any planned activity could be abandoned and replaced with any activities of people's choosing. People played board games, puzzles, took part in quizzes and sing along with staff. Art and crafts, games of skittle, and light exercises that took account of physiotherapists' advice were encouraged. We observed an exercise group led by a care worker where eight people were fully engaged. The care worker had taken guidance of the physiotherapist and ensured people had fun while they were participating. 'Portable pets' were scheduled to visit the service. There was a 'reminiscence shop' fully decorated with a mural and artefacts dating from the 40s era where people could 'step back in time'.

People and relatives we spoke with were aware of how to make a complaint. Detailed information on how to complain was provided for people upon admission and displayed in the units and in the reception area. One relative said, "I have never had cause to complain but would know what to do if I had to."

Good

Is the service well-led?

Our findings

Sixteen team leaders oversaw the day-to day running of each units in shifts. They acted as assistant managers across the four units if the registered manager was absent. People were aware of who they were in their unit and of the team leader who oversaw them. They were complimentary about the management team. They told us, "They are a listening management" and, "I get on well with the unit lead; she is very organised, she's brilliant." A relative told us, "The main manager is very nice and understanding, she seems to run a tight ship and all the staff are very organised." A local authority case manager told us, "I am always happy to see that people had been admitted to Gravesham Place; this is a very good place, well run and genuinely caring."

The registered manager placed emphasis on the continuous improvement of the service. They told us of the positive changes they had made to bring the four units operating together in a cohesive way since they had been in post. A wide range of audits and checks were carried out to monitor the quality of the service and drive improvements. The registered manager carried out daily spot checks to observe staff practice and check people's dependency levels at any time of day and night including weekends. Each week they also carried out visual checks of cleanliness in each unit and looked at documentation relevant to repairs, care plans, activities, infection control and medicines to check all was appropriately completed. These weekly checks were analysed to identify how the service could improve. They fed back their findings to staff in each unit and when any shortfalls were identified, they pointed out to them any remedial action that needed to be completed.

Staff were clearly aware of their responsibilities and were entrusted to carry out a range of audits. The registered manager checked all audits and monitored that any remedial action was carried out until completion. They reported their findings and actions to a head of services. To complement the quality assurance system, a registered manager and senior team leader from a sister home visited Gravesham Place unannounced to inspect all aspects of the Health and Social care Act 2008 Regulations 2014, and check how safe, effective, caring, responsive and well-led the service was. This was followed by an action plan that was monitored until completion. As a result of an inspection in January 2016, the registered manager had researched alternative formats of care plan documentation to meet the needs of the service and this was being gradually rolled out to the units. At the last inspection in April 2016, a suggestion for enhanced personalisation of people's risk assessments had been followed up. The visiting inspectors had stated being "impressed with the décor on two of the units and "came away with some ideas that would be beneficial for their own service."

The registered manager promoted a culture in the service that was person-centred. They told us about their philosophy of care, "Everyone who comes through our doors has the potential to move forward and go home; we strive to improve their quality of life and resume their independence through enablement and empowerment." The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service.

Staff were positive about the support they received from the registered manager. They reported that they could approach the registered manager with concerns and that they were confident that they would be supported. They described them as, "really organised, very capable, assertive and fair." They all said the manager was "approachable" and operated an open door policy.

Staff were consulted and involved with how the service was run. There was a multitude of staff meetings being held to include every department and gather their feedback about all aspects of the service. For example, weekly multi-disciplinary meetings; nine yearly meetings for senior staff that preceded further staff meetings (for day and night staff); quarterly meetings for administration staff; seven yearly meetings with health and safety union representatives; regular infection control meetings and manual handling meetings. All these meetings were appropriately recorded and the actions that were identified to implement improvements were allocated for completion. At the last senior staff meeting, the need for staff to ensure they completed their training refresher courses had been highlighted by the registered manager. At the last health and safety meeting, the need for emptying a bathroom of stored equipment had been highlighted and hospital porters had been contacted to remove electrical items.

People and their relatives had an opportunity to give their feedback about the quality of the service. They were invited to attend regular residents meetings in each unit and provide feedback on menus, activities, staff attitude and any other topic of their choosing. At the last meeting held in May 2016 in one unit, several people expressed dissatisfaction about too many noisy visitors being in the lounge area at times when they tried to relax. This issue had then been discussed at senior staff meetings and cascaded down to all staff involved, to establish how this could be remedied. As a result, posters had been displayed for visitors' attention requesting they came away from the lounges and went to the quiet rooms or people's bedrooms instead.

In addition to residents meetings, quarterly satisfaction surveys were carried out through questionnaires that were sent to people leaving or having left the service. These surveys aimed to collect feedback about the service provided and asked 'what we could do better'. People's comments were very positive and a relative's feedback included, "[X] was very happy while he was in your care and would happily come again; he said the food was wonderful as was the care, most impressed with the unit and it is a credit to all of the staff." People's responses were audited by the registered manager and action was taken as a result. For example, to improve the information people received from the community hospital staff, the registered manager did a presentation to make sure they understood the service criterion for admissions and informed correctly people before referring them to Gravesham Place.

People's complaints were taken into account to improve the service. An audit of complaints had shown that people were not clearly informed about their care package in the community being possibly subject to a charge. As a result an informative letter had been produced for hospital staff and case managers to hand over to people.

Links with the community were actively promoted. There was a coffee shop open to the public and regular coffee mornings held in the reminiscence café. An 'After Breast Cancer' support group, a mental health charity and community occupational therapist assessors used their day centre area without charge for regular meetings with the public. Police held surgeries for the public on the premises. As members of the public visited the premises, connections with the community were established. A fundraising programme was implemented to complement the funds that were made available by the provider, for purchasing 'extras' that had been requested by people and staff, such as portable computer appliances, bedroom safes, juke boxes, musical instruments, activity games, garden plants, and additional lighting. This involved staff active participation as well as the community. For example, a 'Bright Week' and a 'Wild West Week' had been

scheduled where staff could wear brightly clothing and costumes; coffee mornings, raffles and tombolas were organised. These events were discussed at amenity meetings and posters were advertised in the community to invite people in.

The service's policies and operating procedures were appropriate for the type of service and had been clearly summarised by the registered manager, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were very well organised and clear to follow. They were kept securely and confidentially. They were archived and disposed as per legal requirements.