The Regard Partnership Limited

Rochester House

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 12 June 2018 and was announced at short notice.

Rochester House is care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Rochester House provides accommodation and or personal care for up to ten people with a learning disability, physical and sensory needs, including autistic spectrum disorder. The accommodation is provided in a house with access to garden areas. At the time of our inspection ten people were living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection on 05 March 2016, we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

There was a registered manager in post. 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.

People continued to receive safe care; risks associated with people's care and support were managed safely. People's care needs were fully assessed and people were involved in the planning of their care and making choices about their lives and routines.

The provider's policies, training and work practices of staff continued to keep people safe from abuse or harm.

People received their medicines when needed and there were suitable arrangements in place in relation to the safe administration, recording and storage of medicines.

There were sufficient numbers of staff, who had been recruited safely, to support people safely. Staff

continued to minimise cross infection risks by following infection control guidance.

People continued to be effectively supported by staff who were trained and supported to meet their specific needs. Staff were supported through supervision and meetings which took place on a regular basis. Staff said they felt supported by the registered manager. Staff worked to the provider's vision and values.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had sufficient amounts to eat and drink and were supported to access other health professionals to manage their day to day health needs.

The accommodation was designed, adapted and decorated to meet people's needs and expectations.

People's needs continued to be met by staff who were kind and respectful. People's privacy and dignity were promoted at all times.

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.

The service was responsive to people's communication needs in a person-centred way.

People's care plans contained information about their personal preferences and focussed on individual needs. People and those closest to them were involved in regular reviews to ensure the support provided continued to meet their needs.

People's feedback was sought and used to improve the care provided.

There was an accessible complaints policy in place and people knew how to make a complaint.

The registered manager and provider regularly assessed and monitored the quality of care to ensure standards were met and maintained. Good practice information was shared by managers meeting and networking with management colleagues. Business development plans were based on improving people's experiences of the service.

The registered manager understood the requirements of their registration with CQC.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Rochester House

Detailed findings

Background to this inspection

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

This inspection took place on 12 June 2018 and was announced at short notice due to people's needs. The inspection visit was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people about what it was like to live at the service. We spoke with a relative. Other people did not engage verbally about their experiences of the service. However, we gathered information about the care received by observing how people responded to staff when care was delivered. We observed people's behaviours and body language and used pictures to communicate. We spoke with five staff members which included the registered manager, the providers locality manager, a senior care worker and two support workers.

We looked at four people's records to see how their care and treatment was planned and delivered. We reviewed four staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records relating to the running of the service including staff training records, quality assurance audits, complaints, accidents and incident records.

We asked the registered manager to send additional information after the inspection visit. The information we requested was sent to CQC in a timely manner.

Good

Is the service safe?

Our findings

People continued to experience safe care and treatment at Rochester House. One person said, "I feel safe." Another person nodded their agreement when asked if they felt safe. We observed people being relaxed in the company of staff. Using pictures, other people pointed to the pictures of smiling faces indicate that they felt safe and happy living at Rochester House.

A relative told us that their loved one was safe and well looked after.

Staff continued to receive training about how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. There was an up to date safeguarding policy in place and the registered manager knew how to investigate and report safeguarding issues correctly. One member of staff said, "We get safeguarding training updates and we discuss potential safeguarding issues at staff shift handover." The registered manager discussed safeguarding at staff and supervision meetings to maintain awareness amongst staff. There had been one recorded safeguarding notification in the last year. This had been appropriately reported and investigated. Incidents and accidents were investigated for cause and effect. Responses to incidents to minimise them happening again included the provision of assistive technology such as door alarms and epilepsy monitoring alarms. Responding appropriately to safeguarding issues and learning from incidents and accidents reduced the risks of potential harm.

The provider's systems continued protecting people from the risk of service failure. The premises continued to be maintained to protect people's safety. Risks management processes still included staff visually checking equipment was safe. For example, fire systems had been serviced to maintain safety. Infection control risks were managed through staff training and cleaning practices. The service was clean and odour free. Maintaining hygiene, water quality and following good infection control practices reduced the risks of cross infection or exposure to waterborne illness. The management team kept records of the premises and equipment checks they made so that these areas could be audited. Fully assessing potential risk and taking action to control them minimised the risk people may be exposed to.

People were still protected from the risk of receiving care from unsuitable staff. All applicants had references, full work histories and had been checked against the Disclosure and Barring Service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with vulnerable people. Staffing levels continued to be planned to provide skilled and consistent care. Based on a dependency tool, staff were deployed in appropriate numbers within the service to keep people safe and meet the assessed needs of the people currently living at the service.

People continued to be protected from the risks associated with the management of medicines. A comprehensive system of ordering, storage, administering and disposing of medicines was in place. This was supported by recorded audits carried out by trained staff. Detailed daily medicines and care records were kept by staff. Many recordings were made throughout the day and night, ensuring communication between staff was good benefitting the care of each person. Keeping accurate records assisted staff to help

people maintain their health and wellbeing.

Good

Is the service effective?

Our findings

People continued to be supported by staff who had the appropriate skills, knowledge, experience and support necessary for them to provide effective care to people using the service. Using pictures, people pointed to the picture indicating that staff helped them choose what they wanted and knew what was important to them.

The registered manager continued undertaking an assessment of people's needs. The assessment checked the care and support for each person so that staff knew how to care for each person appropriately. At the assessment stage people discussed their lifestyle preferences as well as their rights, consent and capacity. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. A member of staff said, "Staff work within (follow) care plans." Staff received training to effectively manage challenging behaviours should they occur. Training based on people's needs gave staff the understanding they needed to meet people's care needs.

The registered manager assessed each person's ability to do things for themselves or the levels of staff care required. They involved people and their family members in the assessment process when this was appropriate. This assisted the registered manager to determine how they would meet people's needs at Rochester House in a person-centred way.

People's health and wellbeing was maintained and reviewed in partnership with external health services. For example, if people had epilepsy staff worked under the direction of an epilepsy nurse. There was a professional communication folder, where the community epilepsy nurses, GP's and other health care professional's notes were recorded. People continued to be supported to have enough to eat and drink and were given choices. Staff were aware of people's individual dietary needs and their likes and dislikes and any risks there may be to people's health such as choking.

The building remained suitable for people's needs and promoted their wellbeing. People had their own bedrooms and access to showers and bathrooms. There was an accessible secure garden.

The service continued working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff training and supervisions continued to be well managed for effective care delivery. Evidence showed that staff training had been completed. New staff continued to receive support to achieve the required performance standards as part of their work probation. The registered manager continued checking how staff were performing through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. One member of staff said, "Supervisions work well for me."

Staff spoke in detail about people's communication needs and told us they adapted to individual

communication methods. For example, one person used their own version of Makaton to communicate. Makaton is designed to support spoken language and uses signs and symbols. We saw staff quickly tried to understand what was being communicated. Staff understood basic Makaton and one member of staff was trained in basic sign language.

Good

Is the service caring?

Our findings

People using the service indicated to us that the staff treated them with care, respect and kindness.

A relative said, "Very good care, excellent, it is their home."

Staff actively engaged with people and interacted with them positively. Staff showed enthusiasm and knew and respected each person's individual needs and interests. For example, one person liked to dance and staff joined in which left the person smiling. People actively sought staff interaction and staff responded well. There was humour and laughing between people and staff. Staff showed interest in what people were doing. For example, by asking questions of people or making encouraging comments. Staff promoted people's interests by bedrooms being personalised, for example with fictional characters.

Staff knew people well and treated them as individuals. Staff used various methods to support people to communicate their needs, for example staff used sign language, and a system which used signs and pictures. People were provided with information in ways that helped them to make decisions about their care, for example in a pictorial format. They were also supported to access advocacy services, which help people by enabling them to explore and voice their opinions. People were supported to have as much choice and control over their lives as possible.

People were encouraged to live an ordinary and least restrictive life as possible. They were encouraged to participate in some household tasks such as cleaning their rooms and people cleared their things away after eating.

People's care records included an assessment of their needs in relation to equality and diversity. The provider's policies were inclusive and the registered manager gave an example of a person being supported by the provider to reassign their gender. Staff understood the importance of maintaining people's privacy and human rights. People chose where they spent their time, such as in their own room or in communal areas and moved freely around the service. Throughout the day, staff demonstrated they respected people's privacy and dignity. They announced their arrival when coming on shift and knocked on people's bedroom doors before entering.

People were supported to maintain important relationships and have visitors whenever they wished. Staff had been able to gain information on these from the 'person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

Staff were aware of confidentiality regarding information sharing. People's confidential information and records were stored appropriately and securely in the office.

Good

Is the service responsive?

Our findings

People continued to receive a service which was responsive to their needs. Each person had detailed care plans that identified how their assessed needs were to be met. Care plans included information on their background, hobbies and interests and likes and dislikes. Using pictures, people pointed to the picture indicating that staff helped them participate in activities they enjoyed. People indicated they liked listening to music, bowling, cinema, watching TV, going to the park, watching DVD's and going to restaurants.

The activities people were involved in were tailored to their choice and lifestyle to encourage participation and reduce social isolation. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff could learn by the behaviours the person demonstrated if they were comfortable with the activity.

The registered manager was aware of the Accessible Information Standard (AIS) and its requirements. AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information. The service was working according to the framework.

Care plans included detailed assessments, and took into account people's physical, mental, emotional and social needs. Some parts of the care plans presented information using pictures so that they were more accessible to the people concerned. Care plans were regularly reviewed and updated if any changes had been identified. A relative told us they were invited to attend review meetings and were kept informed about their family member's changing needs. Relevant health and social care professionals were involved where required. Health professionals' advice was listened to and acted upon by staff. There was a keyworker system in place which enabled people to have a named member of staff they met with on a regularly basis to talk about all aspects of their support, such as activities they had taken part in, their wellbeing and important relationships.

Care plans were sufficiently detailed to guide staff on the nature and level of care and support they needed, and in a way people preferred. This preserved the balance between levels of care needed and people's independence skills.

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care was discussed regularly at shift handovers to ensure they were responding to people's care and support needs. Staff told us this was important to ensure all staff was aware of any changes to people's care needs and to ensure a consistent approach. A handover meeting is where important information is shared between the staff during shift changeovers. People were encouraged to share their wishes at end of life in the care plan section called, 'What I would like to happen when I die.'

The provider had a complaints procedure which was accessible to people, their relatives and others interested in the service. People were encouraged to raise any concerns and complaints in sessions with

their key worker or during meetings. The provider had not received any complaints in the last 12 months.

Good

Is the service well-led?

Our findings

The service continued to be well-led. People indicated to us the registered manager was friendly and approachable. We observed them with people and they were enthusiastic and caring. They wanted to make changes to the service for people's benefit. For example, they had already had the communal areas in the service decorated to promote a feeling of wellbeing. They planned to install a sensory room in response to feedback from people living at the service.

There had been a change in the registered manager since our last inspection. The service continued to be well-led by a committed registered manager and senior management team who had the necessary skills and experience. The registered manager and staff were working with a clear vision for the service which was based on ensuring people felt like the service was their home and promoting choice.

The provider proactively sought people's views and took action to improve their experiences. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service.

Records demonstrated that there were regular staff meetings at the service and hand over meetings between shifts. Staff continued to receive appropriate supervision and told us that the registered manager was supportive and that they were listened to. One member of staff said, "All senior staff are so approachable." Another member of staff said, "I think there is more consistency [With the new registered manager] and a brighter looking future."

Policies and procedures governing the standards of care in the service were kept up to date, taking into account new legislation. For example, Medicines policies followed guidance issued by the National Institute for Health and Care Excellence.

People benefitted from a quality of service that was driven by the provider and staff's commitment to monitor and improve their performance. Systems were in place which continuously assessed risks and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents. A quality oversight system was used, which was independent of the service to provide organisational monitoring of the service against the provider's aims and principals. There was on-going commitment from the management team and the provider to maintain consistently good levels of service for people at all times.

The registered manager continued to work closely with social workers, referral officers, and other health professionals. The registered manager was aware of when notifications had to be sent to the Care Quality Commission (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 happened at the service. We used this information to monitor the service and to check how events had been handled. This demonstrated the registered manager understood their legal obligations.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the service and on their website.