Mr & Mrs T Blundred

The Old Rectory Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 24 and 25 August 2016 and was unannounced. At the previous inspection in September 2015, we found that the provider was not meeting the regulations in respect of staff recruitment, the management of risks and medicines, and ensuring a complete and accurate record of peoples care was maintained. The provider sent us an action plan detailing the actions they were taking to ensure they met the standards and at this inspection we checked that they had implemented and sustained these improvements.

The Old Rectory is a large detached building that has been extended twice since becoming a care home. It is located in a residential area of the small village of Dymchurch, it is close to a public bus service and there is off street parking available for 16 cars, as well as limited street parking. The service provides accommodation and personal care for up to 35 older people and there were 26 people in residence at the time of the inspection. The accommodation is provided over three floors with 32 bedrooms, the majority of bedrooms were for single person use but three can accommodate two people each for couples or for people who wish to share. People have access to two communal lounges, a dining room, a small library cum quiet room and a well maintained accessible garden to the rear of the premises.

This is a family run home and the registered providers have day to day involvement in the running of the service. One of the Providers is also the registered manager and was present on the days of our inspection. 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.

People, relatives and social care and health professionals told us that they were satisfied with the quality and delivery of care provided in the service and no concerns were raised.

Our inspection found that the frequency of formal supervision sessions held by managers to discuss training and development opportunities with individual staff were not being held in accordance with the service' own supervision policy. We have recommended that the provider liaise with the fire service in regard to the content of personal evacuation procedures to ensure these meet the requirements of fire legislation. Medicines were managed appropriately but we have made a recommendation to expand some current practice in regard to the dating of medicines on opening.

Staff knew how to protect people from harm and the action to take in an emergency. Staff had received training in safeguarding adults and knew what action to take if there was any suspicion of abuse. Business continuity plans were in place to respond to events that could stop the service. All servicing and tests of fire alarm and firefighting equipment were routinely conducted. The premises were kept clean and a maintenance plan was in place and a programme of upgrading ongoing. Risks that could impact on people's safety had been assessed and strategies implemented for managing people's behaviour that could

challenge staff and others. Systems were in place for the assessment and monitoring of service quality and the analysis and review of accidents and incidents; these helped to make relevant improvements to the service and the safety of people.

People were provided with the equipment they needed to mobilise or bathe, and grab rails were visible in communal bathrooms and ensuites. All necessary equipment servicing, checks and tests were carried out. The registered manager also carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was in good working order.

At the time of our inspection there were enough staff on duty during the day and night to meet people's individual needs; this was kept under review in response to changing needs. The suitability of prospective staff was checked prior to employment and records showed all appropriate checks and documentation was in place.

People's health needs were assessed and monitored. Health and social care professionals said that staff were proactive in seeking advice and guidance from them and putting this into practice. People were provided with a varied diet that reflected their personal likes and dislikes, and any specific dietary needs.

All new staff received an induction into their role but those without previous experience or vocational qualification in health and social care were expected to complete a nationally recognised qualification: the 'Care Certificate'. All staff were trained in areas necessary to their roles and some additional training in specific areas was provided where necessary to make sure that they had the right knowledge and skills to meet people's needs effectively.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent on a daily basis. DoLS applications had been authorised for three people to ensure that they were not deprived of their liberty unnecessarily.

Staff spoke kindly to people and treated them with respect. People were able to make decisions and choices for themselves about what they did, and where they ate their meals and with whom, people were encouraged where possible to maintain their independence seeking support when needed.

People's care, treatment and support needs were clearly identified in their plans of care and included people's choices and preferences. Staff knew people well and understood their likes and dislikes.

People were offered an appropriate range of activities and were consulted about changes to this at residents meetings. Relatives and friends were made welcome and people were supported to keep in contact with people who were important to them. Relatives and other stakeholders were asked to complete feedback surveys on a regular basis and their responses were analysed, action taken where necessary and a summary of responses and actions taken published within the service.

We have made one recommendation:

We recommend that the provider seeks advice from a relevant person within the fire service to advise whether the current detail within personal evacuation plans is sufficient to meet the requirements of fire legislation.

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 enough staff to support people, and recruitment procedures ensured important checks were made of their suitability. Staff knew how to protect people in the event of emergencies and understood how to recognise and respond to abuse to keep people safe.

Risks to people's safety were minimised and managed well. We have recommended that personal evacuation plans content is discussed with the fire service to ensure this meets fire legislation requirements. People's medicines were well managed.

Important servicing and checks were undertaken and the premises were clean and well maintained to keep people safe.

Is the service effective?

Good

The service was effective

Staff felt supported and listened to. Staff received appropriate induction into their role, and training to help them provide people with the right support.

The registered manager and staff supported people in line with the principles of the Mental Capacity Act, and sought peoples consent when they received support.

People enjoyed the food they received and could make choices around this. People's health and wellbeing was monitored by staff and the advice of health professionals sought when necessary.

Is the service caring?

Good

The atmosphere in the home was welcoming, visiting times were flexible and visitors were made welcome.

People were consulted about their care and provided with opportunities to comment about the service.

People were treated with dignity, respect and kindness.

Is the service responsive?

Good

The service was responsive

People were assessed before they came to live in the service to ensure their needs could be met. People and their relatives were involved in care planning.

A full programme of activities was provided throughout the week including opportunities for outings on occasion; people chose whether they wanted to participate or not and staff respected this.

People were provided with information about how to make a formal complaint but minor concerns and irritations were also addressed so these did not escalate.

People and their relatives were involved in their care planning and changes in care and treatment needs were discussed with them.

Is the service well-led?

Good

The service was well led

People relatives and staff found the Providers and registered manager and deputy approachable, they felt listened to and supported. Staff had opportunities to express their views through staff meetings. People and relatives were asked to comment on service quality and felt listened to.

The providers were visible on a daily basis and undertook close monitoring of the service, a range of audits were undertaken and actions taken to address shortfalls. The providers were innovative in implementing new technology to aid monitoring processes, reduce paperwork for staff and make better use of their time with people.

The service analysed accidents and acted upon themes and trends to reduce occurrences. The Registered manager ensured the Care Quality Commission was kept informed of notifiable events.

The Old Rectory Residential 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 over two days, on 24 & 25 August 2016 and was unannounced. The inspection was conducted by one inspector.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). 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 looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the previous inspection report and details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

Many people we met were able to talk to us and tell us about their experience of living in the service, others were not and we observed them and their interactions with their environment, and staff over a lunch period and again briefly in a communal lounge, using an observation tool called the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

At inspection we spoke with 8 people and one relative. We observed staff interactions throughout the inspection days when they were supporting people with snacks and daily activities, or undertaking personal care. We visited with people's permission a number of bedrooms to assess the quality of furnishing and cleanliness, and we viewed communal areas and bathing facilities. We spoke to the registered providers and registered manager, the deputy manager, three care staff and an agency worker, and the cook.

After the inspection we contacted a further six relatives to ask for their views. We also contacted seven health and social care professionals who have contact with the service.

We looked at four people's care plans and risk assessments, medicine records, three staff recruitment training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Good

Is the service safe?

Our findings

People told us that they felt safe and secure living at The Old Rectory. Relatives said they were more than pleased with the care and support provided. Comments included: "I would recommend this home to anybody". I have sat and watched staff with other people, they are really excellent, they get my thumbs up". "They pay great attention to detail"

Health and care professionals told us they had no concerns about the service, comments included: "They are extremely keen to put things right". "There are a lot of longstanding staff, I don't get the impression there is a high staff turnover". "It's always clean when I go in, staff are available and interact well with people, I have no big concerns".

People told us they felt safe living at the service because there were always staff available to support them and this and the attitudes of staff made them happy.

Contingency plans in the event of other events that might stop the service were in place. Staff participated in regular fire drills and the initials of those attending were recorded to enable the registered manager to assure themselves that care staff in particular were attending regular drills. A fire risk assessment was in place and fire equipment was routinely serviced and tested at regular intervals. A fire evacuation procedure had been developed; individual evacuation information had been provided for each person but we have asked the provider to check that the detail contained within these meets the requirements of fire legislation.

We recommend that the provider seeks advice from a relevant person within the fire service to advise whether the current detail within personal evacuation plans is sufficient to meet the requirements of fire legislation.

We had previously identified that improvements were needed to medicine management. At this inspection we reviewed the systems for medicine ordering, receipt, storage, administration recording and disposal. Staff were trained to administer medicines and their competency was assessed to ensure they maintained good practice. We were satisfied with the arrangements for ordering, receiving/booking in and disposal of medicines. Medicines that required safer storage were kept secure and a separate register used to record their administration, we checked that the amounts of medicines stored securely corresponded with the register. Medicines requiring colder storage were kept in a locked drugs fridge and temperatures for this were recorded daily. The presence of Oxygen in the building was clearly displayed in the event of a fire. Medicine Administration Records (MAR) were completed well with appropriate use of codes, handwritten entries on the MAR were signed for and dated to correspond with the receipt and start of the medicines. Cream charts were completed in people's rooms when they were supported with aspects of their personal care, and if it was stored in their rooms this was kept secure and risks had been assessed.

People we spoke with were happy with the arrangements for managing their medicines. We observed administration of medicines and saw this was undertaken kindly. People were reminded of the need to take their medicines and what it was they were taking, they were provided with a drink and supervised taking

their medicines by the administering staff member, and staff signed records appropriately when medicines had been taken. The medicine cabinet was locked each time the staff member left to administer medicines. Storage was clean tidy with good stock rotation. Medicine expiry dates were checked and unused medicines and any unwanted medicines were returned appropriately to the pharmacy.

Medicine keys were handled securely. The provider undertakes a monthly audit of medicines and this highlighted any areas where improvements were needed, external auditing of medicine management was also undertaken by the dispensing pharmacy. We noted that new bottled medicines, eye drops and creams were dated upon opening but this was not extended to oral tablet medicines in boxes; this is an area for improvement that we have discussed with the provider and registered manager, as this will help in the audit of medicines.

There was enough of the right equipment to help staff support people to mobilise and to bathe safely, all equipment including the passenger lift, stair lifts, hoists, specialist baths, and wheelchairs were serviced regularly. The electrical installation and oil fired boilers were checked and serviced by external contractors annually. The provider had undergone training to enable them to undertake checks of portable electrical appliances used by people and staff in the service. A kitchen hygiene rating of five stars had been awarded to the service.

The premises were well maintained and provided people with a clean, comfortable homely environment to live in, people spoke positively and appreciatively about the environment they lived in and that it was maintained to a high standard, and a development plan was in plan for further upgrades to the premises. Housekeeping staff were visible and worked to regular daily weekly and monthly tasks to ensure all areas of the service were kept clean and fresh, personal protective clothing was in place, and staff knew how to appropriately handle soiled clothing. The providers had also purchased a sanitising carpet cleaning machine to help maintain a good standard of carpet cleanliness and ensure any odours were kept to a minimum. Repairs and upgrading were undertaken in a timely way by a maintenance person employed by the provider.

At the last inspection some of the assessments of risks people may be subject to lacked sufficient detail and guidance to inform staff; sometimes providing staff with contradictory information to that in other documentation held about some people. Since then the providers had reviewed risk information for each person and ensured that people with specific health conditions like epilepsy or diabetes had detailed risk information and guidance in place to inform staff. The service had revised its risk assessments in relation to people at risk of choking to ensure this was individualised. Charts had been placed in the rooms of people that required regular checks or turning, these formed part of the risk reduction measures highlighted within the risk assessment. Environmental risk assessments and health and safety checks were in place for most other areas to ensure people remained safe. These included for example checks on water outlet temperatures, window safety, the safety of wheelchair users, lift safety, topical medicines management, stair safety, the garden and fire doors; regular reviews of these showed that where shortfalls were identified actions were taken to address them.

Staff had received safeguarding training and this had helped them to understand, recognise and respond to abuse and protect people from experiencing harm. Staff said that they were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the registered manager, the provider or to outside agencies where necessary.

People were protected against the risks of receiving support from unsuitable staff, because recruitment checks undertaken ensured staff selected were safe and had suitable qualities and experience to support

people safely. Prospective staff completed application forms and attended for interview. Documentation gathered about each applicant met the requirements of legislation, and helped the provider make safe recruitment decisions.

People, relatives and staff told us that there were always enough staff available to provide people with the support they needed, but this was kept under review; the provider did not use a specific dependency tool currently although this was under development, they did however say that they listened to what staff told them in regard to the support people needed and adjusted staffing accordingly. Staff confirmed that the provider did take action when they raised issues about support levels for some people. When staff were needed to take people to hospital or to doctor appointments additional staff were rostered on for this, this meant there was no impact on other people's support as the number of staff scheduled to work on that shift remained unchanged.

At the time of inspection there were a number of staff absent through personal reasons, the providers used agency staff to fill gaps in shifts but took care to ensure where possible the agency staff were familiar with the service, its procedures and the needs of individual people. Agency staff had been included in training to use the new electronic recording system. Their familiarity with the service and systems was borne out during the visit when we observed an agency staff member dealing calmly with a situation, they demonstrated a knowledge of the person and what they could do for themselves and resolved the matter quickly, they were able to report the incident immediately onto a handset and had been provided a universal agency login for this. The statement of purpose makes clear the staffing levels when the service is full, these were reduced by one staff member when there were less people to support as on the days of inspection, staff appeared unrushed, visible and responsive to call bells.

Good

Is the service effective?

Our findings

Relatives told us they felt informed and involved in decisions about their relatives health and wellbeing. One said "following a change in medication my relative really went through a difficult patch but they were very supportive of her, they are very caring and considerate", another told us that staff had worked with them to ensure their relative still had access to treats he liked but this was now managed with the involvement of staff to ensure these were not all eaten at once. Health and social care professionals commented: "they are always incredibly willing to look at issues and are proactive, and "they are always willing to bring people to the clinic to receive treatment". Professionals universally said that the service staff sought advice and interventions appropriately, their communication was good and their note and records well maintained.

The majority of staff had received an annual appraisal of their overall work performance for the year. Staff received support to understand their roles and responsibilities often through informal discussion and talks with the registered manager or deputy manager, some of these discussions were documented but others were not. The deputy manager maintained a book of discussions held for reference and actions, and file notes were added into staff files in regards to observations of practice or issues addressed. Staff said they found the registered manager and deputy manager approachable and they felt supported and listened to but the registered manager acknowledged the need to formally record these supervisions and this was an area for improvement. The providers and registered manager and deputy were on site most weekdays and accessible by telephone at weekends so there was good management oversight.

All new staff served a probationary period during which their progress was reviewed. On commencing employment they experienced a period of induction when they were supernumerary on the rota, those who were new to care or without a vocational care qualification were registered to complete the nationally recognised induction qualification previously called Skills for Care but now called the 'Care Certificate'. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The providers had ensured that two of the management team had received training to assess the work produced by staff to ensure this met the requirements of the course. The induction period provided new staff with time to orientate themselves to the environment and the household routines, and people's individual care and support needs.

Staff confirmed they had completed their mandatory training that included first aid, fire, safeguarding, moving and handling, infection control, and food hygiene, auxiliary staff had also been included in the training programme. Records showed that the majority of care staff had a vocational qualification at level 2 or 3 and most had received medicines training. Additional specialist training had also been provided to staff to give them an understanding and awareness of other health issues that people living in the service may experience and need support with for example, Diabetes, Epilepsy, catheter care, dementia care, and pressure ulcers, some staff had also completed training in regard to mouth care, dysphagia, Parkinson's, and respiratory care. The providers were in contact with Nurses from the Clinical Commissioning Group CCG and were keen to take up the offer of training offered by them for staff in a range of areas including 'end of life' care.

Staff had received training in the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. People we met had capacity and staff sought consent, from them in a variety of ways that best suited the person's ability to absorb and handle the information presented. Staff understood that when more complex decisions needed to be made that people might need help with relatives and representatives and staff would help make this decision with or for them in their best interest.

People signed consent to care and support on entering the service or this was signed on their behalf by relatives or representatives who had authorisation to act on their behalf. People were not subject to restrictions in their everyday care and support but Deprivations of Liberty Safeguards (DoLS) authorisations had been authorised for three people due to the possibility that they may try to leave the premises and the front door was locked because of this, they were able to go anywhere else in the home they chose to but the DoLS authorisations ensured that staff were able to keep them safe and protected from harm in the least restrictive way.

Strategies were in place for managing behaviour from people that could at times be challenging and a mental health professional commented positively that the providers were aware of the limitations of the service, and were proactive in seeking advice and guidance when needed and putting this into practice.

Staff supported people with their health appointments where relatives were unavailable to take them. People and their relatives felt staff responded quickly to any health concerns and sought appropriate medical attention based on individual needs. Health professionals said that the registered manager and staff were always proactive in alerting them to possible emerging health concerns. Professionals said they had no concerns about the way people's health was monitored by staff who they felt always took on board guidance and advice provided to them and implemented this in their day to day support.

People and relatives commented positively about the meals provided and told us they could have alternatives if they wanted. Relatives said "the food is excellent". People were observed to eat well and were given time to do so at a pace to suit them. Those who needed staff assistance with their meals had a dedicated staff member on their table, we observed they spoke softly and kindly to the people they were encouraging or helping. In one instance a person assisted with their meal showed little interest and their meal went cold, the staff member gave them a little time then had this reheated and sat down again to try and encourage them to eat some more.

Kitchen staff were actively involved in the delivery of meals to the dining room, the cook received direct feedback from people about what they thought about the meal provided. She was aware of any special dietary needs and ensured the menu took account of these. People were assessed upon admission as to whether they were at nutritional risk, in addition to supplements their food was reinforced with creams, milk and butter where possible. The cook attended resident meetings and developed menus from suggestions made at these meetings. The main meal was provided at lunchtimes with a hot or cold light supper in the evening. Jugs of water and juice were provided if people wanted to drink in between tea and coffee breaks. Some people living with dementia found it difficult to sit and eat a whole meal: the cook ensured those people who wanted small snacks from time to time were given something to eat when they wanted it.

People's weights were monitored every month to ensure they maintained a healthy weight, and any significant loss of weight was reported to health professionals for guidance and advice regarding the possible cause or if further investigation was required.

Good

Is the service caring?

Our findings

People told us that staff were kind and they were happy living at the Old Rectory. Comments included "I am happy here, the girls are lovely", another said "I like it here; there is a mix of people staff do things the way I like". Relatives said "She is very happy there we were lucky to get her in, it's brilliant they are so welcoming", another said "They look after him very well, he's always well presented. It's marvellous there he loves it"

A health professional said "my perception is that the way staff approach people is how I would wish to be treated".

Although it was hot weather people were relaxed and comfortable with their routines, they sat where they wished with one person using the garden sitting in the shade reading a book. Hats were available if people wanted to sit out in the sun. Patio doors were opened to allow the breeze in and people who felt cold were offered a cover.

People were observed utilising their time how they wished, moving freely about the home choosing where they wanted to spend their time and with whom and where they wanted to eat their meals. Staff respected people's privacy. People said staff usually responded well to the buzzer when they rang for help but they understood that sometimes when they were busy they might have to wait a little while. The provider was able to interrogate the call bell system to establish how long some people were waiting for buzzers to be answered, staff carried handsets that enabled them to see which buzzer was ringing without first going to the nearest call panel, this saved time. A new computerised system was in the process of implementation that gave every room a barcode and meant that every time a staff member entered a bedroom their handset would register the barcode and show when the room was visited. This was helpful for those people that needed more regular checks and turning and provided assurance to the provider that this was happening.

The providers had embraced new technology not only to help in reducing staff time in completing paperwork but also to provide Wi-Fi access to people throughout the service who wished to use their own IPad, computer or mobile phone. Each person was provided with an information pack in their bedroom. This gave them details about the services provided; it also made clear to them how they could make a complaint if they wished to do so. Through keeping updated with research and studies the provider had implemented a change in the font style for documentation as this made it easier for people to read.

We spent time observing staff interactions with people at lunch and at other times, we noted staff were observant for example: a person with advanced dementia was sitting in a lounge chair and staff provided the person with a twiddle cushion with different textures on it, the person was seen to enjoy touching the cushion and spent long periods engaging with this, we noted another twiddle cushion elsewhere in the lounge and staff said they also had a dementia doll that had been purchased with a specific person in mind. Staff showed themselves to be observant and proactive in the care and support offered, for example a staff member spotted someone's laces were undone, they approached the person explained that their laces were untied and that they were going to do this for them, on other occasions people were offered pillows or drinks.

We noted that staff were discreet in the way they dealt with personal care matters and respected peoples decisions around this, for example one person was asked by a staff member if they would like to go with them, they declined at which point the staff member said "OK I will come back later". Another person experienced a personal care accident; staff responded quickly, calmly and quietly with the situation drawing the person away from the main areas to their own room to avoid embarrassment.

There was a small shop maintained in the home that provided people with opportunities to spend their money on sweets, and toiletries they might want and also to purchase cards and stamps to enable them to keep up with important family birthdays and anniversaries. People's care plans contained information about the important people in their lives and important events they needed to be reminded about.

There was a board in the corridor outside the main lounge that provided people with information to orientate them to the day, date season, weather and year. There were files in the entrance hall about the activities on offer, and what the service offered. All staff working at the service including the providers and auxiliary staff had their photographs in the main hallway with their names so people could recognise staff and their designation, name badges with the same photos were being developed for staff to wear.

We observed that people were in relaxed moods, some sat companionably alongside others, watched the television, read a book or occupied themselves by observing other people participating in an activity facilitated by a staff member

People were happy to share information about how they came to be in the service and their previous lives. They were happy to talk about their experience of care at the Old Rectory and how much they enjoyed living there. They felt safe and comfortable there and that their needs and wishes were met in keeping with their own preferences.

People could be private when they wished and staff respected this and knew peoples routines. People's bedrooms had been personalised to reflect their individual tastes they had been able to bring small possessions and memorabilia that were important to them, some items of furniture if it met fire standards and most people had photographs around their rooms of the people who were and still are important to them.

People told us about the relatives and friends who visited them and relatives told us how welcome they were made to feel when they did visit, and that they were always offered refreshment by staff. Visiting times were flexible with relatives able to visit throughout the day and to take people out, one person went out to watch local football matches with their friend which was something they really enjoyed.

Most people had relatives or representatives who advocated on their behalf, the Provider Information Return (PIR) told us that 18 were subject to a Power Of Attorney authorisation for their finances, one person was under the court of protection, and another had an advanced decision in respect of their future wishes in place. The PIR told us that 20 people had active Do Not Resuscitate (DNAR) authorisations in place and they and their relatives had been consulted about making this decision. At the time of inspection no one was receiving end of life support because usually people moved onto nursing care if their health deteriorated beyond what support staff were currently trained to provide.

Good

Is the service responsive?

Our findings

Relatives told us that they had visited a number of services before choosing this one, they were happy with that decision, and felt their relative was well cared for and they were always kept informed and consulted about their relatives care. They thought there was a good range of activities but some accepted their own relatives were unlikely to use these very often. Relatives said they felt confident of raising a concern if they needed to.

People we spoke with were happy to share information about how they came to live in the service; some were more involved in that decision than others. People had opportunities to visit before moving in but most people spoken with said their relatives had done this for them, but all those we spoke with were happy with the choice made for them.

The registered provider said that they did not often take people directly from hospital but had taken people from 'step down' services, they were selective about who they took, they visited people at other placements or at home and gathered information from them from their relatives and other professionals who may be involved. The registered manager said that she liked people where possible to come into the service for an assessment period, this allowed staff to see how the person responded in a different environment and with lots of other people and staff and gave a better indication of how much support they needed on a day to day basis. Sometimes even with these precautions they found that information provided was not always as robust as the service would like and the management team were good at recognising the limitations of the service to meet some people's needs, if, this became apparent following admission. Professionals confirmed that the service management staff acted quickly to liaise with them and relatives to move the person to a more appropriate setting.

Professionals we spoke with confirmed the breakdown of such placements although rare was often not a fault of the service but as a result of events that could not have been predicted or to the lack of a full and complete picture of needs gathered from people who knew the person well. We viewed pre-admission documentation relating to several people under consideration for a placement, this captured their basic day to day needs and what they could do for themselves and how much support was needed from staff; this informed the decision as to whether these needs could be met within the service.

Whilst the pre-admission assessment gave staff an understanding of what needs and support the person required, the detail of how this was to be delivered was gathered following admission when the person was consulted about their preferences in regard to how they received support. At the previous inspection we raised concerns that some care plan information was absent and other information about the support people received was not sufficiently personalised to reflect individual preferences. Since then the provider and registered manager had taken action to review care plans and improve the level of personalised detail within them so that they better reflected people's personal preferences and this guided staff responses to their needs and wishes. Care plans addressed the individual support people needed around for example maintaining their personal care, medicines, moving and handling, mobility, pressure care, continence, dietary and social needs.

The development of computerised systems within the service meant that care plans were transferring to electronic records and a print out of the electronic copy was kept for staff reference. At this inspection the service was in a between period of transition from a paper based system to an electronic one. The new format will provide staff with a more holistic overview of people's individual needs and instantaneous access to care records through handsets that linked into the records system. The new system, once care records are fully transferred over required staff to take specific actions in response to some of the information they input, for example if someone had not taken in enough fluid this will signal a response is required by staff. The new system allowed for some personalisation of individual support and the registered manager and deputy were still to fully explore this function so when needed even more detail could be added.

Daily reports were now electronic and every time a member of staff interacted with a person this was added into the daily report, a print out of daily reports for specific people showed a much more detailed picture of the interactions staff had with people throughout the day, showing constant interaction. Staff received a verbal handover to keep them updated with any ongoing issues and people who required specific monitoring during the shift, all staff on duty were allocated a handset linked to the computerised record system. If during the shift they identified an issue of concern that they felt other staff should be alerted to regarding a person's wellbeing they could ensure this was flagged within the electronic handover which all staff were required to read at the beginning of the shift.

Each person was allocated a key worker (these are staff whose role is to understand the needs and personality of the person they were allocated to a greater degree than other staff and to ensure they had everything they needed); currently key workers completed a monthly report about the people they were allocated with the involvement of individuals concerned where possible; these monthly reports informed the registered managers and were used to update and review care plans, the role of the key worker was currently under review as to whether they could take a more active role in the care plan updates. Plans viewed showed evidence of updates where people's needs had changed.

People knew about the activities on offer but not everyone wanted to participate. Some people said they preferred their own company and doing things they wanted to do in their own room for example reading or knitting. Other people who spent much of their time in the main lounge talked about the activities that happened some of which they joined in, we saw people participating but also others who were active observers of activities but not directly involved. There was an activities co-ordinator who helped devise the weekly activities programme; this was displayed in a large format in the hall near to where activities took place in the main lounge. Activities were scheduled for mornings, afternoons and evenings throughout the week and were a mix of in house facilitated activities and external entertainers who visited. Staff kept a record of which people had participated to ensure they monitored those who may be at risk of becoming isolated.

The complaints procedure was displayed prominently, a copy was also provided to people within their room information files. Relatives told us they found the registered manager, deputy and other staff very approachable; they felt very confident and comfortable with raising any concerns if they had them. People said they felt able to talk to staff if they were concerned and also could raise issues with their key workers or in resident meetings or through survey feedback. A review of survey analysis and resident meeting minutes showed no particular issues of concern arising. No formal complaints had been received. The provider recognised the value of dealing with minor grumbles people might sometimes have and recorded these and the actions taken to ensure these did not escalate into complaints at a later stage. The service had received a large number of compliments not only from relatives but also from some visiting professionals who had taken time to comment positively about their observation and experience of the service.

Good

Is the service well-led?

Our findings

Relatives were complimentary of the Old Rectory, its staff and the way it was run, comments included "they are flawless, excellent, they are a decent bunch of people", "they are very good they even wrote letters for us when we had problems", They are marvellous". Professionals commented: "if I had to place one of my relatives in a home I would be happy to place them there" "They are very proactive and will take on board advice and guidance", "It's very homely, the providers are very involved and I feel when that is the case they always seem more willing to resolve issues". "I find the registered manager and the staff knowledgeable about the people they are supporting".

This was a family run service with the registered manager and her husband also the registered providers. Both were visible on a daily basis around the service, they and other family members took on different responsibilities for the operation of the service. The registered providers had a good grasp of what was happening in the service at all times. The providers hands on and visible approach ensured they monitored the service closely and received direct feedback from people, staff and relatives on a daily basis. As a result of shortfalls identified at the previous inspection in regard to record keeping they were motivated to get things right, they had taken on board the areas identified for improvement but had also looked at how they could take improvements to the next level, for example the implementation of a person centred electronic care recording system. The providers used a quality management system that comprised of a range of audits that monitored all aspects of the service; this provided assurance that quality standards were being maintained and supported their visual oversight of the service. Audits viewed showed that where shortfalls were identified actions were taken and the system was working effectively.

Staff told us there was an open door policy by the registered manager and deputy manager who were both very approachable. Staff felt confident that they could raise issues at any time and that confidentiality would be maintained. Staff had opportunities to raise issues in staff meetings which were held regularly and an agenda was put up for staff to add to if they wished to raise a point. Meetings were recorded and staff who did not attend were required to read meeting minutes and sign that they had read them to ensure they were kept updated.

Staff felt that communication was good and that they were always kept informed about people whose health may be causing concern or whose needs were changing through handover meetings at every shift change. Staff were able to add things to the handover discussion through the new electronic recording system which enabled them to flag some issues they had dealt with for discussion at handover. This reduced the risk of some matters being overlooked. Staff good practice was rewarded through an employee of the month scheme which meant their photograph was displayed in the reception area for people, relatives and visitors to see and they received a certificate and gift for their contribution. At the completion of every qualification training course the staff members concerned were rewarded with a monetary incentive.

The atmosphere within the service on the days of our inspection was relaxed and cheerful; staff demonstrated they knew their job and understood people's needs, the culture was open and inclusive. Staff

worked in accordance to people's routines and support needs.

The views of people and their relatives were captured through annual surveys; relatives were also encouraged to make comments directly if they had them. People had opportunities through resident meetings or meetings with their key worker to discuss anything about their care and support. An analysis of feedback from people, relatives and other stakeholders was undertaken and the outcome of this was displayed on the notice board for people to see.

The providers showed that they were keen to get things right and were innovative in using new technology to improve the use of staff time and aid monitoring processes, a service development plan was in place that addressed maintenance and refurbishment of the building and observations showed that the development programme was being worked through. The Statement of Purpose had recently been updated and a copy sent to the Care Quality Commission to reflect changes made to the service.

The providers had signed up to the Social Care Commitment this is a promise by people who work in social care to provide people needing care and support with high quality services and is an initiative of the department of Health, the commitment aims to increase quality standards and raise public confidence in care quality. The providers were active members of the National Association of Care Homes and also Kent integrated Care Association (KICA) attending seminars, meetings and making use of their websites. KICA is an independent body working on behalf of care providers in Kent, it provides forums for discussion and also offers training and advice and a regular informative newsletter. The providers had registered with Careaware so that people in the service could get access to up to date unbiased financial advice. To keep updated they made use of key websites for example Skills for Care in respect of training updates for staff, and updates to legislation and guidance on the Care Quality Commission and NICE websites.

Information about individual people was clear, person specific and readily available. Guidance was in place to direct staff where needed. The language used within records reflected a positive and professional attitude towards the people supported.

The providers had registered with a company that kept them updated in regard to changes in legislation and ensured that policies and procedures kept pace with such changes and were adapted to meet the specific requirements of the service. Staff had access to policies and procedures and updates were placed in a read file; they were required to read the updates to inform their practice and sign that they had read and understood them.

The registered manager ensured that the Care Quality Commission was notified appropriately of events that occurred in the service.

The registered manager analysed accidents, falls and also admissions to hospital to look for patterns or trends and identified whether action needed to be taken for example, for referral to relevant professionals.