Rochester Care Home Limited

Rochester Care Home

Inspection report

Robert Bean Care Centre
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Rochester
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this home on 08 and 10 June 2016. The first day of our inspection was an unannounced inspection while the second day was announced.

Rochester Care Home is divided into two distinct service provisions. One area provides care and support for up to 56 older people who require accommodation and personal care. This area for older people was further sub divided into four separate wings namely, Bishop Olbo, Bishop Gundulf, King John and King Henry. The other area of the service provides respite care for up to eight people with physical and learning disabilities combined with additional complex needs. People who use Napier Unit service are aged 16+. The service is provided during evenings, weekends and bank holidays. The bedrooms in the Napier Unit are equipped with modern aids and adaptations. Rochester Care Home is a large service with ample communal space and gardens. At the time of our inspection, 51 people lived in Rochester Care Home for older people.

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

People's care plans contained information about their personal preferences and focussed on individual needs. However, based on our observation and records we looked at, people's care plans had not been updated with up to date information about their changing needs and staff were not always available to diffuse situations that may occur early.

There were allocated numbers of staff to meet people's needs in both the residential and respite units. However, on the first day of our inspection, we found that the needs of people at the residential unit of the service had changed along with some people's dependency levels and therefore the current staffing calculator did not reflect the number of staff required to adequately meet people's needs. On the second day of our visit, the registered manager provided us with an updated dependency calculator which they said the service was now adequately staffed. We have made a recommendation about this.

The service had risk assessments in place to identify and reduce risks that may be involved when meeting people's needs such as physical disabilities, behaviour that challenges. However, the risk assessments we looked at were all completed with varying amounts of information and were not all complete. The risk assessments did not all correspond with each other and made it confusing to determine what risks were identified and what remedial action was in place to minimise the risk. We have made a recommendation about this.

People's care plans contained information about their personal preferences and focussed on individual needs. However, people's care plans had not been updated with up to date information about their

changing needs and staff were not always available to diffuse situations that may occur early. We have made a recommendation about this.

Staff had the knowledge and skills to meet people's needs, and attended regular training courses. Staff were supported by their manager and felt able to raise any concerns they had or suggestions to improve the service to people.

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

Staff were recruited using procedures designed to protect people from unsuitable staff. Staff were trained to meet people's needs and they discussed their performance during one to one meetings and annual appraisal so they were supported to carry out their roles.

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

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

Staff encouraged people to undertake activities and supported them to become more independent. Staff spent time engaging people in conversations, and spoke to them politely and respectfully.

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

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

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were staff employed to ensure people received the care they needed and in a safe way. However, there is need to review current staffing levels and deployment of staff.

Risks to people's safety and welfare were assessed. However, risk had not been effectively managed.

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

There were effective recruitment procedures and practices in place and being followed.

Medicines were safely stored and administered to people.

Is the service effective?

Good

The service was effective.

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

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

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

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

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

People and relatives were included in making decisions about their care.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff had not always responded to people's needs quickly and appropriately whenever there were changes in people's need. Care plans had not always been updated.

The service had not adequately responded to people with dementia's environmental needs.

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

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

Is the service well-led?

Good

The service was well led.

The service had an open and approachable management team.

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

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

Rochester Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected this service on 08 and 10 June 2016. The first day of our inspection was an unannounced inspection while the second day was announced.

Our inspection team on the first day consisted of four inspectors and two inspectors on the second day.

Before 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 previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

While we were able to speak with people at Rochester Care Home for the older people, people using the respite service at the Napier Unit were not able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing people and how care was delivered and used 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.

We spoke with six people, five relatives, five care workers, two senior care workers, one care manager, assistant chef, chef, deputy manager, manager Napier Unit and the registered manager. We spoke with the operations manager who had the overall responsibility for the service, which were different responsibilities to the registered manager and who was a representative of the provider. We also requested information from healthcare professionals involved in the service. These included professionals from the community mental health team, care managers, continuing healthcare professionals, NHS and the GP.

We looked at the provider's records. These included eight people's records, which included care plans,

health care notes, risk assessments and daily records. We looked at six staff files, a sample of audits, satisfaction surveys, staff rotas, policies and procedures. We also looked around the care service and the outside spaces available to people.

Requires Improvement

Is the service safe?

Our findings

Our observation showed that people were safe at the service. One person said, "It's alright here." Another said, "I have got to know staff and feel safe". One of the relatives who was visiting on the day stressed, "We feel he is safe here." Another relative said, "Very much so, she is safe."

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

People were not always protected from avoidable harm. Staff had a good understanding of people's individual behaviour patterns. Records provided staff with detailed information about people's needs. Through speaking with staff, we found they knew people well, and could inform us of how to deal with difficult situations such as behaviours that challenge staff in meeting people's needs. As well as having a good understanding of people's difficult behaviours, staff had also identified other risks relating to people's care needs. However, people had not always been supported in accordance with their risk management plans. People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. There were four risk assessments in an individual's care file which were centred around the person showing signs of inappropriate behaviour. However, they were all documented with varying amounts of information and were not all complete. The risk assessments did not all correspond with each other and made it confusing to determine what risks were identified and what remedial action was in place to minimise the risk. While in one individual's care files, some risk assessments were incorrectly completed and did not give a full assessment of the risk that had been identified, or the current control measures that needed to be implemented. In others, we found no risk assessments. For example, one risk assessment had been filled out where the identified risk had been completed as the control measure and vice versa but no information about control measures needed to manage the risk were completed. While in the Napier Unit, we found that two people were identified as having behaviours that could challenge staff and there were no behavioural risk assessments in place. Further in Rochester Care Home, we found a risk assessment dated 9 February 2016 which said it was for his inappropriate sexual behaviour but only mentioned the pressure mat and nothing about the inappropriate behaviour. The only information on the risk assessment was in the section headed 'detail any existing controls in place' which said "All staff to monitor 'X' when walking around the building to ensure he does not interfere with female residents especially if they are in their rooms alone". There were no other guidelines for staff on what to do if he was

behaving inappropriately. There was another risk assessment for his sexual behaviour dated 24 February 2016 completed by a member of staff which said he should be observed through the day and night and that staff should use distraction techniques. However, there were no details about what the distraction techniques were. Staff had received explicit guidance from healthcare professionals about how to manage the behaviours which were not in any of the risk assessments. This meant that staff had not been adequately completing the risk assessments which would enable reduction in harm to keep people safe.

Following our visit, the registered manager submitted an action plan that stated 'All support outlined in the care plan for 'X' (person referred to above) has been reiterated to staff and has now been incorporated into our daily handover for 'X' and other residents with behaviour management plans in place. Rochester Care Home do have an excellent relationship with the Dementia Support Team and work closely with them to ensure that the support we provide is person centred and effective.'

Staff maintained record of each person's incidents or referrals, so any trends in health and behaviour could be recognised and addressed. These are then reviewed by the manager and action plans and reviews were documented plus any follow up action such as calling a GP. Body maps were completed when injuries were sustained. However, some of the information in the incident reports was not a full accurate picture of the incident when cross referenced with other records. For example, there were also examples where seizures were documented in daily notes but not in incident reports, ABC charts or seizure records. One person had a seizure record as they were regularly having seizures. There had been no records completed for June however in their daily record it stated that they "Had a funny turn". There was no further explanation despite that the likelihood of the 'funny turn' was a seizure. Accident/incident audits were completed monthly with the most recent completed for April 2016 which covered from 01 April 2016 to 30 April 2016. There were 58 incidents reported in total with 24 of those reported between 20.00 and 07.00. It was identified through the audit that there was a high number of incidents in the evenings and at night and it stated 'Residents tend to be more tired at these times and sometimes tend to walk around more.' The action identified in relation to this finding was that 'Staff needs to be extra vigilant in the evenings and at night.' This issue had also been identified in the January and March audits and same action plan recorded. Despite this, between February 2016 and May 2016, there had been five safeguarding incidents relating to incidents at night. Therefore the action plan had not been effective in reducing or preventing further incidents.

We recommend that the registered manager and provider seeks further guidance on how to put together a risk assessment that meets people's needs.

The registered manager told us that the four separate wings namely, Bishop Olbo, Bishop Gundulf, King John and King Henry for older people had seven staff on duty in the morning, seven staff on duty in the afternoon and four staff on duty at night. The preferred establishment for staff during the day would be eight staff. The deputy manager who was due to be carrying out a care shift would have made the number of staff on the day eight. In addition to the eight care staff there were four domestic staff, the maintenance man and registered manager. During the day there is one staff member allocated to each wing with three or four staff 'floating' and providing cover in all four wings. Part of the care worker's role involved taking responsibility for providing activities for people and laundry. When we arrived for the inspection, we asked the registered manager if there was anyone in the home that displays behaviour that challenges. The registered manager told us that two people in the home displays behaviour that may challenge. However, we observed that there were periods when people were left alone without any staff support. For example, at around 11.45am, we observed a relative supported one person to walk to another table to chat with other people. Further, this same relative assisted people with drinks when they requested it. During these periods, we saw members of staff doing laundry duties, carrying folded clothes around into people's bedrooms. Further, at about 4pm, we observed one person who had challenging behaviour walked to another wing and started

moving tables and chairs without any staff support or supervision. It was stated in this person's behaviour plan that the staff should monitor the person. However, there were was no staff monitoring in place at this time. Staff training plan sent to us showed that 22 staff completed training on 'behaviour that challenge' in 2014, nine staff in 2015 and three staff in 2016.

The registered manager told us that the Rochester Care Home roster is based on the needs of people. The home used a care home staffing calculator to work out how many staff were required to meet the needs of the people at the home. Each person had an individual assessment carried out to determine what level of dependency they were. These were high, medium, low or self-caring. The last time the dependency levels were updated was in April 2016. However, the needs of people at the home had changed along with some people's dependency levels and therefore the current staffing calculator did not reflect the number or staff required to adequately meet people's needs. On the day we inspected. On 13 June 2016, the registered manager sent us an 'action plan' where they stated that the dependency tool had been reviewed on 9 June 2016 and 'The home is adequately staffed for the profile of residents'. A relative said' "I think staffing is a bit short over the weekend. I think there is not enough stimulation for residents. Staff are so busy." and "Only concern is staffing level over the weekend. I have already raised activities and stimulation with the manager." Staff told us that at times staffing levels were too low, but that the registered manager was employing more staff.

We recommend that the registered manager and provider seeks further guidance on the deployment of staff in order to adequately meet people's needs.

There were suitable numbers of staff to care for people safely and meet their needs at the Napier Unit. The manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times to safely meet respite people's needs. For example, we observed a member of staff had been allocated for one-to-one support to keep a person safe. This was in line with the persons assessed needs.

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

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

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner in Rochester Care Home for older people. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures

obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. No medicines needed to be disposed of for the Napier Unit as this unit only dealt with the medicines that people brought into the unit from home. However, an accurate record was kept of when they came into the unit and when people returned home. Accurate documentation and safe procedures were being followed for medicines that were not taken. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. We observed an effective system for the storage and monthly ordering to ensure that prescribed medicines would be available for people on the residential unit. A number of checks were conducted by the registered manager and the deputy manager. This ensured that medicines were ordered and no excess stock was kept by the service. The registered manager conducted a monthly audit of the medicine used and medication administration records. We reviewed 15 people's medicines administration records. They had been completed accurately with no gaps or omissions. This indicated they had an effective governance system in place to ensure medicines were administered, managed and handled safely. The manager of the Napier Unit kept a record of people's medicines when they were admitted for respite care. There was a file with all the information needed to guide staff about the different medicines people were taking. As these were mainly liquid medicines guidance was available as to when these should be taken, why and any contraindications. Accurate records were being maintained for all the medicines people brought into the unit and when they returned home.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed on 24 February 2016. The personal emergency evacuation plans in place which covered whether the person was on oxygen, was bed or chair bound, fully mobile but at risk of becoming lost and whether assistance was required by either care staff or the fire service. There were three identified levels of dependency; high, medium and low and each category had a list of characteristics which helped staff to identify which category people would fall into. The service practiced a 'stay put' plan and people would be evacuated to the furthest point away from the fire. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was reviewed in February 2015. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place monthly and staff recorded those people present. Staff had completed a fire competency assessment.

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

Good

Is the service effective?

Our findings

Relatives said, "The food is good." and "The food served here is like what I will serve at home. When we take him out, he is always saying I want to go back home." People told us they got the support they needed from staff. One person said, "I have been here a few years now, the staff are brilliant, they are there when I need them, I just have to ask." Another relative said, "The staff have coped very well with Mum's health needs."

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

Residential staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support older people and respite unit staff had required skills and experience of supporting people with learning disabilities and autism. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. One member of staff told us that they had attended trainings to help them meet people's needs. These included death, dying and bereavement, food and nutrition and safeguarding. Staff said, "We had attended MCA/DoLS training and understood the importance of supporting people to make informed decisions".

Staff were being supported through individual one to one supervision meetings and appraisals. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We were told that an annual appraisal was carried out with all staff. We saw records to confirm that supervision and annual appraisals were taking place. The registered manager showed us their planned supervision for the residential unit and we saw that of the Napier unit too. A member of staff also confirmed training needs were discussed as part of supervision and she could ask for training that would be of benefit to her in her role. They said, "I receive supervision with the manager. I do receive support now. My supervision was due today."

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed, the statutory

principles underpinning the MCA and related this to people that were subject to DoLS. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People were supported to have their nutritional needs met. People told us that the food was nutritious and of the required standard for their needs. All who could specify said that there was a choice, and always sufficient food. Meal times for people were flexible. People who required support to eat their meals were discreetly supported by staff in a manner which was respectful and dignified. The care and support during lunchtime was at the eye level of the person staff were supporting. Mealtimes were not hurried which promoted dignity and respect. People were supported to have cold and hot drinks when they wanted them. We observed that people who required assistance with eating were aided half an hour before anyone else. This allowed people to have their meal unhurried and not have to wait until staff were available. We saw that the main meal for other people who were able to feed themselves was prepared and sent out to each dining area on a hot trolley. People were served their meal on different sized plates depending on their appetite. However, if people wished to have more food this was accommodated. When we spoke with the chef following the lunch time meal we saw that a choice had been offered at each mealtime. The tea time choices varied each day.

We spoke with the chef and their assistant. They were fully aware of people's dietary requirements and any preferences. They had a dry wipe board which informed them of any person who was diabetic and the requirements they needed to ensure they did not take too much sugar. The chef told us that they did not do any special cakes or desserts for people with diabetes. They would ensure they used recipes appropriate for all people and also a sugar alternative where needed. They said this worked well and people with diabetes did not feel they could not have the same as anyone else. We checked the four people's files that were diabetic against some food charts and found that peoples blood glucose was being monitored as per guidance given by healthcare professionals and that their blood glucose levels remained within normal limits. In one person's care plan we saw that where a person was refusing most of their medicines, including their diabetes medicine, the person was maintaining a good blood glucose level. The GP had recommended that the medicine be stopped altogether as no longer required.

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

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. Records of allergies were kept in people's care plans. For example, one person was allergic to egg and poultry. We saw this in the kitchen food plan adhered to by the kitchen staff. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people twice a day and upon request.

Malnutrition Universal Screening Tool (MUST) assessments were completed and reviewed on a regular basis

in many cases monthly. This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese and it also includes management guidelines which can be used to develop a care plan. This was increased when there were any changes in people's condition. In one person's care file the nutritional assessment had been recorded and the staff completed the daily food and fluid records more accurately to establish whether additional supplements were needed. A healthcare professional commented, 'The staff team share information as appropriate, and will notify me if someone's needs change'.

The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the service regularly.

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

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

Good

Is the service caring?

Our findings

Positive relationships had developed between people who used the service and the staff. People told us that staff were caring. People said, "All the staff are friendly, I haven't met one I don't like." And, "The staff are nice and caring." Relatives spoke highly of the respite service. They said, "The staff are caring and respectful."

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. A relative told us, "It's okay. It's excellent. She is receiving first class care". Another said, "He has Dementia and it's been up and down. They kept us informed. He is always well dressed, never smells, eats well, we are very pleased".

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

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

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

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

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

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

People's rights and choices about end of life care were respected and this delivered compassionately. People, their families and the Community Nursing Teams were heavily involved in the planning of end of life care. This ensured that people were supported to stay as pain free as possible and remained comfortable.

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

Requires Improvement

Is the service responsive?

Our findings

People were encouraged to discuss issues they may have about their care. People told us that if they needed to talk to staff or with the manager they were listened to. Relatives said, "We come to meetings about our son and the staff know how he communicates." And, "I feel the registered manager would listen if I needed to complain." One person spoke to us about how they enjoyed getting involved in the day-to-day routines of the service. They said, "I like doing the washing up and the bubbles." Other people chose to help keep the service tidy.

Relatives commented on their experience of staff being responsive. They said, "They respond well. If mum is unwell, they call me straightaway." Another said, "If we have any concerns, we always speak to 'X' (Registered Manager) first and other staff. They always tell us what is going on". All reported that the home was good at keeping in touch and communicating with them.

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

Each person's detailed assessment, which highlighted their needs could be seen to have led to a range of care plans being developed. We found from our discussions with staff and individuals that the care plans enabled staff to meet their needs in both the residential and respite units. People signed consent forms for the provision of support, as well as how the support was to be delivered and recorded, which showed their involvement. For example, people had agreed to the specific detail of their care plan such as how they would like to be called. One person said, "I have been here a long time. It is my home and I am now a tenant." However, people's care records were not always updated to reflect any changes in their needs. For example, one person in the residential unit who had been identified as showing challenging behaviour's care plan was reviewed. The person's mental health care plan had been reviewed and it was recorded on the review sheet that staff should complete behaviour charts ABC charts (Antecedent, Behaviour and Consequences) every time the person displayed behaviour which was considered challenging. The information had not been transferred onto the main care plan which made it confusing regards which was the most up to date guidance which should be followed. The main care plan did not contain the updates from the mental health team as it should, which would have further enabled staff in responding to this individual's needs. There was also no information for staff on how to complete ABC charts and the chart varied in level of detail and appropriate information for them to be used effectively.

This person had been reviewed by the local mental health team and they had provided guidance for staff on how to try and prevent the person from becoming agitated and gave specific person centred advice based

on how the person best responds such as distracting him with an activity or checking that the person was not in pain. The care plan referred staff to look at the information sent through from the mental health team rather than include the information in the care plan therefore the care plan did not include the most recent advice from healthcare professionals. ABC charts reviewed did not include information to demonstrate that staff had followed the guidance given by healthcare professionals. ABC chart may identify links between the behaviour, and what happened before and events that followed, that reveal or aid understanding of the function that a particular behaviour serves for an individual. There were 16 ABC charts completed in the last seven days prior to our inspection. If these had been reviewed by staff, it might aid/support them in managing the individual's behaviour better. Despite guidance stating that staff needed to monitor the person, we observed that there were times when the person was not in an area where staff were, displaying signs of agitation identified in their risk assessments such as moving furniture and banging things around which meant the person's behaviours were escalating rather than staff diffusing the situation early. In another person's care records, we found in their continence care plan it was identified that they needed to be encouraged to drink at least 1.5 litres of water every 24 hours to reduce the risk of contracting a urinary tract infection. There was no further information about how staff should encourage the person, or what monitoring they should do to make sure they were drinking enough. The person's nutrition and hydration care plan did not contain any information about the person needing to drink at least 1.5 litres a day and neither did the person's nutritional assessment. Fluid intake was recorded in the person's daily booklets however some days it included the total volume of fluid in mls and other times just said things like 'tea'. Where totals were recorded. They were not added up to calculate the total amount of fluid taken each day. These showed that some staff might not be aware of updates needed in people's care as the care plan had not fully documented new guidelines such as for managing their behaviours and documentation of fluid taken.

The registered manager failed to adequately implement healthcare professional's guidance in response to people's changing needs. This is a breach of Regulation 9 (1) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were reviewed monthly at the Napier unit or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. The manager told us that they are currently working towards making sure that the care plans were person centred. We saw evidence of this in the care plans we looked at.

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

The provider contacted other services that might be able to support them with meeting people's mental and physical health needs. This included the local authority's community learning disabilities team and the mental health team. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. A healthcare professional commented, 'Yes - clients are referred to Speech and Language Therapy as needed, and eating and drinking guidelines are implemented well'. This showed that each person had a professional's input into their care on a regular basis.

People in the residential unit were able to express their individuality. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice. However, the doors to people's rooms were painted to look like front doors on houses, such as black, red or white. Not all rooms had people's names on them and those that did were very small. There were no other distinguishing features such as pictures or memory boxes which people with dementia could use to identify which bedroom was theirs. People with dementia can have real problems remembering where their room is in a care home where all the bedroom doors look the same and being unable to find their bedroom can leave them extremely anxious and stressed. Getting design right can make a fundamental difference to the lives of people with dementia. The registered manager said that some people go in and out of people's bedrooms and that there were no measures in place to prevent this from happening other than staff guiding people away. A lady was observed wandering in to a man's bedroom while he was having a shave. The lady was interrupted by the registered manager as she was showing the inspectors around and redirected out of the room. We heard one person who lived at the service complaining to their relatives about how other people keep going into their rooms.

We recommend that the provider and registered manager seeks guidance from reputable source about Dementia Care practice in care homes.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the service. For example, 9 out of 10 people said they had enough activities at weekends and 80% of people surveyed said that the service responded appropriately if they had raised any concern. This indicated that people were satisfied with the service provided.

Organised activities took place daily, delivered by staff or there were monthly activities provided by external entertainers and specialist activities providers. Staff were allocated to activities planning and roles. For example, a senior care worker was responsible for planning and booking external entertainers and other staff were given time to organise activities like bingo. We observed people participating in an activities session provided by an external provider. The session included activities to support people's physical and mental health. People were laughing and joking with each other. After the session people said, "The morning has been beautiful, I really enjoyed it," and "I have really enjoyed the activities and I like the presenter". There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, exercise, music, dancing, sparkle (spelling game), bingo and arts and craft. We noted that people cared for in bed were offered activities in their rooms. There was a weekly activities timetable displayed on the notice board and people confirmed that activities were promoted regularly based on individual's wishes.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). The service had not received any complaint since our last visit.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would

actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". We saw complimentary messages sent to the registered manager and staff. These included comments such as, 'To all staff – Thank you all very much for taking care of our dad'.

Good

Is the service well-led?

Our findings

Relatives gave us positive comments about the service. They said, "Management is good, communicates well." and "Manager is absolutely brilliant. Support wise, we cannot fault them."

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

The service had a clear management structure in place led by an effective registered manager who understood the aims of the service. The management team encouraged a culture of openness and transparency as stated in their statement of purpose. The organisations philosophy included 'Person-centred care, highly trained staff, social life and leisure, a pleasant environment and food-we understand the importance of a balanced, nutritional diet, but also making mealtimes a sociable and enjoyable occasion'. We found that staff understood and adhered to these values.

Staff told us that the management team was very approachable. A member of staff said that she enjoyed her role and the registered manager was supportive, she could always ask her for advice. She said "The registered manager is very good at her job. Very strict but approachable." Another staff commented about the Napier unit and said, "The manager is a breath of fresh air. Prior to him, we did not have that. Things are picking up. Paperwork is improving. I feel quite secure now." Staff were confident that any issues they raised would be dealt with promptly.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Staff told us the morale was excellent and that they were kept informed about matters that affected the service. They told us that team meetings took place regularly and that they were encouraged to share their views. They found that suggestions were warmly welcomed and used, to assist them constantly review and improve the service.

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

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the service. The registered manager and manager of the respite unit told us they were well supported by the operations manager who provided all the resources necessary to ensure the effective operation of the service. The operations manager visited the service every month to support both managers. We found that the provider had systems in place for monitoring the service, which the

registered manager fully implemented. They completed monthly audits of all aspects of the service, such as medicine, care plans, nutrition and learning and development for staff. They used these audits to review the service. Audits routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken. However, the audit failed to identify the gaps we identified above regarding the residential unit. We discussed this with the registered manager and they immediately sent us their plan to rectify these gaps in order to ensure that the audits are more robust.

The manager of the Napier unit also completed monthly audits of all aspects of the service, such as medicine, care plans, nutrition and incidents. They used these audits to review the service. Audits routinely identified areas they could be improved upon and the manager produced an improvement plan, which clearly detailed what needed to be done with timescales and when action had been taken. This showed that both managers are working towards ensuring a robust quality monitoring systems are in place.

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

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager failed to adequately implement healthcare professional's guidance in response to people's changing needs.