Rosemont Care Limited

Rosemont Care Medway

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 13 March 2018. The inspection was unannounced.

The last comprehensive inspection took place on 25 May 2017. The service was rated as Requires improvement overall. Breaches of Regulations 11, 12, 16, 17 and 19 were identified. The provider had failed to follow the principles of the Mental Capacity Act 2005. The provider and registered manager had failed to adequately assess and mitigate risks to people and staff. The provider and registered manager had failed to establish and operate effective recruitment procedures. The provider and registered manager had failed to establish and operate effective complaint systems. The provider and registered manager were required to make further improvements to establish and operate effective systems to monitor and improve the quality of the service. We issued the provider warning notices in relation to Regulations 11 and 12 and told the provider to meet the Regulations by 31 July 2017. We also served one warning notice in relation to operating effective recruitment processes and told the provider to meet Regulation 19 by 14 August 2017.

The provider sent us an action plan on 25 October 2017. This identified that Regulation 16 had been met at the end of June 2017 and Regulation 17 had been met and ongoing monitoring was taking place.

We carried out a focused inspection on 20 September 2017 to check that the provider had met the warning notices which had been served following the previous inspection on 25 May 2017. We looked at the Safe and Effective domains. At the focused inspection we found that the provider had met Regulation 19 and Regulation 11 but had failed to meet Regulation 12. We also found a new breach of Regulation 18.

The provider sent us an action plan on 29 November 2017. This identified that Regulation 12 and Regulation 18 had been met and systems were in place to review and increase staff training.

Rosemont Care Medway is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to people living with dementia, learning disabilities or autistic spectrum disorder, mental health, older people, people who misuse drugs and alcohol, people with physical disability, people with a sensory impairment and younger adults.

Not everyone using Rosemont Care Medway receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. There were 54 people receiving personal care at the time of the inspection.

The service had a registered manager. 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. The registered manager was present at the service during the inspection.

At this inspection we found that there had been further improvements to the service. People and their relatives were positive about the care and support they received.

Risks to people's safety and welfare had been assessed and risks had been mitigated where possible. Each person receiving care had risk assessments in place. Further improvements were planned to ensure that risk assessments were person centred.

The provider had deployed enough staff to provide people's care and support. Staff had travel time and breaks allocated to them. There were sufficient numbers of office staff to keep up with the demand for care and support services which included carrying out assessments, developing care plans, supervision of staff and scheduling care and support.

Effective recruitment procedures were in place to ensure that staff employed were back ground checked and had the skills and experience needed to carry out their roles. Staff had received training relevant to their roles.

Medicines administered were adequately administered and recorded to ensure that people received their medicines in a safe manner. Where medicines audits had found concerns in relation to recording appropriate action had taken place.

People were protected from abuse or the risk of abuse. All staff were aware of their roles and responsibilities in relation to safeguarding people.

There was a stock of personal protective equipment (PPE) kept in the office which staff could access regularly to stock up. PPE was located at each person's home for staff to use.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included the steps staff should take to comply with legal requirements. Staff had a good understanding about how to apply the principles of the MCA 2005 to their work to enable them to protect people's rights.

People were supported and helped to maintain their health and to access health services when they needed them. Some people received support to prepare and cook meals and drinks to meet their nutritional and hydration needs.

People and relatives told us that staff were kind and caring. Staff treated people and their relatives with dignity and respect.

People's care plans had been reviewed and updated to ensure that their care and support needs were clear and their preferences were known. The management team were still working on reviewing and updating care plans to ensure they were person centred. Plans were in place to review the assessment process so that people's religious, cultural, sexual and end of life care needs were discussed. People and their relatives had been involved with planning their own care.

People and their relatives knew who to talk to if they were unhappy about the service. When complaints had been received, these had been recorded, investigated and responded to within suitable timeframes.

People's views and experiences were sought through quality assurance surveys. Relatives were also encouraged to feedback through surveys.

Staff were positive about the support they received from the management team. They felt they could raise concerns and they would be listened to. Staff received regular supervision and were in the process of attending annual appraisal meetings to discuss their performance.

Effective systems were in place to enable the provider to assess, monitor and improve the quality and safety of the service. Records were accurate, complete and securely stored.

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.

People were protected from abuse or the risk of abuse. The management team and staff were aware of their roles and responsibilities in relation to safeguarding people.

Effective recruitment procedures were in place. There were enough staff deployed to meet people's needs.

Risks to people's safety and welfare had been assessed and well managed to make sure they were protected from harm. Further improvements had been identified to make risk assessments more person centred.

People's medicines were well managed. Medicines records were checked regularly and appropriate action taken when errors or gaps had been identified.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of the Mental Capacity Act 2005 and how this applied to their work. Staff demonstrated that people were fully involved in decision making and people confirmed this.

Staff had received training relevant to their roles. The provider had scheduled training to support staff. Staff supervision and spot checks took place.

People received medical assistance from healthcare professionals when they needed it.

People had appropriate support when required to ensure their nutrition and hydration needs were well met.

Is the service caring?

Good

The service was caring.

People and their relatives told us they found the staff caring, friendly and helpful.

Staff were careful to protect people's privacy and dignity. People told us they were treated with dignity and respect.

People's information was treated confidentially.

Is the service responsive?

Good

The service was responsive.

People's care plans provided clear information about the tasks staff were required to support people with in their own homes. The management team were making further improvements to people's care plans to ensure that care met people's assessed and changing needs.

The service had a complaints policy, which was on display in the office and people had a copy in their own homes. People's complaints and concerns had been appropriately dealt with.

Is the service well-led?

Good

The service was well led.

Systems to monitor the quality of the service were effective. Records were stored securely.

The registered manager had reported incidents to CQC. The registered manager had displayed the rating from the last inspection in the service and on the website.

People's and relatives views were gathered in surveys. The management team had planned to send surveys out again in May 2018. Compliments had been received about people's care and support.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

Staff were positive about the support they received from the management team.

Rosemont Care Medway

Detailed findings

Background to this inspection

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

This inspection took place on 13 March 2018. The inspection was unannounced.

Inspection site visit activity started on 13 March 2018 and ended on 20 April 2018. It included visiting people in their homes and their relatives, shadowing staff on their care visits to observe practice in communal areas, telephone calls with relatives and telephone calls with staff. We visited the office location on 13 March 2018 to see the provider and to review care records, management records and policies and procedures.

The inspection was carried out by three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information of concern we had received from a relative.

We spent time speaking with three people and one relative who received support from Rosemont Care Medway. We telephoned 16 people to ask for their feedback and spoke with six people and three relatives to gain feedback about the care and support received.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and a local authority employed occupational therapist. We spoke with 10 staff; including care staff, office staff, the field care supervisor, the coordinator, the operations manager and the provider.

We looked at seven people's personal records, care plans and medicines charts, risk assessments, staff

rotas, staff schedules, eight staff member's recruitment records, training records, management records, policies and procedures.

We asked the provider to send us additional information after the inspection. We asked for copies of the policies and procedures and the training records for staff. These were received in a timely manner.

Good

Is the service safe?

Our findings

At our previous focused inspection on 20 September 2017 we identified breaches of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider and registered manager had failed to adequately assess and mitigate risks to people and staff. The provider had failed to deploy sufficient numbers of staff. The provider sent us an action plan on 29 November 2017. This identified that Regulation 12 and Regulation 18 had been met and systems were in place to review and increase staff training.

A relative said, "I feel safe; there's two carers; I've been there when carers are there and they're all very kind and caring to mum; they move her from bed to chair in a safe manner. There's not much else I can say as mum is bed and armchair bound". Another relative told us, "They're very good at making sure that she's safe (mum's bed and armchair bound); they make sure she knows not to move until they get there."

We observed that people were supported to maintain their safety. Staff prompted people to use equipment that they had been assessed to use. Staff placed telephones near people before leaving to ensure they could reach their telephone to make or receive a call if they needed to. People told us they felt safe. Comments included, "To get from my chair to commode, I now have a hoist, and they've got to learn how to use the hoist, but they seem pretty good and I feel safe"; "Yes, I do feel safe; I don't have the same people but they are all very nice" and "Yes we feel safe. He prefers the male carers but there's one female carer that's good too."

A staff member told us they kept people safe by knowing their medical conditions, medicine information, making sure their homes were secure and reporting any. The staff member was clear about the action they would take in the event of equipment breaking.

At this inspection we monitored the telephone calls that came into the office to check whether staff were running late; we heard no calls of this nature. We also spent time with the coordinator monitoring the computer screens which evidenced that staff were arriving at people's homes at the times they were scheduled to be there. We observed that the coordinator made contact with staff to check when the computer system showed a variation from what was scheduled. We observed some variation on times on the scheduled care. The coordinator explained that during the heavy snow, care visit times had to be altered and amended as travelling times increased due to staff not being able to use public transport (as it was not running) and staff were walking to care visits. The staffing schedule showed that staff had travel time planned into their working day. We shadowed staff in the community on 20 April 2018 and saw that adequate time had been assigned to them to get to their next care calls. We observed staff logging into and out of care visits using their phones. The management team knew which staff walked, bused, cycled or drove which enabled them to allocate adequate travel time. People told us that staff mostly turned up on time. Comments included, "They turn-up on time and have never missed a visit, definitely not. Sometimes they stay longer and sometimes they leave a bit earlier if they have another job" and "She [staff member] does a good job. She's on time and never missed a call and she would let me know if she wasn't well". One person said they had received a very late care visit during the snow. They said, "I didn't have a wash until

13:30 to 14:00ish. The carer that came in today, I was her first ever patient; the previous person didn't turn up because of the snow. The new carer was actually very good considering she's just finished her training. The staff stay for the full time allocated and I make sure of that; I take no nonsense; they're pretty good and don't refuse me anything".

Appropriate systems were in place to ensure people received their care and support in emergency situations. The provider had an on call arrangement to ensure that people and staff could access the management team in an emergency. People were given the telephone numbers for the out of hours contact in their information packs which they kept within their homes. The management team used a laptop computer with access to people's records and the staffing rota system to enable them to operate their on call service. The provider had an emergency plan in place to determine what action they would take to ensure consistent care and support in extreme conditions such as snow, ice, flooding. The plan detailed how the service would operate if the office building became damaged and unusable.

Some people managed their own medicines; others were supported to take their medicines by their relatives. Some people had support from staff to administer their medicines or prompt them to take their medicines. We observed staff prompting people to have their medicines during their care calls and checking that people had taken their medicines as prescribed. Where people were provided support by staff to administer medicines, medicines administration records (MAR) were completed by staff to evidence which medicine they had given and at what time. At the end of the month the completed MAR charts were returned to the office and these were audited by the management team. We checked the completed MAR records and audits and found that the management team had identified where there had been errors or missed signatures. Appropriate action had been taken to investigate these. This included checks of the daily records to check whether staff had written about supporting people with their medicines; which would indicate they had forgotten to sign the MAR. We spoke with the management team about action they had taken to address the gaps in recording and potential medicines errors, they explained that some staff disciplinary actions had taken place, staff had received training and additional checks of staff competency to administer medicines had been carried out.

Risk assessments had improved since we last inspected the service. Risks had been identified in relation to people's environment and premises, moving and handling, falls and these were individual to people. Premises risk assessments detailed potential hazards and in most cases gave clear actions to mitigate the risk. Risk assessments clearly listed actions staff should take to minimise the risk of harm. Risk assessments had been developed in relation to people's health needs. For example, one person had diabetes. Risks in relation to diabetes had been identified risks, there was information for staff so they knew the signs for high blood sugar levels and low blood sugar levels, the information also told staff to call 111 or 999 if they suspected the person was suffering with the effects of high blood sugar. Another person had Parkinson's disease, their risk assessment contained information to help staff understand the disease and the issues this could cause for the person. For example, how the disease affected the person currently, such as difficulty in moving and some speech problems. The risk assessment detailed the person's balance issues, urinary incontinence, constipation and lots more. However, the risk assessment also stated other risks that could be associated with Parkinson's disease such penial dysfunction. Although the information was interesting and would have given staff insight into the possible future affects, it was not necessary with in the care plan and risk assessments. We spoke with the management team about this and they agreed that the information was not relevant to the person and agreed to review and amend the risk assessments further to make sure they were person centred and gave clear guidance to staff about how to mitigate risks.

A relative told us that their family member was safe because staff used equipment safely. The relative said "They move mum safely from bed to chair; they seem to know what they're doing." One person and their

relatives said that office staff had visited them in their home to carry out risk assessments to make sure they and staff were safe. They said, "Yes they visited us to do a risk assessment."

We discussed lessons learnt with the management team, the operations manager told us the service had learnt from previous inspections and had put systems in place to ensure they had adequate staff in place to properly assess a person when they had been referred to the service, enabling time to develop and create care plans and risk assessments to ensure staff knew what care and support they needed to provide and how to keep themselves and the person safe.

Accidents and incidents had been appropriately recorded when they had happened and these had been reviewed by the management team. One staff member told us, "If there was an incident I would write up what happened, there are incident forms within the file at people's homes, I would complete this and return it to the office within 24 hours." We listened to a discussion in the office where staff had passed on that they were having difficulty safely moving a person because they were refusing to use equipment. The management team discussed this and the operations manager then telephoned the persons local authority care manager to pass on the concerns. They discussed the risks to the person and to staff and a multiagency meeting was arranged with the person.

People continued to be protected from abuse and mistreatment. The staff we spoke with had a good understanding of their responsibilities in helping to keep people safe. Staff told us they would have no hesitation raising concerns with the provider. Staff were confident the provider would deal with any issues taken to them for their attention. Staff had access to the providers safeguarding policy. The service had a copy of 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 provider and managers about their responsibilities for reporting abuse.

Recruitment processes continued to be robust which kept people safe. The provider followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked.

Staff continued to be provided with appropriate equipment to carry out their roles safely. They were issued with gloves, aprons, uniforms, hand gel and identity badges when they started. Staff confirmed that they could access more equipment when required. There was a stock of personal protective equipment (PPE) kept in the office which staff could access regularly to stock up. We observed that PPE was located at each person's home for staff to use.

The office environment continued to be safe for staff and visitors. The provider had ensured that checks had been completed in the office premises by qualified professionals in relation to electrical supply, gas appliances, fire safety and moving and handling equipment, the moving and handling equipment was used to train staff. The fire alarm had been tested weekly.

Good

Is the service effective?

Our findings

People gave us mixed reviews about staff and their ability to carry out their roles. One person told us that they had received care and support from someone who did not know how to use a microwave and they had not known how to make cheese on toast so had served them with bread with cheese on, they had reported this to the management team. Another person told us, "They [staff] seem pretty reliable and well trained. They've taken on new staff lately; we're going through a dodgy period at moment because of the new staff; they're not yet used to me and my routine. The other carers are quite good actually."

The staff training schedule showed that the majority of staff were undertaking the training necessary for them to provide care to people. Staff confirmed that they had attended training. Some staff who had been with the service for some time had not been keeping up with the mandatory refresher training which meant that some of their training was out of date. This had been identified by the management team and there was a training plan in place to ensure that staff refreshed their training in a timely manner. Staff had been given clear deadlines in which to meet they needed to complete the required training. One staff member told us they had received training in relation to a promotion. They explained that they had received training in planning staff rotas, spot checks, reviews of care packages, supervisions, safeguarding and medicines.

We observed staff safely using a hoist to help manoeuvre a person from their chair to their bed. They followed their training which meant that the person and staff were safe from harm. Staff were careful to manoeuvre the hoist around furniture and door frame to prevent damage.

There continued to be a comprehensive induction programme in place which all new staff attended. This involved staff undertaking the Care Certificate if they have not already done this. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised. We saw evidence of workbooks being completed by staff as their learning increased. These were being monitored by the management team and staff were being given support where necessary. Staff said that they felt supported and if they did have any problems with any specific training module they would feel happy talking to the management team about this. Staff confirmed they were able to complete further training and qualifications to develop their skills.

Field care supervisors undertook spot checks and observations of staff carrying out care and support to check their practice. Staff files evidenced that this was completed on a frequent basis. Supervisions were carried out between staff and their line managers. Records showed that supervisions discussed training needs, concerns, health and safety, practice issues and individual concerns re people. One staff told us they received a supervision meeting with their line manager every three months.

A health and social care professional told us, 'In terms of hydration and nutrition, the carers [staff] were providing drinks and food at breakfast time only. The client has a fully wheelchair adapted kitchen which he has the ability to use independently.' We observed staff offering drinks to people as part of their support and reminding people to drink plenty to stay hydrated because the weather was hot.

Some people had support to prepare and cook meals. People were offered choices of meals during their support visits. We observed one person getting bread out of their freezer and putting it in the toaster and then asking staff to complete the task by putting butter on and marmalade. We observed another staff member check with a person what they would like to eat for their lunch. The staff member acted on the person's wishes and before preparing the meal showed the person two options to make sure they were going to cook the right one. People were not rushed to eat their meals by staff. Care plans detailed where staff supported was required with preparing and cooking meals. Some care plans did not list people's likes and dislikes in relation to their foods. However, a staff member said they would ask people about their likes and would give them choices. People told us that their food was prepared and cooked to meet their needs. Comments included, "I am diabetic but I'm not restricted on food"; "I just tell them what I want to eat and they prepare the food for me" and "Meals are prepared four times a day and they prepare what I want; I enjoy the meals and have had no problems up to now; they wouldn't ever rush me" People we spoke with told us they did not have any specific cultural or religious preferences in relation to their food. A relative detailed how staff prepared their family member's meals, "She tells them what she wants and they prepare; she then feeds herself. Mum feeds herself and is given what she wants; she has no dietary requirements" and "Mum doesn't eat very much, but all's fine when she asks for what she wants; I don't think she's ever been rushed and she has never said."

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in the best interests and as least restrictive as possible. There were procedures and guidance in place in relation to the Mental Capacity Act 2005 (MCA 2005) that included the steps 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. The policy and procedure had been rewritten in July 2017. The policy and procedure gave clear guidance about who should support people to make decisions if the person lacked capacity. Consent forms had been revamped and people had consented to their care if they had the capacity to do so. Staff had received refresher training in relation to the MCA 2005. Training records showed that 13 out of 34 staff members had attended MCA 2005 refresher training in July 2017, new staff had attended MCA 2005 training as part of their induction training.

People had consented to their care. For example, consent forms showed that people had consented to receive personal care, medicines support and support with preparation of meals. Signatures indicated that people had been involved in the planning of their care. However, for one person, their care had been discussed with a family member and there was no evidence that the person's consent had been sought for this. We spoke with the management team about this and they agreed that this person's records needed to be reviewed and amended. Daily records evidenced people's choices about their lives, people were given time to make choices and were not rushed. One relative told us, "Their [staff] bedside manner is very good and they don't rush her." A staff member told us, "It is important that we get consent and although a sign to say this I always ask them first. I asked them how they would like their care. If they refuse then we cannot provide care, we always have to have their permission."

There was an initial assessment process in place for people before they moved into the service. The assessment checked the care and support needs of each person so the registered manager and the management team could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss key information such as their marital status, sexuality or lifestyle preferences as well as their rights, consent and capacity. People were also assessed to check how many staff were required to safely meet their needs. If people required support to manoeuvre using a hoist

or support to change position the number of staff allocated to the care visit was increased so staff and people were safe. The assessment process involved people and their family members when this was appropriate. Capturing information about people was an evolving process, the provider and management team planned to make further changes to the assessment process to ensure people's equality, diversity and human rights were fully explored. Assessment training had been booked, the management team, field care supervisors and the care coordinator were booked on this on the 14 March 2018.

The initial needs assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records.

People's care records evidenced that people continued to receive medical assistance from healthcare professionals when they needed it. Staff contacted the office to inform the management team when any changes in people's health had been noted and reported to people's families if they lived with a family member. One relative told us that staff were good about reporting to them if their loved one was not acting in their usual manner. One person told us, "The carers call the GP when necessary. They've done it quite a few times actually; they just noticed something wasn't right and they got help." We observed staff supporting a person to carry out their exercises which had been prescribed by a health professional. They followed the exercise plan and encouraged the person to carry out the exercises. They provided reassurance that the person was doing well and that they could see a difference in the person's strength and dexterity. This visibly gave the person confidence. They showed the person's relative the improved range of movement and they all agreed that the exercises had helped regain some movement. Records evidenced that the service had responded to people's changing needs as they had contacted the GP, district nurses, Speech and Language Therapy (SaLT), Occupational Therapist (OT) and local authority care managers when necessary.

Good

Is the service caring?

Our findings

People told us staff were kind and caring towards them, most people told us that they looked forward to seeing staff. People told us they had built good relationships with their regular care staff. One person told us they were treated with, "Kindness and with love and compassion. I'm never rude to them and I appreciate the help and they show me kindness back." Other comments included, "They go the extra the mile for me"; "They're very nice. I can't wish for better ones"; "They are very polite"; "Oh, she's lovely all the time"; "Kind and caring? Yes, absolutely"; "They're very good"; "[Name of staff member] is a special lady. She's so kind; she's like a sister to me. They are all kind" and "They are very good and they care about the whole family including our son and daughter."

Relatives told us that staff were kind and caring to their family members. One relative told us, "They're kind and caring, and make sure mum's comfortable." Another relative told us, "[Name of family member] likes them all, if he's happy I am happy. He is very happy with the carers. They are respectful and polite and they respect me too".

People said staff treated them with dignity and their privacy was respected. We observed staff supporting people to mobilise to their bathrooms to use the toilet or to support them with washing and dressing. People were not hurried and staff checked with people what they wanted to do next. We observed one staff member checking with a person whether they could enter their bedroom to put their slippers back in there. The person didn't hear them at first and did not respond. The staff member waited and asked again and only carried out the task when they had authorisation to do so. One person told us, "They put a bowl on the table for washing me and they supervise me while I use the flannel to wash myself. I can't do my feet so they do that part for me. They're very good and make sure I'm warm and covered."

A staff member explained how they respected people's religious and cultural needs. They explained that some people because of their religion and culture did not want staff in certain areas of their homes. The staff member said, "I have done equality and diversity training. We have to consider what the client wants."

People and relatives told us that staff respected their personal space. One relative explained that the staff respected their privacy. For example, they did not go in to rooms they shouldn't be in and always knocked. We observed staff consistently knocking on doors before entering people's homes. Staff told us and records confirmed that some people had key safes outside their homes to keep their door key safe and secure. Staff used these to let themselves in when they had permission.

People's confidentiality was respected. Care records held by the service were kept in a securely locked filing room at the office. People were able to keep their care records in their homes where they wanted them. One person told us, "They don't say anything about me and they don't talk about their other people too". Another person told us, "They always tell me that my confidentiality is maintained; I trust them a lot." A relative said, "I've never had any reason to question confidentiality; don't think I've been re-assured about confidentiality, but I would expect that anyway." We observed staff accessing these and writing their reports during their care visits. Some people told us they read the entries and some people told us they did not.

We heard staff calling people by their preferred names. People told us their regular staff knew them well. One person told us, "A few weeks ago [staff member] saw that I was getting panicky and he said that I do too much and should calm down a bit; he was right and I really appreciated that he noticed and said those kind words."

People were encouraged and supported to be as independent as possible. One person told us, "I like to do what I can and they help me to do the things I can't do; it's my independence." A relative told us, "They encourage her [family member] to walk and to do things for herself." Another relative told us, "Yes they're very good at it (encouraging their family member's independence); if they see that he can manage to pick things up for himself, they say so in a nice way." We observed one person's care and support as staff supported this person with their physiotherapy exercises. The staff provided lots of positive reassurance, encouragement and praise which the person clearly valued. During the exercises there was lots of chat and laughter. Staff and people interacted well and talked about their different cultures and childhoods. One person told us they liked to learn words from the staff who were born in different countries, we observed the person practising these words and checking with the staff that they had said it correctly.

Staff were clear on how to maintain people's dignity when supporting them with their personal care. They ensure people's curtains and doors were closed. One staff member explained how they maintained people's dignity when providing personal care. They said, "I asked if it is all right for me to take their clothes, I would close the door but ask first at every stage. I would cover them with a towel at all times." Another staff member told us, "I would make sure that the curtains and door to the room was closed before assisting a person to undress." They also said, "I would make sure that I covered the person as much as possible with a towel so that not too much of the body was exposed at any one time. I would ensure that the person has the opportunity to do as much as they can for themselves and I would also ask permission before doing anything". I would always offer for them to wash their private areas themselves if they are able, as obviously this may make the person embarrassed." A person told us, "They're respectful. They cover me and everything."

Good

Is the service responsive?

Our findings

At our previous comprehensive inspection on 25 May 2017 we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider and registered manager had failed to establish and operate effective complaint systems. The provider sent us an action plan on 25 October 2017. This identified that Regulation 16 had been met at the end of June 2017.

We observed staff checking that people were comfortable, warm enough and had enough to drink and eat. People and their relatives told us the service was mostly responsive to their needs, where there had been concerns or complaints about the care provided; the provider had acted appropriately to address people's concerns. People told us they knew how to complain. One person said, "I've made a complaint (albeit minor about a carer turning up late), but they have dealt with it to my satisfaction. They do encourage me to raise concerns; I have no qualms in complaining and feel very confident. I have a good relationship with the supervisor." Other people told us, "No one's been nasty and up to now; I have got no complaints"; "I don't like to complain and have nothing to complain about but I would always report anything I wasn't happy with like those carers who were not good. I reported them to Rosemont Care and they never came back. I'm very grateful to Rosemont Care" and "I just need to ring the office; they all know me and things get done. I don't get any backchat and always get a sensible reply." One person we met with told us about a concern that she had passed on to the management team through their regular staff member. They did not feel confident in their own ability to raise a concern or complaint directly but felt the staff member had shared their concerns. We agreed to also pass on their concern to the management team. We did this after we had met with them and the management team were already aware and had made adjustments.

Relatives were confident in raising concerns and complaints with Rosemont Care. One relative told us, "I have given feedback to Rosemont Care that they missed a medications call and they hadn't offered her any food; they were responsive and acted straight away." Another relative said, "I did make a complaint and they dealt with it quickly." Another relative said, "I know how to complain and would have no problem in complaining. The Agency do say if there's anything else we can do to help, get in contact."

The complaints policy available in the office showed expected timescales for complaints to be acknowledged and gave information about who to contact if a person was unhappy with the provider response. This had been updated to include the Local Government Ombudsman (LGO). The complaints procedure gave contact details for CQC. The provider had an easy to read complaints information guide for people. The management team planned to make further updates and amendments to the complaints and compliments processes so that information was available to people in different languages and fonts to meet people's needs. Complaints information we viewed showed that complaints had been investigated within the agreed timescales. Letters of apology had been sent to people where these were required. People had also been sent out apology letters when the management team had identified issues. For example, the electronic system for planning and scheduling care visits had developed a fault and had not been allocating some care visits to staff. This had resulted in some missed visits to people. The management team had identified this, investigated this, written to people to explain what had happened and put checks and systems in place to ensure it did not happen again. The management team also logged the fault with the

provider of the electronic system.

A health and social care professional gave us examples of how responsive the service had been with a person who was difficult to engage with. They told us, 'In my opinion, in this particular case, Rosemont Care went over and above to accommodate this client's care needs under difficult circumstances. They changed the timings of the care calls on a number of occasions to facilitate the client's wants rather than needs. The staff at Rosemont Care were in regular contact with myself regarding various issues and raised these in a timely manner.'

People's care plans had continued to improve. Care plans and assessments were in place for each person receiving care and support. They provided clear information about the tasks staff were required to support people with in their own homes. Some care plans were very task orientated which made them less personalised. Most were personalised and included essential information such as information about people's personal histories, important people, places they had lived. This enabled staff to engage with people about their past and about important things. Field care supervisors had been reviewing and updating care plans with people and their relatives. Further improvements were required to ensure care and support plans were clear about people's current needs. People's care and support plans had not always been amended to reflect changes to time of care visits and where these had reduced. For example, one person's care plan detailed that they received four care visits per day. However, the person, their relatives and the person's daily records evidenced that they had two care visits each day. Another person's personal history detailed they had been born in Nepal, however there was no guidance in place for staff about what sort of food the person liked despite the fact that staff were required to prepare and cook food to meet their needs. Another person's care plan differed from the information obtained by staff during the assessment process. The assessment had captured details about the person requiring support to put on and take off support stockings but this had not been included in the person's care plan. The management team assured us these areas were being addressed, timely actions were planned to update the care plans further and further training and support was taking place for staff on 14 March 2018.

People and their relatives told us they had been involved in reviewing and developing their care plans. When we visited people in their homes, we viewed records to evidence that field care supervisors had met with them to review and amend their care and support to meet their needs. People had signed their care plans. One person told us, "They normally visit and we have a chat. They're very considerate in planning my care; I'm limited on what I can do so care is basic." A relative told us, "The agency staff help with care requirements and do what's needed in the time allocated; they ensure mum is looked after well and is happy. We went through requirements when drawing up the care plan; the level of care decided is in place." Another relative told us, "I have a meeting with one of the managers from the care agency and we make sure that all is ok. It's all accessible and understandable."

During the inspection we found that the assessment process did not capture information about people religion or culture or preferences if their health deteriorated. We spoke with the management team about this and they had already identified that the assessment process required reviewing, staff responsible for carrying out assessments and reviews had been booked on training on 14 March 2018 and they had planned to update and amend the assessment tool used to gather people's views and wishes in relation to sexuality, gender, religion, culture as well as exploring people's end of life wishes if they had any. The service was not providing care and support to people who had been assessed by healthcare professionals as requiring palliative care. The management team explained that staff were booked on training in relation end of life care. Once every member of staff had received their training the provider would then consider taking on people with this need.

Good

Is the service well-led?

Our findings

At our previous comprehensive inspection on 25 May 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider and registered manager were required to make improvements to establish and operate effective systems to monitor and improve the quality of the service. The provider sent us an action plan on 25 October 2017. This identified that Regulation 17 had been met and there was ongoing monitoring to ensure new systems and processes were robust.

People told us that the service was managed well. Comments included, "I know four managers; I think they manage the service well because they lead their staff well. I've only ever had a groan, but not a real serious complaint. They're pretty good to me"; "I can't name the managers but the head one came to see me for a meeting with my nephews and nieces and there were no complaints. They're excellent 10 out of 10, no, 11 out of 10"; "The service is marvellous"; "When we had the snow, the senior supervisor just lives round the corner and they made sure I was taken care of in the bad weather. Not many bosses would do what she does" and "At the moment it's all fine." A relative told us, "I know the managers; it is well managed, they're very open to suggestions in what mum needs and they take comments on board; they're there at the end of phone when I need therm." Another relative said, "Yes, I would recommend them and I'd give them eight out of 10." One relative told us; "Consistency in sending the same carers" is what the service did best.

Relatives gave us examples of where communication could be improved further. One relative said, "A few weeks ago I cancelled visits because we had an appointment at the eye hospital and I gave them advance notice. The office didn't cancel as the carers came as we were leaving. It's rare that they get things wrong." Another relative said, "They let mum know they're running late, but not me."

People were given opportunities to provide feedback about their care and support. Field care supervisors in the service carried out monitoring visits with people and telephone checks to ensure people were happy with their care and support. One person's feedback was seen in their care file. It stated, 'Quite happy how things are' and 'I am pleased with you all.' This person had also given feedback by telephone which had been documented by a staff member; 'No problem, everything really good, happy with carers, they know what to do' and 'All good no complaints at all.' The operations manager told us how they planned to send out annual surveys to people, relatives and health and social care professionals in May 2018 to enable people to give feedback anonymously if they wished.

Compliments had been received from health and social care professionals and relatives. One dated 14 February 2018 complimented a staff member in relation to their moving and handling practice. Another compliment dated 21 February 2018 evidenced a relative provided positive feedback about the care their family member received from a particular staff member.

Audits and checks were carried out by the registered manager and the management team. Audits included checks of medicines administration records, care plans and risk assessments and audits of staff recruitment files as well as staff training. The provider's training and development manager had undertaken a thorough

audit of training and had developed an action plan which included dates of completion for mandatory courses and induction.

The provider had also engaged an external consultant to carry out an audit of the service in November 2017. Feedback showed that the provider had been advised to review all care plans and risk assessments to ensure they were person centred. The provider had actioned this and this piece of work was still ongoing.

The provider had attended the service on a frequent basis to provide support to the management team. The registered manager explained that during these visits the provider checked audits and carried out observations. The operations manager told us; "[Provider] has been here frequently supporting with the changes".

The management team including the registered manager and provider met frequently to share information. The provider and management team kept abreast of changes in legislation and good practice through attending workshops, utilising the internet including the CQC website. The operations manager had attended a provider forum in the local area to enable them to know what is happening locally and to network with other providers. The provider had registered to receive medical device alerts and patient safety alerts. When these were received they were shared with the management team. The management team carried out checks to ensure that any equipment and medicines that people used which were affected by the alerts were appropriately dealt with.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The provider confirmed these were regularly updated and then shared with staff meetings and in training sessions. The provider was planning to change the policies and procedures and had planned to implement these changes in the coming months. The provider had factored in that this would impact on the staff training, induction and the staff handbook and updates would be required.

The management team and staff told us that communication had improved since we last inspected the service and that staff morale had improved. A member of the management team said, "I am really proud of staff, we've worked really hard to get it done. It's been good." Another staff member told us, "Things are much better, more organised, good communication between the office team, all have a good relationship which means runs smoother. I am getting good support to do my job. I am happy."

Staff told us they had lots of support from the provider and management team. One staff member said, "I find the manager and office staff not a problem, they are very amenable and nice people."

The service worked closely with health and social care professionals. The operations manager told us, "We have an improved relationship with healthcare professionals. They receive copies of accident/incidents forms". The operations manager shared examples of liaising closely with one local authority care manager when a person's needs had deteriorated which meant they required residential care. We viewed records which showed the management team had kept local authority care managers informed of when people had been taken ill and had been admitted to hospital.

Staff were kept up to date and informed about the service through newsletters, memos and through staff meetings. Two staff meetings had taken place since we last inspected and another meeting was planned for 14 March 2018.

The provider celebrated staff achievements by holding a 'Carer of the month' award, the certificate for each month were displayed in the reception area. Staff who had gone out of their way during the month who had

worked hard were nominated by other staff members or the management team. The registered manager shared that those who were awarded carer of the month were presented with a gift voucher and a certificate. Staff valued the awards. One staff member said, "During the bad weather we had recently I went to as many people as possible. I walked everywhere going into people who were normally looked after by staff who drove and could not get there. I have heard this afternoon that I have been given an award for my work last month and I believe that is because of the amount of calls which I managed to cover during that week. I knew how important it was that these people had someone visiting them even if it wasn't at their normal time."

The registered manager confirmed this and said, "Change is positive, we are so much more involved in the monitoring of the service day to day and staff. Staff morale is higher and they are more confident approaching us. Service users also approaching with comments about what they are happy and not happy with" and "There have been so many changes, we are now seeing the positive impact. We are focused on quality and are being realistic."

One of Rosemont Care Medway's aims and objectives was to provide quality services. The statement of purpose detailed, 'Rosemont Care Medway are whole-heartedly committed to providing top quality services and to continuously improve in the level of the care, assistance and support we offer'. Our observations showed that the whole service from the registered manager to the staff providing hands on care were dedicated to ensure that people received the best support and care as possible. Staff did their upmost to ensure that people had the best quality of life. Each staff member we spoke with told us how much they enjoyed working at the service and providing care and support to people living in their own homes. The registered manager said, "We have focused on each area and identified other areas for improvement. We are prepared to do whatever is needed."

The service had organised a Christmas party event in December 2017. Due to the poor weather, people and their relatives did not attend. The staff team delivered the party food to people and their relatives. The management team planned to hold a summer event instead in 2018.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they had confidence in the provider taking appropriate action such as informing the local authority and CQC. Effective procedures were in place to keep people safe from abuse and mistreatment. The provider's whistleblowing procedure listed the details of who staff should call if they wanted to report poor practice.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths. The management team had notified CQC about important events such as safeguarding concerns that had occurred.

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