Toqeer Aslam

Welcome House - The Chestnuts

Inspection report

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Date of inspection visit: 14 July 2015
Date of publication: 06/08/2015

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

Overall summary

We inspected this home on 14 July 2015. This was an unannounced inspection.

The Chestnuts is registered to provide accommodation and personal care for up to 15 people with mental health needs who do not require nursing care. The people who used the service lived with mental health disorders and needed support to understand their particular conditions; identify triggers for relapse; and learn coping strategies. At the time of our inspection, 11 people who lived in the home were fairly independent, hence requiring minimal support.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People 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.

The home had risk assessments in place to identify and reduce risks that may be involved when meeting people's needs such as mental health, and details of how the risks could be reduced. This enabled the staff to take immediate action to minimise or prevent harm to people.

There were sufficient numbers of staff to meet people's needs. 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.

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.

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.

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 home complied with these requirements.

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

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

Staff were aware of signs and symptoms that a person's mental health may be deteriorating and how this impacted on the risks associated with the person's behaviour. People were supported as appropriate to maintain their physical and mental health. People had care plans outlining the goals they wished to achieve whilst at the service and what support they required from staff to achieve them.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

The provider operated safe recruitment procedures and there were enough staff to meet people's needs.

People received their medicines as prescribed and regular checks were undertaken to ensure safe medicines administration.

Good

Is the service effective?
The service was effective.

Staff had the knowledge and skills to meet people's needs, and these were updated through attendance at training courses. Staff received supervision from their manager to ensure they had the support to meet people's needs.

Staff understood the requirements of the Mental Health Act 1983 (amended 2007), Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards, which they put into practice.

People were supported to maintain their health and have their nutritional needs met.

Good

Is the service caring?
The service was caring.

There were caring relationships between people and the staff who provided their care and support.

People's privacy was respected and staff gave people space when they wanted some time on their own.

People were involved in decisions about their care. People actively made decisions about their care.

Good

Is the service responsive?
The service was responsive.

People were supported in line with their needs. People's needs were assessed and care plans were produced identifying how support needed to be provided.

People were involved in a wide range of everyday activities and led very independent lives.

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

Good

Is the service well-led?
The service was well led.

The home had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

Good

Summary of findings

Staff told us they found their registered manager to be very supportive and felt able to have open and transparent discussions with them through one-to-one meetings and staff meetings.

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

Welcome House - The Chestnuts

Detailed findings

Background to this inspection

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

This inspection took place on 14 July 2015 and was unannounced.

Our inspection team consisted of three inspectors and one expert-by-experience who carried out interviews with people using the service. Our expert by experience had experience of using mental health services including hospital inpatient and outpatient clinics, specialised clinics as well as community based services.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us about by law. The provider completed 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 examined previous inspection reports and notifications sent to us by the registered manager about incidents and events that had occurred at the service.

During our inspection, we spoke with five people, two support workers, one senior support worker, the registered manager and the operations manager. We spoke with a care coordinator for the community psychiatry team and a social care officer who visited the home during our inspection. We also contacted other health and social care professionals who provided health and social care services to people. These included community nurses, doctors, Kent and Medway Partnership Trust (KMPT), local authority care managers and commissioners of services.

We observed people's care and support in communal areas throughout our visit, to help us to understand the experiences people had. We looked at the provider's records. These included two people's records, care plans, mental health care notes, risk assessments and daily care records. We looked at two staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures.

At our last inspection on 22 April 2013 we had no concerns and there were no breaches of regulation.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe here". Another person said, "I like it here". We observed that people were relaxed around the staff and in their own home.

Staff told us that they had received safeguarding training at induction and we saw 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 that may occur. Staff told us the registered manager would respond appropriately to any concerns. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place that were reviewed on a bi-annual basis. We saw that these policies clearly detailed the information and action staff should take, which was in line with expectations.

People were protected from avoidable harm. Staff had a good understanding of their mental health needs and people's individual behaviour patterns. Records provided staff with detailed information about people's needs. Through talking with staff, we found they knew people well, and could inform us of how to deal with difficult situations such as behaviours that challenges staff regarding service provision to people. As well as having a good understanding of people's mental health behaviour, staff had also identified other risks relating to people's care needs. People were supported in accordance with their risk management plans. Staff demonstrated that they knew the support needs of the people at the home, and we observed support being delivered as planned. For example, one person became increasingly distressed due to an impending move, and we noted that support staff were able to calm the situation down, by talking in a calm and soothing manner, as advised in the person's support plan, which staff understood and followed.

Staff told us they were aware of people's risk assessments and guidelines in place to support people with behaviour that may challenge them and others. People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. Staff had assessed risks to each person's safety and records of these assessments had been regularly reviewed. Risk assessments had been personalised to each individual and covered areas such as the potential for exploitation. This ensured staff had all the guidance they needed to help people to remain safe. Staff discussed the risk assessments with us and outlined how and why measures were in place. For instance, we heard how staff assessed the impact of people's mental health conditions on how they managed their money. The plans assisted individual's to consider the consequences of actions and the action they could take to keep safe when out and about in the community.

Staff maintained an up to date record of each person's incidents or referrals, so any trends in health and behaviour could be recognised and addressed. For example, a record of each referral to the crisis team was maintained, and used to build up a pattern of behaviour which allowed for earlier intervention by staff. We spoke with two members of support staff who told us that they monitored people and checked their support plans regularly, to ensure that the support provided was relevant to the person's needs. The staff members were able to describe the needs of people at the home in detail, and we found evidence in the people's support plans to confirm this. This meant that people at the home could be confident of receiving care and support from staff who knew their needs.

There were suitable numbers of staff to care for people's safely and meet their needs. The registered 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. The registered manager said if a person telephones in sick, the person in charge would ring around the other carers and other care homes belonging to the same provider in the area to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. We saw that there were sufficient staff on duty to meet people's needs, for example attending hospital appointments. The registered manager told us staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly.

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

Good

Is the service safe?

minimum of three references were sought and staff did not start working alone before all relevant checks were undertaken. Staff we spoke with and the staff files that 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 ensure appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking and why they were taking their medicines. Appropriate assessments had been undertaken for one person who administered their own medicines. We saw that a Community Psychiatric Nurse (CPN) conducted an assessment to ensure the person was safe to take these medicines themselves and this was reviewed on a six monthly basis. The person had their own lockable cupboard in their room with their own key. Weekly and random checks were undertaken and recorded to ensure the person continued to take their medicines as prescribed. The staff told us that they wanted the person to continue being independent with this as it was something they did before they moved into the home.

Medicines were kept safe and secure at all times. They were disposed of in a timely and safe manner. 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. Another lockable cupboard / trolley was situated in the dining room, where daily checks were made of the trolley to ensure the temperature of the medicines did not exceed normal room temperatures. Within the trolley was appropriate locked storage for any additional drugs, such as night sedation. A book to register these medicines was also stored within the trolley and gave an accurate record of the drugs within the locked box.

Staff who administered medicines were given training and medicines were given to people safely. Staff had a good understanding of the medicines systems in place. A policy was in place to guide staff from the point of ordering, administering, storing and disposal of any unwanted medicines. Appropriate arrangements were in place in relation to obtaining medicine. Medicines were received in a monitored dosage system (MDS). This system is where all the medicines for a given time period were prepared by the pharmacy. This meant that systems were in place so that prescribed medicine would be available for people.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered manager conducted a monthly audit of the medicine used. This indicated that the registered manager had an effective governance system in place to ensure medicines were managed and handled safely.

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

People told us they had confidence in the staff's abilities to provide good care and believed that the staff had assisted them to make very positive changes to their lives. People told us that they felt that the staff were effective at supporting them to learn the skills they needed to be more independent.

People said, "I am quite happy here. We get to go out" and "I have been to other places but this is the best place I have been. I am aiming to get my own flat and become independent".

People we spoke with confirmed staff consulted with them about their support needs. One person said, "I am involved in my care plans, which I like." and "I am involved with my care plan and CPA reports".

People told us that their consent was always obtained and they were fully involved in all aspects of planning their care. We found that the staff had a good understanding of the Mental Health Act 1983 (amended 2007) and what actions they would need to take to ensure the home adhered to the code of practice. People confirmed that staff sought their consent before they provided care and support. Consent was sought from people about a range of issues that affected them, for example, consenting to their personal care being provided by staff and the administration of medicines. People's decision making was clearly documented, even when support was declined. This meant that people were supported to make decisions in their own best interests wherever possible.

The registered manager and staff we spoke with told us that people had capacity to make decisions but recognised that in the future this may not be the case so they and the staff had attended training in the Mental Capacity Act (MCA) 2005. MCA is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Staff that we spoke with understood the principles of the MCA, deprivation of liberty and 'best interest' decisions.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS). There were procedures in place and guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). A DoLS ensures a person is only deprived of their liberty in a safe and correct way, and is only done when it is in the best interests of the person and there is no other way to look after them. People in the home had mental health issues such as depression, anxiety, panic disorder and schizophrenia. Staff supported people without any form of restrictions of their liberty. There was no one who lived in home who required a DoLS.

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.

From our discussions we found that staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people with mental illness. 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 support worker told us that staff had recently attended training in the Mental Capacity Act and Deprivation of Liberty safeguards, which had been very useful and allowed staff to feel confident about how to assess a person's mental capacity and maintain their liberty.

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. The registered manager told us that they completed monthly supervision with all staff. 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 had taken place.

Good

Is the service effective?

People were supported to have their nutritional needs met. One person said, “The food is very good”. Meal times were prepared by the staff. People were asked during meetings what they would like to eat and this was accommodated on the menu. People were able to request alternatives to the meals on offer if they did not like what was on the menu. One person said, “The food is very good here. If we don’t like something we can ask for something else to eat”. Staff were aware of people’s dietary requirements and encouraged them to choose meals that met their needs. For example, we saw that where possible staff encouraged an appropriate diet for people living with diabetes and where possible reinforced a healthy living diet. Staff encouraged people to eat healthily and provided people with information about healthy eating.

Staff worked well with the mental health professionals who supported people in the home. They also supported people to make sure their other physical health needs were met. People could see a GP when they wanted. Each person’s medicines had been reviewed by their GP on a yearly basis. The care records identified when these diabetic reviews took place and the outcome of that review. For example, one person’s medicine for their diabetes had been changed to a daily dose which suited them better. The health care appointments showed that people also attended relevant screening for their diabetes. People were supported to maintain a healthy diet and lifestyle at the same time accepting people’s right to make decisions that may not suit them all the time. The care coordinator for the community psychiatry team said, “The home has some very capable staff”. The community psychiatry team also assisted staff at the home with support plans for people assessed as requiring community support. This meant that people at the home received support from external agencies in an integrated manner.

People had health action plans in place which were written in a way that the person could understand. These plans provided advice and health awareness information which may support the person’s health and wellbeing. They were updated annually and people had either just attended some health appointments or were booked in to attend.

We saw records to confirm that staff encouraged people to have regular health checks and where appropriate staff accompanied people to appointments. We saw that people were regularly seen by their treating team, such as community psychiatric nurses (CPN) and consultants. For example, a CPN visited one of the people in the home during our inspection. The visiting social care officer said, “The manager here is very good at identifying any mental health needs, and referring people appropriately”. We saw that all health appointments were documented in people’s care plans and there was evidence that the home worked closely with health and social care professionals to maintain and improve people's health and well-being.

Good

Is the service caring?

Our findings

One person told us, “Staff are very nice. I feel at home here at the service”. Another person said, “This place is a friendly and supportive place”. and “I like to take time to talk to staff. I feel loved by people here”. People also described the home as “Very good”, “Excellent” and “All my needs are taken care of here”. People felt positive about the care they received. We observed that staff showed kindness and compassion.

People were encouraged to be independent and to have as much choice over their day to day life as possible. People told us that they were involved in making the decision about how the home was run. For example, we saw that one person was the nominated ‘spokesperson’ for other people during ‘service users meetings’ in the home. This was a way of supporting people to promote their independent living skills. We found that people were to a very great degree independent. During our visit one person went into town for their own health appointment. The person said, “I have just come back from the GP on my own. This place could not be any better than it is”.

People told us that staff always respected their privacy and did not disturb them if they didn’t want to be disturbed. We saw that staff treated people with dignity and respect. Staff were attentive, showed compassion and interacted well with people. The environment was well-designed and supported people's privacy and dignity. All bedrooms doors were lockable and people had a key. People were able to personalise their bedrooms. Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care for a person. We found the staff team was committed to delivering a service that had compassion and respect for people. Staff respected confidentiality. When talking about people, they made sure no one could over hear the conversations. All confidential information was kept secure in the office.

Staff knew the people they were supporting very well. They had good insight into people’s interests and preferences and supported them to pursue these. For example, one person identified in their care plan that they liked to cook roast dinners. We saw in their care records that this was part of their goals, which staff supported them with. This showed that staff supported people based on the person’s choice and preference.

The registered manager and staff that we spoke with showed genuine concern for people’s wellbeing. It was evident from discussion that all staff knew people very well, including their personal history, preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received support they needed. We observed staff and people engaged in general conversation and having fun. We noted that staff had time to sit and chat with people at the home. For example, we observed one staff member talking to one person in the lounge at length. From our discussions with people and observations, we found that there was a very relaxed atmosphere and staff were caring.

People were involved in regular review of their needs and decisions about their care and support. This was clearly demonstrated within people’s care records and support planning documents that were signed by people. Support plans were personalised and showed people’s preferences had been taken into account. We reviewed daily records of support which demonstrated that staff provided support as recommended in people’s support plans during the day. The operations manager told us that if people’s needs required more support during the night, then this was provided as well. For example, when a person at the home deteriorated and required palliative care, extra staff were made available during night times to ensure the person’s needs could still be met. The social care officer with the local authority told us “I think the support here is very effective and staff treat people with empathy”.

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 home. One person said, “I have heard of advocacy and I have used them before”.

Good

Is the service responsive?

Our findings

People said, “I have been here over X number of years but I have never really had a problem here”, “Staff listen to my concerns” and “I do get depressed sometimes. When I do, I talk to staff and staff listen to me”.

There was evidence that people’s needs were assessed prior to admission and continually throughout their stay at the home. Each person had an initial referral which included a full case history, as well as a pre-admission assessment. The assessment covered all medical, social and mental health history, any challenging behaviour, and previous strategies to manage and safely support the person’s needs. The assessment was used to determine whether or not the home could meet the person’s needs, and if any specialised tools would be required. For example, people’s support plan included mental health relapse indicators and a management programme for crisis intervention. This meant that people’s needs were assessed in detail to ensure they could be safely supported at the home.

Each person’s detailed assessment, which highlighted their needs could be seen to have led to a range of support plans being developed. We found from our discussions with staff and individuals that the plans met their needs. People told us they had been involved in making decisions about their care and support and developing their support plans. 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 support plan. People’s care records were updated to reflect any changes in their needs. For example, if people were discharged from regular visits to the psychiatrist. This was changed in their care plan to ‘as and when necessary’ visits. This ensured that staff had access to up to date information about people’s changing needs.

People had regular one to one sessions with their key worker 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 health needs. This included the local authority’s mental health team, 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. This showed that each person had a professional’s input into their care on a regular basis.

External health and social care professionals told us that staff at the home were capable of recognising when a referral was required, and ensured that people received appropriate care that was safe and met their needs. For example, one person at the home had been referred to the community team as their behaviour meant that the home could no longer safely meet their needs. The person was in the process of being transferred to a more suitable placement during the inspection visit. We reviewed support plans which contained detailed assessments that provided information on how staff should support each person. We noted that changes to the support plans were made whenever people had been seen or assessed by external health professionals. For example, changes to medication after a visit from the psychiatry team, which indicated that people received care which was appropriate and met their needs.

People told us they were encouraged to pursue their interests and participate in activities that were important to them. One person said, “I am going to the day centre today. I am there every day. We also play board games and I like going to church on Sunday, which I do”. Another person said, “Activities wise, there are trips we go to every month. We also do cooking groups on a Wednesday. I don’t attend because I don’t like cooking. However, I will be going bowling today with staff, which I like”. There was a weekly activities timetable displayed in people’s care files and people confirmed that activities were promoted regularly based on individual’s wishes. On the day we visited, people went out to various activities, such as shopping, café and parks. The social care officer with the local authority told us, “The home tries to support people to maintain their independence and to express themselves, with things like cooking”.

Good

Is the service responsive?

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 and then they discussed this at resident's meetings. The information included contact details for the provider's head office, social services, local government ombudsman and Care Quality Commission (CQC). 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. One person said, "I am aware of the complaint process. If I wanted to make a complaint, I think I could". Another person said, "I know my rights and I have never had a reason to complain". We saw that no complaints had been made in the last 12 months. This showed that people had been given adequate information about the home, and how to make a complaint.

Good

Is the service well-led?

Our findings

People were extremely complimentary about the home. They told us that they thought the home was well run and completely met their needs. People said, "This place could not be any better than it is", "If I could describe the service in one word, it would be 'Very good'" and "I feel at home here and I feel loved".

People knew who the registered manager was, they felt confident and comfortable to approach her and we observed people chatting to the registered manager in a relaxed and comfortable manner. One person said, "I can just go to the registered manager and tell her how I feel. I don't have any problems but if I did, I would say something and she will listen". This showed that people and staff felt supported by the registered manager.

The home had a clear management structure in place led by an effective registered manager who understood the aims of the home. The management team encouraged a culture of openness and transparency as stated in their statement of purpose. The organisations values included an open door policy (anyone who wanted to bring something up with them just had to walk through the door and ask), management being supportive of staff and people, respecting each other and open communication. Staff demonstrated these values by being complimentary about the management team. They told us that the management team were very approachable. One staff member said "The manager has an open door". Another staff member told us "I had a concern which I raised in the past and they dealt with it very quickly". 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 home. 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 home.

Monthly meetings were held with the people. At these meeting people were actively encouraged to look at what could be done better. For example, people told staff that they wanted to lead the resident's meeting and we saw that the registered manager had implemented this. The people in the home nominated one person to speak on their behalf at residents meetings.

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the home. The registered manager 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 operational manager visited the home every month to carry out a monthly audit named 'internal home audit'. We found that the provider had effective systems in place for monitoring the home, which the registered manager fully implemented. They completed monthly audits of all aspects of the home, such as medicine, and learning and development for staff. They used these audits to review the home. We found the 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. For example, the latest audit identified during medicine audit that the registered manager needed to return unused medicines to the pharmacy. We saw that these had been carried out and signed as 'done' when we inspected. This showed that the registered manager acted on the findings which ensured people's needs were met.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system. Staff made comments such as, "We document all incidents using the contact sheet, report it to the manager who will investigate and also report it to higher management if need be".

The provider sought people's and others views by using annual questionnaires to people living in the home, staff, health and social care professionals and relatives to gain feedback on the quality of the service. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the home. For example, one person

Good

Is the service well-led?

said, “I would like to go out a bit more”. The registered manager responded to this by providing the person with more choice of activities and the person started attending the local library. Overall the responses were positive. For example, 100% of people felt their privacy was respected by staff.

The registered manager and staff worked well with other agencies and services to make sure people received their care in a joined up way. We found that the provider was a member of Medway Engagement Group and Network (MEGAN CIC). This group provides networking opportunities with other service providers to raise awareness and share best practice in mental health user in the local areas. They are also a member of (MIND) a charitable support group for people with mental health. This organisation provides advice and support to empower anyone experiencing a mental health problem. We found that being a member of both MEGAN CIC and MIND had enabled people to be more active in the home. This had also promoted the support provided and improved people’s quality of life through raising standards of care and support in the home.

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 home. 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.