Kent County Council

Broadmeadow

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection visit took place on 22 October 2014 and was unannounced.

This service provides intermediate care, short term respite and dementia care. Broadmeadow is a large purpose built service, and has 43 en-suite bedrooms and five flats situated over two floors. People are admitted to Broadmeadow from a range of settings – acute hospital beds, their own homes and temporary residential accommodation. The service is designed to prevent further admission to an acute hospital, facilitate a prompt return home and prevent admission to permanent residential care.

Broadmeadow can accommodate up to 48 people, and provides care and support for 35 older people, five younger adults with a physical disability, and eight adults with dementia, both male and female. It operates from

Summary of findings

five units within the same building. These comprise three short term rehabilitation and respite units; one unit for the five flats for respite care; and a dementia unit for respite care and assessment.

The main purpose of the service is for people to receive short term respite care, or be assessed for their rehabilitation needs. They are then supported in making sufficient improvements in their medical health or dementia needs to return home. Some people stay for longer periods of time if they are unable to return home and require social workers to find them long-term placements; or if they are waiting for home circumstances to be made suitable for them. Some people are admitted for respite care, for example, if their usual carer is ill and cannot look after them. The staff work closely with the NHS Intermediate Care Team (ICT), which includes nurses, physiotherapists, and occupational therapists. Referrals are made to other health professionals such as dieticians, speech and language therapists, or psychologists as needed. There is close working with social care professionals to ensure that people's home circumstances are suitable before they return home.

The service is run by a registered manager, who was present throughout the day of the inspection visit. 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 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and DoLS. Some of the people in the service had been assessed as lacking mental capacity to make some decisions, and there were clear records to show who their representatives were, in order to act on their behalf if complex decisions were needed about their care and treatment.

The service had suitable processes in place to safeguard people from different forms of abuse. Staff had been trained in safeguarding people and in the local authority's whistleblowing policy. They were confident that they could raise any matters of concern with their line managers, the registered manager or with the local authority safeguarding team.

The service had measures in place to protect people from risks to their safety. These included building and environmental risk assessments, maintenance checks, regular servicing and checks for equipment, and risk assessments for each individual person receiving care and treatment.

The registered manager carried out on-going checks to assess if there were sufficient numbers of staff on duty. There were suitable numbers of staff in evidence throughout the day, but we identified some concerns about the numbers of night care staff.

We recommend that the provider re-assesses the night staffing requirements for the service, in conjunction with the dependency levels of people using the service.

There were robust recruitment procedures in place. Staff said they were well supported through individual supervision sessions, regular staff meetings, yearly appraisals and daily handovers. Staff were trained in essential subjects during their induction programme; and refresher training was provided at regular intervals. Staff were encouraged and enabled to develop their knowledge and skills with further training courses, and formal qualifications.

People brought in their medicines with them from home or from hospital depending on the reason for their admission. The staff encouraged people to be as independent with their medicines as possible, so as to promote their ability to manage their medicines when they returned home.

The service provided a wide variety of food, most of which was home cooked. People said that the food was very good and they enjoyed it. The catering staff were knowledgeable about people's different dietary needs, and ensured that people received food that was suitable for them.

Staff were attentive to people's needs. People said they felt safe and well cared for. Comments included, "They look after me wonderfully, I don't know what I would do without them"; and "The staff here are lovely and give me

Summary of findings

lots of encouragement to get moving." Staff responded to people promptly when they called for help, and spoke to them in a kind and caring manner. People were confident that if they had any concerns they would be listened to, and their concerns would be dealt with appropriately.

People were involved in their care planning, and care plans reflected their individual needs and choices. People with physical health needs knew that the staff were committed to helping them to regain their independence and return home if possible. People in the dementia unit were encouraged to retain their independence, and staff showed empathy in helping them in times of anxiety or confusion.

People, relatives and staff spoke highly of the manager and said that she listened to them, and took their views and comments into account in the running of the service. Recent results from a survey conducted by the provider showed that people rated the service as 'excellent', and did not have any concerns. There were different styles of questionnaires for different units, so that people with dementia could more easily relate to the questions being asked.

The manager had a visible presence in the service and was available for people to talk with her on a daily basis. There were regular staff meetings for different job roles, so that staff were empowered to take part in the development of the service, and were fully informed about any changes.

The service was well known in the local community, and maintained good relations with other services. There was innovative working with other agencies to facilitate on-going improvements. For example, the service had recently been awarded a 'Gold Accreditation' from Sterling University for the dementia environment. (Sterling University has a Dementia Services Development Centre, to assist services in developing effective care for people with dementia). There was a clear sense of staff working together to achieve high standards of care for people in every unit.

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?

Requires Improvement

The service was safe. People told us they felt safe living there, and staff treated them respectfully.

The premises were suitably designed and maintained to provide a safe environment. On-going checks ensured that equipment was properly serviced and functioned correctly.

There were sufficient numbers of day staff. However, we have made a recommendation about the numbers of night staff, as the service was unable to demonstrate that sufficient numbers of care staff were on duty at night.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and supported in their different job roles.

The manager and staff understood the requirements of the Mental Capacity Act 2005. They ensured that people who lacked mental capacity for making some decisions were appropriately supported by their next of kin or advocate in making those decisions on their behalf and in their best interests.

The service provided a variety of food and drinks to provide people with a nutritious diet.

Is the service caring?

Good

The service was caring. Staff responded promptly to people's requests for help, and treated them in a kind and sensitive manner.

Staff ensured that people were involved in discussions about their care and treatment. They were provided with clear information about the service, and the support they would need when discharged.

People were treated with respect and dignity. They were encouraged to retain their independence as far as possible. Friends and family were able to visit at any time.

Is the service responsive?

Good

The service was responsive. Staff enabled people to take part in their care planning and were committed to ensuring that people received person-centred care.

People were supported in carrying out their preferred lifestyles, and in pursuing their own interests during their stay.

There were procedures in place to ensure that people's concerns or complaints were listened to, and were used to bring about on-going improvements to the service.

Summary of findings

Is the service well-led?

Good

The service was well-led. The registered manager worked with the staff team to provide a co-ordinated approach, ensuring that the service had an ethos of continual development. She liaised with other services and organisations to identify new approaches to health and dementia care, so that staff were envisioned, and were enabled to provide a continually improving service.

CQC was appropriately informed of formal notifications and changes to the service.

There were reliable systems in place to monitor the service's progress using audits and questionnaires. Records were suitably detailed, and were accurately maintained.

Broadmeadow

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, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 October 2014 and was unannounced. It was carried out by one Inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service, and this expert had experience in older people's care.

Before the inspection, 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. The PIR was sent out shortly before the inspection and was promptly completed by the registered manager. We reviewed this information after the inspection visit, and we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the provider is required to tell us about by law. We also looked at the service's Statement of Purpose which had been updated in July 2014 and sent to CQC. We were able to talk with four health and social care professionals who were providing support and treatment on the day of the inspection; and we contacted three others on the day after the visit to obtain their views about how the service was running.

We viewed all areas of the service, and talked with ten people who were receiving care and treatment. Conversations mostly took place with individual people in their own rooms. We talked with some people together in the lounge/dining areas. People in the dementia unit were not able to hold clear conversations with us due to their dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also talked with six relatives and friends who were visiting people; 11 staff from different job roles, and the registered manager.

During the inspection visit, we reviewed a variety of documents. These included eight people's care plans, from different units. We viewed three staff recruitment files; the staff induction and training programmes; staffing rotas over two weeks; medicine administration records for two units; health and safety records; environmental risk assessments; quality assurance questionnaires; minutes for staff meetings and residents' meetings; auditing records; and some of the home's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Broadmeadow, and that staff looked after them very well. Their comments included, "Yes, I definitely feel safe, staff are checking us all the time"; "I feel so much safer now that I am here. I have company"; and "I feel safe here. I did not feel safe at home as I had no help. The staff are lovely and are always willing to help." Another person pointed out that there were call points in different areas, and said they knew how to use these if they needed help.

Staff responded to people quickly, and supported them with their mobility needs. This promoted their safety as they knew that staff would come and attend to them. The service was well equipped with overhead tracking hoists, mobile hoists, profiling beds (which could be set at different levels), and pressure-relieving equipment. Records confirmed that the equipment was appropriately serviced and maintained, and staff were trained in using it. A visitor said, "The staff are very good, they stand behind to stop my relative from falling over when they are walking, and there is lot of equipment about to help them". Individual risk assessments were in place for people identifying their specific risks, and how to minimise the risks. Occupational therapists carried out home visits with people to assess the risks with their mobility and dexterity when they went home, and to ensure that appropriate equipment and support was provided to help minimise risks at home. This included equipment such as grab rails, walking aids, and shower seats.

Staff had a good understanding of what constituted different forms of abuse; and they knew how to report any suspicions of abuse. They were familiar with the local authority whistleblowing policy, and knew how to use this. However, none of the staff that we spoke to had needed to use it.

The manager had processes in place to assess the numbers of staff needed in each unit. Day time staffing usually included a team leader and two care staff for each of the short term rehabilitation units, and the dementia unit, but these numbers could be increased if needed. This was because there was a high turnover of people being admitted and discharged, and sometimes additional care staff may be required. People received care and treatment from NHS Intermediate Care Team health professionals, who were not directly employed by the centre. People staying in the flats were mostly self-caring, but support was available as needed.

Night time staffing was covered by one senior team leader for the whole centre. There were two care staff for all of the main units and the flats; and two care staff in the dementia unit (that is, a total of four care staff for the whole building). The service was situated over two floors, and the dementia unit was set at a distance from the other units. The main unit included up to three people who needed two staff to assist them with moving and handling. When the senior team leader was administering medicines or providing support in the dementia unit, this left two care staff for the other four units with 20 people on each floor - that is, two care staff for forty people. If they were providing care for people who needed two staff, this left all the other areas without any staff available to support people who needed assistance. The manager had identified the need for additional night staff, but this had not been provided.

We recommend that the provider re-assesses the night staffing requirements for the service, in conjunction with the dependency levels of people using the service.

The premises were designed to promote people's safety. There were key pad locks in designated areas so as to protect people from stairs or from going outside at the front of the property where there was a car park and main road. There were attractive gardens at the rear, and these provided a secure area for people to sit in or walk about. Corridors were straight and wide to aid visibility and accessibility. The bedrooms were en-suite and were clean and bright and well furnished.

An environmental report was carried out yearly, and this included an in-depth assessment of the management of environmental policies and procedures, such as the control of waste, checks for water and drainage, gas use and electricity. The health and safety manual contained reports of building risk assessments, including fire safety, storage, maintenance management, and checks for floors, ceilings, doors and windows. Quarterly checks for health and safety included checks such as window restraints and fire exits. Any concerns were identified, and the reports showed who was responsible for taking action, and when it was completed.

Requires Improvement

Is the service safe?

Accidents and incidents were reported to the registered manager within 24 hours of occurring, and she carried out monthly reviews to see if there was any pattern to these, and if action could be taken to lessen risks.

The provider had robust recruitment procedures, and these ensured that staff were suitable to work with vulnerable people. Volunteers and frequent visitors to the service had Disclosure and Barring Service (DBS) checks to assess their backgrounds, and annual identity checks. These were included for students on work experience placements, and visitors such as the chiropodist and hairdresser. There was a separate induction programme for people on work placements, to ensure they were informed about policies and procedures such as fire safety and infection control.

There were appropriate procedures to assess people for their ability to manage their medicines, and for staff to administer them if needed. It was important for people to retain their independence with their medicines' management as far as possible, so that they could continue to manage this on their return home. Each bedroom included two lockable areas, so that people could use one of these for medicines' storage if they were self-administering. We saw that staff worked with people, by ordering any medicines needed during their stay, and by carrying out weekly checks with those who self-administered. This provided people with support in ensuring they were able to take their medicines correctly.

Medicines for people who did not self-administer were stored in clinical rooms in the different units. We inspected two of these and saw that there were clear processes in place for ordering and storing medicines; and in disposing of any unused medicines. Clinical rooms included suitable locked cupboards, a medicines fridge and a controlled drugs (CD) cupboard for correct storage. CD records were clearly maintained. Room and fridge temperatures were recorded daily to ensure medicines were being stored at the required temperatures. Medicines administration records were accurately completed. They were accompanied by a photograph of each person to check their identity. All medicines in stock were counted and the balances checked weekly to ensure that medicines were being given correctly.

Good

Is the service effective?

Our findings

People said that staff explained their care and treatment to them, and encouraged them with their rehabilitation. A person who had been admitted on the previous day told us they had seen the physiotherapist and said, "I have been given a Zimmer frame to help me to get about; they are going to get me a stepping frame to exercise my leg. I am pleased to be here"; and a visitor told us, "My relative has been provided with a walking frame, a wheelchair, an exercise bike and cushions to prevent bed sores." A person who was being discharged said, "All the staff have been brilliant, everyone has been so helpful."

All staff completed required training as part of their probationary period. This included training in moving and handling, infection control, health and safety and basic food hygiene. New staff carried out induction training; and new care staff completed the nationally recognised Skills for Care 'common induction standards'. They shadowed an experienced staff member until they were assessed as competent to work unsupervised. Care staff were strongly encouraged to achieve a minimum of National Vocational Qualification (NVQ) /Diploma level 2 in care, and the service provided the opportunity and support for staff to achieve this qualification. At the time of our inspection, one hundred per cent of permanent care staff had completed NVQ levels 2 or 3 in health and social care.

All staff had individual supervision sessions with a designated leader or manager. Staff told us that these were carried out every six weeks, and enabled them to discuss further training needs, and raise any concerns or grievances. Each staff member had a personal learning and development plan, and the manager was enthusiastic about enabling staff to reach their full work potential.

Staff told us that there were monthly departmental meetings, which provided discussion forums about best practice and opportunity to discuss training received. One of the care staff said there was "A lot of extra training available", some of which was carried out as group training, and some as individual distance-learning. This included workbooks which were checked and signed with their departmental lead. Topics had recently included speech and language therapy, catheter care, stoma care, nutrition, diabetes, and stroke awareness.

All staff received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Some people lacked full mental capacity to make complex decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people's independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. This included meetings with their next of kin, representative or advocate, and with health and social care professionals, to make decisions on their behalf and in their best interests. There was no-one in the service who was assessed as needing to be deprived of their liberty for their own safety, although two DoLS applications had been made during the past year. No restraint practices were used within the service.

There were clear protocols in place to obtain people's consent for all aspects of their care. Care plans included signed consent forms for agreement to the care planning, stating that people had been fully consulted and agreed with the contents. Consent was obtained for taking photographs for the purposes of identity, medicines documentation, and for any bruises or wounds; and for having medicines administered by staff. Agreements for self-administration were in place.

Menus were provided and discussed with people on a daily basis. The week's menu was on display in dining areas. Menus included additional choices to the dish of the day including a vegetarian option. We observed lunch time in the dementia and intermediate care units. In both areas two carers served the food. In the intermediate units, some people chose to eat their meals in their rooms. In the dementia unit people sat together round a dining table, choosing where they wanted to sit. We observed that people were given a choice of drinks and meals at lunch time and one person had an omelette and baked beans provided for them, as requested. Everyone was offered a choice of vegetables as well as their preferred portion size. Additional portions of meat, vegetables and gravy were offered throughout the meal.

In the dementia area, staff sat and chatted with people and encouraged them to eat. We observed care staff speaking kindly and sensitively to a person, offering them other choices of food to encourage them to eat. The food was served in a relaxed manner with lots of chat and laughter between people and staff. The lunch time food was home

Good

Is the service effective?

cooked and looked appetising. People appeared to enjoy their meals and were allowed time to eat at their own pace in a very relaxed atmosphere. We heard one person tell the staff, "A beautiful piece of cooked meat, thank you". Other comments included, "The food is very good, enough, and plenty of choice"; "I don't eat very well, I'm allowed to sit as long as I like and there is lots of choice"; "You can have snacks and drinks at any time, and there is a jug of water in the room all the time"; and "If you want snacks you just ask, there is food all day long".

The catering staff were familiar with people's different dietary needs, and one told us, "When someone is on a soft diet we still like the food to look appetising and colourful and so we liquidise everything separately". The manager told us that nutrition was considered to be an important part of people's stay, and they aimed to ensure that everyone remained well-nourished and hydrated. A nutritional screening programme was used at admission to identify nutrition and hydration needs. Food and fluid charts were used to record people's intake where there were any concerns. People were weighed on admission and then weekly for monitoring purposes.

Health progress was monitored by health professionals who were part of the Intermediate Care Team, based at a nearby hospital. This included nurses, physiotherapists, and occupational therapists visiting people at the centre every day. Referrals were made for other health professionals to visit as needed, such as dieticians or speech and language therapists. One of the nurses explained that the team had a daily handover for people in the service, and this showed if people were newly admitted and needed assessments completing; if assessments needed to be checked and updated; if people were responding well to treatment, and if they were being discharged. The assessments included checks for people's moving and handling needs; if they were at risk of falls; nutritional assessment; if they were at risk of developing pressure sores; and blood pressure and health checks. Care staff carried out pressure area checks twice daily, and reported any concerns to their team leaders and the nurses. All physical therapies were supervised by qualified physiotherapists or occupational therapists, and trained physiotherapy assistants visited to support people through different exercises to improve their mobility or dexterity. Each person was given an individual plan of rehabilitation which was tailored to their unique requirements.

People's health progress was reviewed each week, with the person, staff from the service, and the Intermediate Care Team. It was usually anticipated that people's length of stay would be up to six weeks, but this could be discussed and extended on an individual basis. A proposed discharge date was drawn up as soon as possible, but usually within two weeks of the discharge.

The premises were adapted to meet people's different needs. Intermediate care units included overhead tracking hoists, mobile hoists, grab rails, and other equipment to meet people's mobility needs, and to maximise their independence. Call bells were available in every room. Bedrooms included en-suite toilet and shower facilities; and there were additional bathrooms with integral hoists for people who preferred a bath. The service included ten lounges, some of which had televisions, and some designated as quiet areas. Lounges from each unit on the ground floor opened on to garden areas. There were attractive gardens at the rear, and these were secure so as to promote the safety of people with dementia.

The dementia unit had clear signs to help people to find the toilets or bathrooms; and their names and pictures were on their bedroom doors to help them locate their own rooms. All bedrooms and flats had privacy locks on the doors, and lockable facilities to secure personal items. Each unit included a kitchenette area, from which snacks and drinks could be prepared. People and their relatives were free to use these facilities if they were able to do so. People in the dementia unit were risk-assessed for their safety in carrying out household tasks, but were encouraged to carry out usual tasks with staff support so as to retain their abilities.

Good

Is the service caring?

Our findings

All the people that we talked with spoke highly of the staff. This included people's relatives and visiting health and social care professionals. A person who was being discharged said "It has been a home from home." Another person told us "They look after me wonderfully, I don't know what I would do without them. The night staff come straight away when I ring the buzzer and when I am in pain they sit and chat with me until the pain eases." We noticed that care staff ensured that call bells were placed within people's reach, and calls were responded to promptly throughout the day. One person told us they liked to go to bed late and said "When I want to go to bed I just ring the buzzer and one of the night staff comes in and helps me. They treat you right. I couldn't be in a better place." Another said, "When I was admitted the staff asked me questions about when I get up and go to bed, what I liked doing and what I do at home". This demonstrated that the person felt valued as an individual.

Staff in the dementia unit showed interest in what people were saying. They listened to them and did not rush them when they were talking with them. There was a relaxed and happy atmosphere, with lots of laughter during the day. We saw that care plans for people in the dementia unit included a document called 'This is me', which showed the things that were important to people, and had details of their family history, occupation, hobbies and daily routines. This enabled staff to recognise the values that were important to people, and how to support them most effectively. Staff monitored people's progress using a weekly form called 'Signs of wellbeing'. This showed if people with dementia were able to make their wishes known, if they were able to help themselves, and if they were sensitive and helpful to others. It identified if they were able to experience and show pleasure and humour, or if they were withdrawn, anxious or angry. Staff showed concern and empathy with people. We heard one staff member gently ask someone who wanted to go to their bedroom, "Do you know where you are going, or would you like me to come with you?" They then accompanied the person to their room when they asked them to do so.

People told us they could have visitors whenever they wanted to. One person told us their partner had "Stayed until 11pm last night". A visitor told us, "I can come at any time. My relative's friends visit at weekends and evenings. Staff always make you welcome, they often make me a cup of coffee." Staff were aware of people's individual preferences, and worked with them to promote their wellbeing and give them a sense of worth. They said they ensured that people's privacy and dignity was respected. For example, people could stay in their own rooms during the day if they preferred this. Communication was seen to be a key issue, so that staff could recognise each person's abilities, moods and choices, and ensure they were shown kindness and humanity throughout their stay. A visitor told us, "My relative is quite demanding, but the staff are very patient and very approachable."

The purpose of the service was to help people to regain their health and independence; and to support people having respite care to retain their abilities and make day to day choices. Staff concentrated on ensuring that people were treated as individuals, and had all the help and support they needed to feel comfortable and to make progress. There were many positive comments from people on recently returned questionnaires, from a survey carried out by the providers. People said, "I would like to thank everybody for their help and concern during my stay"; "I have been very happy and well-cared for, staff are always cheerful"; "I thought the support from staff was very good"; and "My praise for day and night staff, they all work hard to look after us."

Good

Is the service responsive?

Our findings

People's care plans reflected their individual needs. A comprehensive assessment was carried out when they were admitted, and this formed the basis for their care planning. Care plans followed all the activities of daily living, such as mobility, personal hygiene needs, continence care, skin integrity, nutrition and hydration, communication and emotions, and sleep and night time routines. It was especially important for staff in the dementia unit to be informed about people's usual routines, as people could not always explain these for themselves. Staff asked people's relatives/friends to provide as much information about them as possible, so that the staff could support them in line with their usual choices.

People receiving intermediate care had assessments carried out by the nursing and therapy staff from the Intermediate Care Team within two working days from the time of admission. This built on the information which had already been obtained in the joint assessment and referral prior to admission. This provided a framework for their care and treatment during their stay.

Care plans included a summary of people's life histories, their likes and dislikes, and their social lifestyles. Staff ensured that people were called by their preferred name, and found out if they preferred to stay in their own rooms or join in with others. People were provided with a range of daily activities to enjoy, and they were facilitated in carrying out their preferred hobbies and activities within the limits of their health or dementia needs. Staff told us that people could choose how to occupy themselves and were encouraged to bring in their own activities. One person said, "I have just completed a jigsaw puzzle and I like to knit". Another person told us they liked to play games on their tablet computer, read magazines and watch television. We saw that a third person was having their nails manicured and painted by a visitor, and others were sitting outside reading, or playing fantasy games with a games console.

Activities facilitated by the staff included going for walks, playing games, armchair exercises, reading from a choice of large print books, music and singing. People in the dementia unit were encouraged and supported in carrying out routine daily tasks, such as washing up, folding laundry and laying tables, if they wanted to do these. Staff worked alongside them to promote their safety.

Special events were provided, such as visiting theatre companies, musicians and singers, and party nights.

The service had arrangements for people's spiritual and cultural needs to be met. They were able to have visits from ministers or clergy at any time, and could meet with them in a quiet lounge area if they wished to do so. A church service was carried out by members of a local Baptist church every month, for those who wished to attend.

People were encouraged to express their views informally on a daily basis, to the care staff or visiting health and social care professionals. The complaints procedure was included in the service's Statement of Purpose, and a copy of this was given to people at the time of their admission. People were encouraged to talk with the team leaders in charge of the units or the manager, in the first instance. None of the people we spoke with had made a complaint about their care, but told us if they had a problem they would speak to the team leader or the manager. One person who was staying at Broadmeadow told us "I was given a lot of information when I first moved in and there is probably a leaflet there."

People were also able to express their views at regular review meetings with health and social care professionals; at residents' meetings; and through questionnaires. This provided different avenues for people to share their thoughts and any concerns. The manager told us that all complaints were taken very seriously, and they would be investigated and, if possible, rectified, as soon as possible. The provider's complaints procedure stated that people would be contacted within ten days of the complaint with the outcome of investigations. The staff felt that it was important to learn from any complaints, so that the service could be improved as a result.

There were reliable systems in place to provide people with a smooth transition from one service to another. People receiving intermediate care were advised of the reason for their admission, and the planned discharge date as soon as possible. People receiving respite care were usually admitted for an agreed length of time. However, some had extended stays due to complex social situations or housing difficulties. People's placements were discussed with them

Good

Is the service responsive?

and their next of kin or advocates as applicable; and they signed their agreement to the placement's objectives. The service included an office on the premises for liaison with Social Services and the Intermediate Care Team. This enabled staff to contact them directly with concerns, and enabled people to have visits from social workers to assess the difficulties of their individual situations.

People who received intermediate care were assessed by physiotherapists and occupational therapists before their planned return home. Where required, a home visit was carried out with the person receiving care and the occupational therapist, to assess how well they would be able to function back in their own home. These home visits identified if people would be able to move from room to room, make drinks and snacks or prepare food, and carry out other tasks within their own home. The visits identified if people needed additional equipment prior to returning home, or support from agency care staff; or if the person needed enablement support or care in a long-term residential service.

People receiving respite dementia care were supported through visits from psychologists and community mental health nurses if the need arose. Staff assisted people to retain their independence as much as possible, and to fit in with their usual daily routines. This resulted in people being able to go back to their own homes where possible, preventing the need for long term residential care.

Good

Is the service well-led?

Our findings

The manager was very motivated about enabling staff to develop their knowledge and skills and to work with her in continual improvement of the service. Staff were encouraged to carry out additional training courses and pursue their interest in different aspects of care and treatment. For example, staff told us that the service was due to take part in an initiative called 'Ladder to the moon'. This is a scheme which provides organisational development for care organisations, particularly in regards to dementia care. One of the staff said, "The staff here are happy and provide care to a high standard and it is a good opportunity to thrive. I am going to be involved in the 'Ladder to the Moon' approach to dementia care when it starts here at the end of the month." The accommodation for the dementia unit was built and furnished in line with best practice guidance from the Stirling University Dementia Services Development Centre, and the service had been awarded with a gold accreditation certificate.

Staff worked together to provide a safe and secure environment where people could stay, and a place where they felt protected and empowered into making their own decisions and choices. All staff had an action plan and a personal development plan; and took part in the Kent County Council's 'Ways 2 Success' programme. This allowed staff to reflect on their individual approach within their own roles, and was aimed at always seeking ways to improve their performance.

Staff meeting minutes confirmed that staff were invited to share their views, and these were recorded, discussed and followed up. A recent senior staff meeting showed that a variety of topics had been discussed, including environmental audits, safeguarding, bullying and harassment, team work and health and safety issues. The latter highlighted a staff concern in regards to poor lighting, which they had found very frustrating. We saw that this had been addressed as a result of the staff meeting, and new 'LED' lighting had been fitted. Other issues recently addressed included a new door system, which allowed doors to designated areas to stay open or stay shut according to their setting; new fire doors; and a new phone system.

People and their visitors thought that the service was well run. They told us, "It is extremely well run. A very good service. I have been comfortable and the staff have been good to me." Another person said "The manager is approachable, and is always around." We saw that the manager interacted with people receiving care, and knew their names and their relatives, and details of their care and treatment. As the service provided a short term stay for people, it was indicative of the manager's dedication that she knew who all of the people were.

The manager kept her own training and experience up to date. Her qualifications included NVQ level 4/The Registered Manager's Award; an NVQ Assessors Award; NVQ level 4 in health and social care; a postgraduate diploma in management studies; and training as an adult protection trainer.

All of the people who stayed at the service were invited to complete a questionnaire when they were discharged. This provided an on-going source of feedback. The results were collated by the administration staff, and the results were given to the manager and displayed in the entrance hall. This provided an open and transparent system for new people to see how the service was running. People's names were not recorded against comments made, so that their confidentiality was protected. There were different questionnaires for different units, ensuring they related to the short term, respite, or intermediate care that had been given. We saw that questionnaires dealt with questions such as the general appearance of the unit; the quality of the food; if people felt they had been treated fairly and equally; how they rated the standard of activities available; and how they would rate the overall care. We looked at recent returns, and saw that the responses were overwhelmingly positive. People's comments included, "Many thanks for your kindness and care"; "I thought the support from staff was very good"; and "I think that Broadmeadow is excellent." The manager arranged regular residents' meetings, but these had not been very well attended. People and their relatives said that they knew the manager had an open door policy, and they could speak to her or other senior staff at any time.

The provider had systems in place for on-going monitoring using audits and assessments. These included risk assessments, maintenance checks, and audits for aspects of the service such as infection control, health and safety, medication and accidents and incidents. These identified any areas which needed attention, and the resulting action plans showed who was responsible for change and when. Any deficiencies highlighted were dealt with promptly. Any

Good

Is the service well-led?

equipment considered unsafe was immediately taken out of service, and was repaired or replaced as necessary. However, the manager had highlighted that night staffing levels needed to be re-assessed, and this had not been followed up by the provider. The manager ensured that CQC was appropriately informed of formal notifications and changes to the service.

Records throughout the service were well maintained and kept up to date. Care plans for people receiving short term care were as detailed as those for people who needed to stay longer. This demonstrated how staff treated people equally, and saw that each person needed the same standards of care as others.