Mallands Care Limited

Mallands Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

Mallands provides accommodation and personal care for a maximum of 38 older people. 31 people were living there at the time of the inspection. People who use the service include people with dementia and people with physical needs, as well as people staying for a short while for respite or convalescence. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mallands also provides personal care support to people in their own homes in the community. Five people were receiving this support at the time of our inspection.

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

People, relatives and staff expressed a very high level of confidence in the leadership and management of the service. Comments included, "I truly believe you have a fabulous leader as someone who understands how care homes should be run and how the patients need to be treated" and, "It's the first home I've worked in and I think it's amazing. The directors are really supportive, not just sitting in the office and telling us what to do."

The providers and registered manager were passionate and committed to developing a service where people received genuinely person centred care. Their ethos was influenced by current evidence based approaches such as 'Dementia Care Matters' and the 'Eden Alternative', and shared across the staff team. This approach saw ageing as a continued stage of development and growth and supported people to play a full and active role in their community by challenging loneliness, helplessness and boredom.

The providers had considered the layout and décor of the building and taken advice from a leading academic in dementia care, to create a dementia friendly environment. This meant they were challenging helplessness by enabling people living with dementia to find their way around independently. They had also considered how technology could be used to promote people's independence through the provision of a 'smart device' which people could ask to play music, tell them the time or the weather forecast. This would be particularly useful for people with a visual impairment, or who were cared for in their rooms.

Activities were developed according to people's history and interests and often had a purpose, enabling people to contribute to the life of the home and community. For example, people supported the homes' cooking club and sewing club by growing lavender in the herb garden for the sewing club to make scented pouches, and spices for use in the cooking club. This challenged loneliness and boredom, giving people opportunities to socialise and a sense of purpose and wellbeing. Community links were established, which

meant people could access life outside of the home.

People received care from staff who had received comprehensive relevant training and induction. There were sufficient numbers of staff on duty to meet the needs of people using the service and spend quality time with them. This meant that 'impromptu' and unplanned activities could take place like a walk in the garden followed by a hot chocolate. The service supported people to develop close relationships with each other and with care staff and we saw lots of positive interactions during the inspection. Staff ran clubs including weaving, cooking and painting after people had said they would like to spend more time speaking with them.

People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known. The service had taken action to improve quality of life at mealtimes through increasing social interaction, promoting choice and encouraging independence. This meant people now enjoyed eating together rather than alone, and food and fluid intake had improved, as well as independence with eating.

Policies and procedures ensured people were protected from the risk of abuse and avoidable harm. Staff had safeguarding training, and were confident they knew how to recognise and report potential abuse. Staff, were recruited carefully and appropriate checks had been completed to ensure they were safe to work with vulnerable people.

There were systems in place to ensure risk assessments were comprehensive, current, and supported staff to provide safe care while promoting independence. The computerised care planning system ensured that information about people's risks was shared efficiently and promptly across the staff team. This meant staff had detailed knowledge of people's individual risks and the measures necessary to minimise them. The registered manager had an oversight of the support being provided at all times. This system could also be accessed by relatives with the persons consent.

Systems were in place to ensure people received their prescribed medicines safely, including when people wanted to manage their own medicines. People were supported to access health care professionals to maintain their health and wellbeing.

People received care which was responsive to their needs. People and their relatives were encouraged to be part of the care planning process and to attend or contribute to care reviews where possible. This helped to ensure the care being provided met people's individual needs and preferences. Support plans were personalised and guided staff to help people in the way they liked.

The service placed a strong emphasis on a 'person centred approach', and ensured people, and their advocates where appropriate, were fully consulted and involved in all decisions about their lives and support. This meant people's legal rights were protected. People's individual communication needs were understood and information provided in a format appropriate for them, which meant they could participate fully.

Policies, procedures and staff training were in place to ensure people were treated equally and fairly. People told us the staff were kind and caring and treated them with dignity and respect. The service recognised the importance for people of maintaining close family relationships and provided the support required to make this happen.

The service was proactive in identifying and meeting the information and communication needs of people

living with dementia and/or experiencing sensory loss. A braille version of the fire procedures had been developed for a person who was registered blind, and the activities programme could be provided in a different format such as tape or braille, for people with sight problems. There were plans to use the 'smart device' in the lounge to tell people the day's activities or menus.

The service was very well led by the registered manager and providers, supported by a dedicated team. There were quality assurance systems in place to help monitor the quality of the service, and identify any areas which might require improvement. The registered manager and providers promoted the ethos of honesty and admitted when things had gone wrong.

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 by safe recruitment practices and there were sufficient numbers of skilled and experienced staff to meet people's needs.

People were protected by staff that understood and managed risk. People were supported to have as much control and independence as possible.

People had their medicines managed safely.

People were protected from avoidable harm and abuse.

Is the service effective?

Good

The service was effective.

People received effective care and support from staff skilled in using an approach designed to challenge loneliness, helplessness and boredom.

People were supported to play a full and active role in their community.

People living with dementia were more independent because the environment had been adapted to meet their needs.

People's quality of life at mealtimes had improved through increasing social interaction, promoting choice and encouraging independence.

All staff were well supported and had the opportunity to reflect on practice and training needs.

Is the service caring?

Outstanding

The service was exceptionally caring.

The service worked to create a warm, caring environment for people, supporting the development of strong relationships with

each other and with care staff.

People's dignity was respected and promoted. The service viewed ageing positively, as a continued stage of development and growth.

The service recognised the importance of continued links with the 'outside world' promoting people's right to continue to be supported by their family carers if they wished.

The service ensured the person receiving care was at the centre, and supported to express their views about all aspects of their care.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People belonged to a vibrant community where they had the opportunity to give as well as to receive care.

People were helped to maintain their independence through 'meaningful occupation' where they could build on their existing skills and interests and try new activities.

People and their families were supported to make an informed choice about whether the service was right for them and could meet their needs.

People were involved in the planning of their care and their views and wishes were listened to, acted on and regularly reviewed.

Equality and diversity was respected and people's individuality supported.

Is the service well-led?

Outstanding ☆

The service was very well-led.

The providers and registered manager had a clear vision about how they wished the service to be provided, and ensured the vision was understood and shared with the staff team. They were continually striving to enhance the care and quality of the service.

There was a positive culture in the service. The management team provided strong leadership and led by example.

The views of people and those important to them were central to

the running and development of the service. They were fully involved and supported to contribute fully. Their views were valued and led to improvements.

Staff were valued and motivated to develop and provide quality care. They felt well supported and fully involved in the running and development of the service.

Quality assurance systems drove improvement and raised standards of care.

Mallands Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 01 and 02 February 2018 and was unannounced. It was carried out by an adult social care inspector and an expert 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.

Prior to the inspection we reviewed information we held about the service, including notifications, previous inspection reports and safeguarding reports. A notification is information about specific events, which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

We looked at a range of records related to the running of the service. These included staff rotas, four staff files, medicine records, meeting records and quality monitoring audits. We also looked at four care records for people living at Mallands Residential Care Home.

We spoke with six people and four visitors to ask their views about the service, and one person being supported in the community. We spoke with eight staff, including the providers, registered manager and cook. We had feedback from three health care professionals who supported people at Mallands Residential Care Home.

Some people living with dementia were not always able to comment directly on their experiences. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing

care to help us understand the experience of people living with dementia.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "My biggest bain is that I can't walk anymore. They (carers) hoist me up and put me in the wheelchair, but yes I feel very safe, I've never not felt safe. The night staff take plenty of time to get me ready for bed and they always make me laugh." Two relatives told us it gave them peace of mind to know that their family member was safe and well cared for. The service had conducted a quality assurance survey, which asked people and their visitors whether they thought the service was safe. The survey asked whether they had been shown how to raise concerns about their safety; whether they felt discriminated against because of their religion, gender or age; whether staff respected their personal beliefs and values and whether they were supported and encouraged to take managed personal risks when they wanted to. 100 percent of respondents agreed, or strongly agreed, that the service was safe.

Information about people's individual risks was accessible to all staff, using hand held computers to access the computerised care planning system. Risk assessments had been completed related to a range of areas including falls, nutrition, pressure area care and cognitive difficulties. They were reviewed monthly or more frequently if required. The system prompted staff to undertake the tasks required to minimise the risks and ensure people's needs were met, for example supporting people with fluids or repositioning them to prevent skin breakdown. Any immediate changes to people's level of risk were discussed at the staff handover and the information added promptly to care records. A member of staff told us, "Any new information is shared in handover and put straight into the care plans. Everything is recorded as the day goes on". This meant staff had clear and up to date information showing how they should support people to manage the risks while ensuring they had as much control and independence as possible. For example, one person's care plan advised staff to "take the time to sit down and chat with me"; if they observed that the person was feeling low in mood or anxious.

Any accidents or incidents that took place were recorded by the staff on the computerised care planning system. The system prompted staff to describe the incident and explain what they had done to resolve the issue. This information was reviewed and analysed by the management team, and action taken where required, to prevent reoccurrence.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Their name badges had the contact details of the local authority and care quality commission on the reverse to support them in this. The safeguarding policy was comprehensive and directed staff to ensure the person concerned was involved throughout the safeguarding process, and supported by a relative or other advocate if they wished. Safeguarding concerns were managed appropriately, and the service worked effectively with the local authority and other agencies to ensure concerns were fully investigated and action taken to keep people safe.

Risks of abuse to people were minimised because the provider ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS)

had been requested and were present in all records we checked. The DBS checks people's criminal history and their suitability to work with vulnerable people.

People were kept safe by sufficient numbers of staff. The provider used a tool to assess the dependency levels of people being supported by the service, calculating the number of staff required to keep them safe and meet their needs. They also analysed call bell response times because they gave a good indication of whether staffing levels were adequate. One person told us, "There's never a problem [with my call bell], I've never had to complain about how long it takes them to come, I've never had any problems with them." We observed that staff had time to spend with people, and interacted with them in a calm, unhurried way.

An effective computerised system was in place for the administration of medicines. This was straightforward and minimised the risk of errors, for example alerting staff if the medicines were missed or given too close together. Staff, were observed during our visit administering medicines in a safe way. Their approach was person centred, gaining the persons consent before giving them their medicines and explaining what the medicines were for. There was a system to monitor the receipt and disposal of people's medicines and a procedure to monitor the daily temperature of the medicine fridge, and medicine storage area. Medicines at the service were locked away in accordance with the relevant legislation, including those medicines which require additional security and recording.

The system enabled the registered manager to monitor the administration of medicines and alerted them if there were any issues. Regular medicine audits were carried out to monitor that medicines were being safely administered. A 'medicines champion' was in post with responsibility for ensuring that staff maintained the knowledge and skills required to administer medicines safely, keeping them up to date with new developments and promoting 'best practice'.

The provider told us people were supported to 'self-medicate' wherever possible, because, "there is a culture in care homes of stripping people of independence." A risk assessment was carried out with the person beforehand to make sure they were able to manage their own medicines safely. People kept the medicines in their own medicine cabinet and signed their medicines administration record (MAR) when they took them. Staff counted the medicines once a week, with the persons consent, to make sure they had taken them as prescribed.

Systems were in place to help prevent and control infection. The home was kept clean and hygienic by a team of housekeeping staff. Staff understood what action to take to minimise risks, such as the use of gloves and aprons, and good hand hygiene to protect people. Hand gel, gloves and aprons were readily available. Clinical waste was disposed of correctly. The registered manager carried out regular observations of staff to ensure standards were maintained. Any concerns were addressed and prompt action taken in response to any issues identified.

People were protected from risks associated with fire. Staff had received training, and fire checks and drills were carried out in accordance with fire regulations. People's needs were considered in the event of an emergency situation such as a fire. For example, their mobility and the number of staff they would need to support them to exit the building safely.

People were protected from risks posed by the environment. Regular health and safety checks were undertaken, electrical equipment was tested for safety, and legionella and temperature checks were undertaken on the water and water outlets. Window restrictors were in place.

Good

Is the service effective?

Our findings

Staff supported people at the service in line with a philosophy of care called the 'Eden Alternative'. This person centred approach aimed to support people to play a full and active role in their community by challenging loneliness, helplessness and boredom. This meant people received exceptionally effective care and support, from a staff team who were committed to promoting their independence and well-being. A relative said, "They have a good understanding of my family member's needs. They involve me all the time. I feel they are well looked after".

The provider was challenging helplessness by adapting the environment to enable people living with dementia to find their way around independently. They had taken advice from a university professor who specialised in this subject. There was clear signage throughout. This included names and memory boxes on people's doors created with the activities co-ordinators, containing objects significant to the person. This helped them to reminisce and navigate to their room. The registered manager also had their own name and memory box on their office door so that people could find them easily. Patterned carpets can be disorientating, raise stress levels and increase the risk of falls for people living with dementia, so they had been replaced with plain ones. Corridors and lighting were being improved to help with orientation. The provider had considered how technology could be used to promote people's independence. Some people were using smartphones and tablets. A 'smart device' was being used in the lounge. People could interact with it, asking it to play music, tell them the time, the weather forecast, read poetry or tell a joke. The provider was hopeful that in time people would have their own smart devices, and had shown people and their families the potential benefits, particularly if the person had sensory loss or spent a lot of time in their room.

The provider told us they wanted Mallands to be a home rather than a 'care home'. Equipment was kept out of sight and there were fresh flowers and ornaments throughout. Posters and objects to promote reminiscence were displayed in the communal areas. A lounge was in the process of having a drinks bar installed and offered a mini cinema and coffee shop experience for people and their families. A section of the home was being refurbished. Each bedroom would have its own painted front door and letterbox, with the colour chosen by the person living there. Artificial trees with lights in the corridor would make the corridor look like an outside space. People living in the home were consulted on every aspect of the redecoration, choosing wallpaper, carpets and new flooring for the bathrooms from a selection of samples.

Lunch time was a sociable and happy experience. Staff laid up a 'social lunch table 'in the dining room. People laughed and chatted with each other and with the staff, who did a quiz. The provider told us they were using research and guidance to improve the mealtime experience for people at the home. Their focus was on quality of life at mealtimes through increasing social interaction, promoting choice and encouraging independence. This had a positive impact on the people at the home as people now enjoyed eating together rather than alone, which reduced the risk of social isolation. Food and fluid intake also improved as did independence with eating. The provider explained this approach and its benefits to people and their families in the homes' newsletter.

People had sufficient to eat and drink and received a balanced diet. People were largely positive about the quality of the food, although some could not remember being offered a choice. Comments included, "The food is very good, I had meat pie today, yes I ordered it and it was beautiful, I couldn't' fault it" and, "The food is brilliant although I don't eat pork or rhubarb." The service catered for people with special dietary needs, for example a diabetic or pureed diet, or allergies. People were weighed and their nutritional status monitored, so any risks around nutrition could be picked up quickly and action taken. There was a 'nutrition and hydration champion' in post, with responsibility for ensuring staff had the knowledge and skills to support people with food and fluids and all the necessary checks and documentation had been completed correctly. They also ensured any risks had been identified and referrals for specialist support made, such as to the speech and language therapist (SALT) or dietician. People at risk of dehydration and malnutrition were on 'food and fluid watch' which meant the registered manager had additional oversight of people's food and fluid intake using the computerised care planning system.

Any dietary preferences were identified as part of a 'pre-admission assessment', before the person moved into the home, for example if the person didn't eat pork or was a vegetarian. 'Kitchen meetings' were held where people planned the menus with staff. There were at least two choices offered each day. On the day of the inspection the cook was serving homemade sausage pie, chicken pie or fish. The registered manager visited each person on a daily basis to ask what food they would like, as sometimes they had forgotten what they had ordered. They told us, "I know one person always has brown toast, but I don't assume this is what they will order. I offer brown bread and white bread, with spreads, so it gives them the experience of choosing."

New staff had completed a comprehensive induction, which gave them the basic skills to care for people effectively. They told us the induction helped to prepare them well for their role. It covered a range of essential topics like moving and handling, first aid, and fire safety. During this period they worked alongside more experienced staff to get to know people, and about their care and support needs. New staff were also undertaking the new national skills for care certificate. This is a more detailed national training programme and qualification for newly recruited staff.

There was an ongoing training programme for all staff which allowed them to keep their knowledge and skills up to date. A member of staff told us, "There's loads of training. It's really good". Topics included infection control, dementia, moving and handling, palliative care, effective communication and equality, diversity and inclusion. The registered manager said the training took place in small groups wherever possible, explaining, "Sometimes people need a bit more support. It's better to do the training face to face so that you can give support and explain anything people don't understand. " Staff were particularly positive about a visit from the 'Virtual dementia tour', described by the Alzheimer's Society as "a multi-sensory experience to give a person with a healthy brain an experience of what Dementia might be like". One member of staff said, "It really helped you to understand what it's like with dementia, about sound distortion and how colours affect you differently. Even how you walk."

Staff told us they were well supported by the registered manager and the providers. The registered manager operated an "open door" policy, and staff told us they found them approachable and supportive. Staff had formal supervision every six weeks which they found helpful. This was an opportunity for them to reflect on their work and their training needs, as well as consider their professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff had received training about the MCA and explained how they applied its principles to their practice to support people in their decision making. 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 their best interests and as least restrictive as possible. Care plans documented that people's consent had been sought in relation to all aspects of their care, and we heard staff consistently asking for people's consent before supporting them. Where people had been assessed as not having the capacity to consent to their care and treatment, decisions had been made in their best interests, involving family and health and social care professionals as required.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of the criteria and process for referring people for assessment under DoLS, and had previously done so. They told us this was not required for anybody currently living at Mallands.

Staff knew people well and monitored people's health on a daily basis. They made prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. This was confirmed by two visiting health professionals who commented, "I would be happy to send a family member here. I have a great deal of faith in them. All referrals have been highly appropriate. They are very sensitive and caring" and, "They contact me appropriately. We have a sensible conversation about what's going on. I'm accompanied when I visit a patient, and recommendations and guidance are followed. They will get in touch if they are unclear or adrift. They are very proactive in that sense and swift to respond when needed".

Outstanding ☆

Is the service caring?

Our findings

The service was exceptionally caring. They used a current evidence based approach called the 'Eden Alternative'. The homes' newsletter explained that this philosophy "focuses on changing the culture of care, from one where aging is seen as a period of decline to one where individuals continue to grow. It is about creating a culture of care and set of values that puts the person receiving care at the centre." Information about this was displayed in the communal area of the home which gave people, staff and visitors a clear understanding of what it meant. Minutes of staff meetings showed how these values were shared across the staff team. The registered manager had emphasised the importance of "all staff promoting life quality just as if the residents were living in their own homes, and to celebrate independence every day. …blurring the roles of all staff to ensure that the residents are always put first, enabling residents to make their own choices as they would do at home."

We observed, and people told us, that staff worked with them in a caring and person centred way. For example, one person told us how they used to become distressed when the fire alarm bell was tested once a week. They said, "One thing I detest is the alarm bell, it makes me jump and then the door closes, I used to scream but now they let me know, and someone sits with me in the room once a week when it happens." Another person had written in their care plan that they felt very unhappy when their spouse left them after visiting and that they were likely to cry. As a result staff were asked to sit with the person when their spouse left, so they would not feel lonely or sad.

People were supported to maintain close family relationships. The registered manager told us, "We have an open house policy for relatives. Relatives can stay overnight if their family member is poorly. They can stay with the person or just be near." A relative, who spent a lot of time with their spouse at the home, told us, "They invite me down on a Sunday and we have lunch together. I was invited for Christmas. They celebrated our wedding anniversary with decorations, balloons and banners." Mallands Residential Care Home had participated in a campaign which promoted the right of people living with dementia to be supported by their family carers. The homes newsletter explained, "Their families must be welcome to support them as often as they are able. Families are more than 'visitors' to a person with dementia. They are an integral part of that person's life and often their last best means of connection with the world".

The service supported people to develop close relationships with each other and with care staff. The quarterly newsletter contained an interview with a person living at the service and an article introducing a member of staff. It said, "We feel in order to create the warmest environment for residents and staff there needs to be a strong relationship between carers and residents, and carers and relatives/friends. It's not possible to build these relationships without knowing something about each other." It was part of the activity co-ordinators role to foster relationships and friendships. We observed a soft ball game with fourteen people in the lounge. There was lots of laughter and interaction between people and with the care staff. Some people living at the service chose to socialise in each other's rooms. The registered manager told us they had invited staff to run workshops based on their personal skills and interests after people had told them they would like to spend more time speaking with staff. For example, during the inspection we saw that people were very engaged in an abstract art painting session with a member of staff. Other workshops

included weaving, cooking and reflexology.

Staff respected and promoted people's privacy, dignity and independence. There was a 'dignity champion' in post, with responsibility for promoting people's dignity at the service, for example reminding staff to use 'dignity towels' so that people were not exposed when being supported with personal care. Staff knocked on doors before entering and asked people for their consent before offering support. A member of staff told us, "People are offered choices about how they want things done. Some like to wash their own face. I will always ask them even if I know they will say 'No'." Staff knelt down and spoke to people on their level if they were sitting, so they could communicate effectively. They moved around the lounge, speaking to people and asking them for their views. Comments included, "What music would you like to listen to? Something a bit quieter?" "Did you enjoy those exercises?" and, "Are you going to see the film this afternoon? It's Mamma Mia. So am I. It's a nice big screen!"

The service encouraged people and their relatives to express their views and be involved in all aspects of care. They held regular reviews with people and those that mattered to them. People, visitors and staff completed quality assurance surveys based on the 'key lines of enquiry,' which underpin the CQC inspection process. There was a clear explanation about what each question meant. For example, "By caring we mean that staff involve and treat people with compassion, kindness, dignity and respect…This means that people, their families and carers experience care that is empowering and provided by staff who involve them and treat people with dignity, respect and compassion". This gave people an understanding of the role of the CQC, allowing them to comment on how well the provider was doing in meeting the minimum standards for quality and safety set out in law. The findings of the survey were published in the quarterly newsletter and reported that "98% of respondents agreed or strongly agreed that we met our caring objectives."

Outstanding ☆

Is the service responsive?

Our findings

The service was highly responsive to people's needs and personalised to their wishes and preferences. The registered manager told us, "We don't treat everybody the same. The care people receive is individual to them".

The service used the 'Eden Alternative' approach, which aims to alleviate loneliness, helplessness and boredom. It had developed a vibrant community where spontaneous and unexpected happenings took place, where people had the opportunity to participate in activity which is meaningful, and to give, as well as to receive care. This meant there was a strong focus on activities at the service.

The activities co-ordinators used a tool developed by the Alzheimer's Society called 'This is me' to record people's history, background and preferences. This enabled them to plan activities in line with people's individual interests. The registered manager told us, "It's so important to know the person and their histories. Photo histories are really helpful because they might not recognise themselves in photos of how they are now. It's a working document. People are quite private and they and their families have to trust me and the staff with very personal information about their loved one. 'This is me' is not just a paper exercise. It's about the life the person's had." The provider and activity staff monitored and reviewed people's participation and enjoyment of activities on a monthly basis, to ensure the programme continued to meet their individual needs. There were two activities co-ordinators on site and a weekly activities timetable although the registered manager told us this wasn't 'set in stone'. For example, during the inspection some people went out for an impromptu walk. They came back in smiling and had a mug of hot chocolate.

The provider emphasised the importance of meaningful occupation in helping people to maintain their independence. This meant that the activities often had a purpose. For example, people made poppies for remembrance and knitted flowers for Christmas which they sold to raise money for the Alzheimer's Society and residents' fund. They made cakes for coffee mornings, and 'fiddle muffs' at a 'knitter natter' knitting group. People living with dementia used fiddle muffs to occupy their hands if they felt restless or agitated. People supported the homes' cooking club and sewing club by growing lavender in the herb garden for the sewing club to make scented pouches, and spices for use in the cooking club. They helped to peel vegetables and potatoes for meals and made their own chutney and pickles. A relative told us people had enjoyed looking after rare breed chicks at Easter, which had hatched in an incubator and later gone to live on a farm. The provider told us, "One of our biggest challenges is trying to find activities and meaningful occupation that appeal to men, as there are more women at the service." Some people had been supporting the maintenance man with odd jobs, such as stripping a bench. There was also a shed in the garden for them to use when the weather improved.

The service organised trips out through a local social enterprise and ensured the trips were open to everybody . People were asked for suggestions about where they would like to go. . The social enterprise completed a risk assessment of the venue, looking at issues such as access for people with mobility problems. If people needed a pureed diet they took it with them. Photographs were displayed of a trip to a local craft centre where people painted pottery, and a trip to a seaside town for a cream tea and a game on

the slot machines for one person's special birthday. A relative said, "It was brilliant, we took my [family member] for their birthday and it had all been risk assessed."

People enjoyed the companionship of the homes' dog and budgie, fitness activities, a variety of clubs run by care staff, the 'cinema experience' with popcorn, and were looking forward to the newly refurbished bar opening. The service identified people's spiritual needs and ensured they were met through a monthly church service at the home, or visitors of their own faith if they wished. The activities co-ordinators spent time with people in their rooms if they were unable to participate in activities and were cared for in bed. They used materials such as a reminiscence newsletter which the service subscribed to, with articles about events in history, and a 'reminiscence suitcase' from a long established company which contained items to trigger memories.

The service invited people to visit Mallands to help them to make an informed choice about whether they wanted to live there. The registered manager told us they wanted this to be a positive experience for the person, so they invited them and their families for morning coffee or afternoon tea, at a time when activities were going on that might interest them. They invited families as well, because they recognised that they might need some support in their own right at this time.

The service provided personal care support to five people in their own home. The provider told us their aim was to build relationships with people who might need residential care in the future. They could get to know the staff and come for respite, which would make the transition into residential care much easier for them.

Comprehensive care plans had been developed with people. They provided clear guidance and direction for staff about how to meet a person's individual needs, and promote their independence. For example, the care plan of a visually impaired person stated, "If you wish to speak to me please ensure you say my name first as I cannot see you clearly." Staff were advised to explain to the person what they were doing when assisting with personal care and transfers. They were to inform them what food was on their plate, ensuring their drink was within easy reach and they knew where it was. The care planning process began prior to the person moving into the home with a comprehensive assessment .This included questions about the person's religious and cultural needs, and end of life wishes, as well as physical and emotional support.

The information gathered during the initial assessment was put onto the computerised care planning system prior to the person moving in. This enabled staff to familiarise themselves with it and provide care tailored specifically to the persons individual needs. People's care records were reviewed three days after admission and then at least monthly to ensure they remained up to date, with the involvement of people and their representatives every three months. Representatives were also able to access the computerised care planning system, with the consent of their family member, which gave them continuous oversight of the support being provided by the service.

People, and their relatives where appropriate, had been consulted about their end of life wishes and they had been documented. This meant staff and professionals would know what the person's wishes were for their future care and final days, and could ensure they were respected. Staff had attended training on end of life care. A member of staff told us," We have done special training. Whoever is responsible for the person will do regular mouth checks, liaise with the family, support the person and sit with them. We will contact the nurses and GP's. Follow how they like things done at the end of their life. Making sure they are nice and peaceful". Relatives were welcome to stay at the home with their family member for as long as required. Feedback we reviewed included, "However, it's when the going gets tough that a place earns its stripes, and under the fabulous tutelage of [registered manager] the last few days of my family member's life would seem to have been very special. Without any pain or suffering and without any loss of dignity they passed

away, and I will be eternally grateful for all that your staff did."

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service was proactive in identifying and meeting the information and communication needs of people living with dementia and/or experiencing sensory loss. A braille version of the fire procedures had been developed for a person who was registered blind, and the activities programme could be provided in a different format such as tape or braille, for people with sight problems. The provider was planning to programme the 'smart device' in the lounge, so that people could ask it what activities were planned that day, or what was on the menu.

A key worker system meant that people and their families had a named member of staff to liaise with, which meant any concerns or complaints would be addressed promptly. Concerns expressed in a visitor's survey had been documented in the quarterly newsletter, with the action taken to address them. For example one visitor had queried the frequency of people being offered baths or showers. The registered manager had provided reassurance that baths and showers were offered regularly, and they were looking at ways to make them a more pleasurable experience for people. They invited people to speak with them if they had any further concerns. There was an effective and responsive complaints process in place and we saw that four complaints had been resolved in line with this process.

Outstanding ☆

Is the service well-led?

Our findings

The service was exceptionally well led. The registered manager and providers were available throughout our inspection. They were very visible in the home and they knew the people who lived there very well. Feedback from relatives included, "In [registered manager] I truly believe you have a fabulous leader as someone who understands how care homes should be run, and how the patients need to be treated. At no stage whatsoever was I ever worried or left after a visit concerned. [My family member] was in safe hands and I just want to make sure [registered manager] gets the plaudits they deserve" and, "We were very fortunate to find this home. It's fantastic. The staff are attentive, there is a family atmosphere. The owners are on site most of the time and there is a first class manager". A member of staff said, "It's the first home I've worked in and I think it's amazing. The directors are really supportive, not just sitting in the office and telling us what to do."

The ethos of the service had been influenced by 'Dementia Care Matters' and the 'Eden Alternative'. These are current evidence based initiatives which view ageing as a continued stage of development and growth, promoting emotional connection and person centred care, rather than institutionalised 'task focussed' care. The providers were using research and guidance about dementia care from leading academic institutions, collaborating with other providers who shared this vision, to develop a service where people were truly at the centre. They described the structure of the service as a triangle, "…a hierarchy with the residents at the top. We are supporting them. We are looking to place the maximum possible decision making into the hands of people using the service." People and their relatives were consistently asked for their views about all aspects of the service, including the safety and quality of the support provided, environmental improvements, activities and menus. They were kept well informed about developments through discussion groups and the quarterly newsletter. One relative told us, "They are always asking if there is anything they should be doing to make things better." Quality assurance surveys had been developed based on the CQC's key lines of enquiry, and there were regular meetings for people and their relatives. The coffee lounge, bar and cinema room had been set up in response to suggestions made by people and their relatives.

The service was proactively supporting people to develop strong community links. For example, they belonged to a 'pen pal' scheme with other care homes in the UK and abroad. People had written inviting residents to get in touch and had had responses from people in homes in Tasmania and Wales. Residents from another care home had come for afternoon tea. People had visited a community organisation in the area where adults with disabilities were supported to achieve their potential.

The service had a clear policy on equality and diversity and staff received training on this topic. The registered manager gave us examples of how the service had provided support to meet the diverse needs of people using the service, including those related to disability and faith. People's individual preferences were identified through discussion with them or their relatives if appropriate. Their preferences were documented in care plans if they wished this information to be shared, and understood and respected by staff.

The service promoted effective monitoring and accountability. The providers were at the home five days a

week and played an active role in monitoring the quality and safety of the service. Monthly management meetings were held to review complaints, call bell response times, accidents/incidents and any errors in medicine administration. This provided an opportunity to analyse the situation, the actions taken and identify any learning and further action required. A comprehensive programme of audits was carried out looking at areas such as infection control, medicines administration, health and safety, care plans and activities. The computerised planning system gave the registered manager oversight of the support being provided to people. They told us, "All the information is there. I can look at any given time day or night and see what care is being provided at that time".

Staff told us they were very well supported. Comments included, "[Registered manager] is wonderful. You can go to them with anything. They will listen and try their best to solve issues.", "It's a brilliant staff team. They are really supportive of each other. They work so well as a team". There was a focus on empowering staff and valuing their individual skills and strengths outside of their caring role. For example, some members of staff ran clubs with people in painting, weaving and cooking. The registered manager said, "We thought we would find out their [staff] different interests so they are not worn down by the caring task. We asked different residents who would be interested and advertised it and provided the materials people needed, like paints and canvasses."

Staff received regular recorded supervision including formal observations looking at the support provided, including their interaction, understanding and knowledge of people. Any training needs were identified and discussed in supervision. The observations were carried out with all staff working at the service, The registered manager told us, "We are all part of the same team. The staff who do domestic tasks and laundry are just as important. Do they have a conversation with that person? Do they ask them if they want a cup of tea?" Additional support was provided by staff in 'champions' roles, with responsibility for medicines, nutrition and hydration, falls prevention, skin integrity, oral hygiene and dignity. These staff took an additional interest in a specific area of care, kept up to date with new developments, reviewed performance and promoted best practice within the team. Staff were encouraged in their career pathway and enrolled on further vocational courses.

Staff were able to contribute to the development of the service by expressing their views through staff surveys, at supervisions and staff meetings. Regular staff meetings provided an opportunity for staff to be updated about any changes or developments and to put forward their ideas about how things might be improved or done differently. A member of staff said, "We are all open and honest. Nobody gets offended. They are constantly making sure you are doing everything correctly. We are always learning new things". Staff had been asked for their views about how activities might be expanded and the environment improved. They had suggested that a mini bar might be offered at teatime, with a snack trolley, for popcorn, crisps, baileys, hot chocolate, wine and sherry. The registered manager had emphasised that residents can have anything they want.

The providers and registered manager were continually striving to enhance the care and quality of the service. The provider said, "We listen; we're always trying to improve. We don't always get it right. We are constantly looking to develop what we are doing. It's about the residents and how good their lives are." The service was working towards its accreditation with the Eden Alternative. The provider attended the two day annual Health+Care event in London, with seminars on developments in the care industry. They were on the steering committee of the Devon Care Kite Mark group of 80 Devon providers, a forum for training, learning from other providers and sharing ideas about best practice. Members of the Kite Mark group carried out peer reviews of each other's services, concentrating on a different area of service provision each time. In addition the registered manager attended the local community nurse forum and registered manager's network where ideas about best practice were shared.

The registered manager and providers understood their responsibilities. They promoted the ethos of honesty and learned from mistakes, this reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment and apologise when something goes wrong.