CLS Care Services Limited

Belong Wigan Care Village

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

In response to concerns about a specific incident, we carried out an unannounced comprehensive inspection of Belong Wigan Care Village on 06 and 16 May 2016.

The service was last inspected on 01 May 2014 and they were found to be meeting all the regulatory requirements inspected at that time.

Belong Wigan Care Village is operated by the CLS Group, providing care and support to older people who require differing types of specialist 24 hour care; including nursing, residential and respite care as well as care for people living with dementia. The Care Village consists of six households; five have the capacity to accommodate 11 residents and one household 12. The six households are internally known as Acacia, Beech, Willow, Elm, Cedar and Laurel. Belong Wigan Care Village is situated in Platt Bridge on the outskirts of Wigan town centre. On the day of the inspection there were 67 people living at Belong Wigan Care Village.

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

The Care Village was designed and built to meet people's needs. The service was clean and comfortable and there was sufficient signage to support people to navigate the service independently. Equipment was maintained and fit for purpose.

Prior to our inspection we had received information of concern in relation to the clarity of the procedure to be followed by support staff when they needed to escalate health concerns. This had been raised in a report from the coroner with regards to a person who previously lived at the home who had sadly passed away. As a result of this report we looked in detail at this area during the inspection. We found the service had addressed the areas of concern. We saw a 'Contingency flow chart for unexpected changes in health' had been developed. We spoke with the night staff and they were able to tell us where the flow chart was located and what the procedure was. We also saw that a night time record sheet had been introduced. The record was time specific and was completed by staff as people's care and support needs were met.

People told us they felt safe living at the service.

People living at the service and their relatives spoke positively about the staff and management at the home. It was observed throughout the inspection that staff knew and understood people's needs and provided flexible, tailored support. Staffing was calculated based on people's independence and level of need. We saw there were sufficient numbers of staff deployed and staff were responsive to people's needs and preferences. Staff went through a robust recruitment process before starting work.

We found the service had an up to date policy and suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. Medicines were stored and administered safely.

Staff received regular training and opportunities for continued professional development. The manager and staff were aware of their responsibilities around legislation regarding people's mental capacity. Staff were observed obtaining people's consent before delivering care.

We saw staff assessed peoples' nutritional needs and varied menu's had been developed. People were offered choice and the dining experience was interactive and relaxed.

The experiences of people who lived at the service and their relatives were positive. We saw that people were treated with kindness and compassion. People and relatives had been involved in assessments, reviews and ongoing discussions about the care received. People were treated with dignity and respect and their privacy and independence was promoted.

People's health care needs were assessed, reviewed and delivered in a way that promoted their wellbeing. People were supported to maintain good health and have access to healthcare services.

People were supported to pursue their leisure activities and maintain their relationships. An effective complaints procedure was in place. There was a caring culture and effective systems in place to continually seek the views of people and their relatives regarding the quality of the service delivered.

People, relatives and staff told us they thought the management were visible and approachable. Management had a clear vision of what was required to provide a quality service. All the staff we spoke with demonstrated a commitment to working towards the Belong values.

There were effective systems in place for monitoring the quality and safety of the service. Where improvements had been required, these had been addressed and followed up timely to ensure continuous improvement.

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 told us they felt safe. Risk assessments were comprehensive, reviewed regularly and changed timely to meet people's needs.

We found appropriate safeguarding policies and procedures in place.

The service had arrangements in place for recruiting staff safely and there were enough staff on duty with the right skills, knowledge and experience to meet people's needs.

Processes were in place to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and had access to a range of training to support them in their role. Supervision was conducted regularly and staff received an annual appraisal of their work.

Staff understood the importance of obtaining consent and supported people's rights under the Mental Capacity Act.

People had mixed opinion about the quality of the food but said they had enough to eat and drink. People and their relatives were able to prepare their own drinks.

The households had been designed and adapted to meet the needs of the people living there.

Is the service caring?

Good

The service was caring

Without exception, people and their relatives praised the staff for their caring and professional approach.

People's privacy and dignity was maintained and people were provided care and support in line with their wishes and preferences.

People said their independence was promoted and staff encouraged them to do things for themselves.

Is the service responsive?

Good

The service was responsive.

People received care and support which was responsive to their needs.

A range of social and leisure activities were provided; which were based on people's choices. People were encouraged to make friends, learn new skills and be involved in their community.

The complaints procedure was outlined in the service user guide and we saw the service maintained a complaints log. These evidenced complaints were followed up appropriately and in the time frame specified.

Is the service well-led?

Good

The service was well-led.

We found the service promoted an open culture, was person centred, inclusive, open and transparent.

Following a specific incident, governance arrangements had been reviewed and records changed to provide a more detailed account of care and support provided.

Regular meetings took place with the various staff groups. Staff supervisions were undertaken regularly and staff attended an annual performance development review meeting.

Belong Wigan Care Village

Detailed findings

Background to this inspection

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

This inspection was unannounced and carried out on 06 and 16 May 2016. Three adult social care inspectors conducted the visit on 06 May 2016 and one adult social care inspector on 16 May 2016.

We asked people for their views about the service and facilities provided. During our inspection we spoke with the following people:

• nine people who used the service
• six visiting relatives
• 21 members of staff, which included; the general manager, registered manager, clinical nurse lead, front house manager, two night senior care staff, nine night care staff, two day senior care staff and four day care staff.

We looked at documentation including:
• six care files and associated documentation
• staff records including recruitment, training and supervision.
• five Medication Administration Records (MAR)
• audits and quality assurance
• variety of policies and procedures
• safety and maintenance certificates

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send usby law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key information about the

home, what the home does well and improvements they plan to make.

We liaised with the local authority and they raised no issues of concern.

Good

Is the service safe?

Our findings

We spoke with nine people and without exception they told us they felt safe living at the service. Comments included; "I feel completely safe and well cared for." "I've no concerns, I am safe here." "I wouldn't feel my belongings were safe as people would go in to my room but I have a key and I lock my door so it's not a problem." "This home is second to none. I have always felt completely safe. I was given only a short time to live, bedbound and completely dependent on staff when I came. They have really cared for me."

We received mixed comments from relatives regarding people's safety at the service. Relatives told us; "[Person] is completely safe. [Person] could barely speak before coming here. Since coming here it's like a miracle. Friends and family can't believe the difference. My only regret is [person] didn't come here sooner." "My heart leapt when [person] got a place here. Near as perfect as it gets. [Person] has Alzheimer's and it can be difficult but we are so reassured by the staff. We have no concerns at all about [person's] safety. Just relief." "I am reassured and confident that if there was an emergency [person] would get help. I just wish [person] was turned more during the day as [person] has some pressure points and complains of a numb bum."

Prior to our inspection we had received information of concern in relation to the clarity of the procedure to be followed by support staff when they needed to escalate health concerns particularly at night. This had been raised in a Regulation 28 report from the coroner with regards to a person who previously lived at the home who had passed away. As a result of this report we looked in detail at this area during the inspection. We conducted two inspection visits and arrived at 07.00 on both occasion in order to speak to as many night staff working at the service as possible. During both visits, we spoke to two senior and nine night support staff.

We found that management were able to demonstrate that they had been proactive in responding to the Regulation 28 report and had immediately addressed the areas of concern identified in the report. However, on our initial visit we received a mixed response from care staff regarding the procedure to be followed in the event of a person requiring medical assistance at night. Staff told us; "Staff members take full accountability, we would liaise with the nurse to get support as to who to contact." "I would call the senior if I had concerns. If the senior was not there, I would call the nurse." "In an emergency, I would contact the nurse if it was a nursing resident and the senior if it was a residential. I'd always ask the nurse to attend though as well, if a resident is unwell its best to ask the nurse and they'll come when they can." "If a resident was unwell, I would phone the nurse. The nurses can be really busy but they get to you when they can." "If a person becomes unwell I would phone a senior. I know the residents really well and can recognise any changes in their condition." Following the first day of inspection, we informed the general manager and registered manager of our findings. Although they were able to demonstrate discussions had taken place with staff regarding procedures, we felt there was some ambiguity amongst the care staff as to what to do in the event of a health concern at night.

On our second visit, we saw that a flow chart named 'Contingency flow chart for unexpected changes in health' had been developed. This had been given to every member of staff and was displayed on every

household on the inside door to the laundry room. The flow chart provided visible guidance and procedures for staff to follow in the event of a health concern arising at night. We spoke with all the night staff on duty and without exception they were able to tell us where the flow chart was located and what the procedure was. Staff told us; "It would depend on the person. I'd ring either the senior or the nurse. If they were both busy, I'd dial 111. If I thought it was an emergency, I'd just call an ambulance." "I'd ring the senior and nurse for support but if the person needed urgent attention, it would be an ambulance." "I'd ring the senior for residential people and the nurse for nursing. If they were both busy, I'd call for an out of hours GP. If it was more important and I was concerned for the person, I'd dial 999."

We looked at how the service managed risk. We found individual risk assessments had been completed for each person and recorded in their life plan. The life plan detailed management strategies to guide staff on how to safely manage risks. We also saw that people had yellow cards in their files, which contained a brief summary of risk information. For example; allergies, nutritional needs and mobility. This meant agency or new staff would have access to a concise risk picture of the person whilst they got to know them.

We saw accidents and incidents were closely monitored via an accident and incident data base. Accident and incident forms were completed on the household and sent to the registered manager who inputted the information on an electronic falls and incident electronic system. The system also captured infection control outbreaks, urinary tract infections (UTI), pressure sores and hospital admissions. It was live data which could be extracted at any time to ascertain trends in incidents. Actions had been implemented following issues arising of a similar nature for people. For example, if a person had a series of falls, risk assessments were conducted and measures implemented to mitigate the risks. We saw life plans had been updated and incidents were handed over to staff to monitor. People had been referred to other agencies to assess the cause of falls. Lessons learnt and outcomes were disseminated throughout the team to promote best practice at team meetings.

We saw that people had personal emergency evacuation plans (PEEPs) in their care files and copies of the plans were kept at reception to ensure they were easily accessible should an emergency situation occur. The service had emergency contingency plans to enable people to receive the care and treatment they required should an emergency occur that stopped people from staying at the service.

We looked at health and safety and building maintenance records and saw documentation and certificates, which demonstrated that relevant checks had been carried out in respect of gas and electrical safety, risks associated with waterborne viruses and hot water temperature checks. Records were also maintained to demonstrate that safety checks had been completed for portable electrical appliances. We checked that upper floor windows were compliant with safety regulations and found appropriate window restrictors were in place. Equipment, fixtures and fittings were well maintained and the service had a system in place, which identified actions required to ensure repairs were carried out in a timely way.

We observed staff using key fobs to enter and leave the household which ensured the security of people living there. People were given their own key fob to enter and leave the household if they had been assessed as safe to do so. People had their own key to their bedroom so they were able to lock their bedroom doors. We saw people living with advance stages of dementia were on the ground floor. They did not have key fobs to exit the household but there was a back door that remained unlocked. We observed people freely leave the household through the back door and enter a large fenced courtyard. The open plan household, offered staff good visibility without encroaching on people and enabled them to monitor people outside whilst maintaining respect for their freedom. We saw people were visibly relieved to have this degree of control, which meant that risks were managed and people's freedom was not unnecessarily restricted.

We saw that there were movement sensors in rooms to respond to people getting out of bed at night which triggered lights automatically. Bed sensors were at the side of people's bed to alert staff to support people mobilising which would maintain people's safety and mitigate the risk of un-witnessed falls.

There was a call bell system in place so that people could call for assistance from staff. We looked at the call bell response times for May 2016 to establish whether people's needs were being met in a timely way. We saw call bells that weren't answered before 90 seconds timed out and alerted the supervisor. We found the majority of call bells had been answered in a relatively short period of time and only a small number had exceeded 90 seconds. The longest time a call bell had remained unanswered was 95 seconds. The registered manager received a block graph which identified the household and detailed the alarm message activity, whether the alarm had been raised for assistance or an emergency and the frequency of alarms per hour. The registered manager told us that this provided them an overview of night activity to consider staffing compliment based on the needs of the household.

We asked people and their relatives if they felt there were sufficient numbers of staff on duty to meet people's needs. We received a mixed response. People told us; "All the staff are obliging but they are rushed off their feet." "The call bell is answered in a minute. I was at another home before here where the call bell was ignored and I was left in a state of disgrace. That has never happened here. I've never had to wait." "They could do with one more member of staff. Somebody always needs help on here." Relatives told us; "I feel they are short staffed particularly at night. When staff are preparing food, it takes them away from care." "No concerns about staffing. I visit day and night and I've never seen an issue."

We spoke with the registered manager to determine how staffing levels were calculated. We saw that an 'indicator of independency' questionnaire was completed with people within seven days of them moving in to the service. The independency questionnaire covered people's needs and whether the person required assistance to perform certain tasks. This was scored out of five. Five equated to having low independency and requiring a lot of assistance from staff. For example; eating without assistance would score zero whilst receiving nutrition by tube or infusion would be rated as five. Independency was measured by assessment of: nutritional support, personal care needs, mobility, communication, well- being, cognition, sensory needs, pressure and falls risk. The score was calculated and determined whether a person had very low independency to very high independency. We saw that staffing hours had been adjusted to accommodate people's needs and an extra member of staff had commenced on one of the household from 06.00 to accommodate the people's needs from this time.

Staff raised no concerns regarding the numbers of staff deployed and told us; "Three staff per household is sufficient but if there has been an issue and we've needed an extra staff member, this has been provided." "People's needs determine the staffing. Seniors base themselves on households that need additional support at high demand times." "We've enough staff when there are eight on at night. When there are seven, it's a bit hard." "We can meet everybody's needs timely when we have two floaters on at night."

During our first inspection visit, we determined which household had very low independency. On our second visit to the service, we based ourselves on that household for two hours in the morning and observed there were sufficient numbers of staff deployed to meet people's needs.

We found the service had appropriate systems in place to help protect people from abuse. We looked at recruitment procedures and found robust and safe recruitment practices were in place. This was evidenced through our examination of employment application forms, job descriptions, proof of identity, written references and training certificates. Disclosure Barring Service (DBS) checks had been undertaken before staff commenced in employment. DBS checks help employers make safer recruitment decisions and

prevents unsuitable people from working with vulnerable adults. The registered manager was able to demonstrate nursing registrations were up to date and maintained.

The service had a safeguarding policy and associated local procedures which were up-to-date. We also saw that the service was actively promoting its policy of 'if you see something…... say something.' Information relating to this was displayed around the service and was discussed with staff during performance reviews.

We saw that systems were in place to support people's medicines which were being managed safely.

Medicines were stored securely in lockable cabinets in people's bedrooms. A medication risk assessment was completed and people able to self-medicate were encouraged and supported to do so. Each person had PRN medication, "prescribed when needed". We saw PRN protocols which detailed the rational and circumstances to offer each medicine, the dose details, route, contraindications and potential side effects. People told us they received there medicines on time and they could request homely remedies when needed. A 'homely remedies' policy was seen for over the counter remedies and provided clear guidance for staff. The protocols gave administration guidance to inform staff when the medication should and should not be given. We saw cream charts and body maps to guide staff in the application of creams. This ensured people were given their medicines when they needed them and in a way that was responsive, safe and consistent.

Controlled drugs were administered by a nurse. Senior care staff completed medication training and were able to administer other medicines. The medication training records were current and staff told us they felt confident in this area.

We saw detailed assessments and life plans with accompanying documentation of best interest meetings with staff, GP, person and nearest relative regarding the administration of covert medication which complied with the Mental Capacity Act (MCA) 2005. We saw discussions had been undertaken with people and their relatives to assess their compliance prior to activation of the covert medication plan.

Good

Is the service effective?

Our findings

We asked people who used the service and their relatives if they thought the staff had the correct knowledge and skills to provide effective support. People and their relatives told us; "Staff definitely know what they are doing." "The staff are second to none." "The staff are well trained. They know what they are doing and seem to have a medical background." "Staff are very competent. [Person] is well cared for."

We looked at the induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. The registered manager told us the induction consisted of staff completing the care certificate and shadowing experienced staff. The care certificate is a nationally recognised and accredited system for inducting new care staff and assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control.

In addition to the care certificate, we saw new staff completed an 'in house' induction that provided safety information, for example; where the fire exits were located and the procedures to follow if there was an incident. New staff would also shadow existing staff members until they felt confident and competent to undertake their role unsupported.

We looked at training and development records for six staff and found each one had completed the induction and further training. We looked at the training matrix which showed staff had access to a comprehensive training programme. Staff had attended training such as; basic life support, customer service, fire, food safety, infection control, MCA, medication, moving and handling, nutrition and safeguarding.

All the staff attended a two day Dementia Awareness course and there were identified Dementia Champions that provided additional support and coaching to staff. The service had an Admiral Nurse who was appointed in partnership with Dementia UK. Admiral Nurses are mental health nurses specialising in dementia care. They offer individualised support for family members, carers and people who have also been recently diagnosed with dementia. The Admiral Nurse offered a wide range of support to people living with a diagnosis of dementia from providing therapeutic approaches to liaison with other professionals to ensure that families received coordinated support.

We looked at staff supervision records and found that individual performance reviews were completed quarterly. We saw that information relating to each performance review had been captured during these meetings and that a wide range of topics was discussed. For example, team performance, well-being, attendance and safeguarding. We also saw that individual performance sessions were used as a mechanism to ensure that lessons were learnt from particular incidents. For example, we saw that an incident relating to a low level medication error had been fully explored with a member of staff and clear information was documented detailing the lessons learnt. We found that annual appraisals were also completed and records

maintained.

We received a mixed response from people and their relatives about the quality of the food. People told us; "Food is not great but it's adequate." "Food is okay." "Food is plentiful and of good quality." "The food can be fabulous. It depends on the chef on the day. Generally very good." A relative told us; "The food is nourishing but a bit dull. [Person] can be lazy around eating, staff assist and make sure [person] gets their meals."

We carried out a Short Observational Framework for Inspection (SOFI) on a household during breakfast and lunch. We saw staff used a picture menu to support people to make their meal choice. The meal times were a relaxed and a pleasant experience. People and staff were engaged in conversation and there was a happy atmosphere during meals. Staff promoted people's independence and people were engaged in supporting meal preparation and setting the table. We observed a person requiring support but staff did this discreetly sitting with the person and maintaining the person's independence were appropriate. We saw people wanting to go to the Bistro to eat were accompanied to the village café to have their meal.

We saw a malnutrition universal screening tool (MUST) in people's care files. This is an assessment used to determine people that are at nutritional risk. We saw if people had been observed to have difficulty swallowing, staff contacted the Speech and Language team and they carried out an assessment of their swallowing reflex. We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's life plans and included Podiatrists, Opticians, Mental health teams, District Nurses, Physiotherapists and Doctors. People's life plans contained the relevant information about people's dietary needs and all the staff questioned were able to identify people's dietary requirements. We saw people were weighed regularly and weight loss was addressed timey to elicit further support from the person's GP or community dieticians.

We saw that when people needed to move between services such as a hospital or nursing home a transfer document was completed. This included the person's life plan, medication record and any other relevant information. This meant people's choices were identified in order to support continuity of care.

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. 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw throughout both inspection visits, staff sought consent before providing care and support. People's capacity to consent was clearly documented in people's care files and written consent had been obtained before people's photograph's had been taken and displayed on people's MAR charts. Concerns were documented regarding people that were unable to consent to specific decisions and an MCA assessment had been conducted.

We saw staff adhered to the legislative requirements of the MCA. For example, one relative informed us that

they had been involved in covert medication discussions with staff, [person's] GP and this was documented in the life plan. A Mental capacity assessment had been conducted prior to convening the meeting, the best interest decision had been documented and the life plan updated.

The registered manager demonstrated effective systems to manage DoLS. When people were deemed not to have capacity, the registered manager had completed standard authorisations which had been submitted to the local authority. There was a current policy in place detailing procedures. The registered manager maintained clear and concise electronic records which detailed when a standard or urgent authorisation had been submitted, whether and when it had been granted and the expiry date. The registered manager rag rated when the standard authorisation required resubmission to the local authority. A rag rating is a project management system for rating importance or timescales based on the colours used in traffic light system; red, amber, green. The registered manager submitted authorisations to the local authority four weeks prior to their expiry.

Staff were able to identify the people that were in their care that were subject to DoLS. We observed people were supported in the least restrictive way and life plans were positively written and considered opportunities to optimise people's freedom. We saw people that were living with a diagnosis of dementia were living on the ground floor household and were able to freely leave through the back door and access a large secure patio and seating area. We observed people come in and out of the back door to the household throughout our inspection visit and nobody approached the main door or requested to leave. The ability to leave the household in this manner gave people a degree of control and enabled them to get some fresh air without being dependent on staff. We noted staff didn't encroach on people whilst they were outside but discreetly monitored their whereabouts and safety from communal areas.

The accommodation comprised of six small households which accommodated 11 people on five households and 12 people on one household. The household kitchen, dining area and lounge were at the centre of each household and clear signage was provided to support people to orientate independently.

Good

Is the service caring?

Our findings

Without exception we received positive comments about the staff and care received. People told us; "The girls are nice and lovely. They all are." "Staff are all very friendly." "I've grown to love all the carers; they've become part of my family." "Staff are fantastic. Absolutely lovely."

Relatives told us; "The girls are absolutely fabulous. Affectionate, tell [person] they love them. I can only say good about the staff and this place." "The staff are like family. They kiss me before I go home. I feel [person] is cared for when I leave. I have peace of mind."

The atmosphere in the households was relaxed and homely. During the inspection visits, we observed staff interacting with people and noted they were comfortable and relaxed in each other's company. We saw appropriate displays of affection and positive interactions between people, staff and their relatives. We saw staff embrace people and their relatives which was reciprocated. Staff sat with people holding their hands and talking.

We saw staff responded promptly when a person was distressed and crying. We saw the staff member sat with the person, got down to the person's level and took their hand whilst asking why the person was upset. The person had a baby doll and two teddy bears. The person told the staff member that they were 'struggling' to look after their babies. The staff member sat with the person and held their hand and cradled a teddy bear. They enquired with the person if they felt better and we saw the person smile and nod at the staff member. The staff member sat with the person for five minutes before enquiring if they could put the teddy bear on the chair. The staff member did this sensitively and covered the teddy bear with a blanket.

We observed a second person crying and saying that they didn't know where they were. A staff member crouched next to them and embraced them. We heard the staff member explain where the person was and asked if there was anything that they would like to do. The staff member got up and told the person that they would be right back. They returned within seconds carrying a baby doll. The person became animated and took the doll from the staff member. The person was seen talking to the doll and stroking the dolls hand throughout the inspection. This demonstrated that staff understood people's needs and took practical action to relieve people's distress.

During the inspection we saw people being treated with dignity and respect by staff. This was also echoed by people and their relatives. A person told us; "Staff always ask for permission before coming in to my room." Relatives; "Staff are respectful, very welcoming to me and ask permission if I'm here to come in and do things." When we asked staff how they aimed to treat people with dignity and respect, we were told by one member of staff; "I always knock on doors, introduce myself. I explain what I want to do and seek consent. If I'm supporting somebody's personal care, I make sure the curtains and doors are closed."

We saw staff promoting people's independence and engaging people in household tasks. We saw people setting the table for lunch and dinner. People were encouraged and supported by staff to make their own

beds. We saw one person keep asking staff to wake their friend when they were having a sleep and staff distracted them by supporting them to bake biscuits for after lunch. We observed a second person supporting staff with laundry and returning it to people's rooms. People told us staff promoted their independence as much as possible whilst living at the service. One person said; "I was given months to live, I was paralysed for four years and now I'm moving in to my own place. The staff here have given me lots of encouragement and never given up. They have supported me and advised me when I was overdoing it." We asked staff how they aimed to promote people's independence and were told; "We don't take anything away from people. We're just here to provide support." "It's people's home. People have their own fob and go out and return when they want." "People pick their own clothes, ask if want me to comb their hair or do it themselves. Encourage people to use the kitchen. People make own drinks if able."

During the inspection we saw people were offered choices. People chose when they retired to bed and got up. People chose what they wore, ate, where they sat and how they spent their day.

The service adopted a companion system which meant people had an identified staff member to support them. The service also enabled people to keep their pets if they chose and were accommodated ground floor households to support this.

There was a bookcase at the entrance of each household which contained leaflets and service information. People were also provided with a service user guide upon moving in to the service which included important information about the service, complaints, contacts and staff.

Staff had the opportunity to attend end of life awareness training and we saw life plans contained information regarding people's end of life wishes. Documentation captured whether people preferred to stay at the service or receive treatment at hospital. A thinking ahead document was available which provided a framework for staff to initiate difficult conversations about end of life wishes. This enabled people to express their choices and make informed advance decisions about their end of life.

Good

Is the service responsive?

Our findings

We looked to see what activities took place at the service and how people were supported to follow their interests. People told us; "There's lots of activities going on here. We've always got something to do." "There is a load going on. I went to watch; 'We'll meet again' at the Warrington civic. We had a great laugh." "There are outings, daily games, pampering or the bistro to go to." A relative told us; "The activity coordinator gets [person] involved. Before coming here, [person] was never supported to come out of their room. If they are up to it, they are supported in to their chair. We go outside or to the bistro. We were all outside the other day; people, relatives and carers singing, chatting and clapping. I loved it."

People were supported to follow their interests and engage socially with others in ways that were meaningful to them. The service had daily activities scheduled and outings were arranged in consultation with people living at the service. Activities were advertised in 'what's on' which was a Belong programme. We saw the April and May 2016 'What's on' detailed Tom Jones tribute act, fine dining, charity bingo, dementia awareness, tea parties, crafts, Royal afternoon tea, dominoes and whist drive, games and exercises. Staff told us there were daily household activities which included; cards, dominoes and movie afternoons with popcorn. We were told staff supported people to attend village activities and weather dependent people sat outside singing or dancing. People were encouraged to do chair based exercises and a staff member showed us a box of bits that they got out for people to 'rummage in' which contained blankets, tactile materials and play doh.

We saw people leaving the households freely to go shopping. Chairs and seating areas were grouped to enable people to sit and engage in different activities. We saw people watching TV, listening to the retro design radio, reading papers or engaged in structured activities. For example dominoes that staff had instigated.

We saw a person with multiple physical health needs had a ground floor bedroom. There was a sliding door off their bedroom with an outdoor patio and seating area. We spoke to their relative who informed us that the person enjoyed looking outside. However, their relative told us that the person and their family had gained the most benefit from being able to privately sit outside together. Their relative told us that since moving to the service [person] had become less socially isolated and friends and family had commented on the positive difference this had made to [person] and their life.

There were no prescriptive visiting times and the service had facilities to enable people and their relatives to see each other in privacy. The service had gardens and benches outside. On the ground floor the service had a large communal reception area and a bistro café which was visited by people, their relatives and people living in the local area. On the second floor, there was an internet room, seating, training room and a function room used for celebrations. Staff encouraged and supported people to use these facilities.

People and their relatives told us that an initial assessment had been conducted to ascertain people's needs before they moved in to the service. Relatives told us; "We went through the care plan initially with all our family to discuss [person's] needs and likes because they couldn't express this at the time." "I've been

involved since the initial assessment and remain involved regarding [person's] ongoing care. I am involved and know everything."

We looked at six care files and found life plans were person-centred and reflected people's individual needs and personal preference. Care files contained personal information about people's background, significant relationships, working life, social activities and interests, significant life events and religion and spiritual needs. We saw how people wanted to have their personal care needs supported and this was captured on 'getting ready for the day ahead'. We saw that people's care needs were regularly reviewed and people and relatives informed us that they were involved in this process.

There was a system in place to investigate and respond to complaints appropriately. We saw there was a complaints procedure on display, informing people and their relatives how they could complain if they were unhappy with any aspect of the service. There were also leaflets displayed on individual households and in public areas, entitled 'How Are We Doing?' This offered a further opportunity for people to provide feedback and influence change at the service. Relatives and people we spoke with during the inspection told us they knew how to complain but had no complaints about the staff or services provided. They told us that if they ever had a problem they would speak to a member of staff or the managers.

Good

Is the service well-led?

Our findings

People who lived at the service and their relatives spoke favourably about management. People told us; "They're very busy but lovely. I love them to bits." "Management always ask me how things are going, how I am doing." Relative's comments; "The staff and the management are all very friendly." "This place is as near to perfect as you can get. It's well-run."

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

The organisational structure was clear and staff were aware of their lines of responsibility and accountability. There was a registered manager, general manager and clinical nurse lead on duty throughout the inspection. The area manager visited on the second day of our inspection visit and was seen on the households speaking with people. We found the benefit to this structure was that it identified clear lines of accountability. Discussions with the management team identified that they worked well together to ensure the service ran effectively. More widely, we found a management philosophy within the service which promoted a culture of openness and honesty. Management were visible and involved in every aspect of the service.

Prior to conducting the inspection, we had received a copy of a Regulation 28 report from the coroner about the service. This identified an issue around the governance arrangements for maintaining complete, contemporaneous records. This was as a result of the night staff writing a global summary at the end of their shift, which did not provide specific details of checks undertaken throughout the night. At our inspection we saw that a night time record sheet had been introduced. The record was time specific and was completed by staff as people's care and support needs were met. This meant clear and concise records were now being maintained throughout the night, which enabled management to illicit information regarding people's health and care needs and the specific time at which things had occurred. We spoke to 11 night staff who confirmed the records had been implemented immediately following the issue being identified.

We looked at records of unannounced night visits which were completed by members of the management team to ensure quality and safety was being maintained out of hours. At our initial inspection visit, the general manager was already on duty and had commenced work at 06.00. Where issues had been identified during these unannounced visits, we saw how positive action had been taken to address the issue.

During our inspection, we asked for a variety of documents to be made available. We found documentation was kept securely locked away and was well organised enabling the documentation requested to be accessed promptly. We found all the records we looked at were structured and organised which assisted us to find the information required efficiently. Information was easy to find and would assist staff if they were required to find information quickly.

We saw supervision, training and support was offered on an on-going basis. Staff meetings were conducted regularly and appropriate records maintained. Staff told us they were able to contribute to agenda items and that staff meetings were useful and productive. We spoke with four senior care staff and 13 care staff who described the management team as approachable. Staff told us; "The management are approachable. We have regular team meetings and are encouraged to influence care." "Management are great. I feel very supported." "It's a lovely place to work."

We saw the service developed staff and lead roles were adopted in areas of interest. There was a dementia champion that was responsible for keeping up to date with current guidance and disseminating information to other staff members. The home also employed an Admiral Nurse who offered additional support and services to people living with a diagnosis of dementia and their families. They provided support, offered assessments, provision of therapy and a range of help from diagnosis to bereavement, assisting with people's understanding of the condition, linking in with other professionals to ensuring care was coordinated and supporting people living with a diagnosis of dementia to live as independently as possible for as long as they were able.

Policies and procedures relating to the effective operation of the service were up-to-date and accessible to staff.

Each 'household' within the service was quality assured on a regular basis with comprehensive records maintained. We found a wide range of topic areas were covered during audit which included dignity and respect, consent and choice, staffing, leadership and supervision, safeguarding and nutrition and hydration. We saw that action plans were addressed within a short timescale and feedback was disseminated to the staff through team meetings and supervision to ensure lessons learnt was cascaded.