Kent County Council

West View Integrated Care Centre

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

Overall summary

The inspection visit was carried out on 15 April 2015 and was unannounced. The previous inspection was carried out in January 2014, and there were no concerns.

West View Integrated Care Centre provides both adult social care and health care on the same site. There is a residential care service with two units on the ground floor. Linden unit has 15 beds for older people requiring permanent or respite residential care; and Wittersham unit has 15 beds for older people living with dementia who require permanent or respite residential care. On the first floor there are two units which each have 15 beds, Benenden East, and Benenden West. These units provide rehabilitation for patients who need help to enable them to return to their own home after illness or injury. The residential care service on the ground floor is staffed by

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employees of Kent County Council (KCC), whilst the rehabilitation service on the first floor is staffed by employees of KCC, and NHS employees who are nurses and other health professionals.

The premises are a Private Finance Initiative (PFI), owned by Integrated Care Solution (East Kent Limited). Management of the premises, maintenance, laundry, domestic and catering services are sub-contracted to Shaw Healthcare.

The service is run by a registered manager, who was present on the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered manager worked closely with the manager for Shaw Healthcare to ensure that the services provided were fully integrated and benefitted the people receiving care and support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. One application and authorisation had been made to the DoLS department for depriving people of their liberty for their own safety, and CQC had been notified about this.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so.

The service had systems in place for on-going monitoring of the environment and facilities. This included maintenance checks, and health and safety checks. Emergency plans and personal emergency evacuation procedures (PEEPs) for people receiving support were in place. Fire evacuation procedures and the fire risk assessment were reviewed and updated yearly by both managers. Accidents and incidents were reported, and systems were in place for following these up for all people and staff using the building, so that there was a co-ordinated approach to identifying any patterns occurring, and if any risks could be lessened.

The registered manager kept staffing numbers under review for care staff and nursing staff; and the Shaw Healthcare manager reviewed the numbers of ancillary staff in discussion with the registered manager. There were sufficient numbers of staff to run the service efficiently, and people were confident that there were suitable numbers of all staff to provide them with the care and support they needed. They said they felt safe and secure in the home, and were never rushed by the staff. People and their relatives said that the home was "Always kept clean" and that the building was "Well maintained". The service followed required infection control procedures.

There were robust staff recruitment procedures by the registered manager and Shaw Healthcare to check that staff had required checks completed, and were suitable for their job roles. Records of on-going staff training, supervision and appraisals confirmed that staff were working to appropriate standards and were supported by their line managers. All staff were encouraged to attend meetings, and to take their part in the development of the service.

Nursing and care staff ensured that medicines were stored and administered to people using safe practices. These included nursing staff on the first floor, and senior care staff on the ground floor. People told us they received their medicines on time.

People and their relatives said that they were fully engaged in discussing their care planning and formally consented to their care plans. This included discussing changes in people's progress with rehabilitation; and any changes in people's care or health needs who were receiving respite care. Staff showed an understanding of assessing people's mental capacity, and when they could make decisions for themselves; and when they may need support in making more difficult decisions. Staff

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contacted people's family members, health professionals and social care professionals for 'best interest' meetings when these were needed to support people with appropriate decision-making.

The food was well presented and a variety of dishes were provided at each meal to give people choice. All the people that we spoke to were happy with the quality of food they received and the choices given. The chefs were familiar with people's different dietary needs and their likes and dislikes; and spoke to people to obtain their feedback about the food.

People's health needs were assessed by nursing and care staff in the different units. Health professionals such as occupational therapists, physiotherapists and a geriatrician were involved in people's on-going assessments to ensure that they had the maximum support possible to assist them with making progress with their health needs. Referrals were made to doctors as needed. The service contained suitable equipment to support people with their health needs, and this was serviced and maintained for safety.

Staff treated people with respect and dignity, and maintained their privacy. People were supported to sit in communal areas or to stay in their own rooms as they wished. They were able to get up and go to bed as they wished, and were encouraged to maintain their independence. This was especially noticeable on the first floor units, where people had agreed to take part in their rehabilitation and were committed to developing their mobility and dexterity, and their general health, to enable them to regain more daily living skills and increase their independence.

People's life histories were documented in their care plans and staff were well informed about people's previous lifestyles and the subjects that interested them.

There was a programme of entertainment and activities throughout the day, which was especially helpful for people living with dementia who needed support with following their interests.

People said they would have no hesitation in raising any concerns with the staff, health professionals or the registered manager, and were confident that any concerns or complaints would be addressed. People were provided with a complaints leaflet when they were admitted to the home, and these leaflets were easily available in reception and communal areas.

People were invited to express their views every day about how they were feeling and how they felt their needs were being met. People who were admitted for short term respite care or rehabilitation were asked to complete a quality assurance questionnaire before leaving. Results from the quality assurance questionnaires were analysed and made available for people to read, and included any action taken in response to people's comments. People receiving long term care were asked for their views on a regular basis. This included attending residents and relatives meetings. People spoke very positively about the service with remarks such as, "I am very impressed with everything, especially the staff and the environment. Both are excellent".

Records were neatly and accurately maintained, and were up to date and correctly signed and dated. The registered manager and staff maintained a culture of continuous improvement, and several staff told us they were "Proud to work here". Staff were informed of the ethos of the service in ensuring that people received the support they needed, and in working together for the on-going development of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were reliable processes in place for emergency procedures and maintaining people's safety.

Individual and environmental risk assessments were carried out and reviewed at regular intervals. Accidents and incidents were recorded and monitored, and were analysed to check if any improvements could be made. The premises were kept clean and followed infection control procedures.

Staff were trained in safeguarding procedures and in raising any concerns. Staff recruitment procedures were carried out correctly and staffing levels were maintained to ensure people's needs were met.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff were suitably trained and supervised to carry out their jobs appropriately.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

The service provided people with a suitable variety of food and drink to give them a varied and nutritious diet.

People's healthcare needs were assessed and monitored, and they were supported by health professionals to enable them to regain their independence where possible.

Is the service caring?

Good

The service was caring. People felt confident in the care given to them by staff, and said that staff were friendly and kind and did not rush them.

Staff respected people's privacy and dignity and supported them with making choices.

People and their relatives said that staff communicated with them well, and kept them informed of any changes.

Is the service responsive?

Good

The service was responsive. People were involved in their individual care planning, and their relatives were included if people wished for this.

Staff were informed about people's individual life styles and interests, and provided them with a range of activities and entertainment for their enjoyment.

People were confident that the registered manager and staff listened to them and would follow up any concerns or complaints appropriately.

Summary of findings

Is the service well-led?

Good

The registered manager worked closely with other management to ensure the smooth running of the service. There was on-going liaison between different departments to ensure that checks and audits covered all aspects of the service.

Staff were encouraged to take part in the on-going development of the service. There was an ethos of making continued progress, and ensuring people received the support they needed.

There were reliable systems in place to monitor the quality of the service using audits and questionnaires. Records were kept up to date and were accurately maintained.

West View Integrated Care Centre

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 was 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 15 April 2015 and was unannounced. It was carried out by a team of three people: one inspector, a specialist nurse, 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.

Before the inspection, we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) A notification is information about important events which the service is required to tell us about the law. We obtained feedback from three people or their relatives who had completed voluntary feedback forms which all contained positive information. We contacted twelve health and social care professionals for their views of the service. These included Social Services case managers and district nurses.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned a PIR within the set time scale.

We viewed all areas of the service, and talked with 13 people who were receiving care. Conversations took place with individual people in their own rooms, and with groups of people in the lounges. Some people living with dementia were not able to tell us about their experiences. We used the Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also had conversations with four relatives and visitors, and 16 members of staff as well as with the registered manager and the Shaw Healthcare manager. Staff members we talked with included nurses, health professionals, team leaders, care staff, domestic staff, maintenance staff and the chef.

During the inspection visit, we reviewed a variety of documents. These included seven care plans. We viewed five staff recruitment files, staff training records, staffing rotas for two weeks, medicine administration records, health and safety records, environmental risk assessments, activities records, 15 recently completed quality assurance questionnaires, minutes for staff meetings, audits, the service users' guide, and some of the home's policies and procedures.

Good

Is the service safe?

Our findings

People said they felt safe, and were confident that staff cared for them well. Comments included, “I feel safe as there are always enough staff around to help me, and I can always press the bell if I need anything"; and “The bed is very comfortable and I have all the equipment I need to help me move around”. Another person said they had been encouraged to walk with a Zimmer frame after having had several falls before being admitted to the unit, and they felt more confident now as “I feel safe with the help they give me". Two other people who had been using wheelchairs before admission said they were now gaining confidence in using Zimmer frames for walking, as staff supported them and “No one hurries me”.

People told us that staff always attended to them quickly if they rang their call bells, and that “Nothing is too much trouble” for the staff. This promoted their feelings of confidence in their safety on the premises. The premises included key pad locks in some areas, including the ground floor dementia care unit. This was to promote people’s safety who may be at risk if they left the unit or premises without an escort.

Staff training records showed that all of the staff had received training in safeguarding adults during the last year. Staff confirmed their understanding of the different types of abuse and what action to take if they suspected abuse might have taken place. They were also informed about the service’s whistleblowing policy, whereby staff should be able to report concerns about other staff members in a way that did not cause them discrimination. The registered manager and other senior staff were familiar with the processes to follow if any abuse was suspected in the service; and how to contact the local authority safeguarding team. There was a copy of the local safeguarding protocols in the registered manager’s office; and this was also available to all staff via the service’s computer system, so that it was easily accessible to staff.

Each person had a lockable drawer provided for safe storage of their own personal items. Some people had personal monies stored on their behalf. These had separate records maintained, showing all incoming payments and expenses incurred. All receipts were retained. The records were checked by two senior staff at regular intervals. People or their appointee could view their records on request at any time. This protected people from any financial abuse.

The service had environmental checks and equipment servicing carried out or arranged by Shaw Healthcare, who had their own manager on site, and who liaised closely with the registered manager. A fire risk assessment and emergency evacuation procedures were reviewed yearly, and included clear instructions for moving people in the event of an emergency. Personal Emergency Evacuation Procedures (PEEPS) identified any specific instructions for moving people safely, and we saw clear instructions in people’s care plans for moving people who had restricted mobility. These were updated as people’s mobility improved.

Environmental risk assessments included the use of chemicals in the building (The Control of Substances Hazardous to Health or ‘COSHH’). There was a copy of these assessments for each chemical used in each cleaning cupboard, so that domestic staff could quickly access any emergency procedures to follow in the event of an accident or spillage. Other risk assessments were in place for laundry equipment, kitchen equipment, clinical waste, cleaning bedrooms, and lone working. Specific assessments included use of scaffolding, vacuuming, putting stores away and cleaning floors, showing that procedures were in place to protect staff as well as for people receiving care and support. Maintenance schedules were followed reliably, and included checks for hot and cold water temperatures, inspection of lifts and hoisting equipment, gas and electrical safety, emergency lighting, and thermostat checks. Fire drills and fire alarm checks were carried out at regular intervals.

People’s care plans included individual risk assessments. These included procedures for moving people safely; risk assessments for nutrition such as choking or malnutrition; risks for self-administration of medicines; risks of slips, trips or falls; and risks of using baths or showers unescorted. These contained clear instructions for how to minimise the assessed risks.

The registered manager monitored the numbers of staff in each unit in accordance to their dependency levels. These fluctuated, as some people were admitted for rehabilitation and needed more support in the first few days or weeks. The numbers of staff on the first floor

Good

Is the service safe?

rehabilitation units reflected this, and staffing numbers for all units were kept to a level where staff could meet the needs of people in their care. The first floor units provided one nurse and four care staff throughout the day for each 15 bed unit. These were supplemented by health professionals from the NHS Intermediate Care Team, which included occupational therapists, physiotherapists, speech and language therapists, and a geriatrician. Night shifts were staffed by one nurse and two care staff for each unit. The ground floor units did not provide nursing care, and staffing levels were for three care staff for each unit, and one team leader across both units during the day. The registered manager told us that sometimes each ground floor unit had a team leader, and staffing rotas confirmed this. The registered manager and staff said that this was preferable for effective leadership of the ground floor units, and the registered manager said she would be approaching the provider to gain agreement for this for all shifts. There were three care staff for each ground floor unit at night, and one team leader.

Sufficient numbers of ancillary staff were provided for domestic duties, laundry services, catering and maintenance. One person laughed saying "I hardly dare leave any clothes out or they go straight to the laundry! But they come back so quickly it doesn't matter".

Staff recruitment files showed that there were robust procedures for recruiting all levels of staff. The procedures included required checks, such as checking the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. Nurses were required to confirm that their nursing 'PIN' number was up to date, and provide confirmation of their qualifications. A record was kept of the interview process.

Nursing staff administered medicines to people on the first floor. Some people had been risk assessed as able to manage their own medicines. On this floor, each person's bedroom had a suitable locked metal cabinet for storing their own medicines. This provided an appropriate storage system for people who were admitted for short term rehabilitation. People who had been assessed as able to safely manage their own medicines had their own cupboard key.

On the ground floor, medicines were stored in locked cupboards in a locked room, and were administered by senior care staff using a medicines trolley. The storage room included a medicines fridge for items which needed to be stored at lower temperatures; and a spare medicines fridge for when the other one was being defrosted. Temperature checks were carried out for each storage area to ensure medicines were correctly stored. Bottles and boxes of medicines were routinely dated on opening, so that staff were reminded that some items had a short shelf life. Staff who administered medicines had dedicated training and competency checks to ensure they kept up to date with the correct procedures. A designated person on each floor carried out medicines audits each month, and these were reviewed by the registered manager.

Medicine administration records (MAR charts) were accompanied by a photograph of the person concerned to check their identity. Clear guidelines were in place for medicines which could be given 'as necessary', for example, pain relief. MAR charts on both floors had been accurately completed, showing that people had been given the correct medicines, at the right times. People said that they received their medicines as needed, with comments such as "I get my medicines on time and I know what they are for".

All areas of the building that we viewed on both floors were clean and well presented. People told us, "It is always spotlessly clean here"; and "The staff do a great job keeping this place clean and tidy". Cleaning schedules for bedrooms, bathrooms and communal rooms recorded that all areas were cleaned on a daily basis. Domestic staff had 'spot checks' carried out on their work, to check they were using the correct colour-coded cleaning equipment for different areas; and to see they were wearing personal protective equipment such as disposable gloves and aprons. The spot checks included asking staff questions, such as how to deal correctly with different spillages. If the staff were unable to answer any questions correctly they were required to update their training. Records showed that all staff were trained in infection control, and how to prevent infection through effective cleaning programmes and correct hand-washing. All areas had soap dispensers and paper towels where staff could access facilities to wash their hands.

Risk assessments were in place for laundry management, deep cleaning of bedrooms and clinical waste. There were clear guidelines for deep cleaning different areas, including bedrooms and flooring. These identified when and how

Good

Is the service safe?

carpets and laminate flooring should be cleaned. All bedrooms were deep cleaned between use; and bedrooms for people living permanently in the service had a minimum of quarterly deep cleaning programmes. Maintenance and domestic cleaning schedules had infection control preventive procedures in place. For example, domestic staff ran people's en-suite showers every day while cleaning bedrooms, so as to prevent legionella bacteria. Infection control audits were carried out by Shaw Healthcare and the provider, so that all aspects of infection control were covered.

Nursing and care staff demonstrated a good understanding of infection control procedures. For example, people who needed the use of a hoist to move them safely from one place to another had their own allocated slings kept in their own rooms and staff were able to tell us the importance of not sharing slings and infection control procedures. People who had urinary catheters had specific care plans in place and they evidenced examples of good practice in regards to infection control.

Good

Is the service effective?

Our findings

All the people that we talked with who were receiving rehabilitation support said they were happy with their progress and were regaining their confidence. Their comments included, “I can't fault anything. I am able to get up and wash and dress myself. It does take time to dress but no-one hurries me”; and “The care here is so good and I'm making real progress”. Another said, “They wake you with a cup of tea, and the day goes very quickly with meals, appointments and so on”. People told us that the food was good and they had plenty of choice, with comments such as “The food is very good and I eat all of it”; “I am very impressed with the food, it is excellent”; and “They really spoil me a bit too much with the food really”.

People said that their health care and rehabilitation needs were attended to. People told us that the doctor had visited them when they were unwell or needed a change in their medicines. They said that nursing staff and health professionals supported them and gave them clear advice and directions when helping them with their mobility. A visitor told us, “I have no worries about my relative. I cannot fault the care and the staff are so careful with him when they move him”.

All staff completed required training as part of their probationary period. This included training in moving and handling, infection control, health and safety, food hygiene, first aid, and safeguarding adults. Staff were required to update their training with refresher courses. Some of the training was carried out with computer on-line training, when staff had to complete a test at the end of the subject, and the result was sent through to the registered manager. The results were followed up with staff at individual supervision sessions, when the supervisor would assess how well the staff member had understood the training subject. Other training was carried out in groups as face to face training. All of the nursing and care staff were trained in dementia care, and could access other relevant training courses, such as stroke awareness, nutrition and hydration, end of life care, and Parkinson’s Disease. A staff member told us, “The dementia training was good and there is so much to learn about dealing with people". A social care professional told us, “I contact the service regularly by telephone and I have always found staff that I have spoken with to be very professional. They also respond promptly to any enquiries I make”.

Nearly all care staff had completed formal training in health and social care with National Vocational Qualifications (NVQs) or diplomas to levels 2 or 3. (NVQs are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the competence to carry out their job to the required standard). The registered manager told us “They all want to do level 3 training”, as care staff were keen to increase their understanding and develop their roles.

Staff were supported through individual supervision sessions with their head of department or line manager. Staff told us that they were allocated with a supervisor, so that they were able to build a rapport with them, and could develop confidence in sharing any concerns or personal situations. Staff had supervision every two months, and a yearly appraisal, and records confirmed this.

Training records for domestic, maintenance and laundry staff showed that they had all completed essential training before starting work. All of the ancillary staff were given some basic knowledge of dementia and how to respond to people living with dementia, and shadowed experienced staff as part of their induction. There were plans for the domestic supervisor to carry out further training in understanding dementia, so that they could then disseminate this training to other staff.

Nursing and care staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This enabled them to carry out mental capacity assessments to ensure that people could fully understand the relevant information when they needed to make decisions. People sometimes lacked full mental capacity to make difficult decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people’s independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. This included meetings with their next of kin, representative or advocate, and with health and social care professionals, to make decisions on their behalf and in their best interests.

The registered manager had made one application to the Deprivation of Liberty Safeguards (DoLS) office and received an authorisation for a person to be deprived of their liberty for their own safety. This was because the person had constantly wished to leave the safety of their unit, but would have been at risk if they had left the

building unaccompanied. DoLS concerns decisions about depriving people of their liberty, so that they can be given the care and treatment they need, where there is no less restrictive way of achieving this. People who were living with dementia were able to go out for walks out of the unit when they wished to do so. The registered manager was in the process of making further applications to the DoLS office for other people living with dementia.

Care plans confirmed that people were asked for their consent to their care and treatment, and people or their relatives (as appropriate) had signed their consent. People were asked for their consent for photographs. These were for identity purposes; and for documenting wounds or bruises, so that there was an on-going record of their healing. Some people had "Do not attempt Resuscitation" (DNAR) orders in their care plans. These had been discussed with the person and their family members and signed by a doctor or consultant. This ensured that people's own wishes were consulted and adhered to.

People said that they had a wide variety of choice in regards to food. The menus provided a choice for main meals and desserts, and a choice from a number of items for tea. Breakfast items were delivered to each unit so that staff could assist people with their breakfast as they were ready for it. A cooked 'brunch' was provided twice a month as a change in routine for people who wanted this. Main meals were served from hot trolleys by the staff, so that they knew the correct portion sizes and diets. The chef visited people who were newly admitted to the service and discussed their personal food likes and dislikes, and any specific dietary needs. The chef also met with people at residents meetings, when food changes were discussed and new items were agreed for a trial period. There had been a recent trial of different sandwich fillings provided at tea times as a result of a recent meeting.

Snacks were always available, and hot and cold drinks were actively offered throughout the day. These were accompanied by biscuits, home-made cakes or fresh fruit. People were able to choose if they wished to eat in the dining areas or in their own rooms. One person said, "I go to the dining room for lunch, but I prefer my own company so I come back to my room afterwards".

A choice of three different meals was offered to people at lunch time as well as a choice of four drinks. There were lots of staff around during the meal time, and they offered help to people discreetly when they needed assistance with eating and drinking. Staff engaged people they were helping in quiet conversation, and lunch time was quiet and unhurried on both floors.

Nursing staff carried out nutritional assessments with people when they moved into the home, ensuring that their dietary needs were met, and that catering staff were informed about their food preferences and any allergies. People were usually weighed monthly, unless there were concerns about their weight when weekly weighing could be more appropriate. Weight records showed if there had been any significant weight gains or losses, and what action was taken in response to this. For example, people with low weights might be offered a fortified diet or supplementary drinks to help increase their calorie intake.

People had regular reviews of their health needs with their GPs. People receiving rehabilitation care had daily or frequent visits from the NHS Intermediate Care Team (ICT) to assess their progress. This included visits from physiotherapists, speech and language therapists, occupational therapists, and a geriatrician. A weekly meeting was held with all of the health professionals to discuss each person's progress, and review their goals and aims. This included discussions about when people were ready to be discharged home. Occupational therapists carried out home visits with people to assess their ability to manage back at home, and if they would need any additional equipment, such as a shower chair, or a small trolley for taking food from their kitchen to a dining area.

Care plans included health assessments, including moving and handling assessments, falls risks, and risk assessments to assess skin vulnerability. These were followed up with detailed care plans and the assessment for specific equipment, such as pressure-relieving mattresses and cushions, and walking frames. Body maps were used for recording wounds, skin tears, and sores, and treatment was identified. Each person had a daily body checklist for their skin care. Wound care plans were detailed and easy to follow with basic step by step instructions on how to dress the wounds correctly. These included details for how the wounds should be cleaned, how often they should be dressed and the progress at each dressing change. A visiting health professional said, "I have worked closely with the link nurse for tissue viability, who has a wealth of knowledge which she shares with and supports her

Good

Is the service effective?

colleagues". And another health professional commented, "I have found that staff make appropriate referrals to me, they are willing to learn, and they carry out the care management plan I put in place for people".

Good

Is the service caring?

Our findings

People spoke highly of the staff, and told us they were "Friendly", "Caring", "Helpful" and "Kind". Some of their comments included, "The care has been so good, and nothing is too much trouble";

"I am well taken care of and quite happy here"; "The staff are nice and friendly"; and "My bed is very comfortable, the room is good and nothing is too much trouble for the staff". A visitor told us, "My relative is beautifully looked after. I can visit whenever I want, and I am able to take part in his care". Another visitor said, "The staff have supported me as well as my relative. The support I have had has been nothing short of wonderful, they welcome me like family and I have had a few shoulders to cry on".

People told us that they were able to get up and go to bed as they wished, with remarks such as "I like to go to bed straight after supper"; and "I am always up quite early, but I like to go to bed early too". People said that staff always answered their bells promptly, and that whenever they needed assistance, staff were there and helped them. On the dementia unit we observed a calm and unhurried atmosphere. Staff assisted people to find their rooms or bathrooms; offered them drinks; and distracted them if they were becoming upset. They knew people's different characteristics, and how to assist them, such as taking them for a walk, sitting and chatting, or played a game with them. A staff member said, "Our training encourages us to help people to be independent but to be aware of them all the time, and if we need to step in".

People were given clear explanations before staff carried out any personal care tasks, or before health professionals visited to assess their progress. People's relatives said that they were kept well informed with comments such as "They know they can ring me at any time and I can do the same. I do ring mostly every day and they know me and tell me what is going on". Staff offered visitors drinks and encouraged people to make their own drinks and snacks as they were recovering and were able to do so. Staff ensured people's privacy and dignity was maintained, through listening to what they wanted, and carrying out personal care discreetly in their own rooms or bathrooms. They knocked on doors and waited for a response before going in, showing their respect for people's private space. People were asked for the name they preferred to be called by when they were admitted. These were documented in their care plans, and were adhered to in practice. Information about advocacy services was made available in the reception and sitting areas, for people who required additional support.

The rehabilitation units helped people to regain their independence before going home. In all units we found that people were encouraged to do what they could for themselves. People who were regaining their mobility were enabled to practice and not to rush, and said that staff helped them to "Take small steps" with progress every day.

People were able to bring in items to personalise their rooms, especially if they were living there permanently. A record of their belongings was completed on admission. All of the bedrooms were for single use and had an en-suite toilet and shower. People said that they liked their rooms, and several people told us they found their beds to be very comfortable.

The staff had created areas to help people feel more at home. These included a 'bar' room in the dementia unit, which included a bar and a jukebox. Sadly the jukebox was waiting to be repaired, but staff told us that people loved being able to use it and put on their own choice of music when it was working. Each unit included an open plan kitchen area where people and their relatives could make their own drinks and snacks if they wished to do so. This increased people's independence, and helped them to feel relaxed. In the dementia unit, a staff member was always allocated to the open plan lounge/dining and kitchenette area for people's safety.

The premises were situated in quiet countryside, and had garden areas for people's enjoyment. These included a safe enclosed garden area for people living with dementia. People told us that they liked to sit outside in good weather, or go out with staff or relatives for walks. Paths were suitable for wheelchair users. This enhanced people's sense of wellbeing. People had commented on recent quality assurance questionnaires, "I loved it here and was sad to go"; "It is a lovely place, I felt like I was on holiday"; and "Thank you everyone, I have had an excellent time. The staff were wonderful and always cheerful".

Good

Is the service responsive?

Our findings

People told us that they knew about their care plans and were involved in discussions about their care and treatment. A person who was shortly due to be discharged said, “I am happy with my treatment and I feel much more confident now. They have told me I shouldn't walk around at home by using the furniture to hold on to, and I will try not to do this”. A visitor said, “I am always involved in what is happening to my relative”. People said that they knew they could talk to the staff or the registered manager if they had any complaints, and said they would feel able to do that; however, they said “There is nothing to complain about”.

Care plans were person-centred, and contained information reflecting people’s individual needs. These provided comprehensive individual risk assessments and care plans about all aspects of daily living. The care plans included washing and dressing, nutrition, continence, sleeping, communication, skin care, psychological care, and health needs. They contained clear details to support staff in giving effective care. For example, ‘Needs help from one staff to wash and shower and to wash hair; to clean teeth and apply moisturiser. Likes to clean teeth after breakfast. Prefers a female care staff’. Nutritional care plans showed if people had specific needs such as, ‘Has difficulty using cutlery, so a wide bowl with a single spoon or fork works best’. Moving and handling care plans showed if people could move with the support of one care staff to accompany them, or if they needed two staff and a hoist to support them. These plans were updated as people made improvements with their mobility or dexterity.

Care plans included people’s preferred routines, such as the times they liked to get up and go to bed. And if they liked to stay in their own rooms, or join others in the lounge or dining areas. Bed time routines showed if people liked their door shut or a light left on; and if they liked a drink or a snack before bedtime. People said, “I prefer my room to the lounge”; and “I am quite happy in my room and going to lunch in the dining room”.

People were enabled to make their own choices in line with their mental capacity assessments. For example, being able to choose their own clothes each day if staff showed them a selection; choosing to have a bath or a shower; and deciding if they wanted to join in with activities, sit quietly or go outside. Staff on the unit for people living with dementia told us, “People have the freedom to go out if they want to go out; and staff will accompany them if requested”.

Care plans for people living with dementia were written from the person’s own viewpoint and included pictures, so that they were easier to discuss with people. These included directions such as, ‘I can become disorientated, anxious and panicky. Please be kind and patient with me’; and ‘I like to be outdoors in good weather’. They included people’s likes and dislikes in regards to their food, lifestyles, activities and interests, and identified if people could communicate their needs and wishes.

The centre provided a range of individual activities and entertainment. People receiving rehabilitation mostly said they were happy with their own books, magazines, newspapers and televisions; and said they found the on-going rehabilitation progress was tiring as they made progress with their mobility and dexterity, and improved in their health. They also said they enjoyed going outside in good weather.

The unit for people living with dementia had a programme of activities on display for the week, and staff said this was flexible according to what people wanted each day. The activities board included exercises, crafts, films and board games in either morning or afternoon sessions. People told us that other group activities included singing and baking cakes. Some people liked to take part in domestic chores such as dusting, or laying tables. We observed people enjoying solving a crossword with a member of staff; and another person being taken outside for a walk. The centre had a ‘pamper trolley’ and people appreciated individual time having their nails manicured or their hands massaged. People said that the activities co-ordinator was very enthusiastic, and encouraged them to make lots of things for events, such as making signs and making cakes for Christmas and Easter parties and other special events. Sometimes there were cheese and wine evenings; special curry nights; and ‘pat dogs’ brought in. The activities co-ordinator arranged trips out. These included train trips; going out to see newborn lambs and bluebells in the Spring; attending a local folk festival; and going to the local supermarket.

People were supported with meeting their spiritual needs, and some went out with staff or relatives to attend church.

Good

Is the service responsive?

Ministers and priests were welcomed at any time to support people who requested them. The centre was sometimes able to arrange church services on the premises for those who wished to attend.

People were provided with a service user's guide at the time of their admission. This included details about the service such as visiting the hairdresser and menus. The centre had signs displayed on the doors stating 'If you have any concerns please speak to the staff or managers', to encourage people to raise issues at any time.

Complaints and compliments leaflets entitled 'How to complain about a health or social care service' and 'Have your say' were evident in strategic areas of the centre, including the reception area and sitting areas outside the passenger lifts. These enabled people to raise any issues of concern if they did not wish to speak directly to staff. The leaflets included contact details for the complaints team, and for other bodies such as Social Services and the Local Government Ombudsman.

Everyday concerns or complaints were dealt with by the registered manager or senior staff as soon as possible, so that people were confident that they were listened to, and their concerns were acted on. The registered manager kept a record of these complaints, so that there were clear details of how they had been dealt with. Any written complaints were sent to the provider's complaints department, and someone was allocated from there to investigate the complaint and respond. The complaints log showed that people were given a written response with clear details of the findings. People were offered an apology when it was appropriate to do so, and were given an explanation of any processes which had been changed as a result of their complaint.

Good

Is the service well-led?

Our findings

People said that they knew the registered manager was available for them to talk to, and they could ask any of the staff questions and know they would receive a response. They expressed their confidence in the leadership of the centre with comments such as "It all seems to run smoothly here"; and "I know I can ask to talk to the manager if I want to". People had sent in written compliments which included, "I wanted to express my appreciation of the highly professional manner in which my relative was cared for. There are so many wonderful, dedicated and caring staff, and their team work was very evident". A social care professional told us, "I have always found the manager and staff extremely helpful and there is always a waiting list for permanent beds which shows how highly the care is regarded".

Staff were motivated about working at the centre, and said, "We have always worked well together but it really is good teamwork now and we get to know what care is needed and also more about each person". Other staff members told us, "There is very good teamwork, we are able to get to know what care is needed"; and "We have a very good manager who listens to us and is very fair". Each floor had a lead person who was responsible for the running of the units on that floor, and these senior staff worked closely with the registered manager. Staff told us they were enabled to raise any concerns or ideas for change at individual supervision meetings, at handovers, and at staff meetings. There were a variety of staff meetings, such as monthly senior staff meetings and care staff meetings. Staff were able to ask for items to be put on the agenda. Minutes were recorded at all meetings, and given to staff who were unable to attend. Staff said "We can always talk about anything at meetings", and "It is a lovely home and a good company to work for".

There were multi-disciplinary care team meetings every week on the first floor, so as to identify how well people were progressing, and any action to be taken to assist them. We observed that handovers were clear and accurate, and communicated new risks that had been identified. Each person receiving support was discussed. Their medical history was provided, their current problems and reason for admission, an update of any outcome from meetings, their general condition, and the estimated discharge date. The team discussed the goals that the person aimed to achieve to ensure they were fit to go home. People's choices and preferences were also discussed, for example one person had requested only female care staff.

The registered manager liaised on a daily basis with the manager for Shaw Healthcare, so that there was smooth working between the different staff in the service. Kitchen, domestic, laundry and maintenance staff had their own monthly meetings. These also included a relevant talk such as an update about infection control or use of chemicals. Changes needed in the building were discussed between the building providers, Shaw Healthcare and the registered manager. This worked effectively, as changes were made appropriately. During the inspection one of the ground floor units was closed to people while new laminate flooring was being fitted in all the corridors. This had been carefully explained to people and their relatives before it commenced, and people were taken to a different unit during the day. They were very relaxed about this, which showed there had been clear communication and liaison between the different managers and staff, who had explained this to the people concerned.

People's views were obtained through their daily comments, through residents' meetings, and through quality assurance questionnaires. Minutes from the most recent meeting showed that people had discussed food choices; cleanliness of the premises, staff, activities and changes to the premises. People said that the cleanliness was "Fine"; the staff were "Clean, well-presented and polite", and had been informed about the flooring due to be changed. They had discussed activities and a project that had been taking place in the unit for people living with dementia. This was part of a national project, but some people said they had found the programme to be "Rather childish". The registered manager said that this was a 12 month programme.

People were asked for their views when they were discharged home after rehabilitation, using questionnaires entitled, 'Please tell us about your stay'. These asked a series of questions including if they had received enough information before their admission; if they had received the care and support they needed; and if staff were available when they needed them. People could rate the questions as 'Always', 'Usually', 'Sometimes' or 'Never'. Out of 15 recent responses we saw that the results were very

Good

Is the service well-led?

positive, with most answers as 'Always'. People added their own comments, which included, "Many thanks for all the care and support I received"; "The staff were wonderful and always cheerful"; and "Staff were very friendly".

The registered manager and senior staff carried out audits to monitor the quality of the service. These included care plan audits and medicines audits; infection control, hand hygiene, health and safety, accidents and incidents, and environmental checks. These were analysed and used to bring about further improvements to the service. For example, the flooring change in one of the unit's corridors had been carried out due to identifying that the carpeting was no longer appropriate.

The registered manager had systems in place which enabled staff to locate records quickly and efficiently. People's personal records were kept in locked areas so as to retain their confidentiality. Records contained appropriate information, had been properly signed and dated where applicable, and were kept up to date.