Luxurycare (Aranlaw House Care Home) Ltd

Aranlaw House Care Home

Inspection report

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Date of inspection visit:
14 December 2016
19 December 2016
20 December 2016

Date of publication:
21 March 2017

Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This inspection took place on 14, 19 and 20 December 2016 and the first day was unannounced.

Aranlaw House Care Home is a purpose-built care home that specialises in the care of older people who are living with dementia. Most people there have complex needs associated with their diagnosis of dementia. The service is registered to provide care for up to 46 people. People are accommodated in individual en-suite bedrooms located on all three floors of the building. There are communal lounges and dining areas on each floor, and the three floors are connected by stairs and a passenger lift. There is an enclosed garden, and some parking at the front of the building. At the time of our inspection there were 45 people living there, with someone due to move into the only vacant room the following week.

The registered manager had been in post since 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care was planned in partnership with people and their families, and people received the care and support they needed to meet their individual needs. People and their visitors spoke highly of the quality of care they and their loved ones received, and said they were kept informed about the person's wellbeing. Staff supported people in a proactive way, recognising where additional assistance might be required.

Creative ways were found to enable people to live full lives. People were encouraged to do things they enjoyed and found meaningful, and this included social activities based on people's interests.

Risks were assessed and managed in the least restrictive way possible. Staff were skilled in intervening when people were at risk from behaviour that could challenge others. They intervened calmly and positively when they noticed anything that could cause a person to become distressed.

The environment had been designed, based on research evidence, to promote the independence and wellbeing of people who lived with dementia. People who liked to move around were positively encouraged to use communal areas throughout the building.

Managers and staff at all levels were committed to working in a person-centred way, respecting people's wishes and preferences and treating them with kindness and compassion. People, including those who had difficulties communicating or who could become upset and present challenges to staff, responded positively to the manner in which staff approached them.

Visitors valued the relationships they and their loved ones had with the staff team, and told us they always felt welcome. All spoke highly of how caring the staff and managers were. Staff knew people and understood their care needs and preferences. They spent time with people, both during care tasks and at other times.

Care and support was not rushed, staff working at the person's pace.

The whole staff team were attuned to needs of people living with dementia, with a recognised and respected model of dementia care in use. The registered manager and director of care services kept up to date with best practice in dementia care and ensured this was adopted by the staff. Staff were skilled in communicating with people and supporting them to express their views, even where people had difficulties with communication.

People's rights were protected because the managers and staff understood their responsibilities in relation to the Mental Capacity Act 2005, and were confident in putting these into practice. People were supported to express their views and were involved in decisions about their care, even if they did not have the mental capacity to make these decisions for themselves. Where best interests decisions needed to be made on the person's behalf, these took into account what was known of the person's preferences, values and beliefs in relation to this care. Relatives, friends and relevant professionals were involved.

There was a strong emphasis on the importance of eating and drinking well. Mealtimes were relaxed and congenial. The staff were organised and attentive; they recognised why some people might find mealtimes challenging and provided the support they needed to be able to enjoy a meal. Food was attractively presented and people were able to choose what they wanted to eat. Special dietary requirements were understood and provided for. Food and drink was available whenever people needed it, even if this was not at regular mealtimes.

Visitors told us they felt their loved ones were safe at the service. People looked relaxed with staff. Staff understood their responsibilities for safeguarding adults, including recognising signs of abuse and how to report any concerns. Medicines were stored and managed safely, and were administered as prescribed. The premises were well maintained, with regular health and safety checks and up-to-date servicing.

There were enough staff to provide the care and support people needed. Staffing levels were based on people's needs and were kept under review. Staff were recruited safely, checks being undertaken before they started work to ensure they were suitable to work in a care setting.

Whilst people received very good care, there was a strong emphasis on continually striving to improve the service. There were active endeavours to involve people, their relatives and staff in this, whether through informal conversation or more formally through reviews, meetings and surveys. As well as consulting with people, the service strove for excellence through reflective practice at all levels, from care staff to senior management. There were systems in place to monitor the quality and safety of the service and bring about any improvements that were needed. The service worked in partnership with other organisations to make sure they were following current practice and providing a high quality service.

The service had a clear management structure, with an established registered manager and director of care services. They and other members of the management team worked closely with staff, frequently observing and providing care. People, visitors and staff were confident in the leadership of the service. They were encouraged to raise any issues of concern, which were taken seriously and the appropriate action taken.

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 was a culture of learning from mistakes and an open approach. Incidents, accidents and safeguarding concerns were managed promptly and investigations were thorough.

Where people behaved in a way that may challenge others, staff managed the situation positively and upheld people's dignity and rights.

The premises, services and equipment were well maintained.

Is the service effective?

Outstanding

The service was very effective.

There was a proactive support system in place for staff that developed their knowledge and skills and motivated them to provide a better quality service.

Managers and staff applied the Mental Capacity Act 2005 with confidence, ensuring that people were as involved as they could be in decisions about their care.

There was a strong emphasis on the importance of eating and drinking well. Innovative methods and positive staff relationships were used to encourage people to have a good dietary and fluid intake.

Is the service caring?

Outstanding

The service was very caring.

The service had a strong, visible, person-centred culture. Visitors valued the relationships they and their loved ones had with the staff team, and told us they always felt welcome.

Managers and staff at all levels were committed to working in a

person-centred way, and treating people with compassion and kindness.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People's care and support was planned proactively, in partnership with them and their relatives. The service was flexible and responsive to people's individual needs and preferences.

The service strove to be known as outstanding and innovative in providing person-centred care based on best practice.

People's concerns and complaints were actively encouraged and seen as part of the process of driving improvement.

Is the service well-led?

Outstanding ☆

The service was very well led.

There was a person-centred, open and transparent ethos. People, relatives and staff were encouraged to raise any issues of concern and these were always acted upon.

There was a strong emphasis on continually striving to improve the service.

There was an established management team that had a track record of putting people at the heart of the service, involving them meaningfully in decisions about how the service was run.

Aranlaw House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 14, 19 and 20 December 2016 and the first day was unannounced. It was undertaken by an inspector and an expert-by-experience on the first day, with the inspector returning alone on the second and third days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses care services, in this case care services for older people.

Prior to the inspection we reviewed all the information we held about the service. This included information about incidents the registered manager had notified us of. In October 2016 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we met many of the people living at the service and spoke with three of them about their experiences there. Because most people were living with dementia that made it difficult for them to describe their experiences in detail, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk to us. We completed a SOFI observation on each of the three floors. We spoke with seven visitors and a further relative contacted us by email to give feedback. We also spoke with the registered manager, general manager, facilities manager, director of care services, managing director and 12 other staff. These staff included seven care and senior care workers, two agency staff, the chaplain and two ancillary staff.

As well as speaking with people and observing care and support, we viewed four people's care and support records, including assessments, care plans, records of care given and medicines administration records. We also looked at records relating to the management of the service. These included three staff files, staff rotas covering 21 November 2016 to the inspection, quality assurance records, maintenance records and meeting minutes.

Following the inspection, the registered manager and director of care services sent us information we requested about policies, and quality assurance. We also requested feedback from health and social care professionals and obtained this from three of them.

Good

Is the service safe?

Our findings

People and their visitors said they felt they and their loved ones were safe living at the service. For example, a relative commented, "I have been very impressed with the fact that all team members are trained in a specific approach to working with Dementia and I have seen first hand how this (validation) technique can help settle residents and make them feel safe". Whenever we saw people, they looked relaxed and comfortable with the staff, indicating they felt safe with them.

People were protected against the risks of potential abuse. Information was provided to people and their relatives on admission and at reviews about what to do if they ever felt unsafe or were being harmed. Information about how to report concerns about abuse was displayed. Staff had been trained in and reminded of their responsibilities for identifying and reporting safeguarding concerns; this training took place at induction and was ongoing, with refresher training being provided annually. The content of refresher training was reviewed and updated to take into account learning from safeguarding investigations, for example to discuss blowing the whistle on friends and colleagues staff felt close to. Management staff had training regarding their role as managers in safeguarding adults. The staff we spoke with knew about different types of abuse and how to report it. Likewise, the registered manager had a clear understanding of their role as a manager in safeguarding adults.

Where staff had reported safeguarding concerns, the registered manager had referred these to the local authority safeguarding team and had notified CQC. They had investigated the concerns thoroughly in line with local multi-agency safeguarding procedures. This had included the use of closed circuit television footage to corroborate accounts given by the people involved. They had taken action to help ensure people remained safe in future, including increased monitoring of people's mood and wellbeing and consulting with health and social care professionals. Our feedback from a professional from the local authority safeguarding team was that the registered manager was proactive, responsive and thorough in communicating with them about safeguarding matters.

Staff were actively encouraged to raise their concerns and to challenge when they felt people's safety was at risk. This was a consistent message delivered through staff training, discussion at supervision and at staff meetings. Colleagues had reported an occasion where a care worker used poor moving and handling practice. The management team took prompt action to ensure people were safe, including a thorough investigation and positive action as a result.

Risks to people's personal safety had been assessed, covering areas such as moving and handling, falls, the development of pressure sores and malnutrition. Plans were in place to manage these risks in the least restrictive way possible, supporting people to retain their independence. For example, one person's care records stated they liked to walk freely and particularly enjoyed being outside, smoking and drinking tea. They were seated outside by the front door when we first arrived for the inspection, and spent a lot of time there subsequently. The risks this presented had been assessed in detail, and balanced against the greater risks to the person of denying them this freedom. When the person was outside, staff were aware they were there, as they sat very close to the reception and registered manager's offices.

Staff had the skills and abilities to recognise and intervene when people were at risk from behaviour that could challenge others or needed positive support from staff. A relative told us, "[Person] has had significant behavioural needs and over the years the team have worked hard to ensure that she has her needs met with minimal disruption to herself and others". This was reflected in our observations, where staff were observant and responsive, intervening calmly and positively when they noticed anything that could cause a person to become distressed. This was done in an unobtrusive, low key way. For example, a staff member noticed when someone was walking around in a distracted and potentially unsettled way. They greeted the person by name, refocusing them by guiding them towards the snack station. The person indicated they were hungry and the member of staff encouraged them to choose a snack. The person's mood brightened, and they smiled as they ate. Someone else who had a history of becoming agitated also often walked around and liked to hold particular objects. Staff always knew where the person was, gently greeted them when they met them and ensured they had one of their preferred objects to hand. This helped the person to remain calm. A number of people living at the service had a history of becoming distressed and agitated; some had moved from other care settings in order to meet these needs.

People's risks from behaviour that was challenging to others were assessed and managed through positive behaviour support plans. These directed staff to support people proactively, seeking to prevent situations arising by ensuring people's needs were met, and intervening in least restrictive way possible when people became distressed. Staff were trained in managing behaviour that was challenging for others. They were skilled in using these strategies, and were clear about how to support people when they needed reassurance or behaved in a way that was challenging for others.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Accidents, incidents and near misses were recorded and monitored to look for developing trends. The registered manager and director of care services gave examples of how the closed circuit television had helped them explore trends. For example, their analysis had identified that a particular person was often found on the floor. The film footage had shown them crawling along the corridor looking at sockets, rather than having fallen, and a positive behaviour support plan was put in place to clarify to staff when they should intervene and how to divert the person.

There was a facilities manager who managed maintenance, domestic and catering staff within this service and its sister homes. They oversaw robust systems to ensure the premises and equipment were safe and well maintained. This included a programme of audits and checks to ensure servicing was up to date. Certification was up to date in relation to gas safety, electrical safety, water safety, fire, and lifts and hoists. Fire procedures were translated into the native languages spoken by the majority of staff whose first language was not English. There had been a recent unplanned fire drill where everyone was evacuated promptly and safely from the building.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Visitors to the home told us there always seemed to be sufficient staff on duty, such that they could always find a member of staff if needed. For example, a relative commented, "A low staff turnover means that she has been able (as able as she can be) to build relationships with team members which in turn helps her settle and feel safe". During our observations, staff were busy but never rushed when they were supporting people. The registered manager confirmed that staffing levels were based on dependency assessments, together with observations and feedback from staff, to ensure these were sufficient to meet people's needs at all times. Regular visitors told us they were always able to find a member of staff if they needed one. One commented, "They're very busy sometimes but they seem to cope very well".

The registered manager and director of care services identified that the usage of agency staff had increased

recently, as some experienced staff had left for positive and personal reasons. The agency staff we spoke with knew people who lived at the service, and staff who worked there, well. When agency staff were required, the service sought to use staff from a particular agency who had prior experience of the service. The service was taking steps to attract and recruit replacement staff.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Records showed that criminal records checks had been made with the Disclosure and Barring Service (DBS) to make sure people were suitable to work with adults in a care setting.

Medicines were managed and administered safely so that people had their medicines as prescribed. Storage was secure and recording was complete, so the amount of each medicine in stock could be accounted for. A member of the management team oversaw medicines ordering and audits of medicines administration records (MAR) to ensure there were sufficient stocks of medicines and that these were properly recorded. The pharmacy also visited every three or four months to audit medicines. Where people were prescribed medicines to take 'as necessary' (otherwise known as PRN), there were care plans with clear instructions for staff that set out what the medicines were, when they should be used, the maximum dose in 24 hours and the minimum interval between doses. Where people had prescribed skin creams and ointments, there were clear instructions for staff about how and where to apply these.

Staff were trained to handle medicines and their competence in this was checked at intervals to ensure they were able to administer medicines safely. If a staff member made an error they were stopped from administering medicines until their competency had been reassessed.

Staff took time to explain to people what their medicines were for. We observed a care worker make several attempts to give someone their antibiotic. When the person refused, the member of staff calmly left them and returned again a short while later, once again providing an explanation of what the medicine was for. Eventually the person was happy to take the medicine.

Outstanding ☆

Is the service effective?

Our findings

Relatives spoke highly of the abilities of the staff. Comments included: "The staff are very good indeed. There's no doubt about that" and "They are extremely hard working".

People received care that was tailored to their individual needs from staff who had a detailed understanding of their requirements and were skilled, knowledgeable and confident in supporting people who lived with dementia. This was clear during our observations; all of the interactions between staff and people using the service were positive, staff respecting and valuing people as individuals. They spoke with them in an adult way and took time to listen and understand what the person said or communicated through their behaviour, facial expression and gestures. Staff and managers often talked about validation, by which they meant communicating their understanding and empathy with people according to the stage people's dementia had reached.

The service worked in partnership with other organisations to make sure they were training staff to follow best practice and, where possible contribute to the development of best practice. The provider had commissioned a local university to provide bespoke supervision training for managers. They had also arranged for a hospice to provide training on end of life care. In addition, as well as dementia awareness training at induction, care staff had a four day course on communication and caregiving in dementia. This is part of the model of dementia care adopted by the service. The model sees dementia as progressing in stages, helping staff understand how this affects the person and find appropriate strategies to help them live as full and enriched lives as possible. Staff applied the model in the way they communicated with people, acknowledging how they felt and providing the reassurance they needed. This was reflected in people's exceptionally positive demeanour during our observations. They were not agitated or upset because staff provided the reassurance they needed, understanding their communication and anticipating what they needed. This represented outstanding practice, with staff demonstrating in their day-to-day work what they had been trained to do.

There was a proactive support system for staff that developed their skills and knowledge and motivated them to provide a quality service. A staff member told us, "We feel the staff here have been very supportive and they will continue to be so". There were staff of the month and annual staff awards, where colleagues and managers could nominate staff in various categories. Information about the employee of the month was displayed prominently on noticeboards around the service.

The service supported new staff through the induction process to develop the knowledge and skills to be able to perform their role, and ensured that only suitable staff were retained. A regular visitor whose relative had lived at the service for a number of years told us new staff who were unsuited to the role never lasted more than a week or 10 days. When staff first came to work at the service, they undertook the provider's eight day induction programme. This covered essential core training, such as fire awareness, infection control, moving and handling, health and safety, first aid, safeguarding adults and children, the Mental Capacity Act 2005, person-centred care, and record keeping. For care staff, this was followed by four shifts shadowing experienced members of staff. After this, the new staff would discuss their induction with the

registered manager to assess whether they were ready to provide care or required additional monitoring. New staff were expected to undertake the Care Certificate. This is a nationally recognised qualification that represents a set of standards care workers stick to in their daily working life in order to provide safe and compassionate care.

Staff had training that was specific to their roles, such as workshops for heads of care. Staff were expected to work towards qualifications relevant to their role, such as diplomas in health and social care for care staff. Staff we spoke with were positive about the training and support they had received towards their professional development, including encouragement to prepare for promotion. A member of staff said they could not thank the management team enough for the opportunities they had been given.

Care staff had a range of training and development following induction to enable them to deliver outstanding care that met people's individual needs. All staff had annual refresher training covering core topics such as safeguarding and moving and handling. Other training included understanding the end of life and mental health awareness. Training had been and was being arranged for experienced staff who had been identified as champions in particular aspects of care, such as moving and handling and oral health.

The service ensured staff were supported and developed through individual and group supervision meetings, and through observations of their work, including competency assessment. There were competency assessments for areas of practice including moving and handling and medicines. One of the management team had a professional background in assessing competence. Staff told us supervisions were generally carried out regularly and enabled them to discuss any training needs or concerns they had. Group supervision in July 2016 had been arranged over four different timed meetings so all care staff were able to attend.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

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 so that they can 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).

People's rights were protected because the managers and staff understood about their responsibilities in relation to the MCA. Where there were concerns about a person's ability to consent to aspects of their care, staff assessed whether the person had the mental capacity to give this consent. They recorded how they established whether the person had understood the decision, rather than simply assuming the person was unable to make a decision because they were living with dementia. Where they assessed that the person lacked capacity, they made a best interests decision on the person's behalf, taking into account what was known of the person's preferences, values and beliefs in relation to this care. Staff consulted with the appropriate parties, such as relatives and doctors, in reaching these decisions. Matters covered by mental capacity assessments and best interests decisions included the delivery of care and the use of restrictions such as bedrails and movement sensors.

Staff were confident in their use of the MCA on a day to day basis. Even where people lacked mental capacity and there was a best interests decision in place, staff still involved the person as far as possible in what was happening. For example, when staff gave someone who lacked the capacity to consent to medication an antibiotic medicine, they explained what the medicine was and that it was needed for a chest infection. Each time the person refused it, the staff calmly acknowledged their concerns and returned to them a short time later to try again. On the fourth or fifth attempt, the person was agreeable to take it.

Some people did not understand they needed assistance with elements of their care and at times needed staff to hold them safely in order to receive personal care. If people needed to be held safely at any time during their care to prevent them hitting out, this was clearly recorded in their positive behaviour support plan, which detailed approaches staff should try first. Safe holding was always subject to a best interests decision in line with the MCA. Safe holding was only to be used by staff trained in the specific techniques and only when authorised by a manager as an additional safeguard that this was the least restrictive option for the person at that time. Episodes of safe holding were recorded on a dedicated form and were reviewed and monitored by the management team.

The registered manager understood their responsibilities in regards to DoLS. They had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body (local authority). There was a system in place to ensure any conditions set by supervisory bodies were met and renewals applied for when these were falling due. A health and social care professional fed back to us that the registered manager was extremely responsive in communicating with them regarding MCA matters.

There was a strong emphasis on the importance of eating and drinking well. The approach taken by the service ensured that people's dietary and fluid intake significantly improved their wellbeing. The atmosphere during the meals we observed was relaxed and congenial rather than cold and institutional, both in the main dining room and in other communal areas. Dining tables were laid with cloths and wineglass-shaped glasses, to help encourage people to drink. Strongly coloured crockery was used, on the basis of research evidence that indicates this helps people who are living with dementia to focus on what they are eating. Meals were freshly cooked and looked and smelt appetising; the meal the inspector ate tasted very good. Soft and pureed diets were presented as attractively as possible.

People were supported to have a meal of their choice by organised and attentive staff. Where people would have difficulty choosing a meal from reading a menu or listening to the options, staff showed them meals on plates and gave people the plate they preferred. Staff sat and chatted with people, and assisted them discreetly where they needed this. During the lunch we observed on the top floor several people were initially reluctant to sit and eat. The staff were aware of reasons why people might find mealtimes challenging or distracting, such as past work in hospitality or nursing, which helped them understand how to address this. Staff sensitively encouraged them to eat, talking about the food and providing alternatives where people said they wanted them. After a while, people spontaneously started to eat and cleared their plates.

People and relatives gave positive feedback about meals at the service. A person told us, "The food is nice and there is a choice". Relatives told us people's individual needs were met and that staff went out of their way to meet their preferences. For example, a relative told us their family member enjoyed their food very much. This individual had particular preferences as well as requiring pureed meals, and the relative found the catering team were very accommodating in offering a variety of meals to find something the person would eat. Care staff were knowledgeable about people's special dietary needs. The kitchen team had details of people's dietary needs readily available in the kitchen.

Staff undertook fortnightly audits of people's mealtime experiences. These checked how the environment was prepared and presented, the service and presentation of the meals, and the assistance people received during the meal. They also checked whether everything that needed doing afterwards was done, including whether any significant information obtained during the meal had been handed over. Any issues identified were addressed with the relevant staff.

Food and drink was available whenever people needed it, even if this was not at regular mealtimes. The service had taken part in a research project, where researchers from a local university had reviewed mealtime experiences and how people living with dementia burnt calories at different times of day, for example by walking around. Practice had changed as a result, for example more finger foods were included on menus and additional provision was made for people who were hungry at night. When the chef went off duty in the evening, they left finger foods for people to eat overnight.

There were 'snack stations' in the communal areas each floor. These had cold drinks and a variety of sweet and savoury snacks, such as fruit and crisps, for people to help themselves to. People used them frequently throughout the inspection, either independently or with encouragement from staff. People would pick up food and eat, often with a big smile. In addition, staff regularly provided hot drinks, as well as drinks and snacks for people who could not get these themselves. We saw people had drinks to hand and a regular visitor confirmed this was always the case.

Prompt action was taken if people were identified as being at risk of malnutrition, for example due to unplanned weight loss. People were weighed regularly and their risk of malnutrition was kept under review using a recognised malnutrition screening tool. If concerns were identified, staff followed the screening tool instructions, for example by fortifying the person's meals with butter and cream to increase the calorie content, more frequent weight checks and monitoring food and fluid intake. Where necessary, dietitian referrals were sought. The registered manager and director of care services reported the service had strong links with the community dietitian service. They said the service was well supported by GPs, who always referred people to the dietitian when the service requested this.

Where people had difficulty swallowing, which could put them at risk of choking, they had been referred to speech and language therapists for assessment and had safe swallow plans in place. We observed that people who had swallowing difficulties were supported in accordance with their safe swallow plans, with drinks thickened to the specified consistency, pureed meals and assistance from staff.

The service had excellent links with health and social care professionals. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A visitor commented that staff were very good at getting the doctor in if their relative in any way appeared unwell. Other visitors told us that when their relatives had been poorly the GP had come to see them. A health professional told us the service had been proactive in seeking advice when there was concern about people's wellbeing. Care records showed relevant health and social care professionals were involved with people's care.

The environment was specifically designed for people living with cognitive impairment. This was based on recognised good practice guidance such as that produced by the University of Stirling Dementia Service Development Centre. Furnishings and floor surfaces were provided in contrasting colours. All bedrooms were ensuite with level-access wet rooms and had individual heating controls. Signage around the building was clear, with words and symbols. People's bedrooms were easily identifiable with large printed names and photographs on the doors. There were memory boxes by the side, which displayed objects and photographs of interest and significance to the person. Bathrooms and toilets had distinctive coloured

doors, and toilet seats were in contrasting colours. Corridors were decorated with colourful wall friezes, different designs on each floor, and handrails along the corridors were in contrasting colours so they could be easily seen. People had access to a fully enclosed garden.

People who liked to move around were positively encouraged to use communal areas throughout the building. They moved around the home freely, independently if they were able, or with staff support. A relative commented that their family member, who walked around a lot, "has the freedom to go up and down in the lifts and down the corridor". The lift was unrestricted for people to travel between floors. Staff working on floors other than a person's usual one welcomed them by name and provided any assistance they needed. Closed circuit television had been installed in communal areas, which enhanced people's ability to get around the building safely as the management team could see whereabouts people were. Where people were at particular risk, for example of falling, from moving around, infra-red falls sensors were used so staff were aware they were walking around and could provide assistance as necessary.

Outstanding ☆

Is the service caring?

Our findings

The service had a strong, visible, person-centred culture. Visitors valued the relationships they and their loved ones had with the staff team, and told us they always felt welcome. All spoke highly of how caring the staff and managers were. Comments from regular visitors included: "Everyone knows everyone… endless patience, they're so gentle", "The staff are unbelievably caring… they just do it with such compassion", "I've never heard a voice raised", and "It's not regimented at all… very personally based. Whatever that person wants to do they've [staff have] gone along with it". They described staff as "very welcoming always" and "genuinely caring people".

Managers and staff at all levels were committed to working in a person-centred way. The provider was part of the national Dignity in Care network, which aims to change the culture of health and social care services, improving the quality of care and the experience of people using services. Managers strove continually to develop the approach of the staff team, motivating and inspiring them to continue offering kind, compassionate care. The expectation of a caring and person-centred approach to people was made clear to staff at induction, and was reinforced through ongoing supervision and training. Group supervision in July 2016 had emphasised to staff how people came first and that their needs were to be met at all times.

People were treated with kindness and compassion. A relative commented on how staff used touch therapeutically, in a way that people found calming and reassuring. Our observations throughout the inspection were consistent with this. People smiled, sang and laughed in response to the positive manner in which staff approached them, and staff in turn responded to this. Staff smiled at people and touched them in a friendly and non-threatening way; people reciprocated, becoming calmer. This felt sincere and natural rather than forced and artificial. For example, there was a lovely interaction between a person who could be unsettled and a member of staff. They were offering the person dessert, and the person grabbed out at their apron. The staff member recognised that the person did not like the apron and removed it; there was good eye contact and smiling between them. Another staff member assisted someone who had limited communication, with their meal. The person stroked the staff member's cheek.

Staff spent time with people, both during care tasks and at other times. Care was not rushed, staff taking the time people needed, such as when assisting them to have a drink or to eat a meal. Likewise, when communicating with people, staff worked at the person's pace without rushing them. Staff did not wear uniforms, which contributed to the homely feel of the service and helped staff and people interact with each other as adults rather than simply as staff and recipients of care. A relative told us staff spent time "actually with the patients themselves – they're never left alone". Most of the time we saw staff sitting with people and speaking with them. When they wrote notes, staff sat alongside people rather than going into an office or to a separate area. Staff had been reminded at a staff meeting that this was expected of them.

People's dignity was upheld. When people needed assistance with personal care, such as to use the toilet, staff offered this sensitively and discreetly. Personal care took place in private, behind closed doors. Some people needed protection over their clothes while they were eating and drinking. Large serviettes with printed designs (beads for women and a tie for men) were provided; these looked more dignified than a

plain bib and were used only if the person permitted it.

At all levels in the organisation, staff showed concern for people's wellbeing in a caring and meaningful way, and responded to their needs quickly and calmly. For example, someone had been asleep in the lounge during the first morning. They woke and asked for water, which a member of staff promptly provided. However, the person was not happy with this, saying loudly, "It's a bit ancient". The member of staff went to get a fresh drink, and returned also with a chocolate, which the person enjoyed. At the start of lunch, another person who was in the dining room, called out loudly, "Nurse, will you sit with me?" A member of staff went to them straight away and spent a while with them, chatting about what they would have for lunch. Throughout the inspection the registered manager prioritised people's need for assistance above all else, interrupting whatever they were doing to support people in the way they needed.

People received care and support from staff who had got to know them well. An experienced staff member commented, "The relationships between the staff here and the residents is second to none". Staff knew about people's backgrounds and life histories, and used this knowledge to talk with people and also to provide the support people needed. For example, a person used to work with children and did not like activities they considered childish, but we observed them engaged in and enjoying a session of flower arranging, and also involved in day-to-day jobs around the service. Care records contained detailed information about people's life histories and preferences, obtained from them and their relatives when they first moved in and added to thereafter. This information was thorough and clear, such that we recognised people from the descriptions given, such as how they liked to spend their time or the way in which they communicated. Staff understood people's individual communication skills, abilities and preferences, and adapted their approach accordingly.

On each floor there was a 'memory tree', which was like a Christmas tree on which were placed personalised baubles for each person who lived on that floor, with the person's photograph and name. A relative told us they had been moved when they saw this. The registered manager and director of care services explained that the trees had been made by one of the activities coordinators following training in dignity.

People were given the information and explanations they needed, and staff encouraged them to express preferences, which were respected. For example, people were asked where they would prefer to have their lunch and staff respected this, supporting them accordingly. While we were speaking with a visitor who had arrived whilst their relative was being assisted with personal care, a member of staff approached them to ask whereabouts they would like to spend their visit; this was so they could assist the person into the appropriate chair. The visitor told us this was typical of the attention and courtesy shown by staff. Staff offered people drinks on an individual basis rather than through a 'tea round', checking what they would like. This felt homely and sociable rather than institutional. Information about local advocacy services that might help people to assert their interests was displayed in communal areas.

Creative ways of communicating were used to help people express their concerns and find reassurance, where their cognitive impairment made it difficult for them to voice their worries or understand an explanation. The registered manager and director of care services explained situations in which they had used role play with people, highlighting that this was often when people wanted authority figures involved. For example, someone had been concerned that they had no independent income. Staff supported the person to write a letter setting out their concern. The person then received, through role play, validation of their feelings and reassurance.

Relatives told us staff kept them informed of things they needed or would wish to know about. Comments included: "The team will always have time to answer any questions and update me on any changes to

[person's] needs or any concerns that they may have", "They just explain things in a simplified way that made us realise what's happening [in relation to their family member's dementia]", and "I'm kept informed of things". Another commented that staff would always tell them if there had been a problem, such as if their family member had fallen or acquired a bruise. They said that staff would also tell them if an event was planned. They noted that staff always reassured them if they called, saying, "It's [staff name] from Aranlaw. There's nothing to worry about" and then going on to explain the reason for their call.

The home was spacious and people were able to spend their time where they wished, whether in their room or in communal areas. People's bedrooms were personalised to their taste, with their possessions and pictures. Communal areas throughout the building ranged between quieter and more active, as the management team recognised some people preferred busier areas and others to be quieter. This extended to Christmas decorations, with some areas of the home heavily decorated and others deliberately less so, again respecting people's varied preferences and tastes. Throughout the inspection we saw some people moving between different floors in the building. Wherever people went in the building, staff there knew them by name and made them welcome, spending time with them, offering refreshment and providing support where necessary.

There was no-one receiving end of life care at the time of the inspection. However, we reviewed the advanced care plans and records for someone whose health had recently deteriorated. Anticipatory pain relief medicines had been prescribed for the district nurses to administer. The plan considered all aspects of care the person might require in their final days, including spiritual care. The person identified with a particular religion but had not practiced for many years and a family member was seeking advice about this.

The chaplain employed by the provider to work across all the homes had devised and delivered end of life staff training alongside the training managers. This training for new and existing staff focused on meeting people's spiritual needs at the end of life. It included good death, the bereavement process and the effects of death on family members, advance care planning and care at the end of life.

Outstanding ☆

Is the service responsive?

Our findings

People and their visitors spoke highly of the quality of care they and their loved ones received. Comments included: "The home is very good", "We're absolutely delighted… I cannot fault the care", "I think they're fantastic, I really do. They do the very best they can do". A relative remarked that staff understood their family member well, and the person had become much calmer since moving in. Another regular visitor observed that people had complex needs yet were very happy. During our observations, staff supported people in a proactive way, providing the care they needed and recognising where additional assistance might be required. Consequently, people were often in a positive mood, smiling, laughing and singing as staff assisted them.

The service strove to be known as outstanding and innovative in providing person-centred care based on best practice. It specialised in dementia care and almost all of the people there were living with dementia. The whole staff team were attuned to needs of people living with dementia, working within a recognised and respected model of dementia care. The registered manager and director of care services kept up to date with best practice in dementia care and ensured this was adopted by the staff. Health and social care professionals who had contact with the service said it was focused on providing person-centred care. One, who had known the home for several years, commented that the service strove to be person-centred and empathetic, and that staff communicated with them in a way that reflected this. They said that when they visited, staff of varying grades were approachable and knew about the care and support people needed.

There was a recognition of the challenges that people who live with dementia might experience, such as difficulties with communication or knowing what time it was, Staff used creative and innovative ways to communicate with people who might be disorientated or have difficulty understanding what was happening. Staff frequently used visual prompts and mirroring to engage with people and get them to join in with various activities. For example, when people needed to eat and drink we saw staff sitting down with food and drink themselves and engaging people, who then started to eat and drink. Likewise, if someone needed to do exercises a member of staff would spend time with the person doing the exercises that the person would join in with. We also saw staff chatting with people in a natural way to provide cues about what was happening. For example, shortly before supper we saw a staff member chatting with someone about their former work as a chef and what they used to enjoy cooking. At night when some people might not realise what time it was, staff wore pyjamas and dressing gowns to provide a visual cue that it was night time. The registered manager confirmed this helped people recognise whether it was day or night and had led to people getting a better night's sleep.

People's needs were assessed before they moved in and once they were there, their care and support was planned proactively in partnership with them and their relatives. Relatives all told us they were involved in care planning and review. For example, one told us they were consulted "all the time" in relation to their family member's care.

Care plans were personalised and comprehensive, reflecting people's individual needs, strengths and personal histories. They were reviewed regularly and kept up to date. People's care records contained a

'care passport', which set out the person's preferences and routines, listed any risks and health conditions, and gave a summary of the care needed. This was followed by care and support plans covering all aspects of the person's life; these were detailed but still clear to follow. Staff had read care plans and had a clear understanding of the care people required. They had a detailed knowledge of people's personal histories, preferences and needs, and spoke about them as people rather than defining them in terms of dementia, impairment and need. This reflected that staff had adopted the person-centred ethos of the service.

Where people needed it, equipment was provided to enable people to be comfortable and to have as much freedom as possible, even though they were living with advancing dementia. Staff had identified how people's freedom and choice could be enhanced. For example, a person was seated by the lounge window in a special chair. They looked calm and peaceful and were watching what was happening outside. A member of staff talked about how this person liked to look out of the window. The special chair had recently been acquired; without it the person would have been unable to sit and so could not have spent time in public areas or looking at what was happening outside. A relative told us how impressed they had been that a special air mattress had been provided for their family member, who was getting sore, without them having to ask for it: "They told me they were going to buy a new bed for [person]". An experienced staff member told us the provider was very responsive in terms of funding necessary equipment, commenting, "He's one of the best to work for".

Creative ways were found to enable people to live as full a life as possible. The arrangements for social activities were innovative and met people's individual needs. Throughout the inspection observed people occupied in a way that was meaningful for them, whether that was watching or doing something. People were involved in day-to-day tasks and routines, for example, we saw someone wearing disposable gloves and an apron alongside staff, setting tables ready for supper.
There were items around the service for people to handle, providing stimulation. This included a robotic cat, a piece of innovative technology for people living with dementia, that miaowed, purred and moved. We saw someone sitting with it in their lap; at first they looked amused, but very soon started stroking and talking to it as if it was a live pet. There were plans in progress to create an indoor park area, complete with aviary and small live animals to hold, lighting, aromas and projected scenic images. This had been inspired by the success of an indoor garden at one of the sister services. The idea was based on research into providing stimulation, through connection with nature and pets, for people living with dementia, particularly those who become agitated and unsettled.

Meaningful activity was seen as important. The service employed a team of activity coordinators to help each person express and follow their individual interests and to organise and run leisure and social activities based on people's interests. Activities routinely included trips to local attractions and amenities, such as garden centres, cafes and pubs. Someone told us, "We get taken on outings such as to the New Forest". During the inspection we saw a range of activities, including flower arranging and a sing-along to Christmas music. There were also special events in the run up to Christmas, including visiting choirs and 'Elf Day'.

People were encouraged and supported to engage with services and events outside of the service. As well as regular opportunities for trips out, visiting practitioners provided complementary therapies for some people, including reiki, aromatherapy, head massage and hand massage. Children from local schools and stage schools visited to give performances in their areas of talents; the management team informed us these events were very popular and the result of links established via the staff team. The service registered people who could vote and took them to the polling station on election days. The director of care commented that people really enjoyed this and remarked on how people knew just what to do automatically after many years of voting. There were arrangements with a local further education college to take students for work placements; one student had recently started as an employee once their studies were finished. The service

had links with a dementia charity, holding fundraising days and taking part in some of the charity's external events.

The service was flexible and responsive to people's individual needs and preferences. Someone was living at the service with their dog. The service also had a cat, which people could spend time with or assist to care for if they choose to. Any risks this posed had been assessed, and there were arrangements in place to look after the welfare of the animals. Another person who loved nature and the outdoors had bird feeders outside their window.

People's spiritual needs were acknowledged and provided for, whether they had a faith or not and regardless of their faith. There were links with local churches and some people living at the service had retained their connection with their churches. The provider employed a Christian minister as a chaplain to work across all four homes. The chaplain provided pastoral, religious and spiritual care to people and their relatives, as well as pastoral support for staff and managers on occasion. The chaplain knew people who used the service by name and, along with the other staff, understood those for whom actively practicing their faith had been important earlier in their lives. They provided support on a one-to-one basis, and had started to become involved in running family evenings with the registered manager. Once a week they held a non-denominational Christian dementia-friendly communion service at the service.

No-one currently needed the chaplain to organise multi-faith support. The chaplain explained that where required for people of another faith, they made referrals to those faith communities. The chaplain had attended a relatives' meeting to discuss the support they provided for family members.

People's concerns and complaints were actively encouraged and seen as part of the process of driving improvement. The service recognised that people may have grumbles or concerns they would not wish to deal with formally and encouraged people to raise these. A visitor commented that although they had never had cause to complain, "[The managers are] very receptive… there's always somebody there you can talk to". The managing director told us, "It doesn't have to be a complaint for us to deal with it". The director of care services had designed training for staff on responding positively to concerns from relatives. There was clearly displayed information about how to complain or raise concerns. Relatives told us they knew how to complain and that they felt able to approach any of the management team.

Complaints and concerns were taken seriously and dealt with in a transparent way. A relative told us that when they had raised concerns, these had, "Always been listened to, always been dealt with, always been sorted, with no hard feeling". The complaints file contained the provider's current policy for compliments, comments and complaints. This detailed sources of assistance that complainants may wish to refer to while their complaint was investigated. It also stated people could refer to the Local Government Ombudsman if they were not happy with the response from the service. There had been one formal complaint over the past year. This was recent; it had been acknowledged promptly and was under investigation.

Outstanding ☆

Is the service well-led?

Our findings

The atmosphere all around the home was positive, welcoming and homely throughout the inspection. Visitors told us this was the norm. Comments included: "It's a very, very jolly, happy place" and "It's not institutionalised at all". This was consistent with the vision and values set out in the service's statement of purpose and resident's rights charter and on the service's website. A health professional with several years' experience of the service remarked on its family, rather than clinical and institutionalised, feel.

The service had established a positive, open culture. The management team encouraged people, their relatives and staff to raise issues of concern with them, which they always acted upon. People and staff had confidence the managers and directors would listen to their concerns, which would be received openly and dealt with appropriately. Relatives and staff told us they always felt able to approach members of the management team if they had any concerns. Staff said the managers' doors were always open and that anything they said was taken seriously and the appropriate action taken: "They listen to whatever you have to say".

Staff were familiar with the whistleblowing procedure and had used it. This was illustrated through records in a staff file that showed colleagues had flagged up concerns about a member of staff's practice. The registered manager and director of care services had taken these concerns seriously, investigating them thoroughly and acting positively on the findings to stop bad practice and inspire the member of staff to develop their skills and knowledge further.

This person-centred, open and transparent ethos was understood throughout the staff team and was consistently put into practice. A member of staff who had experienced work in other care settings told us, "Very good staff here, very warm, very helpful, very caring". A regular member of agency staff said the service was "One of my best places… very friendly, caring, honest… professional". All the staff we spoke with came across as motivated and enthusiastic about their work.

The open and honest culture of the service was evident in the way the registered manager and director of care services were addressing issues with staff morale. They recognised that morale had taken a downturn after some experienced staff had left due to life circumstances, with others on long-term sick leave. Minutes of group supervision and staff meetings reflected frank discussion about this. Action was under way to address the issue, including recruitment initiatives, an overhaul of the process for managing sickness absence, and additional induction training so new staff felt confident to do more. The service was also taking steps to involve staff in each other's professional development. A senior member of staff explained that in the new year they would be running a workshop for experienced care staff about what makes a good induction. They also told us how care staff were getting more involved in recruitment, such as heads of care (the staff in charge of care givers on a shift) showing candidates around the home and sitting in on interviews.

There was a strong emphasis on continually striving to improve the service. People's and their relatives' views were seen as important to this end and were taken seriously, irrespective of people living with

dementia. There were active endeavours to obtain people's and relatives' views, through informal conversation and more formally through care reviews, residents' and relatives' meetings and quality assurance surveys. Comments included: "If you want to go and see a manager there's nearly always a manager around", and "As relatives, we have been encouraged to give the team our feedback… meetings for relatives where we have been updated on the work that's going on within Aranlaw and enabled to give our feedback about any aspect of life at Aranlaw". Quality assurance forms were staggered across a range of people and visitors so that feedback was continuous from different sources, with everyone having an opportunity to return a form in each 12 month period. Feedback from these surveys was analysed and fed back to the registered manager. Over the past year these had been wholly positive.

Most people were not able to tell the service in depth about their experiences of care. However, the registered manager and director of care recognised this. They monitored people's experience instead through observed staff supervision during various aspects of care. The staff member and their supervisor afterwards reflected on what had been observed. The provider had agreed funding for some staff were to be trained in Dementia Care Mapping with a view to introducing this within the service. Dementia Care Mapping is an established approach to embedding person-centred care, developed by the University of Bradford. It prepares staff to take the perspective of people living with dementia as they assess the quality of the care provided.

Residents' meetings took place every few months, and we attended one during the inspection. People discussed the forthcoming development of an 'indoor park', which was planned at the service. They chose the animals they would like to live there, having a rota for feeding them, the style of the hutches and how the area would be decorated. People remained engaged in the discussion, stimulated by the use of pictures and reminiscence about happy memories they had of going to the park. Previous meetings had followed a similar format, with the use of photographs and other visual aids such as fabric swatches and carpet samples, and discussion of people's memories relating to the particular topics. People, who may have had experience of meetings during their working life, took minutes assisted by staff. People's views had been put into action, the colour of furnishings, curtains and walls reflecting the preferences people expressed.

There were also relatives' meetings; we saw minutes of four meetings during 2016. The registered manager told us they were considering how to give the meetings greater appeal, interest and relevance. Recent meetings had taken the style of information-giving sessions, with speakers on topics that might be of interest. The most recent meeting had been held at a later time to give more relatives an opportunity to attend.

As well as consulting with people, the service strove for excellence through reflective practice. The manner in which staff spoke with us demonstrated how reflection had become routine for them. Someone who had taken on a new role described how their training and supervision had caused them to think about their style of work and their working relationships and how they could work most effectively. Another member of staff, who we had observed interacting very well with the person they were supporting, later talked openly and spontaneously about how they could have improved the interaction. Similarly, the registered manager and director of care services reflected on accidents, incidents, complaints, safeguarding investigations, audits and inspections to consider how practice could be improved. This reflection and learning was recorded on opportunity for improvement forms, which had been introduced across the provider's services. These had been introduced to demonstrate the provider's organisation was a learning organisation. They reinforced to staff and managers the provider's ethos of continuous learning and improvement. An example of improvements that had been was introduction of enhanced fire training for night staff after a fire alarm sounding at night had highlighted confidence issues amongst staff, who had responded competently.

Learning from this service and its sister services was shared between the services. For example, recruitment procedures had been tightened after an audit in one of the sister services revealed that some small gaps in employment had been identified but not fully accounted for. The director of care services had established a 'Going for Gold' service development plan. This focussed on how the service could evidence good practice and develop further, in order to meet CQC's characteristics of 'outstanding' ratings. It had been updated recently to reflect learning from an inspection of one of the sister services.

The service also sought opportunities to take part in research, as part of their pursuit of excellence. A local partnership group was undertaking research in leadership and management and the service had volunteered to participate in this.

A comprehensive programme of audits and checks was in place to monitor all aspects of the service, including care delivery, accidents and incidents, health and safety, infection prevention and control, security and beds and mattresses. These were undertaken by managers from the service, managers across the provider's services, and external consultants in residential care. Audits resulted in clear action plans to address shortfalls or areas of improvement; there were numerous 'opportunity for improvement' forms reflecting these. For example, during the inspection there was a delivery of new over-bed tables, as a member of the management team had identified that existing ones were unstable and not fit for purpose.

Experienced care staff had recently been designated as 'champions' with particular areas of expertise including moving and handling, nutrition and hydration, oral care, dignity, dementia care and end of life care. Training and ongoing development was planned for the champions in their areas of interest, so they would be able to provide advice, guidance and supervision to their colleagues.

There were plans to introduce a computerised care record system. The registered manager said that this had been discussed with relatives, who had been positive about it. The registered manager and director of care services explained the system would include a facility for people or their relatives being able to leave messages for the service. However, they recognised that not everyone would be used to computers and were considering ways to improve two-way communication with relatives.

The service had a clear management structure. A general manager had recently started working alongside registered manager, with a focus on staffing issues, such as supervision and return to work interviews. They also covered for the registered manager in her absence. The idea of having a general manager had been piloted at one of the sister services. In addition to the registered and general managers, there was a deputy manager on duty during the day. Each floor had heads of care, who coordinated and worked alongside the care staff on that floor. Catering, maintenance and housekeeping staff were managed by the facilities manager who worked across all four homes.

The registered manager was a role model, demonstrating excellent practice to staff. They and other members of the management team worked closely with staff, frequently observing and providing care. A member of staff told us that managers were visible to them: "Always come and help if we need it, not just sitting in the office and writing, [but] doing our job as well, coming and talking to residents".

The registered manager and director of care services were both established in their posts. The director of care services was director of care services for this service and its three sister services, overseeing their running alongside the managing director/owner of the provider organisation. The registered managers of all four services met monthly to share good practice and any learning from incidents. The registered manager and director of care services confirmed there was regular communication between members of this team.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. The provider strove to improve the quality of care for people living with dementia, both in its services and in the wider community. The director of care services had recently won the Venus Manager of the Year award for women in business in Dorset. The managing director was deputy chair of the Dorset Care Homes Association and the director of care services had been nominated as the Association's safeguarding lead.

The provider had signed up to the Social Care Commitment, a Department of Health initiative that is the adult social care sector's promise to provide people who need care and support with high quality services. This represents the provider's commitment to: use thorough recruitment and selection processes; provide thorough induction training; provide timely, appropriate and accessible learning and development opportunities for staff; take responsibility for how staff work; supervise staff, and; ensure a positive working culture where staff are supported to put their commitment into practice every day. Employees also commit to: take responsibility for what they will and will not do; uphold people's dignity, rights and health and wellbeing; work co-operatively; communicate effectively; respect people's right to confidentiality; reflect on and update their knowledge, skills and experience, and; treat all people fairly and without bias.

The registered manager had notified CQC about significant events. We use such information to monitor the service and ensure they respond appropriately to keep people safe.