Care UK Community Partnerships Ltd

Weald Heights

Inspection report

Bourchier Close
Sevenoaks
Kent
TN13 1PD

Tel: 03333218295

Date of inspection visit:
25 June 2018

Date of publication:
14 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected the service on 25 June 2018. This was our first inspection since the service was registered on 18 April 2017.

Weald Heights is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Weald Heights is a purpose built care home registered to provide accommodation and nursing care to up to 80 adults. Weald Heights provides nursing and residential care, short term respite care plus specialist care for older people living with Alzheimer's and other forms of dementia. Weald Heights has three floors, all of which has access to a secure outside space, and were accessed via a passenger lift. The service has its own coffee shop, hair salon, cinema and library which people were able to access. At the time of the inspection there were 38 people living at the service.

The service had a registered manager in post who had worked at Weald Heights since its registration. 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. The registered manager was supported by a deputy manager, clinical lead for the service and a senior management team.

People felt safe and were protected from the potential risk of harm and abuse. Staff understood their responsibilities for safeguarding people and followed the provider's policy and procedure. People's personal belongings were protected from the potential risk of theft. Potential risks to people had been assessed and steps were taken to reduce any risks. The premises were well maintained and equipment had been regularly serviced to ensure it was in good working order.

There were enough staff deployed on each floor to meet people's needs. People told us staff were available and came to their assistance when required. The provider operated safe and robust recruitment and selection procedures to make sure staff were suitable and safe to work with people.

People received a personalised, person centred service which was responsive to their needs. People and/or their relatives were involved in the development and review of their care plan. Guidance was in place to inform staff of how to meet people's needs whilst encouraging and promoting their independence.

People's nutrition and hydration needs were assessed and recorded. People had access to food they enjoyed and their specific dietary requirements were catered for. Staff worked alongside health care professionals to ensure people remained as healthy as possible.

People were encouraged to make their own choices about their lives. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff respected people's privacy and dignity. Interactions between staff and people were caring and kind. Staff knew people well and had knowledge about people's histories, likes and dislikes. People's equality, diversity and human rights were promoted and respected.

People received their medicines safely as prescribed by their GP. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed regularly. People were protected by the prevention and control of infection where possible, with systems in place to ensure the risk of contamination were minimised. Guidance was available for staff to follow to maintain people's safety in the event of an emergency.

People were offered the opportunity to participate in a range of activities to meet their needs and interests. The views of people and others were sought and acted on. People knew who to speak to if they were unhappy. Complaints were managed in line with the provider's policy; complaints were used as a way to learn and improve the service that was provided to people.

Accidents and incidents were monitored and managed effectively.

Staff at all levels were given the training, skills and confidence to meet people's needs. Staff were supported in their role by the registered manager and the management team, this included clinical support and supervision for the registered nurses.

Effective systems were in place to enable the provider and the management team to assess, monitor and improve the quality and safety of the service. Records were maintained adequately and kept securely.

The registered manager worked in partnership with external organisations to promote best practice and to develop and promote a positive culture between the local community, staff and relatives supporting people that had dementia.

The registered manager and the management team understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at the service. Staff protected people from the risk of harm or abuse and knew how to identify and raise safeguarding concerns.

Potential risks to people, staff and visitors had been assessed and recorded. Action had been taken to reduce any potential risks.

There were enough staff to meet people's needs. Safe recruitment processes were followed.

People received their medicines as prescribed by their GP, by staff that were trained to do so.

People were protected from the risk of infection and cross contamination. The premises were clean and maintained.

Is the service effective?

Good

The service was effective.

Staff received the support, skills and knowledge to fulfil their role to meet people's needs, including their specialist needs.

People's needs were assessed and recorded prior to receiving care and support. People's protected characteristics were promoted.

People had access to the food and drink they enjoyed. People's nutrition and hydration were assessed with action taken if additional support was required.

People were supported to remain as healthy as possible with support from health care professionals.

The service had been designed with adaptations to promote people's independence.

People were encouraged to make their own choices about

everyday decisions. People were asked their consent by staff prior to any care and support tasks being carried out.

Is the service caring?

Good

The service was caring.

Staff were kind and caring towards people.

People's feedback was sought and acted on to improve the quality of the service that was being provided.

People were treated with dignity and respect by staff that understood the importance of protecting people's privacy.

People and/or their relatives were involved in the planning and delivery of their care.

People were supported to maintain relationships with people who mattered to them.

Personal information was stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Care planning documents were reviewed on a regular basis to ensure they continued to meet people's needs.

People were supported and encouraged to participate in a range of activities to meet their needs and interests.

Systems were in place for people and their relatives to raise any concerns or complaints. Complaints had been responded to appropriately as per the provider's policy.

People had been involved in the development of their plan for care at the end of their life.

Is the service well-led?

Good

The service was well-led.

The service had an experienced registered manager in place that

was committed to promoting the organisations vision and values.

There was an open culture between the management team and care staff. Staff were kept informed about any changes through daily handovers and regular team meetings.

Systems were in place to monitor the quality of the service that was provided to people. Action was taken to improve the service when suggestions were made.

The registered manager developed relationships with the local community to promote awareness about dementia.

Weald Heights

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 the 25 June 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a nurse with expertise in medicine management and end of life care 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. The expert-by-experience for this inspection had experience in care for older people.

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. We looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We observed staff interactions with people and observed care and support in communal areas. We spoke with 11 people about the care and support they received. We spoke with two relatives about their experience of the service. We spoke with 11 staff, which included two care assistants, two registered nurses, the clinical lead, the registered manager, the deputy manager, the regional director, a member of the quality support team, the chef support, and an activities co-ordinator.

We looked at the provider's records. These included seven people's care records, which included care plans, health records, risk assessments, daily care records and medicines records. We looked at documentation that related to staff management and recruitment including four staff files. We also looked at a sample of audits, satisfaction surveys, staff rotas, minutes of meetings and policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe living at Weald Heights. One person said, "I feel very safe here, people are very nice to me." Another person said "I feel safe, everyone is very helpful." .Our observation showed people felt comfortable with the staff supporting them. People appeared relaxed with the staff, smiling, laughing and giving eye contact. A relative said, "The staff always know where he is, they help him to walk and I'm absolutely sure he is safe."

People were protected from the potential risk of harm and abuse, by staff who knew the potential signs of abuse and the action to take if they had any suspicions. Staff followed the provider's policy and procedure and had access to the local authority's' protocol. Staff said they felt confident any concerns they raised would be taken seriously by the registered manager and management team. Staff understood the whistleblowing procedure and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly.

People's personal precious items were protected from the potential risk of theft, with lockable cupboards available within people's bedrooms. People's belongings were inventoried on admission to the service. Some people had chosen to keep the key to their bedroom door and locked the room when they were not in it.

The registered manager was aware of their responsibility to report any concerns to the local authority, and records showed they were involved in investigating concerns in a transparent way. The registered manager used a tracking system to monitor concerns that had been raised, the investigation and the outcome. The registered manager also ensured statutory notifications were sent to the CQC in a timely manner.

Staff had up to date information to meet people's needs and to reduce risks. Each person had a risk assessment which identified how they were at risk and these were reviewed at least yearly, or when people's needs changed. Potential risks to people in their everyday lives had been identified, such as risks relating to personal care, their health and mobility. If people required specific equipment a risk assessment had been completed, for example the use of a profiling bed and an air mattress. Risk assessments were in place to recognize people who may need further provision and support to keep them safe. For example, people that had been assessed as at risk of falling out of bed, and requiring the use of a bed rail to maintain their safety.

People told us there were enough staff available to meet their needs; and that their call bells were answered promptly. The registered manager used a dependency tool to calculate the number of nursing and care staff required on each unit. Records showed the staffing levels were higher than the calculated amount of staff required, and these were adjusted when people's needs changed. Staffing levels varied on each unit depending on people's assessed needs, the same level of staffing was kept during the night. There were two chefs, kitchen assistants, activities staff, administration staff, maintenance staff and housekeepers on duty every day of the week so that care staff could concentrate on caring for people. The registered manager and deputy manager were registered nurses and were on call out of hours to give advice and support and would work on shifts if needed.

People were protected by safe recruitment procedures. The provider's human relations team managed the recruitment process, with the registered manager responsible for the interview process only. Staff completed an application form which included a full employment history, written references were obtained from previous employers, including any care related employment and identity checks. Staff completed a Disclosure and Barring Service (DBS) background check. These check criminal records to help ensure they were safe to work at the service. Records showed the recruitment team had checked nurses registrations were current, and they were on the professional register of practising nurses for the Nursing and Midwifery Council. People could be confident recruitment systems were robust and made sure the right staff were recruited to keep people safe.

People told us they received their medicines on time, and they felt their medicines were well managed. People were protected from the risks associated with the management of medicines. Nurses held the responsibility for administering people's medicines on the first and second floor and senior staff held responsibility on the ground floor. Nurses and staff administering medicines completed an induction which included observations of the medicines round, before they were signed off as being competent to administer medicines. Medicines were stored safely, securely, and at appropriate temperatures, including medicines which required refrigeration. There were suitable arrangements for the storage and recording of medicines which required additional safe storage. Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. People were supported to manage their own medicines and self-medicate if they had chosen to.

Protocols and guidance were in place for people who were prescribed 'as and when required medicines' (PRN). These protocols provided clear guidance for its use, maximum dose in 24 hours and the possible side effects. Regular audits of people's medicines were completed by a member of the management team. Records showed action had been taken following identified errors such as, medicines which had been administered but not signed for.

People were protected from the risk of infection, by the systems and processes that were in place, to prevent and control the risk of infection. The provider employed a head of housekeeping who managed a team of housekeeping staff; there was a member of the house keeping team allocated to each floor over seven days a week. A cleaning schedule was used to inform staff of the tasks that required completing during their shift. A schedule was in place for the cleaning of equipment such as, wheelchairs and bath hoists.

We observed the service was clean and odour free. The head of housekeeping completed infection control audits to ensure best practice guidelines were followed. Substances hazardous to health were kept securely within a locked cupboard in order to minimise the risk of people using them inappropriately. Staff were knowledgeable about infection control procedures, and were observed using personal protective equipment (PPE) such as, gloves and aprons. The laundry was well managed and dirty laundry was kept separate within red laundry bags.

People's safety in the event of an emergency such as a fire had been assessed; measures were put into place to promote people's safe evacuation. An evacuation plan and individual risk assessments were in place which detailed the support each person required to evacuate the building safely. There were up-to-date safety and maintenance certificates for equipment. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Any issues that were identified were acted on quickly. These checks enabled people to live in an adequately maintained environment.

Accidents and incidents involving people were monitored and recorded. Staff completed an accident form and, for example, a 72 hour post fall observation check. All incidents and accidents were monitored and

audited by the deputy manager. A root cause analysis was completed monthly, this highlighted any patterns or trends. Where causes were identified action was taken, such as referrals back to the Parkinson's nurse for a medication review. An increase in the number of urinary tract infections (UTI) had been identified; as a result a drinks machine was purchased for people to access. Records showed the number of UTI's had reduced since the implementation of the machine.

Lessons were learnt and improvements were made when things went wrong. Following an incident where one person was able to abscond to the car park after removing the window restrictors; all windows restrictors were replaced. Additional window restrictors were implemented to reduce the risk of a reoccurrence.

Good

Is the service effective?

Our findings

People told us they felt that staff had the skills and knowledge to meet their needs. One person said, "The staff are all very pleasant and seem to know what they are doing." A relative said, "I think the staff are very well trained."

People received nursing and personal care from staff that had the skills and knowledge to meet their needs. Staff were trained and supported to develop the skills and experience required to meet people's needs. The provider had a number of courses which they considered mandatory, the registered manager held responsibility for ensuring the staff were trained. The registered manager used a training matrix alongside an online system to ensure staff had received the training they required. There was an ongoing programme of training which included face to face training, mentoring, online learning and competency assessments. The clinical lead for the service supported the registered nurses with their continuing professional development training. Registered nurses were supported to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. These courses enabled the registered nurses and staff to feel confident in their role and provide people with the care and support they required.

New staff had undertaken the provider's induction which included training, completion of the Care Certificate and working alongside experienced staff. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors Care staff were offered the opportunity to complete a formal qualification during their employment. For example, The Qualifications and Credit Framework (QCF) in Health and Social Care, this is an accredited qualification for staff working in the care sector.

Staff told us they felt supported in their role by their line manager and the management team. Systems were in place to provide support and supervision to staff, through supervisions and an annual appraisal. This was to provide opportunities for staff to discuss their performance, development and training needs. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The registered manager used a supervision matrix to ensure staff received regular support and supervision in line with the provider's policy. The clinical lead for the service supervised the registered nurses and the team leaders on the ground floor supervised the care staff.

People's needs were assessed with them and a member of the management team prior to them using the service. The pre-admission assessment included information regarding what support the person required for the care team. The providers' pre-admission assessment took into account the persons care and support needs, eating and drinking, mobility, social needs and religious beliefs. They included details about how the person wanted to be supported and were written in conjunction with people and their families if necessary. For example, one person's assessment recorded their preferred name choice, as this differed from their Christian name. Another person's recorded the support they required to maintain their cultural beliefs. An admission checklist was used for people that were using the service for respite. The checklist detailed which documents were required to be completed within 24 hours of the person moving in. These were MAR, registration with a local GP surgery, nutritional assessment and a moving and handling assessment. The

remaining care plans and documentation were required to be completed within seven days. However, records showed that these had been completed within 24 hours alongside the other documentation.

People's nutritional needs had been assessed and recorded; these had been reviewed on a regular basis. People assessed to be at a high risk of malnutrition or dehydration had their food and fluid intake monitored and were placed on a clinical risk chart. People's weight had been monitored on a regular basis; this was completed in conjunction with a nutritional screening tool. People's weight, height and body mass index (BMI) were recorded on admission to the service, this enabled accurate monitoring and recording of people's weight. Staff worked alongside health care professionals to support people to maintain their nutrition and hydration. Clinical review meetings were held within the service to discuss people that were assessed as at high risk and staff implemented guidance from professionals such as dieticians.

People told us they enjoyed the food and felt there was a varied menu available. One person said, "The food is always very good." Another said, "The food is lovely, we have a very varied menu." A relative said, "My father loves the food." The provider employed a chef who worked alongside a catering team. All meals were homemade and freshly prepared daily, bread rolls and crème caramels were being made during our inspection. People were offered a choice of two starters, main courses and desserts. People were able to make other food choices of their preference. We observed the lunch service on each floor, there was a calm, relaxed atmosphere. People were chatting amongst each other, the tables were pleasantly laid and condiments were available for people to use.

The catering team were aware of people's likes and dislikes, and these were taken into consideration. Specialist dietary requirements were catered for such as, gluten free, diabetic, pureed or fortified meals. The food stores were adequately stocked, with systems in place for the ordering of fresh food. The provider followed the 'dining with dignity' guidelines, this is a dining experience that enables people living with dementia to maintain their independence and enjoy the mealtime experience. Differently weighted and designed plates were used to enable people with dementia to eat independently. The lunch service was adapted to meet the needs of people living on each floor. For example, on the ground floor people were asked which of the two choices they wanted, whereas on the middle floor example plates of food were used to offer people a choice.

Staff worked alongside healthcare professionals to provide people with a joined up provision of care. People's health was monitored and when it was necessary health care professionals were involved to make sure people remained as healthy as possible. People told us they could access health care services when they required them. One person said, "I needed a doctor and they arranged it straight away." Oral health assessments were completed for each person and reviewed on a monthly basis. All appointments with professionals such as doctors, district nurses, dentists, podiatrist, physiotherapist and opticians had been recorded, along with any outcome. Future appointments had been scheduled and there was evidence that people had regular health checks. People had been supported to remain as healthy as possible, and any changes in people's health were acted on quickly.

People assessed as being at high risk of developing skin and tissue damage, had clear guidance for staff to follow to reduce the risk of occurrence. Equipment was available and in use for people, such as pressure relieving mattresses and cushions. Each person had been assessed by the relevant health care professional. Systems were in place to ensure the equipment was maintained and on the correct setting for the person's weight. Records showed people that were at risk or who had been admitted with a pressure sore were discussed at the clinical review meetings. Action was taken if any changes in the person's health or skin were identified.

Weald Heights was purposely designed and built to offer support to older people some of whom were living with dementia. Each of the three floors had access to an enclosed outside space which was accessible. One person said, "I enjoy sitting out there in the seating area watching the world go by." People's bedrooms were individualised to their taste and included personal items such as photographs and pieces of furniture. Outside each person's bedroom door was a memory box which included items relating to the person's personal history such as, family photographs and work history. Areas of the service, such as, the bathrooms and dining rooms, were clearly identifiable to allow people freedom of movement and promote independence.

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 make 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 authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager, management team and the care staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005, and the Deprivation of Liberty Safeguards (DoLS). All staff had been trained to understand and use these in practice. People told us staff asked for their consent before carrying out any personal care tasks. One person said, "The staff always ask before helping me." Another person said, "They always ask for my consent." We observed staff seeking people's consent prior to being supported to the dining room and the bathroom. The registered manager had carried out MCA assessments with people and/or their relatives for less complex decisions such as, personal care needs and medicine management. Records showed that when people lacked the capacity to make certain decisions about their lives, their relatives and the relevant health care professionals were involved to make sure decisions were made in their best interests.

The registered manager understood their responsibility for making applications to the local DoLS team, when a person was bring deprived of their liberty. A checklist and tracking system was used to record all applications that had applied for, the date the authorisation was granted or refused, the expiry date of the authorisation and the date CQC had been formally notified via a statutory notification.

Good

Is the service caring?

Our findings

People told us the staff were very friendly and kind. We observed good humoured exchanges between people and staff, with laughter and interaction. One person said, "You don't feel it's them and us, we are all together." Another person said, "Nothing is too much trouble, the staff are exceptional." A third said, "I like all the staff, they are not domineering." A relative commented they felt, "The staff are very caring."

Observation showed that staff were kind, caring and carried out their duties in a friendly, relaxed and unrushed way. Staff knew people well and followed people's specific communication care plans; this was to promote effective communication. People and their families were encouraged to record information about their likes, dislikes and personal histories. Some people had a 'meaningful book' within their bedroom which highlighted the person's life history, interests and included family photographs. Staff would use this information to engage people in conversations and get to know people's histories.

People told us they felt listened to and were asked for their views about the service they received. People were supported to attend regular 'resident meetings', these meetings provided people with an opportunity to raise any concerns or make suggestions about the service. People and or their relatives were involved in the planning and delivery of their care. People's care plans included clear information and guidance about their individual support needs, their preferences, likes, dislikes and interests. People's care plans recorded what people were able to do for themselves, followed by the support they required from staff. Some people had recorded within their care plan that their aim had been to maintain their independence as much as possible. People confirmed that staff enabled them to do as much for themselves as possible.

People told us that staff protected their privacy and dignity. One person said, "I am treated with respect and dignity." We observed staff knocking on people's bedroom doors and waiting for a reply before entering. Staff asked people if they would like their bedroom door open or closed. Staff gave examples of how they protected people's privacy and dignity whilst offering them care and support. For example, closing doors and covering people up with a towel following personal care, closing the curtains and asking people if they want to be on their own.

People were supported to maintain as much contact with their friends and family as they wanted. Relatives and visitors told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. One relative said, "I visit whenever I can and the staff know me well." There was a coffee shop within the reception where visitors were able to access refreshments. Arrangements were made for relatives to stay with their loved one overnight if there had been deterioration in the person's health.

Information about people was treated confidentially. The registered manager and administrators were aware of the new General Data Protection Regulation (GDPR); this is the new law regulating how companies protect people's personal information. People's care records and files containing information about staff were held securely in locked cabinets. Computers were password protected and all documents were encrypted and sent password protected.

Good

Is the service responsive?

Our findings

People told us the staff were responsive to their needs and they enjoyed living at Weald Heights. One person said, "It's very pleasant living here." Another person said, "I feel comfortable here." A relative said, "It's a beautiful building but that is not what makes it, it is the kind caring staff. I would give this place 10/10."

People received personalised care which placed them at the centre. Care plans were person centred and contained information about how each person should be supported in all areas of their care and support. One person said, "I do know about my care plan and I was involved in making it." People and their relatives told us they were involved in the regular review of their care plan.

Care plans were detailed and informed staff what the person's abilities were and the support they required from staff. Care plans were individualised to people's needs. For example, one person's care plan recorded that they wanted support with their personal care after their breakfast. Another person's recorded their preferred name choice. Care plans contained a detailed medical history and health needs of the person. Details of emergency contact information such as the next of kin, religious beliefs, MCA information and life history were recorded. Staff knew about people's needs and their backgrounds and the care and support they required. People's care plans provided consistent and up to date information about each individual.

People's care plans were reviewed on a regular basis, changes were made when their support needs changed, to ensure staff were following up to date guidance. People, if able, were fully involved in the development and review of their care plans. Each person had a named keyworker who had responsibility for ensuring people's needs were met and people had what they needed. A photograph of the person's keyworker was available within people's bedrooms, this enabled people and their relatives to see who the point of contact was for the person.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Care plans confirmed the assessment of people's communication to identify any special communication needs. The provider had also developed an easy read complaints and service user guide using pictures to use when required. This was to ensure people who lived at the service had information in the most accessible format.

The provider employed an activities co-ordinator who organised a range of activities for people. People and their relatives spoke highly of the activities co-ordinator. One person said, "The activities co-ordinator is very positive and encourages us to try new activities." A relative said, "The activities co-ordinator is amazing." People told us there was a wide range of activities available to meet their needs and interests. People had access to a hairdressing salon, a cinema room and a library within the service. People were supported to maintain their religious beliefs and faith, with monthly services available for people to attend; people were also supported to attend services in the community if they preferred. A weekly activity guide was created and accessible, this was given to people to inform them of what was available. Activities were available throughout the day on each floor of the service. Activities within the service included, pet therapy, visiting musicians, nail care, arts and crafts and reminiscence.

People and their relatives told us they knew who to speak to if they had any concerns or complaints, they felt staff would listen and take action. One person said, "If I had a concern I would go to the nurse in charge, but I have not needed to." Another person said, "I would speak to the manager but have not needed to complaint about anything." Systems were in place for people or their relatives to raise any concerns or to make suggestions. Relative meetings took place on a quarterly basis in the evening for people who worked to be able to attend. Resident meetings were held on a monthly basis. Although there had not been any formal complaints raised, the registered manager recorded any concerns that had been raised and dealt with these using the complaints procedure. Any concerns that had been raised by relatives were investigated, and a record was kept of any action that had been taken or the outcome of the investigation. Concerns that had been raised included the location of their loved ones bedroom, having blankets instead of a duvet and a faulty brake handle on a person's walking aid.

People's end of life care had been discussed with them and/or their relatives and recorded within their care plan. There was a holistic approach to people who were at or nearing to the end of their life. The service worked in partnership with health care professionals to ensure appropriate pain relief medicine was in place. Some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place. DNACPR forms indicate where a medical decision has been made by a doctor with the person or their representative that cardiopulmonary resuscitation would not be attempted if the person stopped breathing or their heart stopped beating.

Good

Is the service well-led?

Our findings

People and their relatives spoke highly of the registered manager and the management team and felt confident in approaching them. People told us the registered manager always greeted them in a friendly manner. One person said, "The manager is everywhere and we see her most days." A relative said, "The registered manager is very visible."

The service had an experienced registered manager in post who had worked at the service since its registration with CQC in April 2017. The registered manager was supported by a deputy manager and a clinical lead for the service. Staff understood the management structure and who they were accountable to. Staff said they understood their role and responsibilities and said this was also outlined in their job description and contract of employment. There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. For example, equal opportunities policy, capability policy and staff recruitment and selection. Staff knew where to access the information they needed.

Staff told us they felt there was an open culture between themselves and the management team, and they were kept informed about the day to day running of the service. Regular team meetings were held so staff could discuss practice and gain some feedback from observations made by the management team. Staff meetings gave staff the opportunity to give their views about the service and to suggest any improvements. Staff handover's between shifts highlighted any changes in people's health and care needs, this ensured staff were aware of any changes in people's health and care needs.

The provider's vision and values were displayed within the office and service for all staff to see. The registered manager and management team ensured staff were working in line with the company's vision through observations of staffs working practice. The provider operated a recognition scheme for staff to reward staff that excelled within their role and went the extra mile.

People and their relatives were asked for their feedback about the service through regular meetings, an annual questionnaire and a comments and suggestion box. One person said, "There is a residents meeting every month and you can raise anything then." People's views and comments were listened to and acted on. For example, following a suggestion from a relative another two members of reception staff were employed, this enabled the reception to be manned seven days a week. Feedback from people, relatives, staff and the audits were used to make changes and improve the service provided to people.

Systems were in place to monitor the quality of the service that was being provided to people. The registered manager undertook regular audits which were sent to the senior management team and included information about observation records, care plans, risk assessments, medicines management and health and safety. These audits generated action plans which were monitored and completed by the registered manager and management team. They were used to inform summary quality reports submitted to the board. There were a number of additional audits completed by different sections of the organisation.

The provider operated an electronic system that took information uploaded from the service about things such as accidents, safeguarding's, complaints, CQC notifications, staff departures, infection control alerts and sent them to different people within the organisation. This enabled the senior management team complete oversight of the service. All entries had to be signed off twice a day by the registered manager and there was also a formal follow up function whereby the quality team could require additional information and steps to be taken by the registered manager.

The registered manager worked in partnership with the local community to improve knowledge and understanding of people living with dementia. An 'understanding dementia' seminar had been arranged, this was a free training session available to people, their families and members of the local community. The registered manager aimed to raise awareness within the local community and develop working relationships.

The registered manager and the management team had a clear understanding of their role and responsibility to provide quality care and support to people. They understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly.