CareQuality Commission

CLS Care Services Limited

Belong Atherton Care Village

Inspection report

Mealhouse Lane
Atherton
Manchester
M46 0EW
Tel: 01942 898410
Website: www.clsgroup.org.uk

Date of inspection visit: 03 March 2015
Date of publication: 23/06/2015

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?	Outstanding

Overall summary

The inspection took place on 03 March 2015 and was unannounced. The last inspection took place in March 2014 and was a responsive inspection due to concerns raised, the village was found to be meeting all regulatory requirements inspected.

Belong Atherton is a care village operated by the CLS Group, providing care and support to older people who require differing types of specialist 24 hour care. The residential accommodation consists of six households each having the capacity to accommodate 12 residents, up to 72 in total. The six households are situated near to Atherton town centre and forms part of Belong Atherton Care Village.

On the day of the inspection there were 68 people using the service permanently and two people in short term respite care.

There was a registered manager at the village. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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

People told us they felt safe and secure at the village. The building was suitable for people with restricted mobility and equipment was well maintained and fit for purpose.

We saw that the village recruited staff in a robust and safe way. We observed that there were sufficient staff on duty to ensure people's needs were met.

The village had appropriate policies with regard to safeguarding vulnerable adults and whistle blowing. Staff were aware of the policies and procedures and demonstrated an understanding of the issues.

We saw that there were systems in place to help ensure medicines were ordered, dispensed, stored and disposed of safely.

The village's staff induction programme was robust and included a range of training and support, which was on-going. We saw the training matrix which evidenced that staff had completed the required training to help them carry out their roles effectively.

We saw that there was an excellent choice of food available at the village. People's nutritional and hydration needs were catered for and there were nutritious snacks and drinks available throughout the day.

Care plans included a range of health and personal information. There were monitoring charts relating to issues such as weight, nutrition and falls where these were required.

We saw that staff sought consent from people who used the service, when delivering care. Written consent was evident within care files where appropriate.

Staff worked within the requirements of the Mental Capacity Act (2005) (MCA) and understood and adhered to the conditions of Deprivation of Liberty Safeguards (DoLS), which are used when people are deprived of their liberty in their own best interests and lack capacity to make this decision themselves.

We observed care being delivered in a kind and respectful manner during the day. Staff had regard to people's dignity and privacy when delivering assistance.

The households within the village were small, housing up to 12 people in each, and pets were allowed if people wanted them. This helped people feel they were part of regular family households. We saw that people were involved in decisions about their care delivery and the support they required.

The service produced a range of information, which was available for people who used the service. This included information about the services offered, a programme of events, a regular newsletter and feedback forms.

Staff at the village were involved in end of life programme training. This was to enable people to stay in familiar surroundings, with people around them that they trusted, at the end of their lives if they so wished.

We looked at three care plans and saw that they reflected people's individual needs, wishes and preferences. Regular household meetings took place where people felt they could air their views and suggestions.

We saw that a number of activities were on offer for people, and there were facilities in the building, such as the gym, hairdressing salon and internet areas. People could use these resources whenever they wished to and this also allowed them to interact with members of the wider community.

The service had an appropriate complaints procedure, which was outlined in the service user guide. We saw the service's complaints log and this evidenced that complaints were followed up appropriately.

People who used the service, relatives and staff all described the management team at the village as approachable. We saw that the village worked to current best practice guidelines and ensured they were up to date with this information. This was discussed regularly with staff at meetings and within supervisions. Regular meetings took place with the various staff groups and staff supervisions sessions and annual performance development reviews were undertaken regularly.

The village had excellent links with the local community due to having facilities which were used by people who used the service and members of the community. This enabled people to continue to feel part of the wider community after they had been admitted to the village.

We saw evidence that the village worked well in partnership with other agencies. Regular feedback from

Summary of findings

people who used the service, relatives and professional visitors was sought in various ways to help facilitate communication, encourage suggestions and the raising of concerns.

A significant number of audits and checks were carried out and the results analysed. This helped the service to ensure continual improvement to the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe and secure and the building was suitable for people with restricted mobility. Equipment was well maintained and fit for purpose.

Recruitment of staff was robust and there were sufficient staff in evidence to ensure people's needs were met.

The village had appropriate safeguarding vulnerable adults and whistle blowing policies and procedures. Staff were aware of the policies and procedures and demonstrated an understanding of the issues.

There were systems in place to help ensure medicines were ordered, dispensed, stored and disposed of safely.

Is the service effective?

Good

The service was effective. The village's induction programme was robust and included a range of training and support, which was on-going.

There was an excellent choice of food at the village and there were nutritious snacks and drinks available throughout the day.

Care plans included appropriate health and personal information and monitoring of issues such as weight, nutrition and falls was carried out appropriately.

Consent was sought from people who used the service by staff when delivering care. Written consent was evident within care files where appropriate.

Staff worked within the requirements of the Mental Capacity Act (2005) (MCA) and understood and adhered to the conditions of Deprivation of Liberty Safeguards (DoLS), which are used when people are deprived of their liberty in their own best interests and lack capacity to make this decision themselves.

Is the service caring?

Good

The service was caring. We observed care being delivered in a kind and respectful manner during the day. Staff had regard to people's dignity and privacy when delivering assistance.

The households were small, housing up to 12 people in each, and pets were allowed if people wanted them. This helped people feel they were part of regular family households.

We saw that people were involved in decisions about their care delivery and support required.

A range of information was available for people to see, including information about the services offered, programme of events and feedback forms.

Staff at the village were involved in end of life programme training. This was to enable people who used the service to stay in familiar surroundings, with people around them that they trusted, at the end of their lives if they so wished.

Summary of findings

Is the service responsive?

Good 

The service was responsive. We saw that care plans reflected individual needs, wishes and preferences. Household meetings took place where people felt they could air their views and suggestions.

We saw that a number of activities were on offer for people, and there were facilities in the building, such as the gym, hairdressing salon and internet areas, where people could go and use the resources.

The complaints procedure was outlined in the service user guide and we saw the service's complaints log. This evidenced that complaints were followed up appropriately.

Is the service well-led?

Outstanding 

The service was well-led. People who used the service, relatives and staff all described the registered manager of the village as approachable.

The village worked to current best practice guidelines and ensured they were up to date with this information. This was discussed regularly with staff.

Regular meetings took place with the various staff groups. Staff supervisions and annual performance development reviews were undertaken regularly.

The village had excellent links with the local community due to having facilities which were used by people who used the service and members of the wider community.

The village worked well in partnership with other agencies.

Regular feedback was sought in various ways to help facilitate communication from people who used the service.

Audits and checks were carried out and the results analysed to ensure continual improvement to the service.

Belong Atherton Care Village

Detailed findings

Background to this inspection

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

The inspection took place on 03 March 2015 and was unannounced.

The inspection was carried out by a Care Quality Commission adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case someone with expertise in caring for someone living with dementia.

Before the inspection 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. We also reviewed information we held about the village in the form of notifications received from the service.

We contacted three health and social care professionals who regularly work with the service to provide care and support. This was to ascertain their experience of the care offered by the service. We contacted the local Healthwatch service for information. Healthwatch England is the national consumer champion in health and care.

We spoke with four people who used the service. We also spoke with seven staff members, including care staff, maintenance staff and the registered manager. We looked at records held by the service, including three care plans, three staff files, meeting minutes, audits, training records and general information supplied by the provider.

Good

Is the service safe?

Our findings

We spoke with four people who used the service. All told us they felt safe and secure in the village. One person told us, "I feel safe because there is good supervision here. I've had no reason to complain". Another person said, "I've lived here for about three and a half years now and feel safe". A relative commented, "[My relative] is safe here because there's always staff around". Another told us, "I feel that [my relative] is safe here because the staff are vigilant. They don't just ignore requests for help".

We saw that there were sufficient staff on each household to attend to the needs of the people who used the service. These included a host, who was in charge of the kitchen area of each household, and a housekeeper. We looked at recent staff rotas and these evidenced sufficient numbers of staff on all shifts.

We asked people if they felt there were always sufficient staff. One person who used the service said, "There's enough staff but it's not often they haven't got something to do. Staff attend to me quickly". A relative told us, "There's enough day staff but there are problems at night and [my relative] tells me they sometimes have to wait for attention". We spoke with the manager about this and they told us there had been very few occasions when the village had been short staffed. They addressed any shortages by bringing in off duty staff to cover any shifts where a problem had occurred.

We observed all staff using key fobs to enter and leave each household, ensuring good security for people who used the service. People who used the service were given their own key fob to get in and out of the building, if they had been assessed as being able to do this safely. One person told us that having their own key gave them a feeling of independence. There was a call system so that people who used the service could call for assistance from staff. Movement sensors were used so that lights would come on automatically when people got out of bed at night time. Bed sensors were also in situ on each bed. This helped keep people safe and minimise the occurrences of falls.

The building was on three floors and had two lifts in place. We saw that corridors were clutter free and there was room for people with restricted mobility to move around the village easily. All the bedrooms and bathrooms had ample room for the use of equipment, such as a hoist, if required. Balconies, which were in evidence on the top and middle floors of the building, had lockable doors and were securely fenced in. People who used the service were able to use the balconies safely.

We observed staff assisting residents who required hoisting or transferring from wheelchair to armchair in a competent manner with good understanding of the safety issues. Each person who used the service, who required this, had their own individual, labelled sling for use when being hoisted. People who needed assistance to walk were accompanied by a carer.

Equipment, fixtures and fittings were well maintained and the village had a system in place which identified actions required to ensure repairs were carried out in a timely way. This helped to ensure repairs that may have health and safety implications were addressed immediately and covered all cyclic maintenance and legislative checks required.

We saw the service's safeguarding vulnerable adults policy, which was comprehensive and up to date. Safeguarding training was mandatory for all staff and we saw from the training matrix that staff were up to date with their training. We looked at safeguarding issues that the service had been involved with and saw that these had been followed up appropriately. We spoke with seven members of staff, all of whom demonstrated an understanding of safeguarding issues and were aware of the policy and the reporting procedures.

The service also had a whistle blowing policy which the staff were aware, there was also a speaking out at work policy, which encouraged staff to report any concerns about possible abuse or poor practice. We saw that there were leaflets around the village entitled, 'If you see something…say something'. These could be used by people who used the service, visitors or members of the community visiting the communal areas. These leaflets outlined possible safeguarding issues and gave advice on how to report any concerns. All those we spoke with were confident about the reporting mechanisms and the support they would receive if they needed to follow these procedures.

The service had robust recruitment procedures, which included obtaining references, ensuring people had the right to work in the UK and obtaining Disclosure and Barring Service (DBS) checks, which helped ensure people

Good

Is the service safe?

were suitable to work with vulnerable people. We saw evidence of the recruitment policy and saw that efforts were made to ensure staff recruited had the correct skills and values to ensure people who used the service would be protected from harm.,

There was appropriate safety equipment, such as fire extinguishers, in place. We saw that regular checks were carried out on safety equipment. The registered manager told us that a full evacuation was undertaken six times per year and fire alarms were tested weekly, on a randomly chosen day. Each person who used the service had a personal emergency evacuation plan (PEEP) in their care plans and copies of these were kept in the reception area to ensure these would be to hand should an emergency situation occur. We saw evidence of the service's emergency contingency plans to help ensure people would get continuity of care should any emergency mean that they could not remain at the village.

We saw that the service had an up to date medication policy. Only trained staff were allowed to administer medicines, once they had been deemed competent, and only registered nurses were permitted to deal with controlled drugs. We saw evidence that an audit of practice was carried out once staff had received the required training, to help ensure their competency to administer medicines. There was evidence that medication errors were followed up with a reflection of what went wrong and further training or support if necessary.

Medicines were stored securely in lockable cabinets in people's bedrooms. People who used the service could self-medicate, subject to a satisfactory risk assessment. We saw evidence of daily fridge temperatures being taken to ensure medicines requiring cool storage were stored within the correct manufacturers' temperature range. Oxygen was stored correctly with hazard notices on the storage room doors.

We saw that there was a stock of homely remedies kept at the village and these medicines were signed for when dispensed. If covert medicines, that is medicines given in food or drink, were required the correct authorisation was sought and this was documented along with the best interest decision making process.

We saw that the service had an infection control policy and an infection prevention and control lead person, who was responsible for coordinating information and leading on matters of infection control. A new system had been introduced in the village in order to have a high cleaning standard in line with infection control. The system included an audit check, with the use of intra-red torch to identify the quality of cleaning.

Good

Is the service effective?

Our findings

We asked people who used the service and their relatives if the care was effective. One person who used the service said, "The doctor is always called by my personal nurse when I need one. Staff respond quickly to my requests. I think residents are well catered for by staff. There's plenty of assistance". A relative told us, "I've filled in a care plan when [my relative] came here".

We asked about the quality of the food. One person who used the service said, "We are offered a choice of food and I've been weighed recently. I've lost weight but I'm putting it on now". A relative told us, "[My relative] gets enough food and drink. The staff keep a record of this. [My relative] is on a soft diet and is weighed regularly". Another relative commented, "Staff weigh [my relative] regularly and [my relative] gets enough to eat". Staff will always try to find something that [my relative] will eat".

The home had a robust induction programme, which included e learning and skills for care training. There was a probationary period where staff were supported to develop their skills. A six month introduction to care course was offered and supported by a facilitator and named mentor. Mandatory training included safeguarding vulnerable adults, life planning, moving and handling, nutrition and well-being and introduction to dementia. We saw that best practice in dementia care training courses were offered to staff on a regular basis.

Staff supervision was undertaken on a two monthly basis and this was confirmed within the three staff files we looked at. A performance development and review framework cycle commenced on induction and continued throughout staff's employment. Performance development reviews were carried out annually. This created a structured career pathway for staff. Extra support was given when required by any staff member. Senior support workers and support managers met on a daily basis in addition to the more formal meetings, to discuss any occurrences.

We saw the training matrix which evidenced that staff had completed the required training to help them carry out their roles effectively. There was an in-house trainer who delivered the majority of the courses within the building's training room. We saw that the training programme used by the service had the facility to flag up when courses were due, to ensure staff kept up to date with their development.

There was evidence that staff had undertaken training in the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 and aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The lead nurse at the village took the lead in areas such as DoLS and Gold Standards Framework portfolio building, being involved in end of life best practice as well as being the link nurse for the tissue viability service.

The households were set up in such a way that each bedroom opened on to a corridor where the hub of the household, the kitchen and lounge area, could easily be seen. This helped people living with dementia to orientate themselves within the home.

People who used the service were free to take their meals within their own dining area, bedroom or lounge. They could also choose to eat in the bistro if they wished to do so. We saw people taking their meals in all of these areas.

We observed the lunch time meal on one of the households. The meal was prepared by the host on the household and they were aware of all special dietary requirements. Menus and picture menus were available so that people were able to make informed choices. People who used the service could choose their meals from the bistro menu if they did not want what was on the set menu for the household. Shopping was done on a daily basis so people were able to request whatever they wished to have on that day.

The menus were on a four week rolling programme and included a choice in the mornings of fruit, cereal, porridge, toast or cooked breakfast, a light meal at lunch time, a main meal later in the day and supper of a milky drink and light snack. Food was purchased on a daily basis and nutritious snacks, such as fruit, were available throughout the day within the households. A range of drinks were also available at all times.

We observed some relatives assisting their family member to eat during lunchtime and staff also assisting some people. There was a pleasant, quiet atmosphere during the lunchtime meal. We had been told by some relatives and a member of staff that sometimes the staffing levels were insufficient during mealtimes but we did not observe any shortage of staff during the day of the inspection. We spoke

Good

Is the service effective?

with the manager about these comments. She told us there had been a few occasions in the past when the host from the household had been absent, but this had been covered by other staff members.

We saw staff seeking consent when offering care delivery throughout the day. We saw that staff endeavoured to ensure the person was given every opportunity to indicate consent either verbally or by other means of communication, such as body language.

We looked at three care plans and saw they included a range of health and personal information. There was evidence of the home working with other professionals, such as GPs, speech and language therapists (SALT) and opticians. Each care file also included a transfer form so that, if a person had to go into hospital or another care setting, the staff would be aware of the person's needs. This would help them receive the best and most consistent care. We saw that life plans were kept in people's rooms. Relatives were required to formally request to see these and would be allowed to only with the person's consent.

We saw there were monitoring charts for issues such as nutrition and falls. We saw evidence of regular monitoring of weight, where this was required, and actions to address any issues in this area, such as rapid weight loss. Care plans were reviewed regularly and were up to date.

Where it was required, and where people were able to do so, written consent was included in care files, for example for the use of photographs on medication administration records (MAR). In cases where people were unable to give written consent, this was clearly documented and written consent was sought from a relative or other appropriate person.

We saw evidence that the staff worked within the requirements of the MCA. For example, one care plan included information about a decision to be made and there was evidence of a robust mental capacity assessment and documentation of the outcome of this and the process involved in the decision making in the person's best interests. We saw that, where best interests decisions were documented, there was reference to current best practice guidance, for example, National Institute for Health and Care Excellence (NICE) guidance around the administration of covert medicines.

We looked at the documentation relating to DoLS and saw that this was appropriate and included any conditions attached to the DoLS. For example, one DoLS authorisation outlined conditions including staff taking the person out as much as possible and encouraging them to participate in certain activities. We saw that the person's care plan reflected the staff's adherence to these conditions.

We spoke with seven members of staff, all of whom demonstrated a good understanding of their roles and responsibilities. We asked care staff about their understanding of MCA and DoLS. They were all able to give examples of how these requirements were applied.

Good

Is the service caring?

Our findings

One person who used the service told us, “The staff are pleasant. They listen when I talk to them”. Another said, “The staff are kind and caring and explain what they are doing. I’ve been here a long while and the staff know me well”.

One relative told us, “I’m always made welcome when I come”. Another commented, “Last weekend my relative fell and staff phoned me. I was very pleased with the handling of the incident by the staff”. A third said, “The staff are good at anticipating when [my relative] is tired and needs a rest”, and a fourth told us “I’ve not come across anyone other than being kind and caring. There is no one here who is not kind to residents”.

When asked about privacy and dignity one person who used the service commented, “Staff respect my privacy. If I want to shut my door and play my music they don’t interrupt me”.

We spoke with a health professional, who was visiting on the day of the inspection. They told us, “The staff are very welcoming and helpful”. They went on to say that people were encouraged to keep what independence they had for as long as possible”.

We observed care delivery throughout the day and saw that staff were courteous and kind at all times. They took time to explain what they were doing and ensured people were happy to be assisted.

We observed staff transferring a person who used the service by hoist. The staff member checked that the person was as comfortable as possible during the process and offered pain relief or a pillow to rest an arm which the person said was hurting. Another person who was quite confused was given gentle reassurance and assistance by a staff member to a chair. We saw that staff were respectful and ensured people’s dignity and privacy were respected by knocking on doors and asking permission to give assistance.

We saw that people were attending the village on one of the experience days offered by the service. These were arranged for people who may wish to participate in some of the activities at the village but were also an introduction to the service for people who may wish to move in at some later date.

We saw evidence, within the care plans we looked at, that people were involved with decisions about their care delivery as far as they were able, for example contributing to their reviews by voicing their wishes and preferences. Relatives were also involved if the person who used the service wished them to be.

The households were quite small, each housing 12 people, so felt quite villagely and similar to family villages. Each household had a meeting approximately every two months where people who used the service could raise any concerns or make suggestions for improvements to the service.

The village had a companions system in place, meaning people who used the service had a named staff member to support them through their stay at Belong. The village had been assessed as pet friendly by Cinnamon Trust.

There was a range of literature with information about the service for people to pick up and read and each person who used the service had a service user guide. This included information about the services offered within the village. We saw a recent Belong Life magazine, which included news about the Belong services and staff, recent birthdays and activities undertaken or coming up.

There were also leaflets around the households and in public areas, entitled ‘How Are We Doing? These offered another forum for people to give feedback to inform change at the village. The registered manager told us that people who used the service were encouraged to give informal feedback on a daily basis, during chats with staff.

All staff at the village were encouraged to undertake end of life care training and many had completed the six steps programme. This is a North West end of life programme that helps people nearing the end of their life to remain at their care village to be cared for in familiar surroundings by people they know and trust. The management team at the village had recently begun to undertake the Gold Standards Framework (GSF) which is an accredited national training programme for end of life care.

Good

Is the service responsive?

Our findings

We asked people who used the service and their relatives about choices. A person who used the service said, "I have full personal choice here over my own wishes". One relative told us, "[My relative] is very happy not to be up and dressed in the mornings. [My relative] likes to have breakfast in their dressing gown and get dressed later".

There were six households, two on each of the three floors of the building. There were also other facilities in the building, the second floor had a guest suite for relatives' use and the first floor housed the offices, training room, a gym, a library an internet café and the 'Venue', a function room with a bar which could be booked for celebrations or occasions. Staff encouraged and supported people who used the service to use these facilities. The ground floor had a large public reception area, small lounge, internet booth and a large modern bistro cafe. The facilities were used by relatives of those living at the home, as well as members of the local community.

We asked about activities offered to people who used the service. One person said, "Staff do take me out on outings. I like to read or go to the hairdresser or to the cafe. I like it here and am contented". Another told us, "I went on a knitting club visit in the Bistro cafe but it wasn't for me. I do go to the gym occasionally". Relatives gave their views on activities, one said, "I've not seen any of the games which they have around being played. I'd like to see more activities taking place. Residents seem separated and sat around all day on their own. I've come at different times of the day and seen this". Another relative told us, "I last saw activities taking place on Sunday last. They came in the afternoon and did exercises with residents".

We saw that there were a number of activities on offer at all times. Staff told us that all people who used the service were encouraged to participate in activities, but had the choice not to do this if they so wished. Some people did not wish to join in, but enjoyed some quiet time on their own.

The building housed many facilities for people to use, but also had some quiet spaces, which could be pre-booked for use, or where people could sit with family or just have some quiet time. There was a guest suite which could be used by families if they required this. We saw that there was a monthly church service for people to attend if they wished to. Pets were allowed at the home for those people who wanted them.

All activities were advertised in a what's on programme and we saw some activities taking place on the day of the visit. Activities, such as coffee mornings and the knit and natter group, took place within the bistro. This gave the people who used the service the opportunity to mix with people from the wider community. There was a knit and natter group of a few people who used the service taking place in the bistro during the day of the visit. There was plenty of chat and laughter taking place at this activity.

We saw some people being facilitated to do gentle exercise, by the qualified instructor, in the gym area. The registered manager told us the instructor would facilitate exercises in bed if this was required. Some people were walking around the home and some watching TV.

We looked at three care plans and saw that they were person centred, outlining people's choices and preferences in areas such as spirituality, food and drink and activities. The records included personal information in the form of a 'This is Me' document. This gave background history, family ties and information about what was important to the person and had been completed with the person who used the service. Staff had undertaken training in person centred care, which was confirmed by the training matrix.

The households had 'retro' radios, which were playing appropriate music, such as music from the sixties, which people said they enjoyed. We saw there were pictures on each household of the local area in past times, which helped people with orientation to the area and reminiscence.

One person who used the service told us, "We had a meeting at [my household] between residents and staff and staff listened to what we said. I didn't like the light sensors coming on when I got out of bed, it made me feel like a child. Staff allowed me to take control of this. This gives me my independence".

When asked about complaints a person who used the service commented, "I've no complaints but if I had I would go to one of the management". One relative said they had complained as they were not told about a professional visit to their loved one. They told us, "The senior carer did look into this and apologised to me". Another relative

Good

Is the service responsive?

commented, “I’d feel happy to complain but in a supportive manner, firstly to the senior house manager and I’d feel happy that she would do her best to deal with it. If I then had to take it further, I would”.

The complaints procedure was outlined in the service user guide. We saw the complaints log and this evidenced that complaints were investigated and followed up appropriately by the service. A complaints/feedback database had been introduced, which flagged up response dates so that complaints were dealt with in a timely manner.

Outstanding ☆

Is the service well-led?

Our findings

There was a registered manager at the home. 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.

One person who used the service told us, "The manager is approachable. She will listen to what I say. I'm perfectly happy here". Another commented, "The manager is a good leader. You can go and talk to her. If she's very busy she'll get somebody else to talk to me".

The home's philosophy was to practice core dementia values of making people feel secure and give them a sense of belonging. All staff were aware of and worked with these core values at the heart of their practice.

The organisational structure was clear and staff were aware of their lines of responsibility and accountability. We spoke with seven staff members who all felt the registered manager was approachable and training and support was offered on an on-going basis. One staff member said, "There is a good structure of staff, I could ask for help. I do feel fully supported". Another said, "The manager is very approachable". Staff told us they were given lots of opportunities for professional development. All staff could explain their roles and responsibilities and demonstrated a clear value base which underpinned their practice.

The service had up to date information and guidance about best practice from sources such as Action on Elder Abuse, Alzheimer's Society, Bradford University (Dementia Care Mapping), Dementia UK, Dignity in Care Campaign, Eden Alternative, National Institute for Health and Care Excellence (NICE), Stirling University and Social Care Institute for Excellence (SCIE). We saw that the service took the guidance on board and best practice was a topic discussed at meetings and disseminated to staff via training and supervision sessions.

There were examples of how the guidance was put into practice in various ways, such as the décor and lay out of the home. The environment was dementia friendly, as described within some of the current guidance, the building was easy to navigate with accessible and visible kitchen and lounge areas, reminiscence aids in the form of pictures and items, such as radios. The music had been carefully chosen and we saw that people were clearly enjoying and engaging with it on the day of the inspection.

The home had excellent links with the wider community via the facilities available to both people who used the service and others. As per best practice guidance people within the local community were encouraged to mix with people living with dementia. This helped provide people in the wider community with an understanding of the challenges and strengths of people living with dementia conditions. The bistro was popular with the local community and we saw people from the community accessing other services, such as the internet facilities and the library. The experience days were another way of people integrating and participating together in various activities on offer.

The home worked well with other agencies, such as speech and language therapy (SALT), health and social care professionals. This was evidenced within people's care files and confirmed by professionals we spoke with. One health professional told us, "One person I am involved with has obviously improved since coming here. Staff listen, take advice and follow guidance". A social care professional told us, "I have no concerns about this service".

There was a dementia champion at the home, who was the lead in this area, so was responsible for keeping up to date with current guidance and disseminating information to other staff members. The home also employed Admiral Nurses who offered a service for people living with dementia and their families. They provided support, offered assessments, provision of therapy and a range of help from diagnosis to bereavement, assisting with people's understanding of the condition, linking in with other professionals to ensure care was coordinated and helping people with dementia to live as independently and well as possible for as long as they were able. This service was free of charge to anyone who used the service and their relatives.

Some of the guidance produced by the Alzheimer's Society refers to the benefits of regular exercise and physical activity for people living with dementia. In accordance with this guidance the home offered a range of activities and exercise, including having a gym within the building with a qualified instructor who assisted people with appropriate exercise routines. There was also a spa facility where people could benefit from complementary therapies.

Outstanding ☆

Is the service well-led?

We saw that meetings took place regularly and looked at minutes of various staff group meetings, including night staff, lead and senior staff, hosts, reception staff and support staff. Minutes demonstrated discussions on a range of subjects such as staffing issues, service user issues, menus, documentation, infection control, activities, CQC notifications, training and audits. We saw evidence of best practice discussions within the minutes.

Customer feedback was sought through leaflets around the home for people to fill in. There were also annual surveys undertaken to ascertain people's views. These were available to people who used the service, relatives and professionals. A customer satisfaction form that could be used via the website was also available. We saw that many people had left positive feedback about the service.

We saw evidence of daily monitoring checks made on each household. These included checks of the functionality of all kitchen equipment, general cleanliness of the kitchen area, fridge temperature checks to ensure they were within the recommended guidelines, checks on correct food storage and expiry dates of food.

We saw that regular medication audits were undertaken and that any errors were followed up with appropriate action, such as training, support and supervision. We saw that analyses of errors were undertaken to ensure repetition of mistakes was kept to a minimum. Medicine fridge temperatures were taken on a daily basis to ensure they were within the manufacturers' recommended range. Stock checks were carried out regularly and documented appropriately.

There was evidence that falls information was coordinated on the households and audited regularly. Results of the audits were analysed to look for any patterns and trends occurring.

Life plan audits were undertaken on a six monthly basis and issues identified and addressed. Household reviews took place every two months and there were regular household meetings to discuss any issues or concerns.

We saw that health and safety checks were undertaken regularly. There was a full time maintenance person who had a log of all jobs undertaken. We saw that they responded to any repair requests in a timely manner, carrying out small repair jobs themselves and bringing in outside contractors where necessary. There were records of weekly fire alarm tests, monthly emergency lighting checks and equipment checks. We saw that water temperatures were taken regularly and outlets flushed as necessary. Shower heads were checked on a three monthly basis.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.