

Medway Community Healthcare C.I.C

Darland House

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection was carried out on 25 January 2016 and was unannounced.

At our previous inspection on 14 August 2014, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The breaches were in relation to safe recruitment and supporting nursing staff to gain the skills needed to manage some emergency medical situations. The provider sent us an action plan with timescales showing how and when the regulations would be met.

At this inspection, we found that the registered manager and provider had taken action to address the breaches from the previous inspection.

The service provided accommodation and personal care for up to 40 people who are living with advanced dementia and is part of the health services provided by Medway Community Health Care NHS, (MCH). The accommodation was provided over two floors. A lift was available to take people between floors. There were 38 people living in the service when we inspected.

There was a registered manager employed at the service. 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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The registered manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. The provider had a dedicated system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. The registered manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. The risk was assessed and the steps to be taken to minimise them were understood by staff.

The provider and registered manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. The premises were undergoing a refurbishment. This was to modernise the decoration and design to meet current published guidance for services delivering to people living with complex developed dementia. Equipment in the service had been well maintained.

People had access to qualified nursing staff who monitored their general health, for example by testing blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service.

There were policies and a procedure in place for the safe administration of medicines. Nursing staff followed these policies and had been trained to administer medicines safely.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the NMC. Nursing staff received regular clinical supervision and support.

We observed staff that were welcoming and friendly. People who could talk to us and their relatives described staff that were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained they were listened to and the registered manager made changes or suggested solutions that people were happy with.

The registered manager of the service, nurses and other senior managers were experienced and provided good leadership. They ensured that they followed their action plans to improve the quality of the service. This was reflected in the changes they had already made within the service.

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.

Staff were always available in the right numbers to meet people's assessed needs. Recruitment procedures were in place and checks on new staff were robust.

Risks were assessed and recorded. Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protect people from harm and minimise the risk of accidents.

Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted to protect people who needed safeguarding and notified the appropriate agencies.

Is the service effective?

Good ●

The service was effective.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Staff encouraged people to eat and drink enough.

Nursing staff were supported to maintain their professional standards. Staff met with their designated managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

Staff received an induction and training and were supported to carry out their roles well. The Mental Capacity Act and Deprivation of Liberty Safeguards was followed by staff.

Is the service caring?

Good ●

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good ●

The service was responsive.

People were provided with care when they needed it based on a care plan about them.

Information about people was updated often and with their involvement so that staff only provided care that was up to date. Nursing staff were on site to monitor people's physical and mental health. People accessed urgent medical attention or referrals to health and social care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Staff understood people's unique communication styles who were living with complex dementia. Complaints were resolved for people to their satisfaction.

Is the service well-led?

Good ●

The service was well led.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

The provider and registered manager promoted person centred values within the service. People were asked their views about the quality of all aspects of the service.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day to day basis by leaders within the service.

Darland House

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 25 January 2016 and was unannounced. The inspection team consisted of one inspector and one expert by experience. The expert-by-experience had a background in caring for elderly people and understood how this type of service worked.

Before to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We checked the actions had been taken on the provider's action plan. The provider completed a Provider Information Return (PIR). The PIR 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 observed the care provided to people who were unable to verbally tell us about their experiences. We spoke with seventeen people and eight relatives about their experience of the service. We spoke with eight staff including the current registered manager, the head of service, an associate director of the service, the deputy registered manager, one senior nurse, one nurse and two support workers to gain their views about the service. We asked two health and social care professionals for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, six staff record files, the staff training programme, the staff rota and medicine records.

Is the service safe?

Our findings

People described and we observed a service that was safe. People living with dementia were not always able to verbally tell us how safe they felt. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. Relatives we spoke to, without exception, agreed that their loved ones were safe at the service. One relative said, "I don't worry at all now", and went on to tell us about not needing to visit every day as they were so confident that their loved one was safe with staff.

At our previous inspection in August 2014 we identified a breach of regulations. This related to the effectiveness of recruitment checks on recruited staff with employment gaps on their application forms and the levels of checks made for staff employed from overseas. At this inspection, we found the provider had taken robust action to ensure the correct checks were made for new staff before they were employed.

The registered manager had reviewed their policy into checking the suitability of applicants from overseas to work with people who made need safeguarding. The new policy ensured that all applicants for jobs had been checked against the disclosure and barring service (DBS) records and that best practice guidance was followed for new staff from overseas. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Before employment, all applicants for posts at this service were now asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the registered manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

Staffing levels were planned to meet people's needs. In addition to the head of service and deputy manager there were ten staff available to deliver care managed by an additional four qualified nurses between 7 am and 9 pm. At night there were six care staff managed by an additional two qualified nurses. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. For example, one person was on one to one support during waking hours to protect them from risk. How staff would be deployed was organised by the nurse in charge before shifts started so that the skills staff had could be matched to the people they would care for. Staff responded to people quickly when they needed care which reduced the risk of people falling or becoming upset. There were enough staff available to walk with people using their walking frames if they were at risks of falls.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Each person had an emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The registered manager operated an out of hours on call system so that they could support staff if there were any emergencies.

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The registered manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments gave a score for levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough.

People were protected from preventable harm and could call for help if needed. The registered manager checked for patterns of risk. Incidents and accidents were checked to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again.

Equipment was serviced and staff were trained how to use it. The premises were designed for people's needs, with signage that was easy to understand. The premises environment was maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed.

Nursing staff followed the provider's policy on the administration of medicines which had been reviewed annually. Nurses told us that their medicines administration competences were checked by the registered manager against the medicines policy and that they had no concerns about the management of medicines in the service. We saw discussions from competency checks had been recorded in staff files. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

The medicine administration record (MAR) showed that people received their medicines at the right times as prescribed by their GP. The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered and signed for by the nurse on shift. Medicines were correctly booked in to the service by nurses and this was done in line with the service procedures and policy. Nurses administered medicines as prescribed by other health and social care professionals. For example, a person on warfarin was receiving the correct amount as prescribed from the anticoagulant service. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. People said, "They (Staff) get a doctor and he comes here". And, "They (Staff) are looking after me quite well." Relatives were happy with their loved ones' healthcare at the service. Their comments included, "Staff always get a doctor immediately if he isn't well, and let us know." And, "She had a temperature last week and the doctor came in, they get them quickly." Another said, "They understand her dementia so well."

At our previous inspection in August 2014 we identified a breach of regulations. This related to the effective management of medical emergencies such as choking and bleeding. At this inspection, we found the provider had taken robust action by ensuring that nursing and care staff had the most up to date training in relation to medical emergencies.

Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. The provider had systems in place to ensure staff received regular training, could achieve recognised qualifications and were supported to improve their practice. Clinical supervision for nurses was on-going and there were appointed professional leads in areas such as infection control and medical awareness. Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received dementia awareness training and gained knowledge of other conditions people may have such as diabetes.

New staff inductions followed nationally recognised standards in social care. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately. Staff were provided with regular one to one supervision meetings as well as staff meetings and annual appraisal. These were planned in advance by the registered manager and fully recorded. Training records confirmed staff had attended training courses after they had been requested in supervision meetings.

Staff demonstrated a high level of expertise in maintaining safety and reducing the risk of harm from challenging behaviours. Staff had received training in relation to caring for people with behaviours that may cause harm to themselves or others. This often occurred when people living with dementia became frustrated or anxious, often without obvious cause. We observed staff used the techniques they had learnt to keep people calm and prevent potentially harmful behaviours from developing. For example they used items that were familiar to someone to calm and re direct people's attention. This prevented people from becoming distressed and challenging others.

People's health was protected by proper health assessments and the involvement of health and social care professionals. A GP visits three times a week, a consultant psychiatrist visits monthly and people had access to a reflexologist and a podiatrist. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to

protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file which covered the same area. Braden assessments had been completed. (Braden assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Care plans included eating and drinking assessments and gave clear instructions to staff on how to assist people with eating. People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded.

Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and that foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place.

We observed lunch being served in the dining rooms and to people in their bedrooms. Food was presented and served in a way that promoted the social aspect of the occasion. People were not rushed. Staff were on hand to supervise and provide support to those people that needed it. People could choose what they wanted to eat and that if they did not like the main meal an alternative would be provided. We saw staff chatting and laughing with people as they assisted them to prepare for lunch. As people gathered for lunch they were encouraged to take a seat and those who required assistance were gently supported into their seat. People were then given a choice of drinks with their lunch.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that relevant people, such as social and health care professionals and people's relatives had been involved. The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Is the service caring?

Our findings

People living with dementia were not always able to verbally tell us about their experiences of the service. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a service that was caring.

The relatives we spoke with had absolute confidence in the staff and the way the service was delivered. One relative said, "I come in at various times and it is all good". Another said, "We are always welcome. They ask us if we want tea." All of the relatives spoken with had positive comments to make about the actual care received by their loved ones. One said, "We are extremely happy with all the care here. I have a good impression of all the staff and we are totally happy with his care." Another stressed, "It is the care that makes the difference, but the surroundings help, and it is all good here". Another relative called the staff "fantastic" and told us that his family were all "Completely happy with the care, they (staff) are so good with everyone, so calm here."

Staff built good relationships with the people they cared for. Staff told us that as a team they delivered quality care. We observed staff practices reflected a caring and quality driven approach. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We observed staff sitting with people, talking to them and motivating them when needed. We saw staff listening to people, answering questions and taking an interest in what people were saying. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures like a gentle touch, smiles and nods). We saw some caring touches from staff. For example, before staff moved cantilever tables, they checked to ensure that people's feet were not in contact with the frame. People responded well to the quality of their engagement with staff.

People were encouraged to communicate their needs in their chosen style or where they could no longer communicate their needs verbally as their dementia became more progressive. For example, through facial expression and mood. Care plans described people's communication needs on a day-to-day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these. People asked for and were provided with pain relief to help them maintain their comfort and dignity.

Staff described the steps they took to preserve people's privacy and dignity in the service. We observed that staff knocked on people's doors before entering bedrooms to give care. People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. People had choices in relation to their care.

Care plans covered people's preferences about personal care and personal hygiene needs. Relatives told us, "Even though it was hard for us, staff helped us talk through our loved ones end of life care details." The care support staff had given them had really helped them. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. For example, care plans gave details of areas of independence people wanted to maintain. We observed staff encouraged people to maintain their independence when walking staying nearby if people needed them. We observed staff followed people's requests when they wanted to do things themselves. This enabled them to remain independent. People or their representative had signed to agree their consent to the care being provided whenever possible.

People and their relatives told us they had been asked about their views and experiences of using the service. Informal meetings were held and reported on six monthly, these were for people's families and friends and are mainly information giving and sharing meetings. Other meetings were held to ensure that the impact of the refurbishment programme on people was kept to a minimum. People were involved with developments and events within the service and they could influence decisions the provider had made. For example, people had been asked about how they wanted areas of the premises to be re-decorated. A newsletter was under development to inform people of events in the service. There were examples of the registered manager listening to people's views. For example, in feedback relatives had asked for communications by e-mail rather than phone. This was being consulted on and implemented by the registered manager.

Information about people was kept securely in the office and the access was restricted to senior staff. When staff completed paperwork they kept this confidential.

Is the service responsive?

Our findings

People's care was kept under review and changes were made to improve their experiences of the service. People told us they could go to a registered manager in the event of any problems. Relatives told us about examples of staff responsiveness. One said, "There is always staff about to talk to and I see them (staff) responding if they notice someone is unsteady when they stand up." Also, "When (her loved one) needed this special chair for more support, staff got it for the person. Another relative called the staff, "Proactive" and was pleased to say that, "Staff give me a rundown of how he has been." He felt that his loved one "Gets all the help he needs" and was pleased that "They are not just leaving him in bed. As soon as he was feeling better, he was up".

People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing home was suited to the person's needs. Care plans were well written; they focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. The care plans were becoming person centred and individualised. For example, colourful 'About me' plans were in place, telling others who people were and about their lives and loves. Recording this would ensure that all staff and new staff would know people's interest and preferences. Knowing about people's histories, hobbies and former life before they needed care could assist people to live fulfilled lives, especially if they were living with dementia.

Family members were kept up to date with any changes to their relative's needs. A family member said, "Staff phone straight away if he is ill." Another noted, "We have had phone calls when she is ill and they say we can stay with her." Changes in people's needs were recorded and the care plans had been updated. This meant that the care people received met their most up to date needs.

The registered manager and staff responded quickly to maintain people's health and wellbeing. We saw that nurses had implemented weight management plans based on advice from a dietician and in response to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining or gaining weight. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

Staff had arranged GP appointments to monitor people's health and involved other health and social care professionals when needed, like speech and language therapist. There was information about upcoming hospital/other appointments that people needed to attend. The nurse's in charge reviewed these regularly to ensure that arrangements were made so that people were able to attend appointments. Care plans were reviewed monthly and this was recorded.

Changes in people's needs had been responded to appropriately. Care plans and risks assessments evidenced monthly review. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas

developing and enabled staff to move the height of the bed up or down to assist the delivery of care. Hospital outpatient and discharge letters were in people's care plans. These gave guidance to staff and ensured continuity of care.

People had opportunities to take part in activities and mental stimulation. One man said, "I go down for the music," and a range of activities were seen happening. At least 11 people with four staff used the activities room in the morning. A Cliff Richard concert was shown on a large screen and people were singing along at times, encouraged by staff. Some were colouring and others were cutting out articles for reminiscence. There was tea and biscuits and a generally cheerful atmosphere, created by the staff that did their best to include all of the people in the room. A relative commented, "There is always music and plenty of activities as well. At Christmas they had lots of different things and they have fetes, special meals and thoughtful things, like decorating his room on St David's day, because he is Welsh." Newspapers were available and these were always current, so people could stay in touch with the news. There were books and videos on display. Staff said that they used their magazine "The Daily Sparkle" for discussion and reminiscence and copies were seen all over the service. This kept people occupied if they chose to participate and offered opportunities for them to feel less isolated.

There was a policy about dealing with complaints that the staff and registered manager followed. This ensured that complaints were responded to. Information about how to make complaints was displayed in the service for people to see. Everyone we spoke with was happy with the idea of raising any concerns. One person stressed, "I've never had any concerns at all." Another said, "I'd go to the office if I needed to". The last recorded complaint was from March 2015. This had been resolved. The registered manager ensured that complaints were responded to and they discussed these with other people in the organisation if needed. There was a mechanism for people higher up in the organisation who were not based at the service to get involved to try and resolve complaints. People were offered meetings with the registered manager to try and resolve complaints and these were recorded.

Is the service well-led?

Our findings

The registered manager was registered with CQC in June 2011. They had provided consistent leadership for the service since then. They were qualified and experienced in managing services for people living with dementia. They were supported to manage the service by a team of experienced and competent nurses, head of service and deputy manager.

Staff felt supported by their colleagues and the registered manager. One said, "I am being supported to do a master's degree in mental health and dementia", another said, "We have plenty of meetings, the managers are lovely and very helpful".

People's positive experiences of the service were underpinned by consistent improvement. The registered manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. The registered manager told us that the provider listened to, considered and acted on requests made for additional resources. We saw examples of expenditure the provider had made in response to request for improvements. For example, new nursing beds had been purchased to promote effective care.

General risk assessments affecting everybody in the service were recorded and monitored by the registered manager. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits were effective and covered every aspect of the service.

Registered managers from outside of the service came in to review the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. An independent pharmacist carried out audits of medicines. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. We could see that issues identified on audits were shared with the registered manager who recorded how and when they would make the improvement picked up by the auditor. For example, new fire door seals had been needed for some of the fire doors. This had been signed as completed by the registered manager on their action plan which was re checked by the auditor at the next audit. This ensured that issues identified on audits were actioned and checked to improve service safety and quality.

The aims and objectives of the service were set out and the registered manager was able to follow these. A service charter was prominently displayed setting out the standards of care people should expect. Staff received training and development to enable this to be achieved. One member of staff told us they discussed the charter at team meetings. The registered manager had a clear understanding of what the service could provide to people in the way of care and meeting their dementia needs. This was an important consideration and demonstrated the people were respected by the registered manager and provider.

People benefited from staff who felt valued by the provider. Staff were asked their views about the quality of

the service. This included an annual staff survey, the results of which had been analysed and fed back to staff. The results of the last survey were consistent with what staff told us during the inspection. Staff described the culture and values of the service as being grounded in respect and on promoting people to retain what independence they could. Staff told us that team work and communication at Darland House was excellent. They said that they were not worried about sharing any concerns that they might have about the care provided. They talked about person centred care and about shaping the service to people's individual needs.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The registered manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

Senior registered managers at head office were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels with the organisation so that they were dealt with to people's satisfaction.