Hatherleigh Care Village Limited

Hatherleigh Care Village

Inspection report

Hatherleigh Care Village
Hawthorn Park, Hatherleigh
Okehampton
Devon
EX20 3GZ

Tel: 01837810602

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place over two days; 25 and 26 July and was unannounced. This was the first inspection since the service had changed its legal entity and therefore had not previously been rated.At the time of the inspection there were 52 people livng at the service.

Hatherleigh Care village is registered to accommodate up to 53 people with nursing and care needs. They provide care and support to people with nursing needs and those living with dementia. The service is set up over three floors. People with nursing needs are on the ground or first floor and people living with dementia accommodated on the second floor.

The service has a registered manager. 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.'

Hatherleigh Care Village was about to undergo some refurbishments to enable the service to develop a model of care which will divide the service into four houses to cater for different stages of dementia. The provider has developed a care model based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields. This will result in the environment being divided into smaller houses to support small group living. Groups will be determined based on the stage of the dementia of the person living at the home. The provider is implementing this model with the support of specially recruited dementia practitioners. The staff group are currently undergoing training in respect of this new model and refurbishment work is due to begin within the next few months.

During this inspection we found upstairs communal areas had a strong malodour which was unpleasant. We heard from two relatives that this smell was persistent. We also heard from a healthcare professional that when they had visited there was a strong smell in the upstairs area of the service. We fed this back to the registered manager who initially believed this may be due to several people using areas to urinate which had permeated into the fabric of the carpet and furnishings. They later agreed the smell was strong and that despite their cleaning team shampooing and deep cleaning carpets they were unable to get rid of the smell.

We found one of the sluice rooms was not kept locked and one of the bathroom cupboards was left unlocked with some cleaning fluids in it. This presented as a possible risk to people. We were assured by the registered manager that this was an oversight rather than normal practice.She took immediate action to ensure checks wee being made throughout the day to ensure peopkle's safety.

Prior to the inspection we had received some information of concern about low staffing levels particularly at the weekends. Rotas showed there had been three occasions when due to staff sickness care staffing levels had fallen below the providers preferred numbers to ensure people's needs could met in a timely way. The

provider has said that following this feedback, they have commissioned additional agency staff to cover weekends to ensure there are always sufficient staff on duty even if permanent staff go off sick.

People benefitted from staff who knew their needs and wishes to enable them to provide personalised care and support. This was well planned with detailed care plans and risk assessments. These directed staff how to support people safely and in a way they wished.

Medicines were well managed and people received their medicines on time.

Staff had good training and support to enable them to do their job safely and effectively.

Staff understood how to keep people protected and who to report any concerns to. Recruitment practice was robust and ensured only staff who were fit to work with vulnerable people were employed.

People's rights were protected because the service understood and applied the Mental Capacity Act 2005. They assessed people's capacity to make decisions. Where people lacked capacity, Applications to Deprivation of Liberty Safeguarding teams had been made. Where restrictions such as bed rails and pressure mats were being used to keep people safe, best interest decisions were recorded.

People, relatives and staff felt their views were listened to and that the management approach was open and inclusive. People could make their concerns and complaints known with confidence they would be fully investigated.

Systems were used to ensure the building, medicines and records were all well maintained. Quality assurance processes including ensuring the voice of people and staff were used in the development and review of 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?

Requires Improvement

Some aspects of the service were not always safe.

Hazards such as access to cleaning fluid had not been kept secure on the day we inspected.

Malodourous smells in the upstairs communal areas meant people could not be assured the environment was clean and hygienic.

People said they felt safe living at the service. Staff managed risk in positive ways to enable people to lead more fulfilling lives.

Staff knew about their responsibilities to safeguard people and to report
suspected abuse.

People were supported by enough staff to receive appropriate care. Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

People received their medicines on time and in a safe way.

Is the service effective?

Good

The service was effective.

People experienced a level of care and support that promoted their health and wellbeing.

People were cared for by skilled and experienced staff. Staff had regular training and received support with practice through supervision and appraisals.

People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice.

People were supported to eat a well-balanced diet and they had access to health professionals to make sure they kept as healthy as possible.

Is the service caring?

Good

The service was caring.

People received care from staff who developed positive, caring and compassionate relationships with them.

Staff protected people's privacy and dignity and supported them sensitively with their personal care needs.

People were supported to express their views and be involved in decision
making.

Is the service responsive?

Good

The service was responsive.

People received person centred care from staff who knew each person, about their life and what mattered to them. Care, treatment and support plans were personalised.

People were encouraged to socialise, pursue their interests and hobbies and try new things. Their views were actively sought, listened to and acted on.

People knew how to raise concerns which were listened and responded to positively to make further service improvements.

Is the service well-led?

Good

The service was well-led.

The service was well-run by the registered manager and provider who supported their staff team and promoted an open and inclusive culture.

People's views were taken into account in reviewing the service and in making any changes.

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis.

Hatherleigh 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 checked 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 and 26 July 2017. The first day was unannounced. The inspection team included two adult social care inspectors, a specialist advisor on nursing and dementia care. The second day was completed by a pharmacist inspector.

We spent time observing how care and support was being delivered and talking with people and staff. We met with most of the people living at the home. We spent time in communal areas of the home to see how people interacted with each other and staff. This helped us make a judgment about the atmosphere and values of the home. We spoke with eight people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with three relatives who were visiting the service.

We spoke with two nurses, seven care staff, the registered manager, registered provider, one housekeeping staff and the cook.

We reviewed seven care plans and daily records, medication administration records, four staff recruitment files as well as audits and records in relation to staff training and support, maintenance of the building and safety records.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's 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.

Following the inspection we asked for feedback from six health care professionals to gain their views about the service. We received feedback from three.

Requires Improvement

Is the service safe?

Our findings

People were not always fully protected from the risks of hazardous products. This was because during the inspection we found the sluice room was left unlocked. This had very hot water which people could have had access to. This presented a potential risk of people scalding themselves. Also we found a bathroom cupboard left open which had some cleaning products which people may have inadvertently swallowed. The registered manager assured us this was an oversight rather than normal practice, but said she would ensure housekeeping staff completed regular checks on this throughout the day. This would ensure people were protected from such risks.

We found there was a malodorous smell in the upstairs communal areas. We heard from two relatives that this smell was persistent. One said they had noticed how surfaces in communal areas were sticky and they questioned whether the style of carpets and soft furnishings were appropriate because of the smell. Where surfaces were not carpeted they were sticky underfoot, a dining room table felt tacky and the kitchen floor was unclean. We also heard from a healthcare professional that when they had visited there was a strong smell in the upstairs area of the service. We fed this back to the registered manager who initially believed this may be due to several people using areas to urinate which had permeated into the fabric of the carpet and furnishings. They later agreed the smell was strong and that despite their cleaning team shampooing and deep cleaning carpets they were unable to get rid of the smell. This meant we could not be assured the premises were clean or that infection control was fully robust.

We were made aware that the service was due for some refurbishments to enable them to introduce a new model of care, which would divide the service into four houses for different stages of dementia. The registered manager said they would continue to deep clean the communal areas, but would ensure these areas were amongst the first for refurbishment, which was due to begin within the next few months.

There were sufficient staff available for the needs and numbers of people living at the service on the day of the inspection. Prior to this inspection we had received information which stated that staffing levels had been lower than expected during weekends. A visitor and staff raised concerns that staffing levels could be lower than assessed. This was particularly in the evenings and weekends. Staff said this could be particularly hard on the upper floor as one person needed 24 hour one to one support. They gave examples of when there had been had been one nurse on duty plus two care assistants. They said the impact was not being able to provide person centred care because they could not sit with people and spend time with them. Rotas showed there had been three occasions when due to staff sickness care staffing levels had fallen below the providers preferred numbers to ensure people's needs could met in a timely way. The provider has said that following this feedback, they had commissioned additional agency staff to cover weekends to ensure there are always sufficient staffing levels even if permanent staff go off sick.

There were occasions when the deployment of staff meant some people in communal areas were left unattended for periods of time which may present as a risk. For example, on one occasion five individuals were in the lounge area, one person was banging their frame whilst another repeatedly told them to ''shut up''. When we fed this back to the registered manager, she explained how the activities team had taken

people out to the local market for the morning. These staff would normally be present in each of the two lounge areas during the morning period. She said she would remind care staff to ensure there was a visible presence in all communal areas.

People were protected from potential abuse because staff understood what types of abuse to look out for and who and when they should report their concerns to. Staff were able to give a good account of safeguarding practices, types of abuse and the action to be taken if abuse was is suspected. Staff confirmed they had received training in this and had policies and procedures to refer to if needed. In the last 12 months the service had made three safeguarding alerts concerning altercations between people living at the service and one concerning a staff member which was referred appropriately to the local safeguarding team and police. The staff member had been dismissed from the service.

Suitable recruitment procedures were in place and the required checks were undertaken before new staff began to work for the service. Checks included the Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff recruitment files also held copies of staff identification, relevant references and their applications had full employment histories.

Medicines were managed safely. We watched some people receiving their medicines at lunchtime and saw that they were given in a safe and caring way. People received their medicines in the way prescribed for them.

No-one looked after all of their own medicines; however there were policies in place to allow this if it was suitable and had been assessed as safe for them to do this.

We checked 25 people's medicines administration record charts (MAR charts) and their medicines. Charts were completed when medicines were given, or reasons recorded if doses needed to be omitted. Separate charts were kept in people's room for recording any creams or other external preparations that were applied. These had guidance for staff on how to use these preparations. Information was available to make sure that any medicines prescribed 'when required' were given at suitable times.

We looked at the records for two people who were sometimes receiving their medicines covertly (without their knowledge) to check that this was appropriate. Documentation was available that showed it had been assessed that these people did not have the mental capacity to decide whether to accept their medicines. Best interest decisions had been recorded, and signed. The pharmacist had been included to check that it was safe to give these specific medicines in this way.

Medicines were stored securely in locked rooms and cupboards. Temperatures in the rooms and refrigerators were monitored to show that medicines were being kept at suitable temperatures so they would be safe and effective for people. There were suitable arrangements for medicines requiring extra security. Systems were in place for ordering, receiving and disposing of medicines.

All medicines in the home were given by qualified nurses, who had received updated training. There were regular medicines audits undertaken, which included competency checks to make sure medicines were being given safely. The supplying pharmacy also visited to give advice and check how medicines were being managed. Any errors or issues picked up were recorded and dealt with appropriately. Suitable actions were taken if needed, to reduce the chances of them occurring again. Policies and procedures were available to guide staff on looking after medicines safely.

People were kept safe as risks had been assessed and reviewed to ensure measures were in place to reduce any potential risks. For example, staff had knowledge of those at risk of choking, including those vulnerable due to dementia. People identified as having a risk of choking were also assessed by speech and language therapist (SALT). The care plan documentation and list of diets in the kitchen supported this. We met a person who was being supported with a drink. Information contained in the person's care plan summary kept in their bedroom reflected that in the kitchen. However, an error in the preparation of a drink was made by a staff member, which we drew to their attention and they subsequently reported the mistake to the nurse on duty. The registered manager said they would ensure the thickness of drinks to be prepared for people with risk of choking would be discussed in handover meetings.

Where people were at risk of developing pressure damage, specialist equipment had been used to reduce this risk. This included specialist airwave mattresses, pressure relieving cushions and charts to show how often people were assisted to change position. All these measures were good practice in helping to prevent pressure damage. Where people had wounds, good records and wound care plans were available to show how these were being monitored and what treatment was being used to aid recovery.

People who required additional support for safe moving and handling, had risk assessments and care plans to show staff how to safely move people and what equipment was needed. Each person who needed to use a hoist had their own sling. Staff confirmed there was always a good supply of equipment and that they received up to date training to ensure they used safe techniques in moving and transferring people.

There were regular checks of all safety aspects at the home, including fire safety and hot water monitoring. Individual risk assessments regarding fire safety (PEEPS) were also completed.

Good

Is the service effective?

Our findings

People, relatives and health and social care professionals all said care and support was effective and appropriate to people's needs. One person said "Staff are very good. They look after us well here." One relative said "I feel the staff know my relative well and know how to get the best from them. I have no real worries about the care here." One healthcare professional said "I actually have huge admiration for the really difficult job they do, in delivering around the clock care for some of the sickest and most vulnerable patients in our society."

People received effective care, based on best practice, from staff who had the knowledge and skills they needed to do their job effectively. Training included on line e-Learning as well as some face to face sessions. Training covered all areas of health and safety, working with people with dementia and other specialist areas of specific health conditions. Staff confirmed they had received or were booked to receive relevant training. The provider information return (PIR) stated "Staff have had training in respecting people's human rights and diversity, thus preventing discrimination that may lead to psychological harm. We back up all training with competence assessments and formal supervision sessions. People who use our service may exhibit behaviours that challenge; we have developed both procedures and training to ensure that staff manage this in a positive way to protect people's dignity and rights." Some staff said they had not received supervision sessions for several months, but could talk with seniors or nurses as needed. We reviewed a sample of these sessions and saw they were occurring on a regular basis. They were an opportunity for staff to discuss their role and future training and development needs.

New staff received an induction and if new to care were expected to complete the Care Certificate. This covered all aspects of care to help them understand their role and do their job effectively. They were also able to spent time shadowing more experienced staff to help them get used to the role and learn about people's individual needs. One staff member confirmed they had been offered the opportunity to do several shadow shifts before they were included as part of the staffing rota.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes
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 of authorisations to deprive a person of their liberty were being met. Most people had applications pending. Some staff were not aware who may be subject to such safeguards, but did understand the principles of why they would be in place.

Staff worked in a way which ensured people had choice throughout their day and records showed that staff gained people's consent before providing care and support. For example at lunchtime staff checked where people would like to sit, saying "Would you like to sit with your friend?" The two people then sat and chatted in an animated way throughout the meal. Some people changed places a number of times before they settled which staff facilitated.

People benefitted from being offered variety of meals to suit their tastes and promote their health and well-being. People said they enjoyed their meals. One person said "The food is pretty good, lots of choice." Another person exclaimed how much they were enjoying the meal saying it was "marvellous" and "absolutely lovely."

Staff were attentive at lunchtime; ensuring everybody was encouraged to sit and eat their meal. Mealtimes were relaxed but on one floor the presentation of the meal had not been considered. For example, people were not offered condiments, there were no placemats or serviettes. One person looked around and then wiped their mouth in their sleeve after they had finished their meal. People had clothes protectors placed around their neck but then one person had to wait for half an hour before they were assisted with their meal. However staff were attentive at lunchtime; ensuring everybody was encouraged to sit and eat their meal. Staff offered a choice of drink and chatted to people about their meal. On one table a staff member ate with several people to act as a role model and encourage others to eat. A second staff member joined them and patiently encouraged a person to eat initially by prompting them and then by assisting them. This took time as the person could become distracted but the care worker persevered to ensure they ate their meal.

Staff completed a checklist to ensure people drank and ate regularly. There were regular snacks, for example people were encouraged to eat yoghurt in the mid-morning. The checklist was accurate and reflected the support we had seen being given. People were prescribed nutritional supplements where their weight loss or loss of appetite had become a concern. A visitor said staff ensured their relative ate their prescribed amount. Staff topped up people's drinks and checked with people if they were thirsty.

People had access to healthcare and were encouraged to stay healthy through being active, healthy eating and monitoring of their general well-being. Daily records showed people had access to a variety of healthcare professionals, including their GP, community nurses, opticians and chiropodists. Visitors told us their relatives' health needs were monitored by staff and they picked up on changes in their health. They said staff contacted health professionals appropriately and they were involved in discussions linked to their relative's care, such as completing a treatment escalation plan. Two healthcare professionals confirmed the service referred to them in a timely way. One said "I have seen them swing into action in some very difficult situations which have arisen due to the complex nature of the patients for whom they provide care."

Good

Is the service caring?

Our findings

People and relatives felt staff were caring and kind towards them. One said "they (staff) are always lovely, very kind." One relative said "Every time I have been here I have only seen good care, staff appear to be kind to everyone, regardless of their needs or how many times they ask for something. They have a lot of patience." One healthcare professional said "Only last week a wife of a resident was discussing future care plans for her husband, and she was explaining just how grateful she was for their care and support for her husband, and what a great team she thought they were. This does reflect my wider observation of very supportive friends and family whom I have met in my work alongside them."

One visitor described staff as being "absolutely lovely" and welcoming. Another said staff were always respectful towards their relative. A new member of staff praised the attitude of staff and said they had always observed "very kind practice." Staff spoke kindly to people and spoke respectfully about them. One person was anxious and staff said "You are a good man...I'm here for you."

We saw a number of examples of good practice by staff towards people living with dementia. Staff reassured people and spoke affectionately with people. People responded well to staff intervention. For example, at one point a person being supported with their meal gazed at the staff member and cupped their hand around the staff member's face. It was a gentle moment and the staff member smiled and looked back at the person. However, staff also recognised when to give people space and read their body language to interpret their move. For example, one person was reluctant to sit down for their pudding instead they chose to stand and eat it, which staff respected.

People's dignity and privacy was respected. Staff were able to give examples of how they worked to ensure people dignity was being upheld. For example ensuring people were assisted to change if they were incontinent, and offering support to people discretely when it was clear they may need to use the bathroom. We observed some people looked like they needed more support with their personal hygiene. For example a few people looked like their hair was unkempt. The registered manager said for some people assistance with personal hygiene was a trigger for them becoming distressed. She said staff had to strike a balance of duty of care with respecting people's choice and distress when being assisted.

Staff spoke about people as individuals, knew their social histories and who was important to them. What was important to the individual was understood and known to staff, which helped them develop strong bonds and meaningful relationships with people. For example, one person had a real passion for helping in the garden. We heard several staff compliment their work and show an interest in what they had achieved. Another person actively sought the company of staff. One staff member said they could join them to eat lunch in the sunshine and talk about what they had seen at the local market that day.

The service had received many complement cards which highlighted the caring and compassionate approach adopted by the staff team. One said "We would like to offer you our deepest thanks for the kindness and understanding shown to (name of relative). We could not have hoped for anything even remotely as good…everyone we met was so friendly and professional. Another said "The support you

showed us in the final days was really appreciated. Thank you for the care and love you gave to (name of relative)."

Good

Is the service responsive?

Our findings

The service as responsive to people's needs. This was achieved by ensuring each person had a comprehensive pre admission assessment from which a detailed care plan was developed. This helped staff to understand and monitor people's needs. Staff confirmed there was always a care plan available for them to consult. The plan covered all aspects of an individual's personal, healthcare and emotional needs. Care plans included healthcare needs, personal care, communication, night time support, mobility, nutrition, activities and interests and any end of life care wishes. There were clear instructions for staff to follow to ensure these identified needs were being met. Visitors confirmed their relative had been assessed by the registered manager before they moved to the home and they had been involved with their care plan. This meant people's care was individualised to meet their specific needs.

Staff confirmed care plans and handovers between shifts helped them to keep updated on people's changing needs and how best to support people. One staff member said "If I have been off for a few days I make sure I check people's plans to see if there have been any updates. The handover meetings give us a quick update on people's general health and whether we need to follow up on anything." The provider information return highlighted that people's plans were reviewed with them either whenever there had been a change in needs or monthly. The provider had recently introduced an electronic care plan system which was working well. This enabled their quality team to review plans and risk assessments as well as audit whether tools such as nutritional risk assessment was being used to good effect.

People said staff were responsive to their needs and wishes. For example, one person said "I only have to ask for something and staff will get me it." We also saw examples of the responsive approach staff skilfully used. Staff recognised one person was often restless but they said they were reluctant to leave the building with them. Instead, the staff member described playing card games with them and their close friend. They recognised group activities could be difficult for people living with dementia, although a cookery session was planned during the inspection. Instead, they said the sensory room could be used to provide a one to one sessions and a hand massage. A staff member was respectful of people's friendships and recognised how this contributed to peoples' sense of well-being and identity. They recognised people drew comfort from former roles. For example, one person enjoyed folding laundry and this relaxed them. They said they were working on collating people's life histories to help staff connect with them. They described how there were gentleman and ladies lunch groups followed by an event, such as watching a sporting event on the TV.

The provider information return stated "We recognise that occupation is a vital human need and our service is arranged to provide people with the opportunity for engagement and interaction with staff and others." The service employed two activities staff who worked across five days providing a range of group and individual activities, including outings into the local community. On the morning of the first day of the inspection four or five people were assisted to walk to the local market and have coffee and look around. They had also recently used an external agency to help them with the supply of a mini bus so people could go further afield and visit places of interest.

The activity staff were fairly new in post and new to working in this role. They were building up their range of

experiences based on their own research and linking in with websites from organisations linked to dementia awareness. They had made links with local groups, such as the local memory club. They also ensured that at weekends there were paid entertainers to visit the home to provide musical entertainment.

People's spiritual needs were considered and visiting clergy offered services and Communion. Staff said they would facilitate people's diverse needs as best they could and one talked about spending time with individuals talking about their past and their beliefs for the future.

People's views were sought in a variety of ways. This included being involved in the review of their care plan, regular resident meetings and one to one discussions with staff. People said they felt able to voice their opinions and views easily. One person said "I can talk with (name of registered manager) or one of the nurses if I have a problem."

The service had a complaints policy and this was made available to people in public areas as well as in their pack when they first moved in. The registered manager kept a detailed log of complaints received and what she had done to resolve any complaint issues. There had been six complaints in the last year and the records showed these had been fully investigated and a written response given to the complainant. This showed the complaints system was effective and considered all aspects of people's complaints and concerns.

Good

Is the service well-led?

Our findings

People and staff expressed a high level of confidence in the management of the home. People said they knew who the registered manager was and they were available to talk with. One person said "The manager is always walking around and you can go and talk to her if you need to."

Two relatives said they felt they would like more information about proposed changes to the service. One visitor said although they were frequently at the home, they did not always feel informed about meetings and consultations about changes to the service. They said there no newsletters. Another visitor said they were aware there were proposed changes to the layout of the home to create smaller social groups. However, they said there had not been an update on this proposal and they had some concerns people's friendships might be difficult to sustain if they were in different groups. The provider was in the process of setting up further meetings with families and people using the service to explain their new model of care and what the changes would mean for them.

People, relatives and staff were asked to complete an annual survey to gain their views and ideas about the service. Results were collated and shared. This year's results had not yet been collated but the raw data indicated a high level of satisfaction in all areas such as the skills of the staff group, meals, environment and whether they felt they could make their views known and who to.

Staff confirmed they felt their views and opinions were listened to and they felt valued for the work they did. One staff member said "We have meetings and one to ones so there is an opportunity to give your views. You can go to the nurses or manager and talk about any concerns."

The provider information return stated "Our mission statement was originally developed with staff, people who use our service and their families and it is underpinned by a set of values which
Include: honesty, involvement, compassion, dignity, independence, respect, equality and safety. These form part of staff induction (linking to the Care Certificate), supervision and our internal quality assurance procedures to ensure that they are understood and consistently put into practice." We saw examples of these values being used in the way staff worked with people. Staff understood the ethos of the service and several of them talked passionately about the move to the new model of care which the service was proposing. This followed a model of care for people with dementia and incorporated the value base of several leading organisations in dementia care.

The service had a range of audits to review the safety and suitability of the building, the medicines management and the care plan documentation. Prompt actions were taken where audits identified issues. With the introduction of electronic care plans and risk assessments, the quality team linked to the provider were able to access records remotely. This meant they had daily access to records and could audit and advise on care plans and risk assessments on a more frequent basis.

The registered manager understood their role and responsibilities and had ensured CQC were kept informed

of all accident and incidents. There was evidence learning from incidents/accidents and investigations took place and appropriate changes were implemented. For example, changes to a person's care plan and risk assessment to reflect current circumstances.

The last inspection report was prominently displayed for people and visitors to see, together with the full report. The rating displayed on the providers website.