Newcastle-upon-Tyne City Council

Byker Lodge

Inspection report

Bolam Way
Byker
Newcastle Upon Tyne
Tyne and Wear
NE6 2AT

Tel: 01912782831
Website: www.newcastle.gov.uk

Date of inspection visit:
24 May 2016
26 May 2016

Date of publication:
03 August 2016

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 took place on 24 and 26 May 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Byker Lodge in January 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Byker Lodge is a 25 bed care service that provides short stay care for people living with dementia who require emergency care in crisis situations. At the time of our inspection there were 15 people staying at the centre.

The service had 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.

We found that the service had taken appropriate steps to safeguard people from avoidable harm and abuse. Measures were in place to minimise the risks associated with people's care and ensure that care was provided in a safe, clean environment.

New staff were subject to thorough vetting to check their suitability in working with vulnerable people. Sufficient staff were employed to provide continuity of care. Staff received the necessary training and support to develop their skills and care for people effectively.

Robust arrangements had been made for handling people's prescribed medicines. The service worked in conjunction with health care professionals to promote people's health and well-being. People's nutritional needs were assessed and a balanced diet with choice of meals was provided. People told us they enjoyed the food.

People's rights under the Mental Capacity Act 2005 were understood and protected. Staff encouraged people to exercise control and, wherever possible, to be involved in decisions about their care provision. Specialist mental health care support and advocacy services were arranged when needed.

People were given information about the service and had opportunities to express their views about their care experiences. Care was provided with patience and kindness and people's privacy and dignity were promoted. People and their relatives told us the staff were very caring and respectful and our observations confirmed this. A range of activities was offered to support people in meeting their social needs.

Assessments and personal profiles were completed to identify care needs and give staff understanding of what was important to the person. People had individualised care plans for meeting their needs which described the support they required and their preferences. Each person's care and welfare was reviewed on a weekly basis throughout their stay.

There was an open culture in the service and staff worked inclusively with people, their representatives and external professionals. Feedback was sought and any complaints made were properly acted upon. The management team provided leadership and support to the staff team. Standards were continuously checked to assure and improve the quality of the service that people received.

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.

Systems were in place to safeguard people against the risks of harm and abuse.

Risks to personal safety were suitably assessed and managed.

Enough staff were employed to ensure people received safe and consistent care.

Safe arrangements had been made for managing people's prescribed medicines.

Is the service effective?

Good

The service was effective.

Staff were supported in their roles and given training relevant to the needs of the people they cared for.

Legal processes were followed to uphold the rights of people who were unable to consent to and make decisions about their care.

People's health care and nutritional needs were met with support from a range of external professionals.

Is the service caring?

Good

The service was caring.

Staff had developed supportive relationships with people and they were kind and caring.

People were able to give their views about their care, wherever possible, and they were consulted about the running of the service.

Staff treated people as individuals and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care was planned in a way that was focused on people's individual needs and well-being.

People were supported to engage in a variety of social activities.

Complaints about the service were taken seriously and were promptly investigated.

Is the service well-led?

Good

The service was well-led.

The service had an experienced registered manager who provided leadership and set clear standards for the service.

Staff felt they were well supported in fulfilling their roles and responsibilities.

A range of methods were used in monitoring and developing the quality of the service.

Byker Lodge

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 was 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 24 and 26 May 2016 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist dementia advisor 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.

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 reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 13 people staying at the centre and eight relatives. We spoke with the registered manager, the two team leaders and 10 care and ancillary staff. We observed how staff interacted with and supported people, including during mealtimes. We looked at four people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service. On 5 July 2016 we carried out a visit to the provider's offices to examine staff recruitment information.

Good

Is the service safe?

Our findings

People told us they felt safe in the centre. One person said, "I feel very safe here. I was so anxious when I arrived and worried because I had been messed about before but the staff make me feel very safe here." Another person commented, "I feel safe and haven't had to ask for help at all." A third person told us, "I have no fear that anything is going to happen to me." Relatives we spoke with also felt their family members were safe. One said. "[Name] looks well, feels safe and the family think he's safe here." Another relative told us, "[Name] feels safe. Staff are brilliant, she loves it in here."

The service had established systems for safeguarding people against the risk of abuse and for responding to any alleged abuse. Local authority safeguarding information was made available in the centre to inform people about their rights to be protected. Safeguarding and whistleblowing (exposing poor practice) policies and procedures were in place, which were introduced to new staff during their induction. The provider had developed a 'duty of candour' policy and this was being disseminated to the staff team. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

All staff were provided with safeguarding training every three years and the registered manager and senior staff received advanced training in line with their responsibilities. There had been one safeguarding concern in the past year which the service had acted on appropriately, including notifying the relevant authorities. Minimal amounts of cash were held on behalf of people for safekeeping. Any transactions were suitably recorded and backed by receipts. Cash and balances were checked regularly to make sure people's money was handled safely.

All the staff we spoke with felt there were enough staff on each shift. One staff member told us, "There always appears to be enough staff on duty." People using the service also felt there were enough staff and told us they responded quickly to any requests for help. Our observations confirmed this. One person said, "They have great staff – there's plenty staff." Another person said there were enough staff available and commented, "I've never had occasion to ring the call bell but staff respond to me quickly." Relatives confirmed the quick response of staff. One relative said, "There's always somebody around". Another relative said the staffing levels were changeable and there were "lots of staff in training." The registered manager explained that staffing at the centre had recently been restructured and a number of new staff had been employed.

Due to the short stay nature of the service, the numbers and needs of people staying at the centre changed on a regular, often daily basis. Staffing was therefore usually based on full occupancy with six care staff on duty across the day, including health and social care co-ordinators, who led shifts, and two care staff at night. The hours worked by the registered manager and the two team leaders were in addition to these levels. Separate ancillary staff were employed for housekeeping, laundry and catering duties. The registered manager reported that staffing levels were flexibly organised, with scope to reduce or increase, as necessary, to safely meet people's needs.

Existing staff provided cover for vacant posts and absence. External agency staff were not used and on rare occasions care staff from the local authority's domiciliary care service provided cover. Outside of office hours an on-call system was operated between the provider's three resource centres. This meant staff were able to get advice and support at any time and could escalate any emergencies to the provider's senior management.

Our check of staff records showed a robust recruitment process had been followed when new staff were appointed. All necessary pre-employment checks had been conducted including completion of application forms which included a full employment history, obtaining proof of identity and references, including one from the last employer, interviews, and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups.

Risks to people's safety were assessed on admission and measures for reducing risks were built into care plans. Care plans for facilitating safe admission and discharge from the centre were in place. Where applicable, these included support from other services such as occupational therapy to enable a person to return to a safe home environment. Other areas of personal safety addressed in care plans included mobility, falls, nutrition, physical and mental health, and medicines. One omission, relating to skin integrity risks for a person who received input from district nurses, was immediately followed up by the registered manager. Extensive, specific plans had been developed for people who needed assistance with moving and handling, including the safe use of aids and equipment.

The centre was suitably equipped for people's care provision and good hygiene standards were maintained. Daily, weekly and monthly safety checks were undertaken to ensure equipment and facilities were in working order and the environment was kept free of any potential hazards. There was a clear system for maintaining the building and evidence that repairs were dealt with in a timely way. Any accidents and incidents were reported internally and to the local authority's health and safety department for follow up and analysis. Plans were in place in the event of emergencies, including personal plans for people's safe evacuation from the centre.

There were safe arrangements for managing people's medicines. Staff told us they spent time reconciling medicines when people were first admitted. They checked with GP's, hospitals and the pharmacy to make sure they had full details of current prescribed medicines, and where necessary obtained supplies. All staff involved in handling medicines were trained annually and had an assessment of their competency, which was repeated if any errors occurred. A specialist pharmacy advisor provided ongoing support to the service. This had included a recent update to the medicines policy, adding in further guidance about people refusing their medicines and medicines authorised to be given covertly (disguised in food or drink).

People's medicines routines and requirements were set out in care plans and detailed on their administration records. Medicines were stored securely within the centre and during drugs rounds, and were administered by two staff at all times, in line with the local authority policy. We observed that medicines were safely administered to people and recorded accurately. None of the people staying at the centre at the time of our inspection were prescribed controlled drugs (medicines that might be misused). Where these medicines had been administered in the past, we saw separate records were kept which were completed appropriately. There was a thorough regime of weekly stock checks and auditing medicine administration records four times a day to ensure that people received their medicines safely.

Good

Is the service effective?

Our findings

People told us their care effectively met their needs. One person said, "Byker Lodge has been a 'godsend' to me and my husband, I have received so much help during my time here." A second person commented, "I felt so comfortable talking in the planning meeting. I would have been unable to do that due to my anxiety three weeks ago; the staff here have really helped me with my anxiety and depression." Another person said of the care, "I know they look after us well here." They went on to explain how they felt they were getting better at the centre as they were much less nervous than when they arrived. Another person felt that the care had helped them, and said, "Coming here has provided me with sleep, meals and care that I desperately needed."

The service had a clear purpose of supporting people living with dementia in times of crisis. Data was regularly gathered to determine the numbers of people who stayed at the centre, their length of stay and whether they were able to return to their own homes. This helped demonstrate the effectiveness of the service as a valued community resource that aimed to prevent people from being admitted to hospital or residential care.

At the time of our inspection, new employees were completing induction training and shadowing experienced staff in the centre. They had been issued with an employee handbook, a code of conduct, and were working a probationary period during which their performance was regularly reviewed. Plans were in place for all new care staff to undertake the Care Certificate, a standardised approach to training for new staff working in health and social care. Advanced training was organised for those staff who had been promoted, including training to become moving and handling facilitators, advanced safeguarding and mental capacity law.

A range of on-going training was provided to the staff team. All staff had undertaken or were booked to attend courses on safe working practices such as fire safety, first aid, food hygiene and personal safety. This mandatory training was mostly updated every three years. Various training topics relevant to staff roles and the needs of people using the service were available through the Learning Management System (LMS), a programme of e-learning. Access to LMS had been organised for staff and completed training was being monitored. In-house training sessions on topics including nutrition, mobility and falls, and wandering/walking without purpose had been arranged.

The staff we spoke with told us they received appropriate training to allow them to fulfil their roles. They said they were encouraged to take responsibility for keeping themselves up to date by attending appropriate additional training courses, and through online study and research. Staff confirmed they had been given all mandatory safety related training required and many had completed qualifications in care.

Staff were supported in their personal development through individual supervision and an annual 'my conversation' appraisal. We found that the frequency of supervisions had lapsed, though a new schedule had been introduced with planned dates that the registered manager was keeping oversight of.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service worked within the principles of the MCA and staff had a good understanding of the implications for their practice. The majority of people who came to stay at the centre needed DoLS to be put in place. There was a well-organised system for this which ensured applications were made promptly and that authorisation and expiry dates were tracked. Social workers who referred people to the centre were asked to carry out mental capacity assessments. The service also established where people had appointed representatives with power of attorney, to enable them to be involved in decisions about the person's care.

The service did not advocate the use of excessive control or restraint. Staff told us that where people were resistant to care interventions, they sought to gain their co-operation and agreement. The registered manager was trained to deliver NAPPI (non-abusive psychological and physical intervention) training. This training was currently being updated, ensuring all staff were skilled in the techniques to be used when caring for people with challenging and distressed behaviours. Community psychiatric and specialist challenging behaviour nurses also visited the service weekly to support and advise staff.

People's nutritional needs were assessed on admission and, where necessary, were followed by completion of the Malnutrition Universal Screening Tool (MUST) and regular weight monitoring. Where problems were identified, referrals were made to dietitians and speech and language therapists for further assessment. We noted one instance where the MUST had not been completed for a person who had a poor diet and raised this issue with staff. The registered manager also arranged a training session with a dietitian and informed us this would include reinforcing the use of the MUST and keeping accurate food intake records. We saw examples of sound care planning, including for a person with diabetes, along with records which demonstrated they received an appropriate diet. A number of senior staff had been trained in providing enteral feeding (where food and supplements are provided through a tube in the abdominal wall into the stomach), should the need arise.

All of the people we talked with told us they liked the food. Their comments included, "It's tasty", "I had a filling breakfast today", "The food is lovely here", and, "The food is good enough and I like to get a biscuit from the trolley." Another person felt there was enough food but they did not know if they would be able to have snacks between meals. One person said, "At supper time you get a biscuit or sandwiches." Two relatives told us their family member enjoyed the food and added, "[Name] knows his food so he would tell you if he didn't like it here." When asked about the availability of snacks during the day a relative said, "Yes, I would assume so as every time we visit someone is making a cup of tea and giving out biscuits. One visitor said that the food was "Just alright, though [name] has put weight on." We clarified with staff and observed that snacks between meals and suppers were more varied than people and their relatives perceived. This included provision of fresh fruit platters, homemade cakes and scones, cheese and crackers, crumpets and teacakes. During our observations of mealtimes we noted staff served gravy with meals which were not compatible and raised this with the registered manager to follow up.

Drinks were served regularly, both with and between meals, and at other times we observed staff offered drinks from a chilled water dispenser. A seasonal three week menu, which had been developed with a

dietitian, was provided that gave people choices at all meals. The cook told us they had good communication with staff about people's dietary requirements and received feedback from people about the food. They were able to cater for individual requests, any special diets needed and routinely fortified food to add calorific content. The cook told us specially designed crockery and 'finger foods' were provided as a means of supporting people living with dementia to eat independently.

Good arrangements were in place to support people in meeting their health needs. Details of people's medical history were obtained and current health needs were assessed, leading to referrals to relevant health care services. Care records showed that input and advice from health professionals was sought and followed. Staff were vigilant to changes in people's well-being. They were aware, for example, that an increase in a person's level of confusion might be due to an infection and told us they always reported such changes to the senior staff on duty.

The centre was linked to a GP surgery in the area which people could be temporarily registered with, and district nursing services were accessed when needed. Wherever possible, the service facilitated people to continue to see those professionals already involved in their care. Visits by a local optician and dentist were arranged and staff escorted people to audiology and other hospital appointments. There was ability to fast track services, such as podiatry, if people had urgent needs and two staff had undertaken foot care training. Each person had weekly meetings throughout their stay, which were attended by mental health care professionals, to review their welfare and progress. A social worker had also recently been assigned to work at the centre, enhancing the co-ordinated approach to people's current and future care provision.

Good

Is the service caring?

Our findings

People told us they felt they were well cared for at the centre and that staff were very caring. One person told us, "They look after us very well." A second person said, "The staff are brilliant. I get lots of help here." Another person said of the staff, "They're great – no faults." Visiting relatives also spoke highly of the staff. One relative said of the service, "First class, first rate." They explained this further by saying that, "When you see how loving the staff are towards our relative, not just one of them but all of them." Visitors also said they felt welcomed at the centre. One visitor commented, "The staff are all very nice and approachable. We come whenever we want."

The service used a variety of methods to give people and their families' information about the service. An informative guide was made available that described what people could expect from staying at the centre. The guide set out the values underpinning the service including being committed to providing the highest standard of care and supervision and actively promoting dignity and privacy. People also had a 'contract' that set out the terms and conditions of their residency. A range of information was displayed for people to refer to. This included a noticeboard with the day, date and the day's menu; details of social activities; how to make comments, suggestions and complaints; information about dementia; and support for people's carers.

Weekly service user meetings were held for people to discuss different aspects of the service. The minutes showed each person in attendance had been asked to contribute their views about their care, the staff, meals and social activities. Many people had given positive comments including, 'Staff are very respectful. They are very good', 'Staff are very caring' and 'Staff are quite nice and treat us well '. Surveys were also carried out with people, or their representatives, following discharge to obtain feedback about their experiences of using the service.

Wherever possible, people were involved in making decisions about their care arrangements. When people were unable to advocate for themselves, relatives and independent advocacy services were consulted on their behalf. A team leader told us some people had received support from Independent Mental Capacity Advocates. We observed one person's weekly review meeting and saw the senior staff member who chaired the meeting involved each participant fully. A staff member told us, "Families are very involved with their relatives care."

We observed that staff encouraged people to exercise control by making every day decisions. People were able to move freely around the centre, choosing where and how to spend their time and where and when to take their meals. Staff also accompanied people at times to use the garden safely and to go out into the local community.

Some people we spoke with felt they had choices whilst others indicated there was a set routine in the centre. One person indicated they would like a later start in the morning and said, "Staff come to wake me up." A second person thought that mealtimes and bedtimes were static, but said, "This is a positive thing for me as it has given me structure." The staff we talked with were very clear that routines were flexible and told

us they gave people space and time to do things at their own pace.

People told us that staff knew them well and treated them as individuals. Their comments included, "Staff are kind and patient and I feel as if they have got to know me", "I think they get to know you", and, "They make me feel that I am a person. We are all pals together." People told us their dignity was respected. For instance, a person said they could choose when to have a bath and commented, "The staff leave me and come back. They're respectful and caring and try to preserve our dignity." One person spoke highly of the personal care and added, "There is an excellent nurse [staff member] who will wash and blow dry your hair." Another person explained their preference for having their door open during the day but said staff made sure they closed it when giving assistance. At night time they chose to have their bedroom door closed.

People's individuality and means of protecting their dignity were reflected in the way that care was planned. Preferences for support with personal care from male or female staff were stated. In one person's care plans it was noted they preferred to sleep without clothing and their choice was respected. Staff were instructed to be aware of this and prevent their dignity being compromised should they leave their bedroom during the night. The centre had a staff member who was a designated 'dementia champion' and whose role included promoting best practice. They had developed a personal profile which had proved to be beneficial in enabling staff to understand people's lifestyles, preferences and what was important to them.

During our visits we saw staff supported people in a caring manner and were mindful of seeking permission before providing any support. People looked well-cared for, with well-groomed hair and clean, pressed clothing. There was a calm atmosphere and people looking relaxed and happy, sitting chatting with one another and engaging positively with staff. Some people clearly enjoyed the company, whilst others chose to spend time in the privacy of their bedrooms or in quieter areas such as the conservatory. There was a lot of affection demonstrated between people, with one person telling us, "This lady is my friend." On another occasion, a staff member immediately picked up on a person becoming anxious about the whereabouts of their friend and went off to find them.

We observed that staff were friendly, courteous, and took a gentle approach. For instance, we heard one of the housekeeping staff politely asking a person if they could go in to clean their room prior to them entering the room. Whilst most communication was appropriate, we noted one exception during mealtimes when staff repeatedly attempted to explain the different choices of meals, vegetables, sauces etc. It was evident that this extent of information was confusing to people with many just saying 'yes' to the last item offered. The registered manager acknowledged this undermined people's ability to make an informed choice. They assured us they would direct staff to show people the choices of meals in future and consider having menus in each of the dining rooms.

Good

Is the service responsive?

Our findings

People told us the staff were responsive to their needs. One person felt that staff responded very quickly to requests and recalled an example of when a box of tissues had been brought in immediately when they asked. Another person, when asked about the response to any suggestions or requests, said, "There is never an answer "no" here." A third person told us, "There's always a carer around and they come straight away. They are very responsive."

Relatives also spoke positively about the responsiveness of the staff team. One said that when their relative came into the centre, they were using the wrong size zimmer frame. They told us staff immediately ordered another one which was there the next day. Another visitor described a concern they had previously regarding the mobility of their relative and explained that staff arranged for the appropriate health care professional to visit the next day. A visiting health care professional commented, "The staff here have been very responsive to the individual needs of the person that I am working with."

A baseline assessment of each person's needs and any risks associated with their care was completed upon admission. Referrals were made for further assessment or input from external professionals where more complex needs were identified. People's comments on their aims and priorities of using the service were documented as part of the assessment process.

Detailed personal profiles were recorded which had often been completed by families. These gave lots of useful information including what was important to the person, their background, personality, preferences, interests and people who were significant in their lives. Good use was made of the information from profiles in drawing up care plans and guiding staff practice. For instance, a team leader told us how it had helped staff understand why a person became agitated and wanted to leave the centre. Their family had explained that when they were at home they used to go out every day to buy a newspaper and chocolate, so this was facilitated during their stay. Another example given was of a gentleman for whom it was important to wear a tie on Sundays, and this had been included in their care plan.

Personalised care plans were in place which we saw were routinely updated as people's needs changed. The care plans addressed all areas of physical and mental health and emotional well-being. Daily entries were recorded by staff directly into the plans, including comments about the individual's welfare and progress. Each person's care was discussed during handovers between shifts and formally reviewed at their weekly review meetings.

One person we talked with said they felt involved in their own care as they had been included in a recent meeting with professionals and family to discuss their care. Two relatives told us they were very much involved in their family member's care. One said, "We were asked about his likes and dislikes and after a week we had a review to discuss care."

We talked with people about how they spent their days. Comments included, "I have breakfast and then go to choose a book from the library", and, "Watching television and going out in the garden." One person told

us, "Before I came here I could no longer read. Now I'm selecting books and it is a source of pleasure. I just sit in the 'cubby hole' and read." Another person described how they spent their day watching television, reading books or a family member came to visit. They felt they were able to choose where to sit at any time, and said, "Sometimes, if it's busy and you want to go somewhere else, they [staff] will take you."

We observed a quiz taking place in one of the lounges with eight people. People were actively engaged in the activity and were laughing and joking with the staff member asking the questions. All appeared relaxed in this environment. The staff member gently prompted people with clues to the answers and the quiz sparked further conversation and some spontaneous singing.

Visitors spoke of a tea dance party that had taken place earlier in the month (during 'dementia awareness week') and said that their relative had enjoyed the experience. Another relative told us, "They've got a lot of time for people. I've seen them watching a film, putting a CD on, sitting one-to-one, holding hands and joking on." However, two relatives said they felt their family members were bored at the centre. One explained their family member watched television "but doesn't do anything else, so he's bored." They said there were other gentlemen staying at the centre but that communication was difficult. The person's profile included details about their interests in boxing and football. A staff member told us they had chats with the person about this, though gave no further examples of how staff engaged the person around their interests. The other person's relative told us their family member wasn't particularly sociable, though had complained of being bored. We relayed these comments to the registered manager and staff to follow up.

A weekly programme of social activities was planned in response to discussion and suggestions from people who attended the service user meetings. We saw that varied activities were provided, including armchair exercises, arts and crafts, bingo, board games, potting plants, baking cakes, reminiscence, and crosswords. There were also coffee mornings and film, quiz and social nights with dancing and occasional outings in the summer months. The registered manager told us the service held a themed event annually, focused on the needs of people living with dementia, and in 2015 this had been social inclusion.

People told us they felt they could raise a complaint or concern and would be listened to by staff. One person said, "I've no complaints." Relatives also felt that they could make suggestions and/or complaints to any member of staff.

Information about how to make a complaint, including offering support, was included in the guide to the service. Details were also displayed and people were asked at service user meetings if they had any concerns. We saw three complaints were logged in the past year, each of which had been promptly investigated and responded to. A number of compliments had also been received from or on behalf of people who had used the service.

Good

Is the service well-led?

Our findings

The service had an established registered manager who was experienced and qualified in managing care services for people living with dementia. They were fully aware of their management responsibilities and registration requirements, including notifying the Care Quality Commission of any events which affected the service.

The registered manager was supported in their role by senior managers from the local authority, service development meetings, and meetings with their peers. Within the centre there was a defined management and staffing structure that supported the running of the service. Team leaders and health and social care co-ordinators had completed some management and leadership training provided through the trade union. The two team leaders took on lead roles with responsibility for monitoring the upkeep of the environment, health and safety, and staff training. On a daily basis, tasks were allocated to care staff to ensure accountability for all work undertaken. A system was also in place that kept a clear overview of the status and needs of people currently using the service, including details of the referral and discharge processes.

Staff told us the registered manager provided stable management and leadership within the centre. Some staff explained there had been a difficult and unsettling time recently when the service was under threat of closure. They described the registered manager and senior staff as having been very supportive during this period. One staff member told us, "The manager is very good and supported us through the turmoil."

People using the service told us they had confidence in the staff and the way that the centre was managed. One person said, "I couldn't really do without them. They are great people, they really are. I wouldn't go anywhere else." Another person said, "This place is so good, you can't tell any hierarchy in here as everybody is so kind and caring and working together." They added, "This placed is so well managed I feel I could tell anybody anything." Visiting relatives also spoke highly of the centre. One said, "It's lovely here. It seems well run." Another relative said of the staff team, "They are smashing." A third visitor agreed and said, "Yes, it's well run."

We found there was a strong team ethos in the service and new staff were being supported in adapting to their roles. One staff member told us, "This is a good team of staff, very caring and we work well together." Another said, "I really love working here. Everyone is committed to doing their best for the service users." All the staff we spoke with felt comfortable in approaching the management team with any issues which arose.

Monthly staff meetings were held where we saw employment and practice issues, such as health and safety and medicines management, were openly discussed. The meetings included questioning practice and reflecting on lessons learned from incidents that had occurred, such as a medicines error made by the pharmacy. The registered manager told us they had also reinforced with staff the importance of keeping accurate records of welfare checks on people using the service, following an investigation they had carried out.

The service worked inclusively with people, holding weekly meetings to get their feedback. Following

discharge, surveys were sent which asked people, or their relatives, to rate and give comments on their admission experience; the assistance offered by staff; the standard of accommodation; the food provided; whether their needs, wishes and privacy were respected; involvement in care planning; and their views about discharge arrangements. The majority of responses in recently completed surveys rated these areas as either excellent or good.

Various methods were used to monitor the quality of the service. These included regular checks and audits of safety, medicines arrangements and care documentation. A service manager visited the centre regularly and reported on the standards of the service. The latest reports had been focused on people's support and care planning, staffing issues and the environment. A joint visit had also taken place with health partners. This was a starting point to a qualitative review that was being conducted, with the aim of capturing the health and social care benefits arising from the model of care adopted at the service.

The registered manager had a number of developments for the future of the service which were either planned or in progress. These included the introduction of competency-based moving and handling assessments; the possibility of setting up a carers support group; directing staff to log any minor concerns raised and how they had been resolved; making further improvements to social activities; and ensuring all staff received training on best practice in caring for people living with dementia.