

Dementia Care

Dementia Care

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?

Outstanding 

Overall summary

This inspection took place on 4, 5, 26 March and 21 May 2015, and was unannounced.

We last inspected this service on 5 June 2013 when we found no breaches of the regulations.

Dementia Care provides a range of services for people living with dementia and other degenerative neurological disorders in the Newcastle area. These include domiciliary care services, a five-bed respite unit, and small independent supported living homes.

The service has a separate registered manager for each of its regulated activities, which are 'Accommodation for

persons who require nursing or personal care' and 'Personal care'. 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.

People using the service and their relatives said they felt safe and protected by the workers providing their care and support. Risks to people were carefully assessed and

Summary of findings

appropriate actions were taken to minimise potential harm. Systems were in place to monitor environmental health and safety issues, and there were regular audits to promote good standards of hygiene.

Staff members were fully aware of their responsibilities to keep people safe and showed a genuine commitment to protecting people from any abuse. Appropriate systems were in place to report any safeguarding incidents. Accidents and other significant incidents were closely monitored and actions were taken to minimise the risk of further accidents.

Staff were trained and monitored to ensure people were supported to take their medicines safely.

There were sufficient staff to keep people safe from harm, and to identify and report any safety issues. Staff recruitment systems were thorough, and protected people from the risks of unsuitable workers being employed.

People told us they felt the staff team had the skills and experience needed to meet their needs effectively. There was a strong commitment to staff training. Staff received good induction and ongoing training in all relevant areas. Any training needed to meet the individual needs of people using the service was identified and carried out promptly.

Staff were given good support to carry out their roles and responsibilities, and were given regular supervision and performance appraisal by the management team. Staff told us they took pride in their work and felt valued and respected.

The service protected the rights of people who lacked the mental capacity to make significant decisions about their lives. Any decisions made about such issues were taken in their 'best interests'. Decisions were taken in conjunction with the person, their families and involved professionals and followed a careful assessment of the person's capacity.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the provider had

submitted appropriate applications to the local authority for authorisation to place restrictions on certain people's movement, in their best interests to protect them from harm.

People were routinely asked for their consent before any staff carried out tasks for them. They told us staff respected any decision by them to refuse such interventions. People were also asked to give written consent to significant areas of the care, such as having their medicines administered.

Care was taken to make sure people's nutritional needs were fully understood and met.

People told us they were very well cared for, and they were always treated with respect and courtesy. Relatives we asked confirmed this. They said their privacy and dignity were respected at all times, and they were consulted about their care and given the necessary information to make decisions. We observed staff members were pleasant, sensitive and caring in all their approaches and interactions with people. People were encouraged and supported to be as independent as possible. We noted staff had been trained in equality and diversity issues and saw no evidence of any discriminatory practices.

People and their families were fully involved in the assessment of their needs, and their wishes and preferences about their care were sought and recorded. Detailed, person-centred care plans were drawn up to meet those needs and preferences.

Systems were in place for responding to complaints and other matters of concern, but people told us they never had anything to complain about, and felt they could resolve any issues informally. The provider's representatives and staff all demonstrated a clear and genuine commitment to listening and responding sensitively to any issues that arose. They used such feedback to improve the service.

The registered managers and all levels of the management team displayed clear and appropriate values and provided strong leadership to their staff. Staff members told us they knew what was expected of them, and were given the support, encouragement and training they needed to meet people's needs in a timely and caring way. Staff at all levels showed, by their words and actions, an impressive drive to provide a dynamic,

Summary of findings

pro-active and continually developing service that was clearly focussed on enhancing the lives of the individuals receiving services. The service was open and responsive to feedback and new ideas, and had robust systems in place for monitoring its progress in meeting its goals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People told us they felt protected and had no concerns about the service.

Risks to people were well managed. Systems were in place to identify and respond to any suspicions of abuse.

People's medicines were safely managed.

Good



Is the service effective?

The service was effective.

Staff had the knowledge, skills and experience to meet people's needs effectively. Staff received good support and supervision, and benefitted from regular training.

People's rights were respected. People who lacked capacity to give consent to their care were protected by proper legal processes.

Good



Is the service caring?

The service was caring.

People and their relatives spoke highly of the caring ethos of the service, and said they were treated with respect and compassion.

They said they were fully involved in all decisions about their care, and spoke of a 'family feeling' within the service.

People's privacy and dignity were respected. Their well-being was enhanced by the service at all times, including end of life care.

Good



Is the service responsive?

The service was responsive.

The service was person-centred and tailored people's care to their wishes and preferences.

People's care needs were fully assessed and detailed and sensitive care plans were in place to direct their care.

People told us they had no complaints. Strong systems were in place to deal with any complaints received.

Good



Is the service well-led?

The service was well-led.

Effective, value-based management systems were in place that gave clear guidance and support to staff members.

Outstanding



Summary of findings

The management team was open and transparent in its approach to people, their families and professionals. Managers listened carefully, and responded positively, to all feedback it received.

Robust systems were in place to monitor the quality of the service offered, and a genuine ownership of quality issues was apparent at every level of the organisation.

The management team was innovative and demonstrated a real commitment to continuous development of the service.

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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 4, 5 and 26 March and 21 May 2015 and was unannounced.

The inspection was conducted by one adult social care inspector, a specialist advisor in the areas of quality and governance, 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 dementia care service.

Before the inspection we reviewed the information held about the service. We reviewed the notifications of significant incidents the provider had sent us since the last inspection. We contacted local commissioners of the

service, Healthwatch, GPs and other professionals who supported some of the people who used the service, to obtain their views about the delivery of care. We have included their views in this report.

Before the inspection we had requested the provider send us a Provider Information Return. This is a form in which we ask the provider to give some key information about the service, what the service does well and what improvements they plan to make. We have used evidence from the information submitted in this report.

During the inspection we spoke with 11 people who used the service, five relatives, 13 care staff, and the two registered managers. We also talked with the chief executive and the heads of best practice, human resources and training, compliance and business continuity. We looked at the care records for eight people. We pathway tracked the service received by two people. This means we followed their care experience, from referral to current care. We observed practice in communal areas. We also looked at records related to the management and operation of the service, including the personnel and training records for six staff members.

Is the service safe?

Our findings

People told us they felt safe and secure whilst receiving their care and support. One person said, “I definitely feel safe.” Another person commented, “I have no concerns about my safety, here.”

A recent (2014) survey carried out by the provider found 99% of people using the service said they either ‘strongly agreed’ or ‘agreed’ they felt safe when receiving a service.

Family members were equally assured of their relatives’ safety. One relative of a person receiving care told us, “They make sure he is safe and well when doing his personal care. They prompt him to take his medication and stay with him until he has taken it.” Another relative said, “Carers look after (my relative) during the night they keep him safe.” A third commented, “They make sure she is safe and if they have any concerns they talk to me about it.”

The service had rigorous processes for reporting any incidents of actual or potential abuse. Only four relatively minor safeguarding incidents had needed to be reported to the local authority, none of which demonstrated abusive behaviour by any staff members. Staff were fully aware of their responsibilities for recognising and reporting abuse, and for reporting any poor practice by colleagues (‘whistle-blowing’). We were given examples of issues appropriately raised by staff and were told senior staff were very supportive. We saw from our records that the service notified the Commission of all safeguarding incidents. The provider told us a key value was the “zero tolerance” of any form of abuse. We noted that money held on behalf of people in supported living houses was checked twice daily, and recorded.

A robust set of policies, systems and processes were in place to manage risk and health and safety. These assessed the likelihood and potential severity of risks to the person regarding, for example, nutrition, skin integrity, uncommunicated pain and the environment. The person and their relatives or representatives were involved in this process, which was reviewed at least quarterly. However, the service also promoted ‘positive risk taking’, where, following careful assessment, people were supported to take reasonable risks to enhance their independence,

sense of self-worth and well-being. The provider told us the service was employing a specialist consultant in moving and handling, to minimise the risk of falls and other injuries.

We noted correspondence from a firm of insurance assessors following a recent insurance risk survey. This stated they were impressed with health and safety arrangements in place, and spoke highly of the “professionalism and attention to risk management.”

Staff members were alert to non-verbal signs of pain or discomfort in people unable to communicate this verbally. A team leader told us they looked out for changes in the person’s demeanour and body language and reported any concerns for further investigation.

A ‘workplace inspection checklist’ was used to systematically monitor the safety of the working environment, including working at height, gas, water, and electrical services, fire safety, work equipment and control of substances hazardous to health.

The service had a ‘business continuity plan’ that would enable it to continue to provide safe services in the event of an emergency. An out-of-hours management support system was in place, and care workers carried mobile phones to access the manager.

All accidents and incidents were logged. Report forms were reviewed by senior officers and appropriate action was taken by respective managers and members of staff. Reports on trends were produced and shared with the senior management team and health and safety committee and used as an opportunity for learning and improvement for the benefit of service users. Records showed that no serious accidents had occurred in the previous year.

We saw people received an appropriate and safe level of staff support. People who used the five bed respite accommodation had the support of one to two care workers at all times, based on the number of people using the service and their needs. Staffing levels for people in independent supported living houses were agreed with the professionals who commissioned the service, and kept under review.

Staff members told us they regularly worked between different parts of the service, and this meant they could be flexible in responding at short notice to changing needs.

Is the service safe?

They told us they always tried to provide extra cover themselves if there was staff sickness, and there were sufficient staff to allow for this. This ensured consistency of staff. We noted that travel time was factored into the rotas of staff working in the community. Staff members told us this meant they were nearly always able to get to their calls on time, and that people did not have the concern of waiting for overdue staff.

The systems for recruiting new care workers were robust. Checks were undertaken to ensure that only appropriate applicants were employed. These included contacting the Disclosure and Barring service (DBS) regarding any previous convictions which would mean that the person is not able to work with vulnerable people, taking up references from previous employers and ensuring the applicant supplied a full employment history.

The service had a detailed policy in place to ensure people received their prescribed medicines in a safe manner. Each person had their medicine support needs assessed and

recorded, and detailed care plans were in place. All staff had been given training using the UK Homecare Association medicines training package. The competency of individual members of staff members to administer medicines safely was checked, by observation and written test, at least every year. Additional training or supervision was given to anyone who was not judged fully competent. All medicines given were properly recorded on a detailed medicines administration record. These were audited rigorously every month and random spot checks were also carried out. Safe storage of medicines was provided in the independent supported living houses and in the respite care unit.

The service had an infection control lead officer and conducted regular audits of potential infection control issues. We toured the respite care unit and one supported living house. Both were maintained to a high standard of hygiene and décor.

Is the service effective?

Our findings

People said they felt the staff were well trained and able to meet their needs. One person told us, “I think the staff have the skills and training they need.” A second person said, “Everything is excellent. I’ve never found any faults at all. I would rate it 1000(sic)%”

A recent (2014) survey carried out by the provider found 90% of people using the service rated the effectiveness of the service as either ‘good’ or ‘excellent’.

Relatives told us they felt staff had the skills and experience necessary to meet people’s needs. One said, “Fantastic, a wonderful group of girls that care for my relative. They can (display behaviour that challenges) yet the girls just chat to them. They treat them with great dignity and respect.” A second relative told us, “Yes, a very good service and we are both very happy with what they do for us.” Other comments from relatives included, “The staff and my (relative) sit together at the computer and do their online shopping” and, “It is a happy, safe place for all the clients who live there. I have peace of mind that my (relative’s) needs are fully met.”

Professionals involved in working with people whilst at the service told us they felt the staff were knowledgeable and skilful. A social worker told us, “I have no concerns about the standard of training. The staff are skilled and seem to be up to date with their training.” Another professional said, “I’ve been really impressed with how they manage the care of my client in supported living.”

The service had good induction systems and processes in place, with new staff shadowing more experienced staff for up to two weeks, before working unsupervised. One staff member commented, “We were given a very thorough induction.” Another staff member said, “I was given two weeks induction, covering all the policies and procedures, covering the entire organisation, and all my training.”

Staff at all levels benefitted from an annual performance management cycle. This included annual and mid-year performance reviews, and bi-monthly one-to-one supervision sessions. Minutes of these meetings demonstrated they were carried out robustly and professionally. Any performance deficits were identified and discussed, with targets set. Positive feedback was

given, to confirm good practice. Staff told us they felt they were well supported by the management of the service. One staff member told us, “We get lots of opportunities to talk; we can speak with any of the senior staff at any time.”

Robust and embedded processes were in place to monitor staff training. Training records showed all staff were kept up to date with all areas of required training, and had regular ‘refresher’ training. Staff told us their training was relevant and of good quality. For example, training in the care of people with dementia used the latest research findings from Stirling and Bradford Universities, and included role playing scenarios to embed their learning. We noted 60% of care staff held training in care of people living with dementia, equivalent to National Vocational Qualifications (NVQ) level three in social care, and others were currently working to achieve this qualification. Staff told us they were actively encouraged to ask for further training to support their personal and professional development. As an example, a team leader told us they were to enrol on an Master of Arts course in dementia studies shortly. We noted the staff team included graduates in health and social care, in nursing and a registered mental health nurse.

Staff members we spoke with displayed a very good knowledge of the needs of people living with dementia and related conditions, and were able to describe the needs and preferences of individuals in good detail.

The accommodation for people receiving respite was designed to be ‘dementia friendly’, and featured specialist signage and equipment, contrast colouring and door coding to allow people to orientate themselves and find facilities such as the toilets.

Staff were aware of their responsibilities under the Mental Capacity Act. There was an assumption that a person had mental capacity to take decisions unless there were clear indications to the contrary. Staff took what steps they could to support people in maintaining their decision-making capacity. They told us they were frequently involved in the assessments of people’s mental capacity. One said, “The (mental capacity) assessors use our input and knowledge of the individual when making their decisions about capacity.” This person gave us examples of how the service tried to always maximise an individual’s ability to understand the issues requiring a decision (for example, signing a tenancy agreement), and supporting them to make such decisions, if they were able. Where it had been

Is the service effective?

decided the person lacked capacity to make an informed decision, staff were similarly involved in working out what measures would best support their interests, whilst minimising any necessary restrictions of their liberty.

The provider's representatives were fully aware of their responsibility to ensure no person was deprived of their liberty unlawfully. They were able to demonstrate they had acted appropriately in line with the law in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005. They are a legal process followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. They had also engaged with the DoLS lead officer at the local authority to understand the local expectations for DoLS applications. Seven applications had been submitted to the local authority for authorisation to place restrictions on certain people's movement, in their best interests.

The service operated a 'no restraint' policy, in line with the 'management of actual or potential aggression' (MAPPA) advanced training, as given to staff members. Staff told us they were trained to recognise the underlying causes and triggers of aggression and to respond positively to such challenges.

Care records showed consent was formally requested regarding the person's support plan, administration of medicines, financial matters, photographs for identification

purposes and any changes to the support plan. Consent forms were signed by the person (where able), their representatives, support worker and manager. People told us they were always asked for their consent before staff members carried out any care task. Staff told us they were attentive to a person's facial expressions and body language, if they were unable to give clear verbal consent to any actions. They said that, as they get to know individuals very well, they felt this was safe and effective.

Nutritional risk assessments were carried out if there were any concerns regarding a person's food and fluid intake. Any risks identified were shared with relevant professionals such as the GP or a dietician. Records were kept, where appropriate, of people's nutritional intake. People living in a supported living house were involved in menu planning and food preparation.

Staff members told us they were trained to be alert to changes in a person's health, and to report any concerns to the person's family or involved professionals. The provider's representatives told us they supported the person's family to report any health issues to maintain independence, but would assist in this process where requested by the family. They told us staff kept a close watch to make sure people's routine health needs, such as chiropody or dental check-ups took place.

Is the service caring?

Our findings

People receiving a service told us they felt very well cared for. We heard very many highly complimentary comments about the service and the caring approach of staff. One person spoke of the “very nice staff, very pleasant and very helpful, and always positive.” A second person told us, “The staff are kind. They listen to me.” Another person said, “I’m very happy indeed. Everyone gets lots of attention.”

People told us staff helped them keep their self-respect. One person told us, “They are very good around privacy and dignity. They never intrude. They ask you if you want a male or female carer.” Another person spoke of the “mutual respect” between people and those providing their care.

Relatives confirmed the caring attitude of the service. One told us, “I feel part of the family when I visit, that’s how good the team of carers are.” A second relative said, “My (spouse) has the respite service ...and the care was wonderful, caring, gentle and dignified, they were wonderful.” A third commented, “What can I say... absolutely great. Dedicated staff, always smiling when they complete (my relative’s) personal care. They arrive mainly on time. They treat him with dignity and care and tell him what they are going to do and they ask if that’s ok.” Other comments received included, “The staff are very good with my relative. They are kind, compassionate and treat them as a person” and, “They are compassionate, caring and always bright and cheerful when I visit.”

When talking with people who received respite care or who lived in the supported living house we visited, we were impressed by the positive and sensitive interactions between people and staff members. The atmosphere in both parts of the service was warm, inclusive and happy. Staff were observant, attentive and smiled and chatted freely with people, who were relaxed and cheerful. Several people commented on the ‘family’ feel to the service. Visiting relatives told us they were made very welcome and were encouraged to join in activities.

Staff members spoke of the enjoyment, fulfilment and job satisfaction they experienced in giving what several described as “excellent care.” They told us they were able to give consistent and high quality care.

Family carers and those people able to express themselves verbally confirmed they felt fully involved in agreeing and reviewing the appropriate levels and types of care and

support. Staff members actively sought their views and treated them as equals in discussions about all areas of service provision. Where appropriate, technology such as ‘talking mats’ (a system using communication symbols) was used to enable people to communicate their views. The service also provided support, information and training to family carers on its website.

Managers told us people and their families were kept informed of any changes planned in the service, and sought their agreement to such changes. If the person’s normal support worker had to be changed, for reasons of ill-health or holidays, as much notice as possible was given, and every effort made to find a substitute member of staff already known to the person.

A communications officer had been recently employed to facilitate communication with people using the service, their families and staff members. Monthly ‘best practice’ bulletins were sent to all stakeholders, and monthly newsletters to staff. The registered manager told us a free training support programme would be introduced in autumn 2015 for family carers to help families become more effectively involved in their relatives’ care.

Staff were trained in recognising the importance of equality and diversity issues, and to respond appropriately to issues such as religion, life choices and cultural needs. The service employed staff with a range of ethnic backgrounds and, where possible, matched them to the individual needs and preferences of people using the service. Staff told us their training had made them sensitive to the importance of understanding and meeting the expectations of different ethnic, cultural and religious groups. They gave us specific examples of, for example, taking slippers to change into when entering one person’s home, and being aware not to take items of meat into a second person’s house. They told us they were guided by the person’s family members on such issues.

Staff members were aware of the concept of advocacy and, although none said they had been involved in its use, all said they would raise any concerns that a person was not being heard with their managers.

The service’s ‘service user guide’ promised people their privacy would always be protected. It gave examples such as ensuring people were appropriately covered when dressing or undressing, and closing doors when people used the toilet. Any personal contact was always with the

Is the service caring?

person's consent and was appropriate and sensitive. The service was also committed to protecting the person's right to confidentiality, and did not share personal information without specific permission.

People confirmed they were encouraged to be as independent as possible by staff.

A senior manager told us, "The independent ethos [of the service] is an absolute priority and workers must not impinge on it." This was confirmed in care plans seen, with examples such as "Ensure I have control of my care" and, "Ensure I am able to make my own choices and decisions." The provider's representatives told us they were always

alert to the dangers of people being over-prescribed with medicines that impact on their ability to make decisions. They told us they would challenge the person's GP where necessary regarding this.

The provider's representatives told us they were introducing the 'gold standard' end of life training package for staff in the coming year. They told us they worked closely with health care professionals to ensure people's dignity wishes were respected throughout this sensitive time. We noted from the service's records a high proportion (88%) of people in supported living schemes were enabled to reach the end of their lives in their own home.

Is the service responsive?

Our findings

People told us they were impressed with the personalised approach of the service. One person who regularly received respite care said, “Everything is excellent, I have never found any faults. We are given lots of choice and they ask us how we want to be helped. The staff are sensitive and pick things up quickly, and they treat you with respect. They can’t do enough for you.” Another person said, “If they think I’m in distress, the staff come over to me. They are very aware of what is going on.” A third person said, “They do whatever you ask. Sometimes they offer (care) before you ask.” Other comments received included, “They ask me how I want my care to be given. They meet my needs” and, “They ask me how I want to be cared for.”

People said they had been given copies of the service’s complaints procedure, but nobody we spoke with had any complaints. Typical comments were, “I have no complaints at all, no worries”; “I have completed questionnaire forms about the service and if I had any reason to complain I would speak to the staff and I know they would put it right.”

Relatives said they were very happy with how the service responded to their needs and the needs of their family members receiving care. One relative told us, “One day I rang them. I was at my wits end and asked if my relative could come in the next day for respite. The manager came the same day after work and spent time with my relative – what kind of service is that? If the staff have concerns while my relative is in respite care they call me at home and discuss the situation. I’m involved in the planning of my relative’s care.” Another relative said, “If I had any concerns I would speak to the staff and they would respect my views. I’m involved in any changes to her care planning.” A third relative commented, “The staff look after my relative very well. I don’t know what I would do without them.” Relatives said they felt staff responded well to any concerns raised. One relative told us, “I did have to complain once as the jobs were not always being done. Also there were different carers coming and this didn’t help his confusion but all this has been resolved.”

We noted in the most recent (2014) survey of customer views carried out by the provider 91% said they felt the support delivered met their needs and that they felt listened to.

Professionals told us the service was responsive. One commissioner of services said, “I have always found them very accommodating when trying to support our clients. When I ring, they always respond to my query and are quick to respond to changes in care packages.” Another told us, “They are very pro-active.” A social worker said, “They are really good at promoting what is best for the client.”

Detailed assessments of a person’s needs and wishes were carried out before any service was offered. The person was fully involved in their assessment, where they had the capability to be so, and the views of the person’s relatives and family carers were always included, as were previous assessments from health and social care professionals. Particular attention was paid to the person’s social history, to gain as full as possible a picture of the person’s life to date, and to incorporate their known likes, dislikes, wishes and preferences. Where the assessment of an individual’s needs indicated the need for specific staff training in, for example, the use of continence products, continuous positive airway pressure or specialist feeding techniques, this training was sourced and given to relevant staff members before the care package was started.

All identified needs and preferences were included in a support plan for the person. This gave staff members detailed guidance on how to meet those needs, and allowed them to develop respectful empathetic relationships with people who might not always be able to express their preferences.

Staff members we asked told us they were expected to always read the person’s care plan, and that the care plans gave them good advice on how to meet people’s needs. They said they were expected to view care plans as dynamic documents, which were to be constantly under review, and were to be updated as necessary.

Meetings were held with people using the service and their relatives at least every three months, to review the progress in meeting the agreed goals for the person.

When talking with staff members we noted a strong ethos of person-centred care and good working relationships. This was typified by comments such as, “The staff are dedicated and will work around the clock whatever the need”; “we try to have a personal approach to every aspect of service”; “people always come first”; and, “it’s the people

Is the service responsive?

who matter, at the end of the day.” This was confirmed in people’s care plans. For example, we saw, in one person’s plan, it was stated, “I have the capacity to inform staff how I like tasks to be carried out. All staff follow my instructions.”

People living in independent supported living told us they were never bored, and had plenty of social stimulation, activities and staff attention. The provider’s representatives told us ten hours staff time per week was dedicated to social activities. Many people also used the adjacent Dementia Care day centre.

People using the independent supported living and respite parts of the service said they were encouraged to make choices about all aspects of their daily lives and the ways their support was given to them. One person told us, “We have lots of choices, and the staff listen to what we decide.” Examples of choice included what to wear, when to bathe or shower, social activities, involvement in house chores, meals and social activities. A team leader in one of the independent living homes said, “Client choice is integral to everything we do.”

The service had a complaints policy and procedure in place. This was well advertised. The provider’s representatives told us every effort was made to resolve any issues or concerns quickly and informally, where possible. People were always reminded of their right to instigate the formal complaints procedure, if they so choose. Staff members confirmed this. We noted from the complaints records, only three minor complaints had been received in the previous year. All had been resolved appropriately and to the satisfaction of the complainant.

The provider’s representatives told us the service was as flexible as possible, and people were able to access the various elements as they needed. For example, a person receiving the ‘home support’ service would be eligible to use the respite facility, if their needs required this. Staff members told us, “We can adapt to any change in a person’s circumstances – they can move between services.” The service had standardised its paperwork across the different elements of the service to facilitate this. The provider’s representatives told us they engaged with all involved health and social care professionals when the need to access external services arose.



Is the service well-led?

Our findings

The service had two registered managers. One was registered in relation to the provision of accommodation for people requiring personal or nursing care; the second manager was registered in relation to the provision of personal care.

We asked people their opinions of the management of the service. Those who expressed an opinion told us they were satisfied with how the service was run. One person said, “I’d say it was definitely well-managed.”

A relative commented, “The systems of organisation which are in place to ensure that my relative’s needs and those of other people are met, are a hallmark of the running of Dementia Care.”

Professionals told us they felt the service was very well managed. A social worker told us, “I have no problems with the management – they’ve always been really helpful.”

The service was well-supported by a clear and effective management structure. Strategic oversight was provided by a board of trustees, comprised of a chairman and 10 trustees from the disciplines of the public sector, finance, housing, pharmaceuticals and marketing. Four committees (finance and audit; health and safety; housing and care quality) reported to the board of trustees.

The day-to-day management of the organization was overseen by the Senior Management Team (SMT). This team consisted of the Chief Executive, Head of Best Practice, Finance Director, Head of Human Resources and Training, Head of Services, and Head of Compliance and Business Continuity. All the SMT members we interviewed demonstrated an open and honest culture and genuine desire to improve the services for people using the service. We found a culture of real commitment to continuous development of the service. A growth strategy was in place. As one senior officer told us, “We can always do better.”

The organization had clearly and concisely articulated its vision and values in the ‘draft business plan 2015-2018’. These were to support people to have ‘self-worth’, to ‘feel good’, to ‘be valued’, and to ‘have a sense of purpose’.

The provider had strategic documents in place to assure the organisation that it was making progress and achieving its aims. A comprehensive set of policies and procedures was in place that covered the full range of activities and services provided.

Well-embedded systems and processes were in place for risk management, health and safety, incident reporting, performance, business continuity and human resources. A range of key performance indicators were used to monitor areas such as safeguarding, reporting of serious incidents and accidents, and complaints.

A comprehensive risk register was in place that covered governance, quality and reputation, external and political environment, and service delivery. Controls for each risk were well articulated.

We found there was mutual respect between the SMT and those directly involved in giving care and support. One member of the senior team told us, “I think the world of the people I work with.”

Staff told us they felt very well supported by the organisation. One told us, “We are massively supported, work-wise, personally and emotionally. We get amazing support.” Another staff member said, “We get 24/7 support.” A third member of staff spoke of the “very professional and very caring managers” and told us, “We can talk to all levels of management; they are all very approachable and have open doors.” The consensus was that the service had always been very caring, but was now also more professional and effective.

Staff members told us they felt fully involved in the organisation, and were being fully involved and consulted upon developments. One told us, “We know what’s happening. We are being informed more, and get regular newsletters so we don’t feel left out.” We noted regular forum meetings took place between staff and the management team, and staff said their views were taken very seriously, and suggestions (such as the provision of mini buses) were often implemented. One staff member told us, “We are always looking for new ways of stimulating people and meeting their needs.” Another staff member said, “We are encouraged to put new ideas forward. The managers listen and try things out.” Staff members also told us of the “clear values and expectations” communicated to them from the management team, and told us they were given reminders, where necessary.



Is the service well-led?

The service had excellent community links, with a vibrant day centre and café attached to the office and respite accommodation. Links had been developed with other local organisations, such as Newcastle United Foundation and Sage plc.

There were a number of systems and processes in place for monitoring the quality of care. These included: direct observation, night observations, medication observations, records of care workers medicine competencies, and schedules and records of staff supervisions and appraisals. We saw correspondence from a firm of insurance assessors following a recent insurance risk survey. This referred to the “superb standard” of the quality systems in place.

An annual survey of the views of all stakeholders was undertaken. People’s views and comments were collated, considered and used to develop the service further.

We noted the service had a good reporting culture which indicated an organisation that was open and willing to learn from incidents to improve care for people using the service. The Head of Service told us, “If anything, I think that our staff over-report.”

The service used the most current best practice to inform its work, including specialist therapeutic techniques such as cognitive stimulation therapy, well-being measurement

tools and life skills retention. It had a ‘people strategy’ in place aimed at positive reinforcement of good practice, action learning and cross-organisation ‘interest’ groups such as ‘end of life’ care. The service was also innovative. Of particular note was the development of its own specialist dementia training course and observational tool for people with dementia, to replace the standard ‘dementia care mapping’ tool. There were also plans to make a film of the respite unit facilities, to reduce the need for potentially intrusive visits by professionals and other interested parties to see the unit.

The service was a member of the Contractors Health & Safety Assessment Scheme (CHAS). This is an external accreditation for Health and Safety conducted by an independent organization.

The provider had recently attained the ‘Investors in People’ bronze award. We noted the comment of the independent assessor that the organization should consider applying for the gold standard.

Overall, we found Dementia Care to be a very well led organization with a strong person-centred, caring ethos. The service had robust and well-embedded systems and processes at all levels of the organisation.