The White House (Curdridge) Limited

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Inspection report

Vicarage Lane, Curdridge,
Southampton, Hampshire SO32 2DP
Tel: 01489 786 633
Website: www.whitehouseresidentialhome.co.uk

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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection visit took place on 13 and 14 October 2014 and was unannounced.

The White House provides accommodation and personal care for up to 46 younger and older people who are living with dementia and other mental health illnesses. There were 45 people living at the home at the time of this inspection. The home is comprised of the main house and three purpose built interconnecting units, each with its own unit manager and staff team.

The service is overseen by the owner/provider and the 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 and associated Regulations about how the service is run.

Staff working at The White House understood the needs of people using the service. We saw that care was

Summary of findings

provided respectfully and sensitively, taking into account people's different needs. Staff took account of people's personal anxieties and worked as a team to support and reassure people in their care. People who use the service spoke appreciatively and positively of the staff and the care they received.

Throughout the inspection we observed examples of creative and personalised practice. We saw staff use smart technology to support people to have freedom to move around the different parts of the service safely and without restriction. The staff worked as a team to share information and problem solve. The provider and registered manager had built up good links with relevant professionals and organisations to support and implement good practice within the service.

Staff received a comprehensive induction and training programme to support them to meet people's individual needs. Staff had received training to support them with specific conditions and to understand and implement relevant legislation such as The Mental Capacity Act 2005.

They all fully understood their roles and responsibilities as well as the vision and values of the service. Staff were supported to make sure they provided safe and effective care to the people using the service.

The provider had employed skilled staff and undertaken all necessary checks prior to them commencing employment. Staff were supported to take on roles such as 'champions' to share and implement best practice and promote discussion on how the service could improve. Staff were able to influence the running of the service through making suggestions for changes.

All staff were involved in the monitoring of the quality of the service. The provider and registered manager had clear systems in place to assess the quality of the service and to implement and track progress with improvements. People who use the service were encouraged to be actively involved in the running of the service. The provider demonstrated a drive to continually improve the service and the experience of people in their care.

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.

There were appropriate systems in place to identify and manage risks, so that people were protected while their freedom and independence was respected.

Staff received training about protecting people from avoidable harm and abuse and demonstrated their knowledge of the relevant procedures.

People were supported by sufficient numbers of suitable staff to keep them safe and meet their needs.

People's medicines were managed so that they received them safely.

Good

Is the service effective?
The service was effective.

Staff received relevant training to give them the knowledge and skills to deliver care and support effectively.

The service sought people's consent to care and treatment, in line with current legislation and guidance, so that people's rights were protected.

People were supported effectively to make sure they had enough to eat and drink and individual diets and choices were catered for.

The service monitored people's healthcare needs and took appropriate action when necessary.

The design and layout of the premises promoted the independence, safety and wellbeing of people living with dementia.

Good

Is the service caring?
The service was caring.

A key worker system helped to promote positive caring relationships with people using the service. People spoke appreciatively of all staff and particularly of their allocated key workers.

Staff were creative in supporting people to be involved in the service. They participated in many events that were put on to entertain people, which often fell outside their official hours of duty.

The atmosphere throughout the home was friendly, calm and caring. The staff spoke about people in a respectful manner and demonstrated knowledge and understanding of their individual needs. Staff treated people in a way that respected their privacy and dignity.

Outstanding

Is the service responsive?
The service was responsive.

Good

Summary of findings

The service recognised and responded to people's changing needs, including needs for social interaction and stimulation.

A system was in place to monitor and respond to any concerns or complaints about the service.

The service was proactive in responding to people's comments and views. Regular resident association meetings were held to ensure everyone was kept informed about what was happening in the service and to ask for their views and suggestions. As well as being informative, the meetings celebrated people's achievements.

Is the service well-led?

Good

The service was well led.

There was a system of quality monitoring for all aspects of the service and involving all staff in the service.

Measures were in place to seek and act on the views and experiences of people using the service.

Staff were knowledgeable about the vision and values of the service.

The provider had developed links with relevant professionals and organisations to support and implement good practice.

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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 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 13 and 14 October 2014 and was unannounced.

The inspection was carried out by two inspectors 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. The expert by experience on this inspection had personal experience of caring for someone who lived with dementia.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law. No concerns had been raised since we completed our last inspection.

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.

During our inspection we observed how the staff interacted with the people who used the service. We looked at how people were supported during their lunch and during social activities. We reviewed a range of care records for 10 people, including nutritional assessments, GP visits and behavioural support plans. We also reviewed records about how the service was managed, including risk assessments and quality audits.

We spoke with 12 people who lived in the home and two relatives of people who used the service. We also spoke with the home's owner, the registered manager and 13 other members of staff.

Following the inspection visits, we also received feedback about the service from an external healthcare professional.

The service met all of the regulations we inspected against at our last inspection on 7 October 2013.

Good

Is the service safe?

Our findings

People told us they felt safe. There were policies and procedures about how to keep people safe from abuse. Staff demonstrated understanding of what constituted potential abuse and were aware of their responsibilities in relation to reporting any safeguarding concerns. They were confident that any concerns they raised would be acted on appropriately by senior staff. There was also a whistle blowing policy and procedure in place to enable staff to raise alerts about poor practice or allegations of abuse without fear of reprisal. Staff were aware of the procedure and told us they would feel confident to use it if necessary.

The provider had notified us about any potential safeguarding concerns and this information showed that they dealt with these matters in an open and transparent way. Issues were reported to the relevant authority promptly and agreed follow up actions were completed. Observations were carried out regularly but unobtrusively, to support people's safety following any incident, without the need to restrict a person's freedom of movement.

A system was in place to monitor and evaluate incidents. A designated member of the management team reviewed incidents in order to identify and respond to any patterns that emerged. For example, one person had been referred to their GP and the community psychiatric nurse as a result of the evidence from monitoring incidents. This had resulted in further tests and medical reviews and a decrease in the number of incidents.

Smart technology was used to assist staff in monitoring people who may be at risk of falling. For example, mats were positioned to send a signal when a person at risk of falling left their bed or chair. Records were kept of investigations that were carried out to clarify any concerns and actions taken. A new lock down system enabled areas of the home to be isolated, for example in the case of an infectious outbreak. The technology was used to promote people's independence whilst supporting them to move around the service as safely as possible without restrictions. Use of the technology was based on assessment and reviewed. The environment had been set up to help avoid situations where people became distressed and restless. Where people may become anxious or agitated, staff used the technology, including a phone communication system to respond positively and consistently, keeping everyone informed of what was happening.

Risks to people's safety were appropriately assessed, managed and reviewed. Care records contained risk assessment and risk management plans that were specific to each individual. For example, risks associated with people travelling in the home's vehicle were assessed and managed. Staff were aware of the risk assessments in place for people.

The home was made up of four units and people had freedom of movement around all the units. The managers were proactive in ensuring any pertinent risk assessments were shared with staff on all the units. Where someone required more observation, responsibility for recording these was shared amongst staff on any unit the person may be walking around. We saw staff actively manage the risks associated with people becoming agitated by communicating with each other and working as a team to problem solve. Specific risks or changes were communicated at handover meetings when the staff group changed. Health and safety checks were carried out at each staff handover to help ensure that any risks were identified, removed or minimised. Staff signed a record when the checks were completed.

Staff were clear about how to act in the event of an emergency. There were nominated fire marshals and first aiders for each shift. We observed staff responded swiftly when the fire alarm was accidentally set off. The home employed the services of an external company who audited and monitored health and safety procedures within the home.

Arrangements were in place to protect people against the risks associated with medicines. The service had a policy and a set of procedures in relation to obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. The staff training programme included medicines management and a competency test. Care and support plans contained detailed personalised guidance about the levels of support individuals received in relation to medicines. There was a system in place to audit and monitor the effectiveness of medicines management in the home.

Good

Is the service safe?

We observed medicines being administered safely. The member of staff wore gloves and checked the administration records, the name of the person and the medication before administering. The member of staff explained what the medicines were for and stayed with the person while they took them. Once the person had taken the medicine the member of staff signed the administration record. One person refused their medicine and the member of staff recorded this and put the medicine in a jar to be returned to the pharmacy. The medicines were stored safely in a purpose built trolley.

Controlled drugs used by the service were stored and audited. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these medicines are called controlled drugs or medicines. Staff were storing some controlled drugs for the district nurse to administer to a person receiving end of life care. There was a record of the drugs being kept for this and a photograph of the person they were for. The person had not taken any of these drugs so there were no entries in the controlled drugs register. The manager understood her responsibilities to monitor this closely.

The rota was planned and organised in advance to help ensure there were sufficient numbers of suitable staff to keep people safe and meet their needs. The home had recently been extended to provide four additional bedrooms and the service had recruited additional staff. There was a low turnover of staff at the home so people received consistent care and support.

During the day, the three nine-bed units each had two members of staff on duty from 8am until 10pm. The main house can accommodate 19 people and had four members of staff on duty during the same hours. In addition to these staff there was an activities member of staff from 9:30am until 3:30pm and a support worker from 8am until 8pm who was available to all the units as and when required.

Nights were covered by four waking night staff. An additional sleep in member of staff could also be used if the needs of people using the service required. These arrangements provided flexible staff cover across the home. The service also employed domestic, laundry and catering staff. This enabled care staff to focus on providing care and support to people who use the service.

Staffing levels at the time of the inspection matched those recorded on the rota and were sufficient to meet people's needs. Staff confirmed that the current staffing levels enabled them to meet people's needs. One member of staff said "It works quite well. We can always call in the (additional) support worker".

Records showed there were appropriate recruitment processes in place. There was a system for ensuring relevant checks had been completed for all staff. The records included evidence of Disclosure and Barring Service (DBS) checks; this is confirmation that the staff were not on the list of people barred from working in care services. The checklist showed that the provider also obtained references from previous employers and employment histories. This showed that appropriate checks were undertaken before staff began work, to protect people from those who were unsuitable to work in care services.

Good

Is the service effective?

Our findings

People were able to access relevant medical appointments to maintain their health and address any health issues. People told us they saw the GP, District Nurse and/or Community Mental Health Nurse regularly. We were told these health professionals visited the home every fortnight, as well as at other times if required. People also had access to regular healthcare from dental and optician services.

A healthcare professional told us they visited on a regular basis to support staff and people who use the service. They said staff were pro-active and always contacted them if they needed advice or support. Referrals were always appropriate as the staff discussed them with the GP, who decided if a referral was needed. A referral could also be an outcome of multi-disciplinary review meetings. They told us staff had good training and were very aware of the importance of maintaining people's physical and mental health.

Staff monitored people's day to day health needs through a system of regular review and observation and this was clearly recorded. Each person had a key worker, a named member of staff who participated in reviewing the person's care and support with them. Staff told us about their responsibilities as key workers, which included consultation with people and their family members about decisions affecting them. This helped to ensure that people and their relatives were involved and informed about their care and support.

Staff confirmed there was a thorough and induction process followed by further training. We saw a new member of staff was shadowing a senior care worker and being introduced to the people in the unit.

A support worker was available to all the units as and when required, which provided flexible staff cover across the home. The home had its own bank of staff to provide additional cover if needed, so that agency staff were not used. This meant that people were always cared for by staff they were familiar with and who knew their needs well.

A comprehensive training programme was in place to help support staff in meeting people's needs. The staff training programme included a six part dementia course. Records showed that regular training updates were taking place throughout the year, such as moving and handling, first aid, fire safety, infection control, mental capacity, continence management, nutrition and hydration. A member of staff was employed to coordinate staff training and was trained to deliver some courses in-house.

The service also sourced specific training for people's needs as and when required. For example, Parkinson's disease, diabetes and Huntington's disease. All staff were encouraged and supported to undertake diploma level qualifications in health and social care and the majority of staff had attained these.

Staff received supervision and appraisal sessions that were based on their job descriptions and associated competencies. A standard form was used for supervision, comprising questions which prompted discussion and reflection. This helped assure the registered manager and provider about staff development in the understanding of their job and their implementation of training and other learning.

A member of staff told us the training on dementia was "Very informative" and helped them to better understand people's needs. For example, they described how one person's illness affected their speech and mobility. The increased understanding of people's needs also helped staff to respond appropriately when people became distressed or anxious, when their behaviour could change and become challenging. The member of staff said "It helps you to step back and know how to approach the situation".

Another member of staff gave an example of how staff worked together to de-escalate situations on a daily basis. A person using the service would occasionally decline personal care. When this happened, the staff would withdraw and another member of staff would try again later. Staff said they found this approach worked well. Another member of staff told us the training they received was "Really good and thorough. It makes staff aware".

A member of staff told us how they encouraged people to make choices and decisions about meals and other daily activities. For example, through the use of pictures. We saw that all care staff received training in relation to mental capacity and related legislation. They said that if there were any issues around a person's mental capacity then external agencies, such as social services and the community mental health team, were involved. They gave examples of respecting decisions even when they disagreed, such as a person's choice of clothing.

Good

Is the service effective?

A healthcare professional confirmed that staff took into account peoples mental capacity and whether they were able to consent. They told us staff always sought advice if they had any concerns.

A unit manager told us about the processes to ensure that any decisions made on another person's behalf were in their best interests, following a mental capacity assessment to determine a lack of capacity. They told us that the person would be as involved as much as possible throughout the process, as well as their representatives such as family and health and social care professionals. Any decisions made in this way would also be based on the least restrictive option for the individual while seeking to minimise any risk. Another unit manager also told us that they all would be expected to work in the least restrictive way if someone had been assessed as lacking capacity to make a specific decision.

The management understood when a Deprivation of Liberty Safeguards application should be made and how to submit one. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Following a Supreme Court judgement which clarified what deprivation of liberty is, the management had reviewed people in light of this and submitted more applications to the local authority. There was a designated member of the management team who took responsibility for ensuring that the applications and supporting information were sent to the authorising body. No outcomes for the recent applications had been received back from the local authority.

The manager told us that decisions about mental capacity were made as part of a multi-disciplinary team where these involved major decisions about aspects of care and treatment. We saw two people's care plans stated they were no longer able to participate in planning their care. We were not clear how this decision had been arrived at. There was no mental capacity assessment in their files for this decision. The manager stated that the monthly review documentation brought together this type of information, but agreed that they would make it clearer where the information was showing the steps taken to reach the decisions about everyday living.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. The layout of the dining area gave a variety of seating options for people to choose from. Some chose to sit together while others preferred to sit alone. Staff assisted people who required support and encouragement to eat their meals in a calm, friendly and respectful manner.

One person used their cutlery in an unorthodox way. A member of staff encouraged the person to finish their meal and did not attempt to change the way the person ate their food. The member of staff told us their aim was to promote the person's independence and not to complicate matters for them, which could result in them leaving their meal.

Staff also supported people at a pace that suited each person. We saw two people being assisted individually by staff and another person assisted by their relative who had come to have lunch with them. Staff supported people in a personalised way with lots of eye contact, asking if they were ready for more food.

On the lunch menu was a choice of two main dishes and two desserts. Pictorial menus were also used to assist people to make choices about what they would like to eat. Alternatives such as omelettes and salads were available, and special diets were catered for, such as diabetic options. People's dietary needs and menu choices were recorded and a copy sent to the kitchen each day to inform the kitchen staff. Care staff also kept a daily record of what each person ate. We saw examples of completed food and fluid charts for people who had been assessed as being at risk of malnutrition or dehydration.

People told us the food was "lovely". Meals were presented attractively. One person did not want any of the menu items and requested an omelette, which they were given. They told us it was fresh and hot and they were enjoying it.

The purpose built home provided a spacious, calm and safe environment for people living with dementia. People were able to walk freely and purposefully indoors and out, and to visit other units without restrictions. Each unit had its own colour theme in the corridors to aid people in orienting themselves in the building. Bedrooms were personalised and most had a picture of the occupant on the doors with picture cues as to their likes and interests. Some people chose not to have pictures.

The main rear garden provided a secure and tranquil area with a walkway encircling an enclosure with an ornamental duck pond with swans, a large aviary with exotic birds, and wallabies. There were also pygmy goats and pigs, and a

Good

Is the service effective?

vegetable garden where people who use the service were supported by staff to grow a variety of produce. There was a courtyard in the centre of the complex, accessed from all units. A member of staff said the layout of the building supported the delivery of care and "Gives people their freedom". Through the design of the environment the service promoted people's independence, safety and wellbeing.

Outstanding ☆

Is the service caring?

Our findings

We asked people how they felt about living in the home and received answers such as: “It’s very nice”; “It’s fab”; “Very friendly”; “I sleep well every night”; and “They take very good care of you”. Each person had a key worker, a member of staff who could assist them to understand the risks, benefits and alternative care and support options that were available. The key worker system helped to promote positive caring relationships with people using the service, their family, friends and representatives. People spoke appreciatively of all staff and particularly of their allocated key workers. For example: “They’re lovely” and “They help me out with my problems”. One person told us “My key worker is taking me shopping tomorrow. I always look forward to that”. Another person said “My key worker takes me to the library. I take a newspaper and my books and it’s a nice day out.”

A relative commented: “Those that are well advanced in dementia, they look after them well.” We asked them how they would rate the service. They said: “Five star. It has a friendly atmosphere. They always tell me what’s happening and I’m always able to speak to the medics (visiting GP and Community Psychiatric Nurse)”. Of the care provided, they told us: “I wouldn’t want her to go anywhere else. It’s difficult to tell now whether she’s enjoying anything, but they have a moving light ornament in her room and lots of her own things”.

The atmosphere throughout the home was friendly, calm and caring. The staff spoke about people in a respectful manner and demonstrated knowledge and understanding of their individual needs. One person asked staff the same question, referring to their previous occupation, several times during both days of the inspection. In each unit the person visited, staff responded and reassured the person in a warm and sensitive manner. Staff were knowledgeable about people’s history and what mattered to them, enabling them to communicate positively and valuing the person.

Another person wanted to go to their room upstairs and was asking the way. A member of staff responded to their request for help in a timely way. They offered the person a cup of tea and assisted them with their walking frame, by giving verbal prompts: “Hold it there (name) so your weight is evenly distributed. Remember, heels down, big steps. Heel to toe, heel to toe, it works better like that”. The member of staff suggested the person needed to do some shopping and said “I’ll have a look at my calendar and see when the car’s free and we’ll go”.

Staff told us a person living in the house sometimes offered to help them and so was included in tasks, such as wiping the tables. Staff understood that this had an empowering effect on the person.

People were dressed in clean clothes and appeared comfortable. Those who needed them had walking aids within easy reach. People’s bedrooms looked clean and comfortable and contained personal items and pictures. Staff acted in accordance with the home’s stated approach of treating, speaking to and assisting people in a way that respected their privacy and dignity. The design and layout of the building were used to promote and maximise privacy and independence. Each person was accommodated in a single room and personal care took place in the privacy of this room.

The service had a dignity champion who attended three forums a year to help keep them up to date with best practice. Their role was to promote dignity and awareness through induction and training. They also provided guidance at unit manager meetings to facilitate discussion and new ideas on promoting choice and dignity.

A person centred approach to care was evident in the service. Care plans contained information about how people communicated their needs and wishes. A member of staff told us about the care plan guidance for communicating with one person. We observed other staff used the person’s preferred method of communication in line with this guidance. Staff told us the person’s family had been involved in planning the person’s care and support. For example, by providing staff with a list of foods the person liked. We saw the person’s meal at lunchtime had been prepared in the way they found appetising. Staff said that they encouraged the person to experiment with tasters, which had broadened the range of foods that the person would now eat.

The service had links with a local advocacy service and details were provided in the service user guide. The manager told us they had involved advocates for two

Is the service caring?

people as part of the deprivation of liberty application process. They had learnt from this and were starting to raise awareness of the advocacy service via leaflets around the service and in the residents' meetings.

Staff were creative in supporting people to be involved in the service and providing entertainment. They participated in many events that were put on to entertain people, which often fell outside their official hours of duty. These had included a football match (with two staff dressed in inflatable sumo suits) and a competition where people using the service were asked to be the judges. An anniversary party was held each September, with people's family and friends invited and members of the wider community.

Special days were held on each unit every week when a person living at the home had an outing, activity, or meal arranged especially just for them. For example, visits to Marwell zoo, Portsmouth docks, a meal at an Italian restaurant, Chinese takeaway, a school assembly in the local primary school. A person's keyworker told us about how the special days had changed over time to meet the person's needs. The person had liked to go running and staff had accompanied them. As the person had become older they now preferred to go walking on the seafront and so their keyworker arranged for this to happen.

The staff training programme included two modules on palliative care. Staff told us how the service involved external healthcare professionals in arrangements to support people at the end of their life. For example, staff would monitor people for any signs or symptoms of pain or discomfort and refer to the GP or district nursing team. People's care records showed that they had been consulted about their end of life wishes.

Good

Is the service responsive?

Our findings

A person was being admitted to the home at the time of the inspection and was meeting with their social worker and the home's managers. An assessment of the person's needs had been carried out and relevant information obtained from their previous placement. This was being used to write the care and support plan to guide staff on the most appropriate ways of meeting the person's needs. The unit manager told us they were going to send the risk assessment information to all units, so that all staff were appropriately informed. We saw examples of these risk assessments in each of the units.

One person had been anxious during the morning and staff had identified that the person may have been experiencing pain in their shoulder. Staff spoke with the person's relative who provided further insight. It was reported during the handover that this was being taken forward to discuss with the GP. The staff told us the person's medicines were currently under review. They showed us how they documented and monitored risks on a daily basis, including any potential pain people may be experiencing.

Care records showed that people, or their representatives if appropriate, were involved in the reviews of their care and support. One person had corrected some spelling mistakes in their care plan. Another person read and signed their care plan but did not want to be any more involved than this. Detailed records were kept of the regular reviews of care plans and risk assessments. Daily care records were collated, including any reviews by external health professionals, into a monthly review. A three monthly review was held to check that all care records were up to date and accurate. People were involved via the key worker system with their reviews. Any training needs for staff would also be identified through this process.

The service recognised and responded to people's needs for social interaction and stimulation. We observed an Activities Co-ordinator involving a large group of people in various activities in one of the lounges. People were engaged in doing different things: some were potting plants, others were making fruit salad to be served later for lunch. One person was doing a jigsaw. Another person paused from what they were doing to listen to their favourite music CD, which was being played in the room at their request. The provider had purchased an old fashioned ice cream cart and machine so people could enjoy fresh ice creams in the garden.

The Activities Co-ordinator facilitated all this activity, making sure that each person was engaged, whilst talking to everyone in simple, respectful language. In the afternoon, this same member of staff was assisting people to play a game of bingo, one of whom took the part of 'caller'. There were prizes and people were clearly enjoying the activity.

A daily record was kept of the activities that individuals had taken part in. One person said "There's so much to do in terms of activities. I went to [a crafts group] and made fruit salad; and this afternoon there's an art class".

Handover sessions between a unit manager and the senior care worker coming on duty were used to discuss anything that might be affecting the health and wellbeing of people who used the service, as well as what tasks had been done or needed completing. A handover log was used to inform staff if they needed to read any individual's review records, so they were aware of any issues. Email communications were also used. Staff carried phones and we observed a member of staff giving advice to staff in another unit about a person who had gone into that unit and was asking staff there about a particular matter.

A unit manager told us the service had good contacts with the GP and mental health professionals, who were responsive to referrals and requests for advice. A healthcare professional told us staff provided high quality care because of their knowledge and the ethic of the home. They said everyone was treated as an individual and given one to one time with their key worker. There were lots of activities in the home and numerous outings which people were encouraged to go on. Staff would also acknowledge that not everybody wanted to go out and that it was okay to not want to.

While we observed few instances of people showing any sign of being anxious or distressed, staff were able to identify the signs and responded positively people's needs. When one person became anxious and confused, a member of staff assisted them to find their room. The care worker addressed the person by name and spoke reassuringly in a calm and gentle manner, with a hand under the person's elbow.

Good

Is the service responsive?

A complaints procedure was available in a leaflet format and customer satisfaction forms were also available throughout the home. All of the people we spoke with told us they had not had any reason to make a complaint, but would feel comfortable about doing so. The provider told us that the service had received one formal complaint in the past year which was resolved, to the person's satisfaction, within 28 days in line with the procedure.

The service was proactive in responding to people's comments and views. Regular resident association meetings were held to ensure everyone was kept informed about what was happening in the service and to ask for their views and suggestions. We saw the minutes of five consecutive meetings, which included discussions about activities and events inside and outside of the home, the vegetable garden and livestock, regular swimming outings, meals, building work on new bedrooms and the day centre, and support to vote. As well as being informative, the meetings celebrated people's achievements.

At one meeting people had mentioned they would like some new musical entertainment. The minutes of the following meeting showed this had been followed up by the provider. People were asked at the meetings if they were happy with the services offered them; they confirmed that they were. People were reminded that they can speak with the owner at any time about any feedback or concerns. The people present at these meetings had confirmed they knew where to find the owner if they wanted or needed to.

Good

Is the service well-led?

Our findings

The provider told us in their Provider Information Return about their development plans for the service. They said they constantly looked for new ways to stimulate people, improve practice, maintain the facilities and enhance the ambiance of the home. At the time of this inspection, the premises were being extended to provide improved space for the day centre. There were also plans to introduce a 'Pub' serving non-alcoholic beverages, complete with a juke box and darts board, within the next 12 months. This was intended to provide an additional social meeting place for people. The provider also invested in the staff. One of the management team had started a diploma level course in management.

The owner lived nearby and told us they were at the home most days and so was able to monitor the quality of the service provided. One of the management team was employed as a mentor. They told us part of their role was to undertake file audits and showed us how they had improved the process for quality assuring care records. There were detailed computer records of monthly and three monthly reviews that were continually updated. Staff in each unit participated in the updates. For example, people's dependency levels were reviewed following time spent in hospital, including any equipment they required to meet their changing needs.

Both planned and completed reviews were communicated to unit managers. This system ensured that everyone who used the service had their needs regularly reviewed and also that their 'special days' took place. The system was also used to inform staff appraisals and performance management. The registered manager undertook spot checks regularly throughout the home and kept records of this. Outstanding actions were colour coded and monitored until completed.

The manager told us they monitored the quality and effectiveness of the service with regular staff meetings, resident association meetings, customer feedback and online comments through national websites. A company was also employed to carry out annual health and safety audits and employment law reviews. Action had been taken following suggestions in resident association meetings for more outings and menu changes. Staff had influenced changes in the service in areas such as the employment of the floating support worker and a laundry assistant as well as new laundry and kitchen equipment.

There was a performance management system in place, overseen by the registered manager that provided regular on-going supervision and appraisal for all staff. The system enabled unit managers to set targets and follow these up. For instance, where a member of staff should update a care plan, there was a colour coding system to monitor progress. This helped the provider know that staff were supported to provide care to people using the service, in line with the organisational philosophy and values.

A member of staff told us they felt well supported; they had bi-monthly performance management appraisals and could approach the management at any time. They said the management encouraged staff to make suggestions about how to improve the service for people who used it, and would follow these up if possible. For example, a new bed had been purchased for a tall person who had not appeared comfortable in a conventional sized bed.

Management meetings were held and recorded. The meetings were used to discuss business issues and to keep up to date with any relevant news stories and policy changes. For example, changes to the Deprivation of Liberty Safeguards.

There were clear lines of accountability throughout the service. There was always a unit manager or a designated senior member of staff responsible for each shift. Each care worker was allocated a small group of people on a daily basis to help ensure everyone's needs were met. As key workers for individuals who used the service, staff also contributed to the overall monitoring and review of their changing needs. The unit managers worked alongside the care staff delivering personal care and were given allocated time to do administrative tasks. This meant they had first-hand knowledge and experience of meeting the needs of people who used the service.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. The provider paid for the regular on-going professional support of a GP. This was to ensure that the same GP visited, who had knowledge of the people who used the service. The GP, a mental health consultant and a community psychiatric nurse attended

Good

Is the service well-led?

bi-monthly review meetings at the home. This provided consistency of medical care for people. This was further confirmed by one of the participating health and social care professionals, who told us all aspects of the person's care were reviewed at these times.

Following our inspection visit, a healthcare professional told us they saw lots of good practice at the home, with people who lived there being at the heart of everything the service did. They told us that a clinical psychologist had taken some psychology students to help facilitate a group in the home. The feedback from them had been very good regarding the staff's knowledge and capabilities within the group.

The service also worked closely with The Memory Assessment & Research Centre based at a local hospital, which runs clinical research trials into memory problems and dementia. The service had links with a specialist training company to help ensure that staff training on person centred dementia care was based on current practice.

Staff received training on equality and diversity, specifically as part of their training on dementia. We observed staff treated people respectfully and as individuals. The service provided outings, for groups and individuals, to a wide variety of places including restaurants, theatres, pubs and swimming pools. The service's stated aim with these is to encourage everyone to enjoy events that are special to them and for the wider community to see people living with dementia having fun and freedom. Records informed us that people who wished to vote were supported to do so.

The service had a track record of providing a high quality service for people who lived with dementia. They had developed and sustained a positive culture in the home, which ensured people were at the heart of the service, through staff understanding and implementing a shared vision and values. Staff were aware of the aims and objectives of the service. For example, staff mentioned it was important to "Treat people how you want to be treated, or how you would expect your loved ones to be treated". This statement was also included in the service statement of purpose.