Statement of Purpose

This document provide information as required by the Care Quality Commission (CQC) Essential standards of quality and safety 2010.

There are 17 standards covered by this document and the aim of the statement is to outline how the service maintains these standards for their service users. The CQC uses these standards to inspect the home annually.

The outcomes are divided into 5 groups:

The first group cover outcome 1-3 and is involvement and information. The aims of these outcomes is to provide information on how the service respects and involves their residents in their care, how they consent to care and treatment and fees that are payable.

The residents have personalised care plan these are now electronic, and compiled with the help of the staff, pre admission assessments, community teams, GP information, family, friends and the resident. The family and resident will read these care plans and sign that they are happy that the information is accurate and that they consent to the care outlined. These care plans are reviewed at least monthly are any major changes. Family and residents are encouraged to contribute to their care plans. The key worker system in the homes gives a point of access for both the resident and family to discuss any day to day issues. The trained staff are always available as well and the manager, who has an open door policy.

As a home the aim is to provide a welcoming, relaxed homely atmosphere to allow residents to settle and then feel part of the home. The staff work with the residents' to care "with them" and not" for them" allowing them as much independence and choice as is possible.

The second group covers outcome 4-6 and involves personalised care, treatment and support. The aims of theses outcomes is to provide the care and welfare for the service users, met their nutritional needs and cooperating with other service providers.

The residents have personalised care plans and these cover all aspects of the care they may required whilst using the service, the plan reflects immediate needs and develops to incorporate their long term needs and wishes. Their welfare will cover all aspect of their wellbeing including physical, social, emotional and personal relationships. The staff will aim to reflect on episodes of care with the resident and other staff members to ensure safety and maintain the standards of care looking for improvements and staff development as applicable. Within the care plan is the nutritional assessment and this will be used to identify individual nutritional needs and requirements. This is assessed and reviewed regularly, all staff including the cooks and dieticians would be consulted to optimise the nutrition for the residents. The residents would have a named nurse to identify with, this allows a line of communication and as required this named nurse would liaise with any outside agencies that may be required to optimise care.

As a home the named nurse would with all the information from the care plan help the resident and staffs identify any urgent needs and plan their long term care. This allows the resident and family to be involved and give then ownership of their care. The home has a high standard of food providing residents with choice and enabling them to give feedback regarding the food. The kitchen staff all

interact with the residents and family this allows for good communication, and active participation. The named staff would also identify any other agencies required by the resident to optimise their care and stay in the home and action these allowing for open discussion.

The third group covers outcomes 7-11 and these include all the issues around maintaining a safe environment for the resident, maintaining equipment that is required by different residents and, protecting them from harm. Ensuring that the home is clean and infection control policies are adhered to within the home setting. All medicines are administered in a correct and timely system to all the residents.

The home has a robust complaints policy that all residents and family members are given this information is in the welcome pack. The staff current and new are given the North Somerset" no secrets" information this explains about safe guarding issues and how to report it. The home provides training for all staff to cover safe guarding, this is provided annually. Within the home there is a member of staff who is the infection control lead and the aim s of this is to provide on going information to all staff regarding infection control principles how they work within the home setting and importance of hand washing. The aim is to maintain best practice, identify any problems early and work with outside agencies if required. All staff is required to ensure that the resident's rooms are tidy and safe any issues are reported to the manager and recorded in the maintenance book. All equipment is maintained regularly and any inspection annually, staff is required to check all equipment before use to ensure that it is safe and correct to use for that resident. The care plan records all the risk assessments for the equipment to be used of the individual residents. Medicines are all prescribed by the registered GP for the resident; these are then administered by the trained staff member according to the prescription and medication policy. The home has a dedicated pharmacy that is used to dispense all medication and service is audited and reviewed regularly. Any changes to medication are discussed with the resident and family as appropriate. The resident care plans will state their wishes regarding life prolonging treatment; this will be conveyed to the GPs and out of hours service to ensure that the treatment is correct to the resident's wishes.

As a home we aim to provide the safe, welcoming, caring and enabling environment for residents to maintain and develop further independence. The staff ensures that the home has a high standard of cleanliness with the decor adding to the surroundings giving the home that homely feeling. The home has an open house policy to visiting encouraging family and friends to visit join in with activities and entertainment. The manager has an open door policy to residents, families and staff to encourage a positive atmosphere within the home and promote good communication between everyone.

The fourth group covers outcomes 12-14 this includes all staff issues around recruiting, interviewing, checking the suitability of staff to work in a care setting, supporting and developing staff whilst in the home environment. Ensuring that the staffing level is sufficient for the number and care needs of the residents.

The home has policies and procedures to follow when recruiting staff, all staff are interviewed and have a DBS check to ensure there is not any reason why they should not work with vulnerable groups. The new staff has an induction programme and learner portfolio to follow with the help of a mentor. The aim of the portfolio is to give a basis for the standard of knowledge to be attained by the carers; this can be used as evidence in their continuing development through the diploma in health

care. All homes have a staff appraisal programme which runs throughout the year, and a supervision system that covers a wide variety of topics these can be organised as group or individual sessions depending on the staff and home requirements. All homes cover all mandatory training that is required for all staff on an annual basis.

As a home when recruiting staff the manager and trained staff discuss the home and residents needs and aim to add to the staffing team by looking at the group dynamics and how to build the staff team. As a smaller home then the group dynamics are important and retaining staff, here some members of staff have received their 20 year long service award and are very proud to have worked for that length of time and have the recognition from the owner. When recruiting for new staff the manager or trained staff will interview with a resident as well to get different points of view. The residents enjoy being part of this and their feedback is very useful in the decision making process. As a home we use in house and external trainers to provide all the mandatory training each year, this ensures that all staff new and old has the relevant and up to date information. This also provides a good area for discussion around topics and how to apply in the home situation.

The fifth group covers outcomes 15-17 which look at assessing and monitoring the service provided, how to ensure good practice, a complaint process that is known to all and affective. The statement of purpose which this required within the home and this document is highlighting a concise version.

The home has an in depth statement of purpose which reflects all aspects of the care , choice, support, management and treatment that may b e required by any of the residents within any home setting. The home uses for monitoring, quality assurance questionnaires that are completed by the residents, family, staff and outside professionals. The information gained from the questionnaires is put in an audit from and an action plan developed for the home to action in a given period of time. The home has a complaints procedure which is used robustly in the homes to ensure at issues are dealt with promptly.

As a home the in depth statement of purpose is available within the home, this concise version is in the residents welcome pack for themselves and family to read. Staff are happy to explain any issues that might arise, the residents have a named nurse and key worker to communicate with, and this is outlined in the welcome pack as well. The open door policy within the home for residents and family to visit and talk with the staff and manager helps ensure that any concerns are dealt with promptly and that complaints are reviewed and responded to promptly as well, ensuring that any regulators are informed as necessary. This ensures that there is an open dialogue between everyone responsible for the support and care at all times. The quality assurance questionnaires are completed every six months within the home and a sample of the staff, residents, families and outside professionals are taken. The audit information forms the action plan and this is then addressed by the different teams within the home. The home feels at auditing the service is very useful to improve and move the service forward.