Moorland View
Residential Care Home

Service Users Guide

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MOORLAND VIEW CARE HOME SERVICE USERS GUIDE 2025 CONTENTS

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1) OVERVIEW and ACCOMMODATION

This care home currently enjoys a good local reputation, enjoying a near full occupancy when the current average is 85%, thanks to its team of competent, mature staff. The team is highly regarded by the two local GP surgeries, as well as the local social work team. The care home, managed the Covid Pandemic, not losing any of the residents to the disease.

Moorland View is registered with the Care Quality Commission as a 32 bed residential care home for older people without nursing. We cannot accept anyone under the age of 65 years. The former St James vicarage, built in 1895, situated on the Chapels area of Darwen, a mile from the centre, in its own landscaped, wooded grounds of one acre, surrounded by a traditional, dry stone wall. For directions, the postcode is BB3 0DT.

The Home provides accommodation in 32 single rooms, half of them offering an en suite washbasin and toilet. There are 25 rooms on the ground floor, the remaining seven are on the first floor, accessed by a modern Platform Lift. The fire enclosed staircase is modern. Many residents seek to maintain their independence within their ensuite rooms, with the secure knowledge they have access to a large group of well trained, local competent mature staff, 24 hours of the day. As a team, we possess a wealth of residential care and nursing experience.

The care home employs over 40 staff, most of whom have completed their Health and Social Care Diploma (NVQ). The majority have an NVQL3 and some have Level 5 in Management Studies.

An imperative aspect of running a care home in the current employment market is I have a UKVI “Licence to Sponsor”. There are no local work candidates, we are totally reliant on people from overseas. All of these people are well educated and possess a supreme work ethic. The home would no longer be able to offer a service if it was not for these hard working people.

There are three lounges, allowing people a choice of seating within the Home. Whether the potential client suffers from arthritis, incontinence, stroke, non challenging dementia or other age related illnesses, such as diabetes, kidney failure, Parkinson’s, falls, the management and staff are all committed to the successful integration of all service users taking into account the individuals physical and mental limitations.

You may bring your own furniture if you wish, to encourage familiarity and remind the service user of families and friends. There is an emergency “Aid Call” accessible alarm bell in all rooms, and toilets and staff are on call twenty four hours a day. We have a modern, serviced platform lift and a fully compliant fire detection system. There is an “Evacuation” chair at the top of the stairs. And every person risk assessed as unable to mobilise in the event of a fire has a fire evacuation mattress. There is 60 minute protection between floors and up to date steel enclosed fuseboxes.

There are four bathrooms of which three are assisted but the main one has a choice of shower as well as an assisted bath. To aid with the moving and handling of our residents we have three mobile hoists and a “Stand Aid“, sometimes we use a turntable. We request up to date Moving and Handling assessments from the Blackburn Independent Living Centre. All staff members must hold a current annual Moving and Handling certificate, and to support these we offer competency assessments, as part of the process.

2) HEALTH AND SOCIAL CARE ACT 2008 AND THE REGISTRATION & SERVICE USER CATEGORY:

Like all care homes, we are registered with the Care Quality Commission under The Health and Social Care Act. Following our most recent inspection dated the 7th/8th March 2023 this home has been rated as GOOD.

1) **SAFE**, are people protected from abuse and avoidable harm? The Key Lines of Enquiry (KLOE) include Safeguarding and protection

from abuse; managing risks: suitable staff and staff cover: medicines management: infection control: learning when things go wrong.

2) **EFFECTIVE** is the peoples care, treatment and support achieving good outcomes, promoting a good quality of life. The KLOE being assessing needs and delivering evidence-based treatment, staff skills and knowledge; nutrition and hydration: how staff, teams and services work together; supporting people to live healthier lives; accessible premises; consent to care and treatment.

3) **CARING**, are the staff involved and do they treat people with compassion, kindness, dignity and respect.

4) **RESPONSIVE**, meaning that the service is organized so that they meet people's needs. Person centred care; concerns and complaints: End of Life care.

5) **WELL LED**, that the leadership, management and governance of the organization assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

3.0 AIMS AND OBJECTIVES

3.1 To provide a "Homely" means of living for older people, who by reason of increasing frailty choose to leave their existing living environment, accepting that they cannot meet their own needs and seek to have ourselves to provide such personal care and accommodation for older people over a 24 hour period.

3.2 The registered provider, manager and staff aim to offer you the best standards of care and personal attention possible by providing a secure and happy home. We aim to keep the environment of the home relaxed and comfortable, as well as offer you the opportunity of independence and to maximise personal choice, through our agenda of"Personalisation".

3.3 To support individual service users with their physical, emotional, spiritual and psychological, political and human rights such as fairness, respect, equality, dignity and autonomy as well as respecting diversity.. This may be provided from within the home,

by relatives or by involving outside agencies. This should enable the service user to remain at the Home unless specialist medical attention is required.

3.4 You will be encouraged to be involved in decision making within the home. This is achieved by holding monthly care plan meetings as well as residents meetings. To ensure that service users rights are fully advocated and that their needs are met in full.

3.5 We will fully involve you and your family when planning care for you and this is reviewed on a three monthly basis. We will provide each service user with an individual plan of care, which is regularly reviewed and updated with their involvement. There is a paper and digital overview.

3.6 To provide an environment where, through individual and group discussions, the ideas and concerns of service users, their relatives and staff are recognised and acknowledged.

3.7 We will encourage you to pursue hobbies and interests previously enjoyed, as far as this may be possible. We will, in accordance with your wishes, invite services, guests and entertainment into the home to enhance your lifestyle. We have someone who holds activity sessions, sports physio and organized concerts.

3.8 You have the right to choose your own General Practitioner (GP) as well as other healthcare professionals such as Dentist.

3.9To provide service users with a means by which their complaints are listened to, taken seriously and appropriately responded to and to be represented by friends and an advocate if they so wish.

3.10 The Safeguarding of vulnerable adults is at the core of everything that we do. People are safe because the service protects them from, bullying, harassment, avoidable harm and potential abuse and “acts of omission”. There is a culture of learning from mistakes and an open approach. The service manages incidents, accidents, and safeguarding concerns promptly, and where required, investigations are thorough. We are required to send in Safeguarding alerts via their portal to the local social services, as well as notifications to CQC. There is a consistent approach to

safeguarding and matters are always dealt with in an open, transparent and objective way.

4.0 FACILITIES AND SERVICES

4.1 MEALS Currently have a Food Hygiene Rating of 5. Breakfast with a choice is offered to every client at 7.30am, up to 10am . All meals are generally provided in the dining room, breakfast, dinner and tea. The client can have their meal in their own room or sit in the dining room at their own chosen time. Clients can assemble in the dining room. Those that get up later in the morning, may have their breakfast in their room, as well as the dining room. The main meal starts at 12 midday. Clients sit in the dining room. Some may prefer to eat in their room. All meals being prepared in our kitchen. Special dietary needs for medical, such as diabetic or cultural reasons or preferences such as vegetarians are catered for. The provision of soft foods, for those who require assistance is important as is the allocation of staff members to ensure each resident receives appropriate support for their assessed needs. A request for the advice of the Dietician can be made by ourselves, as can a SALT assessment, for those with poor swallowing technique. The resident then has their own nutritional assessment, involving the use of fortified foods, based on the industry kitemark of the IDDSI scale of 1 to 7 for food and IDDSI scale 0-3 for drinks. They can be prescribed a thickening agent for their drinks. This is to reduce the risk of aspiration.

We have three cooks, one of whom is a full time chef, working four days per week, who have taken it upon himself to organize the kitchen area, renew the records, providing clearer governance, placing daily menus in the dining area, for the residents to access, including information concerning allergens. The kitchen receives an annual Deep Clean.

Afternoon tea, consisting of a light meal or soup and sandwiches is provided at 4pm and there is a supper at 7pm. There are frequent cups of tea and other drinks provided during the day, as well as to the visitors. We have an four week menu and put up an Alternative Menu to encourage choice. Feedback is encouraged. You can discuss and contribute to the menus. The menu is available to view on the website www.moorlandview.page.

Staff protect people, especially those with complex needs, from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions that affect their health. People's needs are regularly monitored and reviewed in their care plan and relevant professionals and people using the service are actively involved in this, such as a SALT assessment for those who have a difficulty with their swallowing. People say that the food and mealtimes are consistently good and speak positively about the menu and the quality of food provided. They feel actively involved in this aspect of the service and able to give feedback on a regular basis. Innovative methods and positive staff relationships are used to encourage those who are reluctant of have difficulty in eating and drinking. This approach makes sure that people's dietary and fluid intake, especially for those, living with dementia significantly improves their well being.

We weigh, assess BMI and monitor on a monthly basis the nutritional intake of our clients. Those that are losing weight, will be considered a concern and referred to the GP and /or Dietician. For those residents who struggle to maintain their own eating skills, additional staff assist them, at meal times with their eating, of soft fortified foods and by providing them with supplementary

drinks, to enhance their weight, such as the daily provision of high calorie smoothies for those with low weight. All of the above is evidenced.

4.2 **SOCIAL ACTIVITIES:** Many clients who come in, require a social input.

Each month at the Residents Meeting a program is circulated so that you are aware of what is on offer. Suggestions are always welcome. It is my intention I have a daily activity session.
We have a very good visiting sports physiotherapist, four times a week, who assesses and delivers his service on a group basis as well as one to one. We have a list of games, not all suitable for everyone. We have those who are interested in Arts and Crafts and you will see examples around the home. Pictures, cards and Forget Me Not. There are visits from both local churches. Concerts are also arranged about once every two months. We have a monthly Residents Meeting to discuss Activities, planned outings, customer feedback. We seek to have two activity sessions per day whether it involves simple games, physio, bingo or music, being aware that everyone needs to be involved at some stage.

4.3 **LAUNDRY**: Clothing is washed and dried within the Home, using our two commercial washing machines and two gas dryers and then distributed to the clients' rooms. It is advised that all clothing should be marked by the client or their relatives. Some relatives take the washing home. **4.4 TELEPHONE**: Many people now possess a mobile and /or Tablet. There is internet through the care home via two modems and a booster**. 4.6 NEWSPAPERS**: We would ask relatives to organize this. **4.5 VISITING**: Now unrestricted**. 4.8 HAIRDRESSING**:There is a hairdressing room, within the Home. The hairdresser visits on a Wednesday afternoon. It will be to her, that the client will be responsible to, for making a payment. She now has a card reading machine. Clients are welcome to bring in their own hairdresser. **4.9 CHIROPODY/OPTICIAN/ DENTIST**: To meet the clients needs, we have a visiting optical service that will ensure that everyone's eyes are tested annually. The local CCG provides a chiropody service, for those who qualify and will visit once each three months, otherwise people need to access their own chiropodist. We are accessing a Dentist in Blackburn.

4.10 RESIDENTS MONEY: Each resident is welcome to have money on the premises, although there is a particular policy. We will ask the relative or whoever may have power of attorney to deal with such matters. There is a small safe. It is important that each resident has access to their pocket money and is freely available for clothing, activity sessions. An audit of such sums is carried out. There are small wall mounted cupboards and/or a lockable drawer in some rooms. We ask you to consider, not bringing in any belongings such as jewelry that is of financial or sentimental value.

5.0 PRIOR ASSESSMENT OF THE CLIENT, INCLUDING ADMISSION

For us the admission process seems to have changed. We now usually get referrals via recommendation and will discuss with the social worker or Hospital Social Work Team. Due to Covid, we no longer visit the Hospital to undertake an admission but rely on their Trusted Assessment Document (TAD). The aim of this assessment is to make sure that the placement is suitable, thereby minimising the risk of failure. Additional information such as an "Overview Assessment, Moving and Handling Assessment" from a social worker can be useful. Both the

assessment and care plan will be “Person Centred”. We are also able to use a virtual video tool via computer such as Microsoft Teams. Therefore we will ask the client or those involved in their welfare for a Personal History as well as a list of their “Likes and Dislikes”. We can assess people in their own home.

A contract is prepared as soon as the appropriate information is made available, such as source of funding, residents contribution. Those funded by Blackburn with Darwen will also receive a contract from them.

5.1 ADMISSION If a vacancy exists and both the enquirer and myself agree that the proposed admission is suitable, arrangements can be made for a transfer to the home. Funding must be agreed usually via a social worker, usually via a D2A unless the client is self funding. People usually look around the home before deciding whether to bring someone in.

5.2 TRIAL PERIOD via SHORT TERM or RESPITE: The option of a two or four week six week short term trial period always exist. Many use the latter to enable rehabilitation, perhaps after a fall, before returning home. people are encouraged to use this system for getting to know the Home. Such cases are usually considered an emergency.

5.2A DISCHARGE TO ASSESS (D2A) This is a new scheme administered by the NHS. Essentially the NHS will fund a placement for 28 days in a care home, whilst the client, gains access to both rehabilitation, as well as professional assessment. It can be that the person is required to stay in nursing care, may need residential, and it may not be this home as well as a return home. The funding can end before the 28 days, with the LA agreeing to take over, or the person actually returns home, before the end of the term.

5.3 HOME FOR LIFE: Placing a loved one into a care home is difficult. We offer a home for life. We have experience with those that become physically highly dependent, who can be supported by the District Nurse Team as well as those who experience a mental decline. However should the decline, lead to a situation where the client infringes upon the rights of others. It is then we may have to discuss asking you to consider an alternative environment where their new assessed needs can be better met. We will ask you to think about details and necessary arrangements to manage your End of Life.

6.0 CARE PLANNING.

People receive care and support from staff who know and understand their history, likes, preferences, needs, hopes and goals. The relationships between staff and people receiving support consistently always demonstrate dignity and respect. We are currently using a software package called Caredocs to provide enhanced reading experience. Staff know, understand and respond to each person’s diverse cultural, gender and spiritual needs in a caring and compassionate way. The individual service users agreed plan of care or service plan provides the basis on which our service is delivered. It is a document outlining the assessed needs of the client and detailing how we as the service provider will meet and deliver those needs. It is reviewed monthly and will involve the client and or their significant person. The daily care programme is organized as a response to the service user’s individual and combined needs. Each service users plan includes a description of their preferred daily routine, their likes and

dislikes in relation to food and any specific dietary requirements and similar matters. It includes their preferences in respect to how they like to be addressed and what dignity, respect and privacy means to them in terms of daily behavior and actions. We find that it is particularly important to find this out in relation to any intimate personal care activities that staff are expected to carry out.

The care plan also contains a risk assessment and any risk management plan needed. It includes details of health care needs, medication, their GP and any community nursing or other therapeutic services provided or, that which the service user commissions for her or himself. The service plan also includes details of their social interests and activities and how these are met, and any arrangements to attend religious services of their choice and for contact with relatives, friends and representatives.
It will include a summary of the care plan, details of the client, a personal history, this we update as time progresses, nutritional assessment, risk of falls, manual handling, risk assessment, whether help is required with eating, toileting, sight, mouth, hearing, skin care, Waterlow scale, sleeping, advanced care planning and oral hygiene and so on.

7.0 STAFFING

Twenty years it has taken to accumulate the team that is here at Moorland View. It possesses an enviable team of competent senior carers who support each other, to deliver the best care in the area, that is recognized by our Health and Social care colleagues. At this moment we are fully staffed with some bank staff who are helping get through the school summer holiday. We are full because of the sponsored license system, so we can employ people from overseas. This is an enviable position to be in. Kindness, respect, compassion, dignity in care, maturity, equality, diversity and empowerment are the key principles on how the service recruits, trains and supports its staff. There are robust systems that make sure that this is happening in practice. Staff develop trusting relationships and understand and respect confidentiality. Staff recognize the importance of the values of the service and challenge staff behaviour and practices which fall short of this.

Staff manage medicines consistently and safely. The service stores medicines correctly, disposes of them safely and keeps accurate electronic records. There is a daily audit of our own medication records and the creams that are applied to residents. People are assured they receive their medicines as prescribed via the software system. On every shift because of the volume and importance of the medication, we use two care staff to dispense. Many rooms have their own cupboard, for storage, thereby encouraging personalization. Ongoing training includes undertaking a “Medication Competency Assessment”. Where appropriate, the service involves people in the regular review and risk assessment of their medicines and supports them to be as independent as possible. We currently have Proxy Medication status with the local GP surgeries, so that we can order medication items on behalf of the residents, direct from the surgery via a computer app.

I am proud that I have a solid core of mature, competent staff members. The home has a low turnover of staff. We are constantly training, supporting and developing new members of staff.

We offer an interview with those that enquire about this home. Most of our staff are older and this reflects a problem within society.

It is very important that we deliver care to our residents within a safe environment. Quality of staffing is important, presentation, approach to residents and visitors. When potential clients or their visitors visit the home, this is one area where an instant impression can be made and a difference made with other homes. I am confident my staff have similar ideals to myself as to what is good quality care.

Some may feel that a larger home will feel institutional. I hope this is not the case. The larger the Home, the greater the staffing pool available. We have to deliver safe care and manage genuine staff absence. This is more likely with a larger home.

With our current occupancy we have the owner/ manager or equivalent, a senior care and five carers, three on domestic and someone in the kitchen, during the day. One senior and four carers in the evening and three at night. This is around an average of 30 hours of staffing for each resident per week. We feel that society does not value the role of carers within their community.

7.1 STAFF TRAINING: The care home is fortunate to have its own dedicated trainer. Again not many care homes can say that. The service ensures that the needs of people are met consistently by staff who have the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours. Staff are trained by our experienced provider, at the home, on an annual basis having to renew their annual awareness training for Moving and Handling, Protection of Vulnerable Adults (abuse), Food, Health and Safety, Infection Control, Fire as well as three year certificates for First Aid and the Safe Handling of Medication. There is additional training to cover Mental Capacity Act 2005, DOLS, Respect and Dignity. The service has a proactive approach to staff members' learning and development. All new staff must undertake and complete the Care Certificate within three months, regardless of experience. Because of the Pandemic and the advent of elearning, training has changed and is no longer carried out in groups but through individual elearning.

7.2 STAFF RECRUITMENT (DBS): Potential staff members at all care homes, undergo an interview. If successful, we will then follow up on their references. We offer an interview to all those that contact the care home. This has meant I have not needed to advertise. I do not need to use bank staff.
It is usual for myself to ask for up to four references, seeking to cover their recent employment history, where employed, at school, or further education establishment. We will then apply for a DBS (Disclosure and Barring Service). A candidate cannot start without at least two references and a clear DBS. It is expected that my recruitment process is robust.

7.2A UKVI SPONSORSHIP LICENCE: recruitment has recently become a serious problem for all care providers. A system exists where we can employ those who possess a work or study visa. People come from abroad, will study for a masters degree and can work upto 20 hours or their spouse is able to work unrestricted hours. Their work visa will expire at the end of the year unless I offer to sponsor them via the Home Office. We would not be able to cope without these people,

they offer to work many hours, are flexible, eager to learn and seek to give us no problems, merely solutions. I use six people and they probably provide a quarter of my hours.

7.3 THE CARE CERTIFICATE : Staff have a thorough induction that gives them the skills and confidence to carry out their role and responsibilities effectively so that people have their needs met and experience a good quality of life.. I am fortunate to have an external trainer who is able to induct staff and set them work to enable them to achieve their Care Certificate, within three months. Those with previous experience will can achieve their recognition within a shorter time scale. We have a system, whereby we offer qualified training to such people and allow them to gain experience, before they can work on shift.

7.4 HEALTH AND SOCIAL CARE DIPLOMAS (QCF) The majority of staff must have their NVQ, whether L2 or L3 usually. There are more NVQ L3's, than L2's, the manager holds the Registered Managers Award. We have a policy that all staff will achieve their NVQ. There are some candidates who have achieved their Level 5 Certificate in Management Studies. To achieve L3, staff members need to provide evidence of their competency with English, Maths and IT. Our current provider is called Training Works based at Blackpool.

7.5 HEALTH AND SAFETY INCLUDING FIRE: We keep the premises, services and equipment well maintained. We take all possible action to reduce the risk of injury caused by the environment people live in, and look for ways to improve safety. Staff are trained to use equipment correctly to meet statutory requirements and to keep people safe. We have needed to change our evacuation protocol. The home has a fully complaint fire and smoke detection system, fire alarm, fire doors etc. Further to this the Home has Gas Safety Certificates for the boilers and gas cooker. Electrical certificates for the main updated fuse boards, as well as all appliances. Monthly water temperature readings are important in monitoring the risk of Legionnaires Disease. We have a closed pressurized water system, with water circulating at 60C so eliminating Legionella. Biannual LOLER certificates for all hoisting equipment as well as the lifting aids within bathrooms and slings.

The renovated area, has a fire alarm system, that is able to show which room has detected a problem. Current status is L1 for fire, having recently fitted smoke detectors in all roof voids. We have a professionally written Fire Risk Assessment. Main fire panel was replaced in June 2022 All rooms have self closing doors with smoke seals as well as two means of escape, via the enclosed fire resistant staircase. All equipment is serviced, such as hoists, hospital profile beds, bathing equipment. There is a smoking ban as supported by the Health Act 2005, starting July 1st 2007. Each resident within their care plan will have a Personal Emergency Evacuation Plan (PEEP) and we are currently looking at fire evacuation involving an emergency evacuation sledge within a building, with its many designated compartments or curtain walls.

8.0 ACCESS TO BOTH PRIMARY AND SECONDARY HEALTHCARE

People experience positive outcomes regarding their health. Staff know their routine health needs and preferences and consistently keep them under review. The service engages proactively with health and social care agencies and acts on their recommendations and guidance in people's best interests. Appropriate referrals are made to other health and social care services. The service takes preventative action at the right time to keep people in good or the best of health. Links with health and social care services are excellent.

Where people have complex/ continued health needs, staff always seek to improve their care, treatment and support by identifying and implementing best practice.

We are considered a leader within this area, in facilitating virtual video consultations between GPs and their patients within the care home, using such digital platforms as Microsoft Teams. We have a Virtual Video Ward Round on a Thursday morning. We get support from an Advanced Nurse Practitioner and A Community Pharmacist.

People feel informed about, and involved in, their healthcare and are empowered to have as all of our clients, have access to their own GP and all of the services associated with their practice such as the IHSS, District Nurse, Falls Assessment, Physiotherapy, SALT team, wheelchair supply and repair, equipment loan stores. We are able to access these services through the GP or Social Services. People always have access to hospital services whether it be outpatients or through A&E. We feel we work well with all of these services and are happy to expand, should you want some further information.

9.0 USER SURVEY AND VIEWS OF THE HOME

We are committed to maintaining and improving the quality of our service. We have a comprehensive set of Policies and Procedures that include all aspects of the running of the home, that are constantly revised. This includes our Complaints Procedure. An important aspect of our approach to quality assurance is to obtain the views of all stakeholders, particularly those of residents, relatives and their representatives. We do this by our regular care plan reviews with individual residents, customer feedback questionnaires and separate meetings with residents and relatives.

The local authority who commission and fund the majority of our clients have their own Quality Assurance System. They wish to make sure that they are getting value for money for the fees that they pay to this and every other home. The Authority wishes to make sure that their residents are getting a full range of service input and that there is sufficient staffing, nutrition and choice of food, staff training, care planning and a range of activities. We currently meet their standard.

Quality Assurance is also about encouraging feedback and enhancing the role of the resident within the Home. We frequently use QR questionnaires with the residents asking if they enjoy their food, activities, are their rooms clean. We are seeking to make this a regular occurrence, a part of the formal activity session, where the residents "voice" can be heard, as well as the regular monthly care planning. The effectiveness of our own "Governance" is also consistently reviewed.

Further to the above, CQC, I am currently undertaking my own internal quality audit. This includes the kitchen, medication, staff supervisions and appraisals, health and safety, infection control.

10.00 DEPRIVATION OF LIBERTY STANDARDS (DOLS)

Since March 2014 it has been a requirement to seek and obtain a Standard DOLS for someone to reside within a residential environment, who does not possess sufficient capacity to make the decision as to whether to resident within a residential setting, when it is in their best interests. This is usually for those with severe dementia and need to have restrictions in place, to ensure their safety but means they lose some of their liberty. A person with capacity can choose to leave or stay. A person with dementia may say they want to leave but it is not in their best interests, therefore the home must seek a DOLS. Restrictions are an important reason for seeking a DOLS. The majority will have an authorization, or a request is in place.

11.00 HOW WE DEAL WITH END OF LIFE

When people are nearing the end of their life they receive compassionate and supportive care. These people, those who matter to them and appropriate professionals such as the GP and the DN. IHSS now come out and discuss an

Advanced Plan of Care (ACP) so that staff know their wishes and make sure the person has dignity, comfort and respect at the end of their life.

The GP service will now discuss the Ceiling of Care for the most vulnerable of our clients. They will talk to the client and to the family members. This is about minimizing visits to hospital and unnecessary transfers. There are various levels, the highest of which involves the home having prescribed comfort drugs on the premises should the person deteriorate. This is about enabling a good death.

Clarity for difficult future events can be provided by a DNAR or Do Not Attempt Resuscitation order, provided by the GP or Hospital Consultant with the involvement of family as well as the above. The majority have one.

People are given support when making decisions about their preferences for end of life care. When necessary, people and staff are supported by palliative care specialists. Necessary services and equipment are provided as and when needed as above.

The service makes sure that facilities and support are available for people, those who are important to them and staff before, during and after death. It is important during Covid that access is granted to those who need to visit loved ones, during the End of their Life.

12.0 SUMMARY OF STATEMENT OF PURPOSE

It is our aim that Residents who live in our Care Home should do so with dignity with the respect of those who support them and be entitled to live a full and active life and be given the fundamental right to self-determination and individuality. These basic rights are accorded to all who find themselves in our care; there is no attempt to distinguish between one group of clients and another. The purpose of our home is to enable service user's to achieve their full potential. This is best achieved by sensitive recognition and nurturing of that potential in each individual and understanding that it may change over a time.
Our aim is to preserve the self respect of those who depend on the support of others.
Privacy of space is important, as it is client's right to hold and express opinions. Courtesy and respect to all relationships will be observed. The staff must respect confidentiality and what is personal and private.

Staff are to be responsive to the needs and requirements of each individual client and not to impose the needs and preferences of others. For example, clients from ethnic minorities who come into residential care will increase and staff should be aware of, and provide for religious and cultural observances, both dietary and ritual.

The needs of the individual client are paramount. Discrimination does not take place, on any grounds.
Emotional support is also considered to be of vital importance to the general well-being of each client.

Provision for leisure activities in and outside the Home is essential and staff should be sensitive to individual tastes and capabilities, and be flexible to meet these needs. Where it is seen to be appropriate, resources in the community are engaged to meet the client's needs, such as public library, daycentre, dentists, hairdressers, community care, hospice care and counselling team etc.

A positive regard for the client's family and friends reinforces the esteem in which the service user's are held. The presence of personal possessions is considered vitally important, as are the opportunities to go shopping, attend places of worship, visit the theatre and go to the pub.

Clients have normal opportunities for emotional expression and physical human contact; however, excessive paternalism and concern, leading to the infringement of client's personal rights and privacy is avoided. Those clients who are competent to judge the risk to themselves, are free to make their own decisions so long as they do not threaten their own safety and/or that of others.

13.0 TERMS AND CONDITIONS, INSPECTION AND COMPLAINTS

1. The terms and conditions in respect of accommodation to be provided for service users, including the amount and method of payment of fees.

   This can be sent to you.

2. A standard form of contract for the provision of services and facilities by the registered provider to service users

   This can be sent to you.

3. The most recent inspection report

The most recent CQC report, dated the 7th/8th March 2023 is available to read from their website, this being www.cqc.org.uk, as well as our own moorlandview.page. We have a Good rating from BwDBC PAMMS report.

4. A summary of the complaints procedure

   You and your relatives or representatives must feel free to complain or express concerns about any issues relating to the running of the home that are not to your liking. Complaints can be made through the management, with the service provider, dealing with it personally, if there is no resolution within a week.

   A copy of the complaints procedure is attached at the annex a)

The resident (or his/her relative/representative) can make a direct complaint or express a concern to the inspecting officer at the Care Quality Commission.

Address and Telephone Number of the Commission

CARE QUALITY COMMISSION NORTHWEST
CITYGATE
GALLOWGATE
NEWCASTLE UPON TYNE
NE1 4PA

THANK FOR READING THIS GUIDE. I WELCOME ANY FEEDBACK THAT CAN ENHANCE ITS CONTENT.