MEDDYG CARE
YOUR CARE... YOUR CHOICE

01766 800 900 www.meddygcare.group enquiries@meddygcare.co.uk

STATEMENT OF PURPOSE

ABOUT THE PROVIDER

SERVICE PROVIDER	MEDDYG CARE (PORTHMADOG) LTD
NAME OF SERVICE	MEDDYG CARE DEMENTIA HOME - PORTHMADOG
ADDRESS OF SERVICE	GARTH ROAD, PORTHMADOG, LL49 9BN
LEGAL ENTITY	LIMITED COMPANY
RESPONSIBLE INDIVIDUAL	KEVIN EDWARDS
REGISTERED MANAGER	RICKY HERNANDEZ RGN
DEPUTY MANAGER	THOMAS DOE
CLINICAL LEAD	CHARLES MIRAM

DESCRIPTION OF THE LOCATION OF THE SERVICE

Meddyg Care - Porthmadog is a 41 bedded, dementia specialist nursing home located in an elevated part of Porthmadog overlooking the historic harbour and with views of Snowdonia in the distance. We are within a 2 minute drive of all transport and community facilities. All areas within the home and grounds are accessible by wheelchair.

FACILITIES, SERVICES & EQUIPMENT

38	3	41	2	3	1	3	1
SINGLE ROOMS	DOUBLE ROOMS	EN-SUITE ROOMS	SHOWER WET ROOMS	BATHROOMS	DINING ROOMS	COMMUNAL LOUNGES	OUTSIDE PATIO

RANGE OF SERVICES WE CAN SUPPORT

We provide person centred care for people aged 30+ who need residential support with daily living. Nursing care is provided for those with more complex medical needs that require the support of registered nurses, 24 hours a day.

DEMENTIA CARE

Every person's experience of dementia is different. That's why, at Meddyg Care, we personalise our care to you. We'll help you stay connected to family and friends on your journey with dementia.

Our expert dementia care teams provide round the clock specialist care and we'll support you to continue living a purposeful and fulfilling life within our safe and supportive environment.

RESPITE CARE

Respite care is available, when occupancy allows, to provide short stay support and temporary relief for caregivers, by offering alternative care arrangements for the person they are looking after. This can involve a few hours of care per week or longer breaks.

Respite care aims to support the caregivers well-being and prevent burnout while ensuring the person receiving care continues to receive the necessary support.

NURSING CARE

Everyone deserves to live with purpose, dignity and comfort, whatever their circumstances. Our person centred approach enables you to live life as fully and independently as possible, with all your nursing care needs in the very best of hands.

Our expert teams of independent practitioners place you and your loved ones at the heart of everything we do. We'll take time to listen to you, laugh with you, comfort you, and offer a supportive shoulder to lean on when things feel tough.

PALLIATIVE CARE

We believe dignity in death is just as important as quality of life. That's why our end-of-life nursing care aims to make the final stage of your life as positive and peaceful as possible. We'll support you and your loved ones by understanding and upholding your wishes with compassionate care planning.

Most importantly, we'll do all we can to allow you to spend your last moments peacefully, in a place you call home, surrounded by the people you love the most.

ADULT DAY CARE

We offer half and full-day adult day care sessions for individuals living with dementia, alzheimer's and other complex conditions, making sure they're treated with the same dignity, specialist care and attention as our full time residents.

We offer day care for people who might be considering respite or permanent care.

Our approach aims to assist people to maintain their independence and remain in their own homes for as long as possible, whilst also making an eventual move into the home less daunting.

We provide:

– Nursing care and medication assistance
– Personal care such as toileting and hygiene assistance
– Engaging and therapeutic activities
– Games, group exercise classes, and outdoor time
– Cognitive stimulation via crafts, music, and social interaction
– Nutritious meals and refreshments

Suitability is done on an assessment basis which takes into account the delicate balance required to meet those already living at our home.

HOW THE SERVICE WILL BE PROVIDED

The philosophy of our management team is to care for everyone equally, regardless of their sexual orientation, religion, race, age, disability and linguistic background. Our pre-admission assessment includes a language assessment. This is an ongoing assessment in respect of how the resident's language needs will continue to be met.

Care delivery is provided through the medium of English and Welsh. Individual care plans can also be made available in Welsh. Our staff routinely engage with people using the service through the medium of Welsh. The culture of our residents are reflected in the life of our home by way of cultural and sporting events, significant dates and anniversaries, food and music.

People will be cared for and supported in an environment that is safe, well maintained, and secure.

Risks will be identified and eliminated where possible to promote active independence via completion of Health and Safety risk assessments, environmental audits and person centred individual risk assessments.

The home employs a maintenance team that hold direct responsibility for daily, weekly and monthly checks of the environment, building and equipment. These include:

- Hot surfaces
- Nurse call system
- Window restrictors
- Extractor fans
- Ladder inspections
- Visual PAT testing
- Gas / Electricity / Water
- Tall furniture checks
- Emergency lighting
- Equipment checks
- Profiling bed checks
- General periodic checks

The checks are reviewed, validated for completion and plans agreed to expedite any outstanding area of need by the Home Manager and Environmental, H & S Director.

Further to internal safety checks the home is fully supported by Meddyg Care Facilities Management 24 hours a day, 365 days a year, who respond to operational issues. They also organise, monitor and manage all building and equipment servicing requirements and resultant action that may be required.

We conduct monthly assessment checks around the home specifically designed to pick up on security issues. Evidence of these checks and any remedial action taken are available for review and inspection and will include:

- Alarms
- Security lights
- Window and door locks
- Intruder risk assessment
- Data storage systems
- Nurse call alarms
- Exterior fences and grounds security
- Staff adherence to security processes

TRANSPORTING & ESCORTING FOR APPOINTMENTS / VISITS / SHOPPING

Typically, a family member or friend will accompany residents on appointments or visits, however if this is not possible the home can arrange for a staff member to accompany them.

Hospital transport can also be organised for residents where necessary. Alternatively, families can also make arrangements with local taxi firms for other appointments.

ARRANGEMENTS FOR ADMITTING, ASSESSING, PLANNING AND REVIEWING CARE

On request of a potential care placement, the Home Manager or designated competent person will carry out enquiries to obtain sufficient information to make an informed decision in regards to progressing the care enquiry through to admission.

Prior to admission a pre-admission assessment must be carried out, this will be completed by a competent person. If the enquiry is for nursing care the assessment must be completed by a registered nurse.

The home is supported by the company's approach of tailoring a service to meet the needs of individuals as much as possible. Individual care plans take into consideration a person's preferences, differences, and level of support required to assists them in reaching their optimum level whilst minimising any risks to that person.

Each pre-admission assessment seeks to obtain personal information, ability, risk and preference in the following areas:

- Medical history
- GP details
- NOK details
- Capacity and consent
- Medication
- Continence
- Personal hygiene
- Skin integrity
- Psychological needs / sleep
- Communication
- Cognition
- Breathing
- Altered state of consciousness
- End of life
- Level of care required
- Mobility
- Nutrition
- Infection control
- Human behaviour needs
- Length of stay

The Home Manager, or designated competent person, will also seek to gather any further information available in order to obtain a comprehensive overview allowing for an informed decision to be made. This may include liaising with the source of referral to obtain current plans of care in use, the GP to confirm medical background, and medications and family members or advocates.

Once the pre-admission assessment is completed and all information has been obtained, this is jointly reviewed and a decision is reached as to whether the home can safely and adequately meet the care, social, nursing and well-being needs of the individual.

Consideration must also be given to how the individual will impact upon other residents living within the home, and if a potential risk is identified this should be supported with agreed remedial action and extended multi-disciplinary input prior to any admission taking place.

Any equipment identified as being required should be made available prior to admission into the home.

Prior to admission, the home will complete a "short term care plan" utilising the comprehensive information gathered from the pre-admission assessment to allow staff an insight and awareness of the person's needs, preference and wishes immediately upon admission.

Following admission, the initial care plan will be reviewed and updated to include further detail as staff commence building effective communication and a positive care relationship with the person.

A fully comprehensive care plan, incorporating resident choice, preference, and outcomes they wish to achieve will be written in conjunction and in agreement with the resident or their chosen representative. This will give a clear guide to staff on how best to support the resident to achieve their outcomes.

The requirement for an initial care plan and a full care plan 7 days post admission is part of the required standards and regulations and as such, must be adhered to.

For emergency admissions it is accepted that the above process may not be followed concisely, however we will make every effort to obtain as much information as is possible from relevant sources before a decision on admission is reached.

In regard to privately funded placements where there has been no previous Local Authority involvement or care package, a full pre-admission assessment will be conducted with the resident, family, and significant others in order to obtain the information required.

The same admission process applies to respite stays. Should a resident return to the home for further stays we will obtain updated information to identify any change in need, preference of care requirements prior to each admission, and care documentation will be updated accordingly to reflect this change.

Once an admission has been agreed we will write to confirm that we can meet the person's needs.

The confirmation letter is sent to the appropriate person, relative of potential resident, who then attends the home to complete the necessary documentation to ensure the move into the home is managed as per our admissions policy.

STANDARD OF CARE AND SUPPORT

The service will support people to:

- Be as physically, mentally, and emotionally healthy as possible
- Be safe
- Be involved in activities, hobbies, or individual interests
- Access education, learning and development opportunities
- Have control over everyday life
- Maintain their linguistic, cultural and / or religious identities
- Maintain family and personal relationships; and develop their potential, learn and practice life skills

Each resident will be supported with a comprehensive plan of care which will be fully written within the first week of admission.

The care plan will be formulated with the resident and / or designated relevant person(s) involvement and agreement, record personal wishes and preference, care and support needs and any aspiration the resident may have. The care plan will seek to obtain this information and how we can best support the resident to achieve their outcomes in the following areas:

- **Capacity and consent**
- **Medication**
- **Mobility**
- **Nutrition**
- **Skin integrity**
- **Psychological needs**
- **Communication**
- **Infection control**
- **Personal hygiene**
- **Cognition**
- **Breathing**
- **Altered state of consciousness**
- **Continence**
- **Human behaviour needs**
- **Sleep**
- **End of life**

For nursing residents, care plans will be formulated and maintained by registered nurses. Each section of the care plan will seek to identify risk and record action to reduce this risk whilst allowing for resident preference to be achieved.

Capacity and consent will be determined prior to admission and any agreed support methods such as Lasting Power of Attorney (LPA) for care and welfare, best interest decisions and any Deprivation of Liberty Safeguards (DoLS) authorisations will be identified.

LPA details will be recorded within the care plan and any DoLS or best interest decisions will be reviewed and reapplied as necessary.

PRESCRIPTIONS & MEDICATION

Prescribed medications will be confirmed prior to admission and required Medication Administration Records (MAR) and any supporting documents will be written, counter checked and signed.

Consent for photographs will be obtained and these will be taken to apply to the MAR Chart to clearly identify the resident and eliminate the risk of medication error.

On admission the pharmacy will be made aware of all medication details for the resident and GPs contacted to advise of change of address to update their system.

The resident will be correctly registered with the GP and pharmacy to enable correct monthly repeat medications.

For residents that require registering with a GP this will be completed.

All medications will be managed by staff who are trained and have been deemed to be competent.

Our company policies are fully available to staff who hold responsibility for the management and administration of medicines. These have been read, understood and accepted by relevant staff.

Residents who require medicines to be administered covertly will be protected and kept safe as per the Mental Capacity Act. Best interest decisions will be made taking into consideration clinical advice, as well as the care plan which will give a clear and constructive guide for staff.

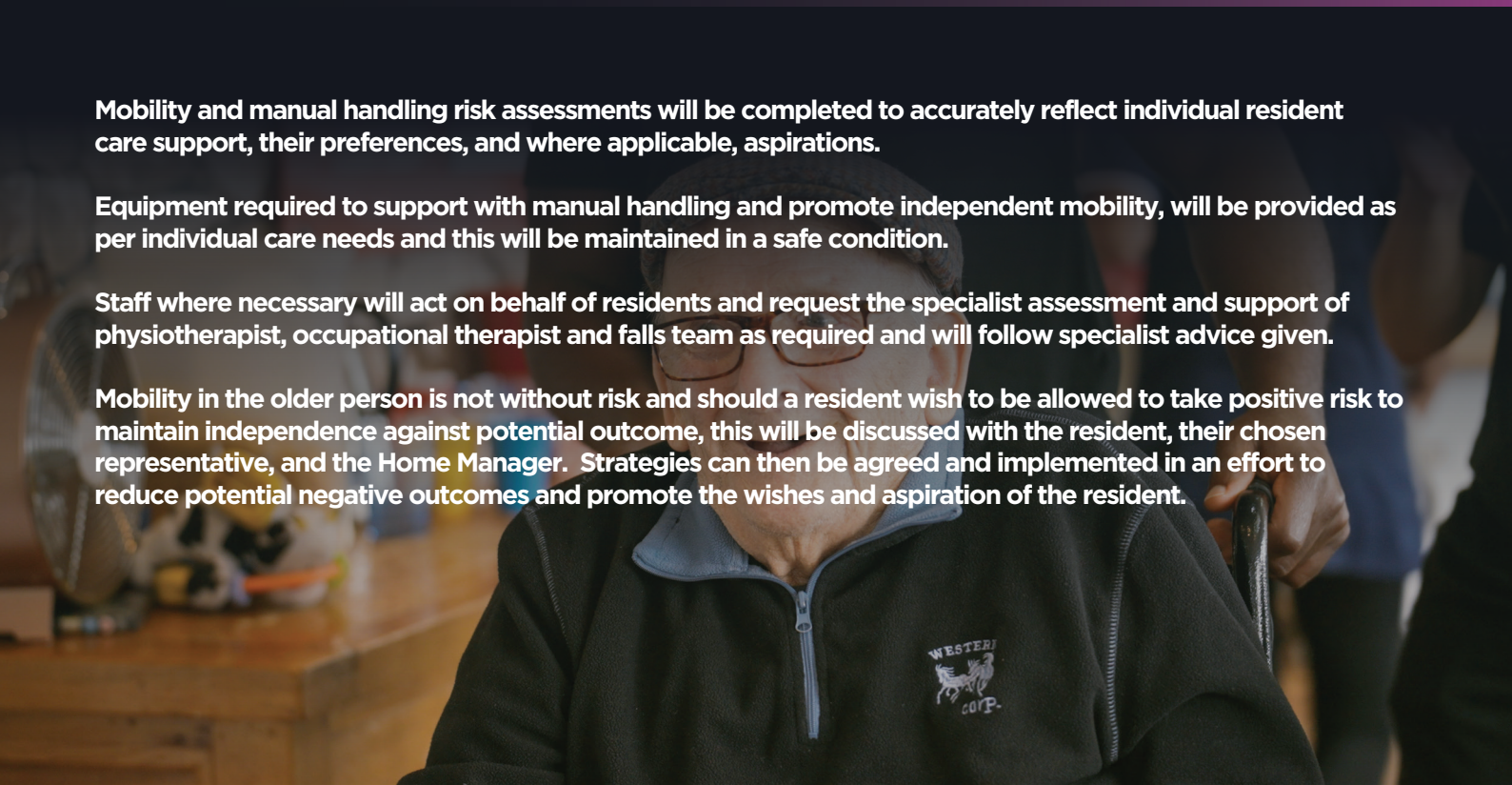
The home will actively promote, and support residents wishing to maintain independence and continue to manage their own medications. This process will be completed via accurate assessment, agreed outcomes between the resident and staff team, and will be kept under review.

Where necessary, referrals to specialist external services will be made to support the home. For example; physio, occupational health, mental health, infection control etc.

We also have agreements in place with local opticians, or residents can continue with an optician of their choice.

All visual and hearing aid requirements are monitored internally, and referrals made to external specialist providers where needed.

MOBILITY & MANUAL HANDLING



Mobility and manual handling risk assessments will be completed to accurately reflect individual resident care support, their preferences, and where applicable, aspirations.

Equipment required to support with manual handling and promote independent mobility, will be provided as per individual care needs and this will be maintained in a safe condition.

Staff where necessary will act on behalf of residents and request the specialist assessment and support of physiotherapist, occupational therapist and falls team as required and will follow specialist advice given.

Mobility in the older person is not without risk and should a resident wish to be allowed to take positive risk to maintain independence against potential outcome, this will be discussed with the resident, their chosen representative, and the Home Manager. Strategies can then be agreed and implemented in an effort to reduce potential negative outcomes and promote the wishes and aspiration of the resident.

NUTRITION

Nutritional care plans and risk assessments will be completed to accurately reflect each individual resident's preferences, and where applicable, their wishes.

Staff will act on behalf of residents, requesting specialist input from dieticians, speech and language therapists, GPs and mental health teams as required, and care plans will be updated to best support the resident.

Resident dietary likes, dislikes, allergies, and any identified risk will be determined prior to admission and developed further following admission. Each resident will have a choice focused diet that is continually reviewed by the team.

PHYSICAL LIMITATIONS

Residents who experience difficulty with eating and drinking independently will be supported with care and sensitivity by trained staff. There is a focus on healthy and nutritional foods, and fluid intake that best supports the resident's well-being.

ALLERGIES & INTOLERANCES

Residents with a diagnosed medical condition resulting in dietary restrictions, will be supported by staff to understand the condition and the restrictions so that they can make informed choices.

DIETARY WELL-BEING

Those residents who express an aspiration to lose or gain weight to achieve a better sense of well-being, will be supported by both care and catering staff to achieve this.

DYSPHAGIA

Residents who require an altered textured diet in order to maintain safety will be supported with a wide selection of meal choices that are well presented and nutritionally balanced.

The dining experience will be monitored to ensure a calm, well organised and dignified environment which promotes positive social interaction between residents.

All staff are supported to obtain the best outcomes for residents with training and access to detailed policy and comprehensive documentation to promote understanding, enhance skill set and best practice.

PERSONAL HYGIENE / SKIN INTEGRITY / CONTINENCE

Supporting residents to maintain a standard of personal hygiene, including continence and healthy skin integrity, is critical to all residents in the home. This is a very personal and often sensitive area of care and it is essential that staff provide the necessary support in a dignified and caring manner, respecting the wishes of each resident, and maintaining privacy at all times.

The promotion of healthy skin integrity, early identification of problems, and timely effective healing of pressure damage, is paramount to the well-being of our residents and as such, their needs must established prior to admission. All potential residents will undergo a thorough pre-admission assessment process where their current skin status will be observed. Any existing wound or current pressure damage will be identified, and any treatment regimes in place are recorded and maintained.

Personal hygiene plans identify the best practice for each resident and staff follow the plans ensuring a person's dignity is maintained at all times. Our staff training focuses heavily on hygiene and skin integrity, and as such our care team are proficient at identifying, monitoring and managing complex skin integrity issues.

Support with continence is an individualised and very person-centred process. Each resident is assessed for their requirements and staff work in partnership with the continence service to order the correct products for residents to achieve the best outcomes, promoting dignity and maintaining well-being.

Staff attend regular training in effective use of incontinence products to ensure their practices and knowledge are current.

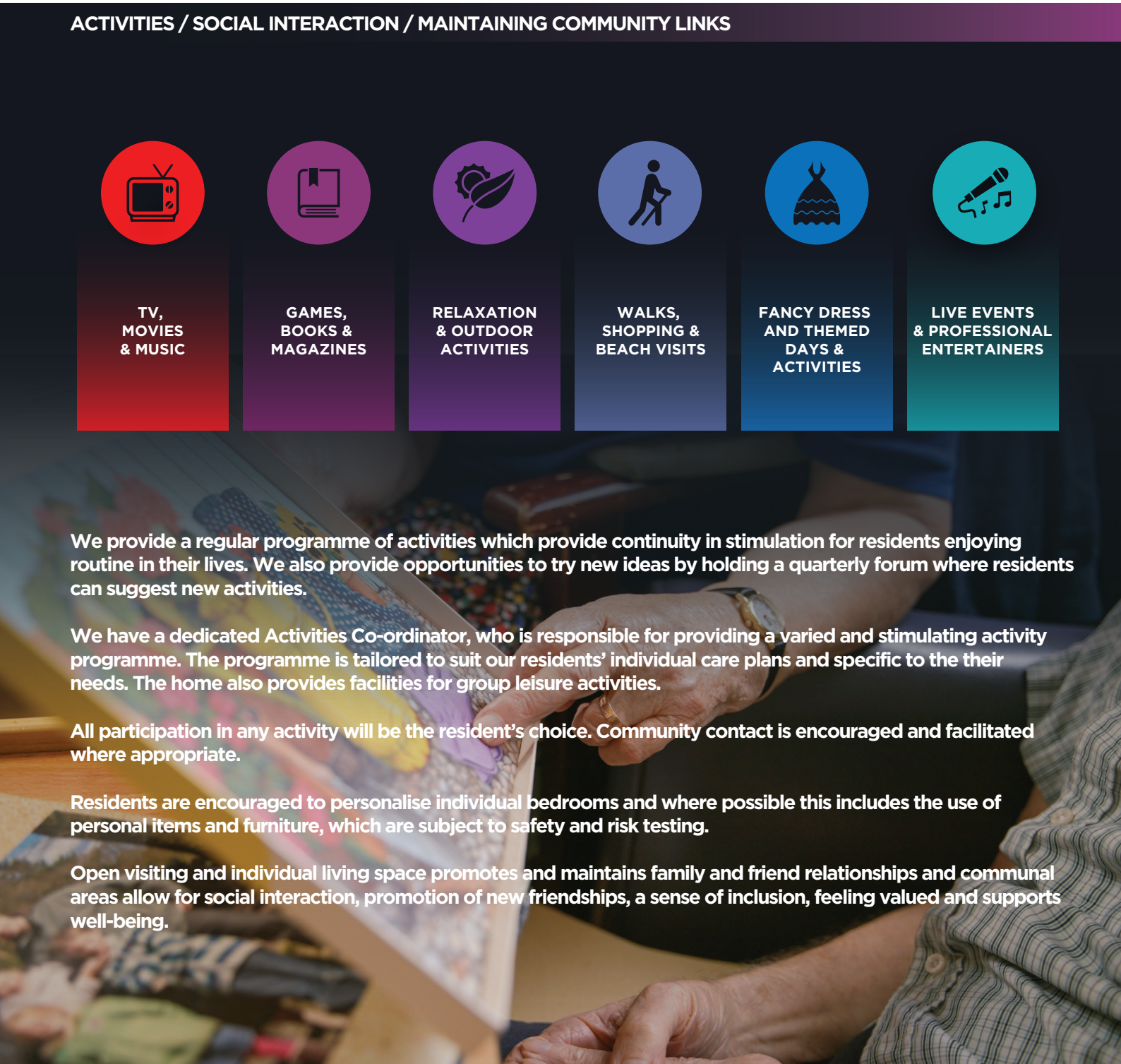
All equipment that is required to support the residents to achieve effective outcomes and promotion of well-being will be provided and available on the day of admission.

Our staff have access to documentation and assessment tools to guide them in the assessments, care planning, completion of supplementary documents and implementation of services. The supplementary charts support the monitoring and evaluation of the needs of our residents.

The promotion of independence and choice underpins the values of the home and is audited regularly to evidence the values in practice. External agencies are accessed to support the home and ensure evidence-based practices are being promoted. The agencies also support training events for staff to access in order to maintain best practice.

Residents' needs are continuously reviewed and any changes identified are communicated.

ACTIVITIES / SOCIAL INTERACTION / MAINTAINING COMMUNITY LINKS



We provide a regular programme of activities which provide continuity in stimulation for residents enjoying routine in their lives. We also provide opportunities to try new ideas by holding a quarterly forum where residents can suggest new activities.

We have a dedicated Activities Co-ordinator, who is responsible for providing a varied and stimulating activity programme. The programme is tailored to suit our residents' individual care plans and specific to the their needs. The home also provides facilities for group leisure activities.

All participation in any activity will be the resident's choice. Community contact is encouraged and facilitated where appropriate.

Residents are encouraged to personalise individual bedrooms and where possible this includes the use of personal items and furniture, which are subject to safety and risk testing.

Open visiting and individual living space promotes and maintains family and friend relationships and communal areas allow for social interaction, promotion of new friendships, a sense of inclusion, feeling valued and supports well-being.

RELIGIOUS / SPIRITUAL NEEDS

Religious preferences will be respected and catered for, and the home will welcome any representatives of any religious denomination, and provide private space if required. Emphasis is placed upon human rights, as an integral part of the quality of care the home provides, including moral, ethical, social, political and legal rights. The home has a responsibility to ensure those rights are never infringed and that people living in the home are fully supported to exercise their rights.

CONSENT

Prior to admission, the capacity and ability to consent to decisions will be established. Where required a person lacking the capacity to consent to care will undergo a MCA and a best interest decision will be made involving the home and family.

Confirmation will be sought, and evidence held in regard to granted LPA.

Any DoLS authorisations that have been granted will be reviewed and a procedure followed to transfer this on admission.

The home has a large variety of training modules within their E-Learning platform. Every member of staff has to complete mandatory modules which include DoLS and MCA. Staff are also involved in identifying residents who may require a DoLS application and have access to a matrix of who has a DoLS in place and when a review is due. Staff are instructed in the MCA principles and have face to face training with DoLS assessors when available.

COMMUNICATING WITH A CLIENT WITH COGNITIVE IMPAIRMENT

Mapping a person's well-being allows the development of a care plan that provides the resident with positive experiences that enhance their interactions and daily living.

The documentation will evidence the following:

- Monitoring and recording of incidents
- Development of care plans, trigger points, de-escalation, and distraction methods
- Support for family members
- Staff training
- Specialist service input e.g., Mental Health Team / Challenging Behaviour Team

LANGUAGE AND COMMUNICATION NEEDS FOR PEOPLE USING THE SERVICE

Staff engage with residents using everyday greetings, words and phrases in Welsh. We have placed posters of Welsh words and phrases around the home to prompt staff to use them. The promotion of the Welsh language and culture features prominently in the home.

Advocacy services are available through Age Connect and translators may be accessed.

Residents experiencing language and communication barriers are supported using visual aids, family and friends, access to writing material, sign language and using smart applications on digital devices such as an iPad to translate upon request.

The Local Authority audiology departments are very supportive and allow the staff to access the training events wherever possible.

DEPLOYMENT OF STAFF AT SERVICE

The accommodation features 41 bedrooms across 3 floors.

We have registered nurses on duty throughout each 24-hour period who are responsible for the day-to-day management of the clinical care of our residents. The Team Leaders take responsibility for the Dementia Carers on each floor of the home. The occupancy and needs of our residents are considered, with staffing levels increased accordingly.

Our staffing levels are based on and average occupancy of 40 residents, with staff allocation split between a day shift (8am till 8pm) and a night shift (8pm till 8am).

	DAY SHIFT	NIGHT SHIFT
1 HOME MANAGER	1	-
1 DEPUTY HOME MANAGER	1	-
1 CLINICAL LEAD	1	-
2 SENIOR / DEMENTIA TEAM LEADER	1	1
10 RGN / PRE NURSES	2	1
15 DEMENTIA CARER L2 / L3	8	3
1 KITCHEN STAFF L3 FOOD HYGIENE	1	-
4 DOMESTIC STAFF	4	-

STAFF TRAINING & FIRST AID

At Meddyg Care we have a qualified Training Manager who co-ordinates and structures a training programme designed to meet the needs of our residents. This ensures that our staff deliver the best care possible.

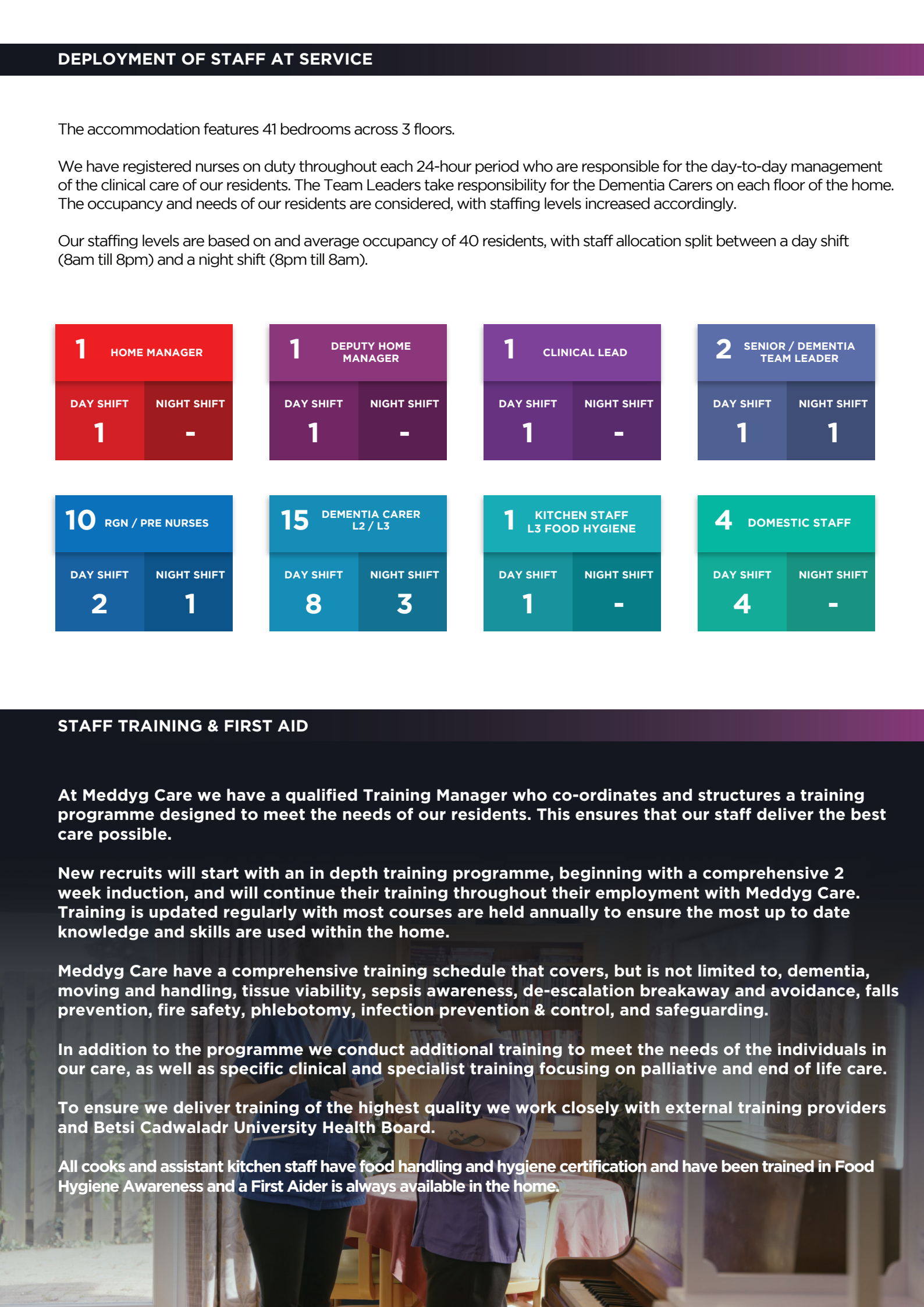
New recruits will start with an in depth training programme, beginning with a comprehensive 2 week induction, and will continue their training throughout their employment with Meddyg Care. Training is updated regularly with most courses are held annually to ensure the most up to date knowledge and skills are used within the home.

Meddyg Care have a comprehensive training schedule that covers, but is not limited to, dementia, moving and handling, tissue viability, sepsis awareness, de-escalation breakaway and avoidance, falls prevention, fire safety, phlebotomy, infection prevention & control, and safeguarding.

In addition to the programme we conduct additional training to meet the needs of the individuals in our care, as well as specific clinical and specialist training focusing on palliative and end of life care.

To ensure we deliver training of the highest quality we work closely with external training providers and Betsi Cadwaladr University Health Board.

All cooks and assistant kitchen staff have food handling and hygiene certification and have been trained in Food Hygiene Awareness and a First Aider is always available in the home.



OUR SENIOR MANAGEMENT TEAM

KEVIN EDWARDS

MANAGING DIRECTOR RESPONSIBLE INDIVIDUAL

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M: 07788 256 681

TANYA NESLING

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M: 07912 947 665

RICKY HERNANDEZ RGN

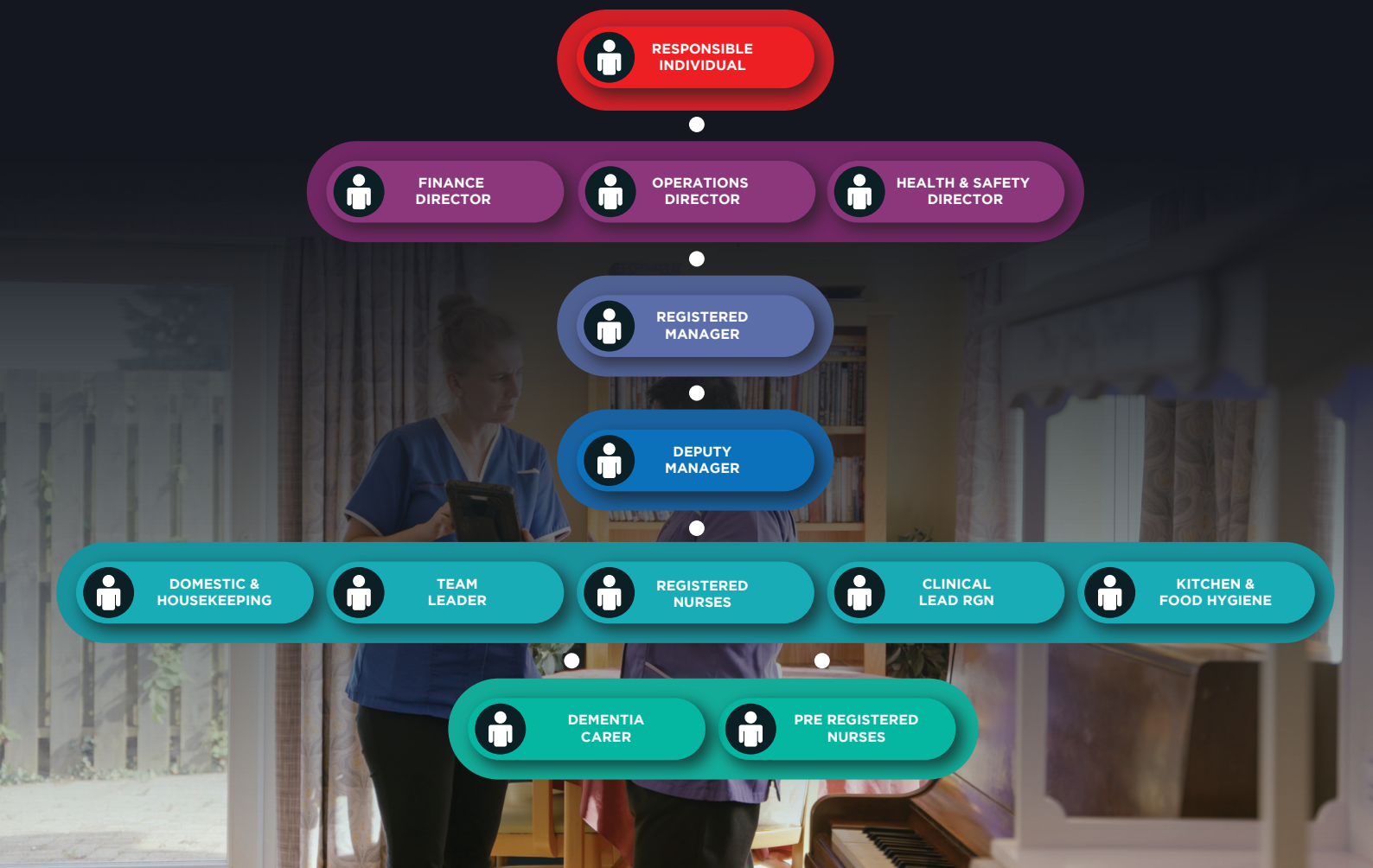
HOME MANAGER

RICKY.HERNANDEZ@MEDDYGCARE.CO.UK

T: 01766 800 900

COMPANY STRUCTURE

Our senior management team consists of a Registered Home Manager, supported by a team of dedicated staff, all reporting to the Operations Director and overseen by the Responsible Individual.



GOVERNANCE AND QUALITY MONITORING ARRANGEMENTS

The Responsible Individual will visit the home at least every 3 months. Prior to these visits the Responsible Individual will be provided with a quality analysis report for the service covering governance outcomes internally and externally.

The Responsible Individual must:

- Oversee the management of the service
- Assure that the service is safe and well run
- Assure that the service complies with the service standards and regulations
- Make sure that the service has a Manager, sufficient resources and support to provide a safe effective service that enables residents to achieve their personal goals

The Responsible Individual conducts a monthly management meeting with the Registered and Clinical Managers. It is the responsibility of the Responsible Individual to complete a review of the quality of care every six months and maintain a system for monitoring, reviewing and evaluating. Our weekly key performance Indicator reporting process, covers the following areas:

- The quality of care provided for residents
- The feedback and opinions of the residents about the home, its facilities and the quality of care they receive in it
- Any actions that the Responsible Individual considers necessary in order to improve or maintain the quality of care provided to residents
- The feedback and opinions of the families, placing authorities and other significant stakeholders in the care of the residents and in the home such as the staff working there

Our six-monthly inspection will entail a review of the following audits undertaken to ensure the quality, safety and effectiveness of the service:

- **Continence audit tool**
- **Quarterly falls audit**
- **Care plan audit and action plan**
- **Intentional rounding chart monthly audit**
- **Care competencies**
- **Monthly mattress / weights audit**
- **Fluid balance / bowels monthly audit**
- **Manual handling competencies**
- **Monthly call bell audit**
- **Residents creams / ointments monthly audit**
- **Medications administration record monthly audit**
- **Infection control and cleaning audit**

Please rest assured that all concerns and complaints brought to our attention will be treated with the highest degree of confidentiality and respect. We will inform you in writing of the outcome of the investigation and any action taken to remedy the situation as soon as possible.

You will then receive in writing a summary of the nature and substance of the complaint, the conclusions and the action to be taken as a result. A copy of this letter will be sent to CIW and the local authority. Should these lines of action not prove satisfactory to you, or you do not feel able to approach us directly, you have the right to make a formal complaint to the statutory regulatory body as follows:

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

Care Inspectorate Wales (CIW)
Sarn Mynach,
Llandudno Junction,
Conwy,
LL31 9RZ
Tel: 0300 062 5609

Gwynedd Social Services,
Canolfan Frondeg,
Pwllheli,
Gwynedd,
LL53 5RE
Tel: 01286 704418