The Royal British Legion

Lister House

Inspection report

Southgate
Ripon
North Yorkshire
HG4 1PG

Tel: 01765694740
Website: www.britishlegion.org.uk

Date of inspection visit:
18 January 2016

Date of publication:
16 March 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and was carried out on 18 January 2015. Lister House is owned and managed by The Royal British Legion, and has been since 1988. Admission is normally limited to those people who have served in the Armed Forces or their dependants. The home has sixty rooms in the main building and sixteen beds in the Colsterdale Unit, a purpose built dementia care unit. The home is registered for people who require nursing or personal care; they can also accommodate people with dementia and younger adults. There were 61 people living at Lister House on the day we inspected.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
Care staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and managed. People were supported by care staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe. People we spoke with said they felt safe and they spoke positively about the care and support they received.

Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people.

The home had safe systems in place to ensure people received their medication as prescribed; this included regular auditing by the home and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

Staff received a range of training which supported them to understand and meet people's needs. Staff received supervision of their work and felt well supported by more experienced staff and the registered manager.

The assessment and the planning of people's care was thorough and ensured staff had good information of people's individual needs and preferences. People had a variety of activities available to them and the staffing arrangements helped to provide a flexible approach, such as supporting people to go out into the community.

Staff followed the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions.

People received a varied and nutritious diet which they enjoyed. People's diet was closely monitored to

ensure they received food and fluids necessary for their welfare. People who required special diets were catered for.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

People told us that they were well cared for and happy with the support they received. We found staff approached people in a caring manner and people's privacy and dignity was respected.
People looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

People were involved in activities they liked and were linked to previous life experience, interests and hobbies. Visitors were made welcome to the home and people were supported to maintain relationships with their friends and relatives.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

People completed an annual survey about the quality of the service. The provider reviewed this feedback used it to address any shortfalls and improve the service.
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The registered manager and care staff promoted a culture which focused on providing individual person centred care. People were assisted by care staff who were encouraged to raise concerns with them and the registered manager. The provider had a routine and regular quality monitoring process in place to assess the quality of the service being provided.

Staff told us they were clear about their roles and responsibilities. Staff had a good understanding of the ethos of the home. They told us the registered manager was supportive and promoted positive team working.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to protect people from abuse and avoidable harm.

There were sufficient staff to meet people's individual needs and provide flexibility to promote their well-being.

Risks to people's safety and welfare had been assessed and information about how to support people to manage risks was recorded in people's plan of care.

There were systems in place to protect people against the risks associated with the management of medicines.

Is the service effective?

Good

The service was effective.

Staff were trained, supervised and supported to provide the care and support people needed.

People were supported to make their own decisions and where they lacked
the capacity to do so care staff ensured the legal requirements of the Mental
Capacity Act (MCA) 2005 were met. Care staff understood the principles of the MCA 2005 and understood the Deprivation of Liberty Safeguards (DoLS).

People were supported by care staff who sought healthcare advice and
support for them whenever required.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

Is the service caring?

Good

The service was caring.

People told us that care staff were caring. Care staff were encouraged and motivated to develop positive relationships with people.

People received care which was respectful of their right to privacy whilst maintaining their safety.

People's end of life wishes were documented and respected. Guidance was provided to care staff on how to best support people.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed and staff reviewed and updated people's care plans on a regular basis, additional reviews were held when people's needs changed.

People were encouraged to make choices about their care which included their participation in activities and where they wished to spend their time at the home.

There were processes in place to enable people to raise any issues or concerns they had about the service. Issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which placed the emphasis on care delivery that was individualised and of high quality.

The provider sought feedback from people and their relatives in order to continually improve.

Care staff were aware of their role and felt supported by the registered manager. Care staff told us they were able to raise concerns and felt the registered manager provided good leadership.

The provider and registered manager regularly monitored the quality of the service provided. Quality assurance audits were completed to identify where improvements could be made to the home and increase the quality of the service provided.

Lister House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 January 2016 was unannounced. The inspection was carried out by one inspector, a specialist professional advisor who specialised in providing services to people living with dementia. and an expert by experience. The expert by experience had personal experience of caring for older people living with dementia.

The registered manager had also completed a Provider Information Return (PIR).The PIR 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.

Prior to the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the registered manager. A statutory notification is information about important events which the service is required to send to the Commission by law. We planned the inspection using this information.

We spoke with eight people who lived at the service and six relatives. During the inspection we pathway tracked six people who used the service. This meant we spoke with staff, read people's care records and associated medicine records to see how the people were supported.

We reviewed three staff recruitment files, records required for the management of the home such as audits, minutes from meetings, satisfaction surveys, and medication storage and administration records. We also spoke with six members of staff, including nurses, senior care staff, care assistants, the activities organiser, chef, registered manager and deputy manager as well as one visiting health professional.

Good

Is the service safe?

Our findings

People who lived at the service and their relatives told us they thought people who lived at the home were safe. A relative commented, "I don't need to worry, they are well looked after; the staff are very good here." Another relative told us, that they "couldn't fault it" They also told us that this was the first time in four years that they had "slept".

We spoke with staff about safeguarding people who use the service. They were clear of the procedure to follow and said they would have no hesitation whistle blowing (telling someone) if they saw or heard anything inappropriate. One member of staff told us that they "Would have no hesitation in reporting a safeguarding issue." The provider told us all staff had received updated safeguarding training and this corresponded to the training records we looked at. Staff were able to explain the process to follow should they have concerns around actual or potential abuse. Information the Commission had received demonstrated the registered manager was committed to working in partnership with the local authority safeguarding teams and they had made and responded to safeguarding alerts appropriately.

We spoke with the registered manager about how risks were managed. They explained that risk assessments for individuals were completed as part of the assessment and care planning process. This meant that risks had been identified and minimised to keep people safe. Risk assessments included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to keep people safe. Established risk assessment tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure people's nutritional and pressure sore risks were appropriately assessed and managed.

All accidents and incidents were reviewed by the registered or deputy manager to ensure appropriate action had been taken. They were also analysed for trends and patterns; for example if someone started to fall more frequently. A further analysis of these were carried out by the regional manager as part of their monthly auditing process.

There were risk assessments in place relating to the safety of the environment and equipment used in the home such as hoisting equipment and the vertical passenger lift. We looked at maintenance certificates for the premises which included the electrical wiring certificate, gas safety certificate and weekly fire checks. We reviewed auditing systems and saw regular checks and timely follow up with regard to the environment and equipment. We saw a system in place to ensure maintenance checks were carried out with regard to gas, hoisting equipment, passenger lifts, electrical systems and legionella testing. The service had in place emergency contingency plans in the event of power failure or adverse weather for example. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals. We saw people had individual mobile calls buttons so they could summon help irrespective of where they were in the building. People told us that staff responded in reasonable time when they rang the call button

day or night.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and Disclosure and Barring Service (DBS) (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed. The registered manager told us that depending on job role applicants would complete a presentation and written test. All oversees staff complete a spoken and written English test. We saw the provider had a system to check every month the current status of nurse's professional qualifications with the Nursing and Midwifery Council (NMC).

We spoke with people about staffing levels. A relative said, "Although the staff are busy they always seem to attend to people, you never hear call bells going all the time." Two relatives said they thought staffing levels could be improved but said their relatives were attended to.

We spoke with the registered manager about how they determined staffing levels and deployed staff. They told us each unit had a dedicated staff team which included either a nurse in charge or unit senior care assistant. Staffing levels were determined according to the needs of people living at the service. The registered manager told us this was based on a ratio of one to five people living at the service for the nursing and Closterdale unit and one member of staff to eight people for the residential unit. They told us they had the authority to increase staffing levels if required, for example if people's needs increased. The registered manager explained that staffing levels were reviewed at the head of department meeting held every week and adjustments made. They gave the example that staffing had been increased on one of the unit's because someone had been newly admitted and staff were required to help this person settle in to their new home.

During this inspection people told us they received all their prescribed medication on time and when they needed it. Lister House used a Bio dose medication system, for administration of medication. This system has individual medication pods for each dose. Every medicine pod was individually labelled, with name and list of drugs contained. Each bedroom, had a locked storage area for medication and a photograph of each person was attached to the medication administration record (MAR) in order that staff could assure themselves of the person's identity. We did observe that people's allergies were not prominently recorded. We spoke with the registered manager about this and they gave assurance people's allergies would be recorded in red pen on the front of their MAR sheet. We observed medication being administered to people safely.

Appropriate checks had taken place on the storage, disposal and receipt of medicines. This included daily checks carried out on the temperature of the rooms and refrigerators which stored items of medication to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines.

Appropriate arrangements were in place for recording of medicines. Staff had signed people's medicine records when they had given people their medicines. Records had been completed fully, indicating that people had received their medicines as prescribed for them. Where people had not received their medicines for example if they refused them or were too ill to take them a record of this was made on the reverse of the MAR sheet.

Some people had been prescribed medicines to be given 'when required'. Information was available to staff about these medicines for people. This included information about when the medicine might be needed and whether the person was able to request the medicine themselves. This helped to ensure that people would receive these medicines in a safe and consistent way.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs. Controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register and saw they tallied correctly. Stocks were audited at the end of the working shift, to
check that records and stock levels were correct.

Staff were not permitted to administer medicines until they had completed medication training. The training included a written exam and observation of competency which meant people could be assured they received the medicines they were prescribed safely.

Regular audits were carried out to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted, the deputy and registered manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

There was a clear and concise medication policy, with regard to medication administration which met with NICE guidance (National Institute for Health and Care Excellence).

We walked around the building and saw grab and handrails to support people and chairs located so people could move around independently but with places to stop and rest. Communal areas and corridors although homely, were free from trip hazards.

The home was clean. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

Good

Is the service effective?

Our findings

People we spoke with were positive about the ability of care staff to meet their needs. People and relatives said that they felt care staff were well trained and had sufficient knowledge and skills to deliver care.

We asked the registered manager about staff training arrangements. They told us newly appointed staff completed a twelve week induction based on the new care certificate. The care certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviours they need to provide compassionate, safe and high quality care. Staff completed training which included mandatory health and safety training such as moving and handling, first aid and safeguarding adults. During induction new staff completed 'job chats'; an opportunity to meet with their mentor to discuss who their induction was going and ensure any difficulties are picked up and addressed at an early stage. Staff also completed a period of shadowing. Shadowing is where new care staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them.

Staff were encouraged to complete National Vocational Training (NVQ) and the provider's training team offered access to specialist training such as end of life care, dementia awareness and Mental Capacity Act (2005) training. The registered manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training and it was relevant to their role.

The registered manager was committed to ensuring staff developed their skills and knowledge to benefit people living at the service. They held a strong commitment to the ethos of Dr David Sheard of Dementia Care Matters and used his theory on wellbeing in assessing and meeting peoples need's for those living with dementia. These values we saw embedded in the delivery of care and were shared across the staff team. Two members of staff are registered and due to commence a 12 month course with Dementia Care Matters.

The registered manager also told us they were aiming to achieve Gold Standard Framework for end of life care and also ensure opportunities are provided for nursing staff to maintain and develop their clinical skills, for example nursing staff had recently updated syringe driver training. This meant people were supported to be comfortable and pain free at the end of their life.

Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. Staff also completed an annual appraisal. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. Care staff told us and records confirmed supervisions occurred every two to three months. This process was in place so that care staff received the most relevant and current knowledge and support to enable them to conduct their role effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and staff showed a comprehensive understanding of the DoLS which
was evidenced through discussion, care records and the appropriately submitted applications and authorisations.

All staff spoken with understood when and why DoLS were required. If staff had any concerns regarding a person's ability to make a decision this was reported to the registered manager and action taken to ensure appropriate mental capacity assessments were undertaken. This was in line with the MCA Code of Practice which guides staff to ensure practice and decisions are made in people's best interests.

Staff were able to describe when a best interest decision would be most appropriate. Best interest decisions are made when someone no longer has the capacity to make a specific decision about their life. Records showed the appropriate mental capacity assessments and accompanying decision specific best interest meetings had been held for people when they no longer had the capacity to agree to a certain course of action involving their care.

Care staff assisted people to make decisions and sought their consent before supporting them. We observed people were asked their permission before being moved or assisted with their mobility. Explanations were provided by staff about what action they were going to take, for example, when using the hoist to move a person. Staff took the time to explain what was happening allowing the person to respond and ensure they were happy with what was going to be taken.

The main dining room was large and the tables were set attractively with flowers, serviettes, condiments and menus. The atmosphere during lunchtime was a relaxed and sociable occasion which people appeared to enjoy.

People told us, "They're wonderful cooks." And, "The food is always good." One person told us they had recently lost weight when they first came into the home, but were now gaining weight. They told us the cook had asked them what they wanted and got salmon in specially for them. Another person told us their favourite sandwich filling was prawns so the staff often made those for them. They said, "You've only to say what you like." A relative told us, "The staff (waitresses) in the dining room are excellent. The food is excellent. They make a big effort – they are very accommodating."

We joined people for lunch on Closterdale. Tables were set appropriately, with table cloths, cutlery, and crockery. Staff offered people a choice of meal and drink, and showed people sample plates of food which helped people to make an informed choice. People were discreetly offered clothes protectors. Everyone was given the choice, of eating in the dining room, or if they preferred having their meal in their bedroom.

We spoke with the chef who told us all food was fresh and locally sourced. They baked every day to ensure fresh cakes and high calorie smoothies were available to supplement people's diet where they were at risk of weight loss. They told us they had a good relationship with people and they knew people's preferences.

Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. We saw those people at risk had been assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a screening tool to identify if adults were malnourished or at risk of malnutrition. Staff told us if they noticed that someone's nutrition and /or fluid intake had changed they would record and monitor this. If there was no improvement then a referral to the doctor would be made. We saw in people's records that staff had completed daily 'food and fluid balance' charts. The food charts were used to record the amount of food a person was eating each day. Fluid charts recorded the fluid intake goals and there was consistent completion of the totals recorded. People's weights were monitored in accordance with the frequency determined by the MUST score. This information was used to update risk assessments and make referrals to relevant health care professionals, such as doctors, dieticians and speech and language therapists, for advice and guidance if appropriate.

People were supported to maintain good health and could access health care services when needed. Records showed that when required additional healthcare support was requested by care staff. We saw that people were referred to their dental surgery and opticians when required. There was evidence of referrals to the community mental health services when required and collaborative working with healthcare professionals, families, and people and care staff. Staff reported a good relationship, with District Nurses, and the Community Mental Health Team, along with other health professionals. As one staff member said, "We are all part of a team, to ensure that the residents receive the best possible care."

The service was linked to two local general practitioner surgeries. They held a surgery in the home every week and responded to emergency visits if required. We spoke with a visiting doctor, who informed us that he, "could not fault the home", "They are always professional." He also told us that, "In his opinion other dementia units could benefit from visiting Lister House." He also said that if one of his relatives required care, he would definitely consider Lister House.

The service had a hydrotherapy pool and on-site physiotherapy. Some people we spoke with took advantage of these facilities. For example, one person told us they used the pool regularly while another told us they had physiotherapy four times a week to help with their health condition.

We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden.

When we looked around the service and saw distinct contrasts between the areas where nursing care was provided and the areas where people living with dementia lived. We could see that consideration had been given to research associated with supportive environments for people living with dementia. For example we saw in the communal areas the walls were plain which provided a contrast to the coloured furniture. There were pictures on the walls from the 50's and 60's which seemed relevant to the age of people. Rummage boxes were available for reminiscence and there were scrapbooks for people to look at featuring events from different decades. There was a board telling people what day, date and season it was and what the weather was like outside.

Good

Is the service caring?

Our findings

People who lived at the service told us they were very happy with the care and support they received. People commented to us, "All the staff are tremendous", "I'm quite happy and have no complaints." And, "They've been so good and nice to me. If I want to get up at night, they'll take me. I'm getting so much help I can't grumble." Another person said, "The people who work here are lovely. They always look after you so well." And someone else told us, "I'm delighted. The girls are a scream really – they're quick off the mark. We send the laundry one day and it comes back the next, ironed and aired."

One person said, "I think they do very well here. Staff are courteous, speak to people in a proper and private manner."

Another person commented, "Staff encourage me to shower by myself. The staff are warm, friendly and caring."

We spoke with three relatives who were very complimentary about the care provided at Lister House. One relative said, "It's incredibly comfortable, my relative is very well looked after." They also said that they trusted the home implicitly."

Another relative said they, "Could not fault it, I have no concerns, and that the staff keep me informed of any developments. My mother is very safe and well cared for."

We spent time in the lounge areas of the home and observed staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. There was a positive atmosphere throughout our visit and people's requests were responded to promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. We heard staff call people by their preferred names. Staff knocked on people's doors and waited before entering, ensuring people's privacy was respected.

People were treated with dignity as care staff spoke to them at a pace which was appropriate to their level of communication. Care staff allowed people time to process what was being discussed and gave them time to respond appropriately. Care staff told us that they saw people living at the home like family and there was a family atmosphere in the home with enjoyable, supportive and positive interactions between people and all care staff. This included engaging people in friendly conversation.

Whilst care staff were busy they continued to treat people with respect and showed a genuine care for peoples. When we asked a member of staff about weighing people they told us, "We take them to their bedroom, to maintain dignity; you don't want to shout out someone's weight in the main lounge, it's all about their dignity."

The registered manager had introduced best practise development groups, one of which related to dignity. The staff member given the lead for this group was responsible for developing policy and best practice

around dignity through staff peer groups. Staff we spoke with demonstrated a genuine commitment to providing support to people in a caring manner. During our observations of the handover from the night staff to day staff we noted that as well as passing on clinical information people's well-being was discussed. One member of staff told us, "I love my job, and working with people with dementia, every day is different.".

Our observations indicated that people were able to spend their day as they wished. We saw some people involved in communal activities and others preferring to spend time in their rooms. People we spoke with told us that they were asked about their preferences. We saw people's bedrooms were personalised with their own furniture and possessions or family photographs.

People who were distressed or upset were supported by care staff that could recognise and respond appropriately to their needs. Care staff knew how to comfort people who were in distress. One person was seen to be distressed during the inspection and care staff were kind, compassionate and gentle with their approach to this person. This person exhibited repetitive behaviour and care staff encouraged this person to assist them with tasks as a way of soothing their distress. Information regarding this person's agitation was recorded in their care plan and the actions required to ease this distress clearly known by care staff.

Staff told us they had received training with regard to providing end of life care. Staff told us they received excellent support from district nurses. One member of staff said, "We always make sure there are extra staff on duty and sit with people." We were told there was accommodation available for relatives in order that they could be close at hand. We saw an advanced care plan/end of life care plan for one person which included information about the relevant people who were involved in decisions about this person's end of life choices and details about anticipation of any emergency health problems. This meant that healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

We were told people had access to an external advocacy service if required and we saw leaflets around the home. The registered manager told us they promoted an open door policy for people who lived at the service and their relatives. During the day we saw visitors coming and going and they were offered a warm welcome by staff. We spoke to two visitors who said they were very happy with the care their relatives received.

Good

Is the service responsive?

Our findings

One person told us, "They consult with me and ask me what I want to do." Another person commented, "They do it just how I like it, I prefer to stay in my bedroom but they pop back regularly to see if I'm ok."

A relative we with said, "They did not have any previous care experience to go on, but the staff seem to respond to their relative's needs". All relatives we spoke with told us they were involved with the care planning process, and that their input was, "valued, by staff."

Another relative said they, "Could not fault it. I have no concerns, and the staff keep me informed of any developments."

People's care needs had been fully assessed and documented by the registered manager or the deputy manager before they started receiving care. These assessments were undertaken to identify people's support needs and care plans were developed outlining how their needs were to be met. Records showed that the care plans reflected the information which was gathered during the pre-assessment stage. People's individual needs were routinely reviewed at a minimum of every month and care plans provided the most current information for care staff to follow. People, care staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. Care plans were updated where a changed need was identified.

We found people's care plans were up-to-date and informed staff about people's care and support needs. Assessments had been carried out which showed people were at risk of developing pressure ulcers. Preventative pressure relieving measures that were in place included pressure relieving equipment, re-positioning charts and body maps. This meant that people's care records contained a detailed care plan to instruct staff what action they should take to maintain skin integrity and that people were receiving appropriate care, treatment and specialist support when needed.

We also saw care plans included information with regard to a continence assessment being undertaken where people needed this and we saw people's needs relating to mobility were also in place. Care plans contained information regarding the level of support required to maintain personal hygiene.

People's care plans had been written in a person centred way. Person centred care is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Care staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families, previous work and hobbies.

From our discussions with staff and our observations on the day it was evident that staff knew people well and responded to changing needs to ensure people received the most appropriate care and their emotional, as well as physical, needs were meet.

The provider sought to engage people in meaningful activities. Care plans detailed the need to help people participate in activities to prevent them from becoming socially isolated. Care plans detailed people's particular social interaction needs.

The service employed one full-time and two part-time activity coordinators who worked across all the units in the home. A schedule of weekly activities was on display. Some of the activities, such as some crafts, involved day care members as well as people who lived at the service.

We spoke with one of the activities organisers. They talked about their role in extremely positive terms especially their commitment to ensuring activities were personal and relevant to people and how they enhanced people's sense of well-being. They explained they had links with NAPA (National Activity Providers Association) and were to commence a 12 month course run by Dementia Care Matters. We observed a music session with a guitarist-singer who visited the home regularly. The guitarist had a good repartee with people and chatted to them between songs. Some people joined in the chat and the singing, some just watched but were engaged, others clapped while some showed, by moving their hands in time to the music, that they were enjoying the activity. The activities organiser told us they evaluated activities to ensure people both enjoyed and benefitted from them. As an example they said they had been concerned that the small lounge where the music activity had taken place had been very crowded and had considered using a larger communal area next time. However, they felt a larger room might lose some of the intimacy people had experienced.

People spoke positively about the activities on offer. One person said, "I am never bored." Another person told us they attended the monthly communion service. The service had its own minibus and people had an opportunity to attend community activities such as the singing for the brain choir held once a week locally. We saw people had newspapers delivered to them.

The home had recently invested in a reminiscence package which was due to be shown on several screens in lounges in the home. The service was due to install internet access in recognition that many people who live at the home had personal iPads and computers. The home had a licenced bar which was not currently open because they are seeking volunteers to staff it. There was an enclosed garden area which is due to be redesigned in the spring; this area provided safe outdoor space which people could access independently.

People were encouraged to give their views and raise any concerns or complaints. Relatives told us they knew how to make a complaint and felt able to do so if required. Relatives were confident they could speak to staff or the registered manager to address any concerns. We reviewed the complaints records; the records indicated the service's complaints procedure had been followed and the complainants had been satisfied with the outcome.

The service had a relative's support group which had been instigated by a relative of person who had lived at the home. We spoke with the organiser of the group and they explained the group met monthly and said that it was a forum for relatives to discuss issues, and any concerns that they may have. They said they had arranged a speaker to come and talk about the experience of having a relative living with dementia and the registered manager told us they also planned to arrange for a speaker to attend to discuss advanced decisions and end of life care.

The provider completed an annual survey of people who used the service and their relatives to gather feedback on all aspects of the service provided. Survey questionnaires were confidential and analysed by the provider's quality team. Results were published and with appropriate action plans put in place.

Good

Is the service well-led?

Our findings

The registered manager promoted an open and supportive culture at Lister House and sought feedback from people living at the home, their relatives and staff to identify ways to improve the service provided. People told us the registered manager was a visible presence around the service.

People and relatives said they were very happy with the quality of the service. One relative told us, "The manager and the deputy are very approachable and always have time for you." Another relative said, "She (the registered manager) is very approachable and always has the residents well-being at the forefront."

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team. They told us the registered manager spent time in the home talking with and working alongside staff. They told us they felt valued and were given opportunities to develop professionally and take on new responsibilities, such as the best practise development groups.

Staff we spoke with said they felt the service was well led and they received good support from the registered and deputy manager and heads of department. One member of staff commented about the support and knowledge of the Unit manager of Closterdale saying, "She has such a wide range of knowledge of dementia care; the relatives speak very highly of her. The unit is well run as is the rest of the home."

Staff meetings had been held at regular intervals, which had given staff the opportunity to share their views and to receive information about the service. Staff told us that they felt able to voice their opinions, share their views and felt there was a two way communication process with managers and we saw this reflected in the meeting minutes we looked at. They said the registered manager offered an open door and was fair and honest with them.

The registered manager told us they held a heads of department meeting every Monday morning in order to share information, plan and put in place any actions for the forthcoming week. The registered manager was able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service. They demonstrated a commitment to providing excellent care and valuing staff. The service ran a staff member of the month award. They also told us they wanted to support staff in developing professionally. The registered manager told us the service had recently set up best practise development groups for areas such as Nutrition and Catering, End of Life, Activities, Dignity and Dementia care. The group was based on peer support but had an identified lead who was responsible for cascading best practise to all staff employed in the home and represented Lister House nationally across the providers other services.

The registered manager told us they were proactive in developing good working relationships with partner agencies in health and social care. They were committed to their own personal development particularly in investing in knowledge and skills in providing high quality, up to date dementia care.

The registered manager explained there were a range of quality assurance systems in place to help monitor

the quality of the service the home offered. This included formal auditing, meeting with the provider and talking to people and their relatives. Audits included regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire fighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop.

Monthly audits and monitoring undertaken by regional managers helped managers and staff to learn from events such as accidents and incidents, complaints, concerns and whistleblowing. The results of audits helped reduce the risks to people and helped the service to continuously improve.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.