Bupa Care Homes (ANS) Limited

Brierton Lodge Care Home

Inspection report

Brierton Lane
Hartlepool
Cleveland
TS25 5DP

Tel: 01429868786

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of Brierton Lodge Care Home on 22 and 24 August 2016. The first day of the inspection was unannounced. We last inspected Brierton Lodge Care Home in October 2013 and found the service was meeting the relevant regulations in force at that time.

Brierton Lodge Care Home provides accommodation, nursing and personal care for up to 58 people, including people living with dementia. There were 58 people accommodated there on the day of our inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the 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. The registered manager was on extended leave and a deputy manager was in day to day charge.

People told us they felt safe and were well cared for. Staff took steps to safeguard vulnerable adults and promoted their human rights. Incidents were dealt with appropriately, which helped to keep people safe.

The building was safe and well maintained. The property was purpose built and adaptations had been made and additional signage provided to improve safety and highlight potential hazards. Other risks associated with the building and working practices were assessed and steps taken to reduce the likelihood of harm occurring. The home was clean throughout.

We observed staff acted in a courteous, professional and safe manner when supporting people. Staffing levels were sufficient to safely meet people's needs. The provider had a robust system to ensure new staff were subject to thorough recruitment checks.

Most medicines were safely managed. The administration of topical medicines (creams applied to the skin) was inconsistently recorded.

As Brierton Lodge Care Home is registered as a care home, CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the deputy manager was familiar with the processes involved in the application for a DoLS. Arrangements were in place to assess people's mental capacity and to identify if decisions needed to be taken on behalf of a person in their best interests. People's mental capacity was a common thread considered through all care plans and risk assessments. Where necessary, DoLS had been applied for. Staff obtained people's consent before providing care.

Staff had completed safety and care related training relevant to their role and the needs of people using the service. Further training was planned to ensure their skills and knowledge were up to date. Staff were well

supported by their managers and other senior staff. Staff performance was assessed annually and objectives set for the year ahead.

People's nutritional status was assessed and plans of care put in place. The recording of people's fluid intake and associated guidance for staff to follow was not always clear. This was being addressed by the provider. People's health needs were identified and external professionals involved if necessary. This ensured people's general medical needs were met promptly. People were provided with assistance to access healthcare services.

Staff displayed an attentive, caring and supportive attitude. We observed staff interacted positively with people. We saw that staff treated people with respect and explained clearly to us how people's privacy, dignity and confidentiality were maintained.

Activities were offered within the home on a group and one to one basis. Adaptations had been made to the home to provide a calm and comfortable environment for people living with dementia. Staff understood the needs of people and we saw care plans and associated documentation were clear and person centred.

People using the service and staff spoke well of the home's managers and they felt the service had good leadership. We found there were effective systems to assess and monitor the quality of the service, which included feedback from people receiving care and oversight from external managers.

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.

People said they were safe and were well cared for. New staff were subject to robust recruitment checks. Staffing levels were sufficient to meet people's needs safely.

Routine checks were undertaken to ensure the service was safe. There were systems in place to manage risks and respond to safeguarding matters.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were well supported and who received safety and care related training. Further training reflective of people's needs was planned.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had developed good links with healthcare professionals and where necessary actively worked with them to promote and improve people's health and well-being.

Is the service caring?

Good

The service was caring.

Staff displayed a caring and supportive attitude.

People's dignity and privacy were respected.

Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

Is the service responsive?

Good

The service was responsive.

People were satisfied with the care and support provided. They were offered and attended a range of social activities.

Care plans were person centred and people's abilities and preferences were recorded.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager in post. People using the service and staff made positive comments about their managers.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service and staff. Action had been taken to address identified shortfalls and areas of development.

Brierton Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 22 and 24 August 2016 and the first day was unannounced. The inspection team consisted of an adult social care inspector.

Before the inspection we reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home, including observations, speaking with people, interviewing staff and reviewing records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who used the service and three visiting relatives. We spoke with the deputy manager and seven other members of staff, including two nurses and four care workers and an ancillary worker.

We looked at a sample of records including four people's care plans and other associated documentation, medicine records, five staff files, which included staff training and supervision records, four staff member's recruitment records, complaint, accident and incident records, policies and procedures, risk assessments and audit documents.

Good

Is the service safe?

Our findings

People who used the service said they felt safe and comfortable at Brierton Lodge Care Home. When asked if they felt safe one person said, "I am safe here." Another person told us, "It's safe, it's lovely." The relatives we spoke with all expressed the view that their loved ones were safe.

Staff we spoke with were clear about the procedures they would follow should they suspect abuse. Those we spoke with were able to explain the steps they would take to report such concerns if they arose. One staff member said, "I'd go to the nurse or a manager." They expressed confidence that allegations and concerns would be handled appropriately by their managers. They said, "I'm 100% confident." Staff confirmed they had attended relevant training on identifying and reporting abuse. The deputy manager and other senior staff were aware of when they needed to report concerns to the local safeguarding adult's team and where appropriate to other agencies. We reviewed records and saw that concerns had been reported appropriately so steps could be taken to protect people from the risk of further harm.

People's finances were safeguarded. Only small cash balances were held for people using the service. Financial records were audited by an external manager to ensure staff at the home kept accurate records and people's money was safeguarded.

Arrangements for identifying and managing risks were in place to keep people safe and protect them from harm. Where concerns were apparent about a person's mobility, behaviour, or general welfare and there was the risk of them being harmed, staff had developed plans of care and risk assessments. These were designed to inform staff of the area of concern and to ensure a consistent approach was taken to minimise risks. Needs assessments, support plans and risk assessments were all regularly reviewed and kept up to date to ensure they accurately reflected people's level of need, and the associated level of risk. Examples included risks associated with manual handling, falls and pressure area care. Accidents were logged and analysed. Where people were at particular risk of falls, or other accidents, appropriate referrals were made to other professionals and staff took steps to increase levels of monitoring.

Several door gates were fitted to bedroom doors. These were fitted to prevent people wandering in to other people's bedrooms where they were cared for in bed, but who needed regular observations and checks carried out. We queried the safety of these with the deputy manager and advised the deputy manager to keep their use under review. They informed us that the fitting of these was risk assessed and assured us that no accidents had resulted from their use. Records confirmed this. Their view was that they improved the welfare of people who could not get out of bed, as other people using the service would not wander in and out of these rooms uninvited. Relatives had been involved in the decisions on fitting these and often requested their use.

Staff were available 24 hours a day to respond to calls for help and assistance. An alarm call system was fitted throughout the home to enable help to be summoned remotely. When referring to using the alarm call, a person told us, "I have an alarm call. If I need help they're there." Another person remarked to us, "They're there for you. If I ring the bell they're there." Some people were unsure about using their call bell.

Staff therefore carried out routine room checks to monitor people's wellbeing. We heard one person call out verbally several times for help. We intervened by asking the person if they required assistance and sought this on their behalf. We saw the person's call bell was out of reach and the alarm cord disconnected. We highlighted this to staff who assured us this was not a normal occurrence. Other people we spoke with had their call bells within reach and plugged in.

Practical measures were in place to keep people safe. For example, bath hot water temperatures were automatically controlled by thermostatic mixer valves. Those we tested were within a safe and comfortable range.

Overall, the home was safe and clean. Individual rooms were clean and fresh-smelling. One person remarked to us, "They're nice rooms. The cleaners are in regular. They take things [ornaments] off and give it a good dust." Staff had taken steps to make the service more homely, interesting and suitable for the needs of the people living there. A simulated garden area had been created on the first floor, there was level access to an enclosed garden on the ground floor and seating areas for people to take a rest break.

Utility services were subject to safety checks and copies of service records including electricity, gas and water system checks carried out by external contractors were retained for inspection. Sharp or hard fixed furnishings which could cause injury were minimised and doors to the units had key pads to keep people safe from leaving by wandering from the unit and coming to harm. Bathroom and lounge areas were free from other obvious hazards and level access was provided throughout the home. Shared areas of the home were free from unpleasant odours and appeared clean.

The deputy manager's view was that staffing levels were sufficient to ensure people remained safe. Staff appeared to be busy, but not rushed. We observed staff had time to chat with people and provided support at a pace that suited each person. Individual need levels were assessed and then totalled to formulate an overall figure for staffing levels each month. From this the rota was planned. People using the service said their needs were attended to promptly and we saw staff were deployed to ensure suitable levels of observation. One person said to us, "They pop by and check on me." Staff expressed the view that levels of cover were sufficient. One described staffing levels as, "alright", another said, "The staffing's fine. There's always staff around. They [people using the service] get 100% of the care they need."

Staff were vetted for their suitability to work with vulnerable adults before they were confirmed in post. The application form included provision for staff to provide a detailed employment history. Other checks were carried out by the registered manager and included ensuring the receipt of employment references and a Disclosure and Barring Service (DBS) check before an offer of employment was confirmed. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions. We looked at the recruitment records for the most recently recruited staff members. Appropriate documentation and checks were in place for them. They had not been confirmed in post before a DBS check and references had been received.

Suitable arrangements were in place to support the safe administration of most medicines. People expressed confidence in the way their medicines were handled. One person said, "I'm happy with my medicines." During this inspection we observed medicines being offered to people safely, and with due regard to good hygiene. A monitored dosage system (MDS) was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medicines by placing the medicines in separate compartments according to the time of day. Medicines were stored safely. The store room was locked when not in use and during the medicines administration round the trolley was locked

when unattended. The nurse offered gentle encouragement to people and waited to check they had taken their medicine before signing the administration records.

We found medicines which were dispensed in the MDS were well accounted for, with clear records of administration kept, corresponding to stocks held. Those supplied in bottles or the manufacturer's original packaging was subject to regular checks and stocks held corresponded to records. Records and stocks were accurate for variable dose medicines, as were those where doses were regularly reviewed and changed.

Some medicines applied to people's skin, such as barrier creams and emollients (moisturising and soap substitute creams) were administered by care workers. The provider's procedure was for staff to record the administration of these medicines in each person's daily notes. We found staff had not consistently recorded these medicines in line with the prescriber's directions. For example, the instructions for one person's medicine was to apply daily, however for the period 12th to 20th August we saw there was only one recorded administration. For another person, between 9 and 20 August we saw only two administrations recorded. There were also contradictory instructions between the medicine administration record supplied by the pharmacist, which stated the medicine was 'as required' and the 'topical protocol' which said to administer daily. This was raised with the deputy manager to ensure record keeping was robust. This matter was being dealt with at a national level with the care provider and CQC as it has been a common issue across BUPA services.

Good

Is the service effective?

Our findings

People who used the service made positive remarks about the staff team and their ability to do their job effectively. One person said of the staff, "They're willing to help, they are brilliant." Another person told us, "They're wonderful." A further comment was, "They're definitely skilled and knowledgeable." Staff made positive comments about the support they received and training attended. One staff member said of their training, "It's really good. Well before I started here I did four weeks training. The training person is in regularly and does drop in sessions." Another said of their supervision and support arrangement, "They're really quick at keeping you up to date and supervisions are on time."

Staff we spoke with said they received supervision with their managers and felt the supervision they received was helpful. A staff member described the support available to them as flexible, stating, "If I need to speak to someone there's always someone to speak to." A staff member explained they also received annual appraisals. They told us, "We set targets and options if we want to do further NVQ's. We get to say how we feel and how the nurse feels we're doing." Records confirmed staff attended regular individual supervisions and group meetings. The records of these supervision meetings contained a summary of the discussion and the topics covered were relevant to staff roles and their general welfare. We saw that unless there were specific problem areas discussed, these were identical between the staff. We also saw all staff had the same performance targets set at the start of the year. We highlighted this to the deputy manager so they could consider how to individually tailor performance objectives and development targets and better evidence individual supervision meeting discussions.

Records showed staff had received safety related training on topics such as first aid, moving and handling, and food hygiene. Topics and learning opportunities relevant to the health and care needs of people using the service were also offered. Further training was planned, including refresher training once training was deemed to be out of date. Staff also had access to additional information and learning material relevant to the needs of people living at Brierton Lodge Care Home.

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 of authorisations to deprive a person of their liberty were being met.

We discussed the requirements of the (MCA and the associated DoLS with the deputy manager. They told us people's capacity to make decisions for themselves was considered as part of a formal assessment. We also

saw people's decision making capacity and consideration of 'best interests' was a common thread considered in each care plan and risk assessment. Those people living with dementia had their capacity to make decisions assessed. Where they lacked capacity and decisions were taken in their best interests, a DoLS had been applied for. A copy of the authorisation was retained on file so staff were aware of any relevant conditions attached to the authorisation. We saw staff did not assume the capacity assessment was a one off event and staff considered if a person's capacity would vary over time or be re-gained. Staff also tried to identify what each person's known beliefs and wishes were in relation to any best interest decision taken, with the least restrictive options considered.

People expressed positive opinions on the food provided. One person said, "I like the tasty food; it's all written down." Another person commented about the support they received stating, "I'm happy with the way they manage my PEG (Percutaneous Endoscopic Gastrostomy) feed." PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines. A further comment was, "There's always drinks available." Relatives were similarly complimentary about the support offered to their loved ones. One relative commented, "She's now putting on weight." Another said, "She asks for salmon and she gets it."

Staff undertook nutritional assessments and if necessary drew up a plan of care for meeting dietary needs. This was reviewed periodically; either monthly or weekly depending on people's needs. People's weights were regularly monitored to ensure care was effective and to identify the need for additional advice and support from the GP or dietitian. We saw this support and advice had been arranged where people were at risk of malnutrition and supplementary food products had been prescribed for them. We observed staff were kind and caring when offering support at meal times, being seated with those people who needed help to eat and drink.

We observed people living at the home being offered drinks (and asked their preference) at regular intervals and drinks were available for people in their bedrooms. However, there was less of a focus in care plans and risk assessments on supporting good hydration, and this was only mentioned in passing in care plans. Target fluid intake levels were set, but guidance for staff to follow should these not be achieved was not clear. A running balance was kept, which helped with monitoring. A staff member told us, "The nurses advise on fluids. If we've any concerns we encourage foods that contain fluids and report to the nurse." One person's records showed they regularly did not achieve the target set, however the evaluation notes said the person, 'drinks well.' Another person's care plan stated that they weren't at risk of dehydration, but that a fluid chart should be completed. We highlighted these inconsistencies to the deputy manager to review and if necessary address.

People using the service and their relatives confirmed that health care from health professionals, such as the General Practitioner (GP) or dentist could be accessed as and when required. One person said, "I have a doctor who comes here on a Tuesday." Records showed people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. Links with other health care professionals and specialists to help make sure people received appropriate healthcare had been made. For example, the input of the dietitian was documented and their advice was incorporated into care plans. Care plans relating to healthcare needs were up to date and completed appropriately. Medical history information was gathered and was available in a way that could easily be communicated with other services, for example when someone needed to be admitted to hospital at short notice.

Good

Is the service caring?

Our findings

People using the service told us they were happy living at the home and their privacy and dignity were promoted. One person said, "It's just like my home." Regarding their privacy another person commented, "They definitely close the door and promote dignity." A relative remarked to us, "If [name] is happy here it means I can go home happy."

We saw people being spoken with considerately and staff were seen to be polite. We observed the people using the service to be relaxed when in the presence of staff. We observed staff members interacted in a caring and respectful manner with people using the service. For example, support offered at meal times was carried out discreetly and at a pace that suited each person. Where staff provided one to one support they sat with, chatted to and interacted politely with the person. We observed appropriate humour and warmth from staff towards people using the service. The atmosphere in the home appeared calm, friendly, warm and welcoming.

Staff also acted appropriately to maintain people's privacy when discussing confidential matters or helping people with their medicines. Staff we spoke with were clear about the need to ensure people's privacy; ensuring personal matters were not discussed openly and records were stored securely. People confirmed staff would knock on bedroom doors before entering and we saw this during the inspection. One staff member told us, "We knock on doors and ask permission before we do anything. We keep people covered up and explain everything." Another said, "Knocking on doors, people covered, doors not open. We treat people as we would want to be treated." During the inspection we observed people were able to spend time in the privacy of their own rooms and in different areas of the home. We also saw practical steps had been taken to preserve people's privacy, such as door locks fitted to toilets and bathrooms.

People and their relatives told us they were involved in decisions about their care and stated if they had any worries they could approach the staff and they would help. Relatives also informed us that they were kept up to date and involved in important decisions about their loved ones care. Evidence that people using the service were involved in aspects of planning their care and treatment was also documented in care files. The deputy manager was aware of local advocacy services available to support decision making for people should this be needed. Staff told us they were updated about people's needs at 'hand over' meetings to ensure such decisions were implemented in practice. One staff member said, "We're kept well informed [about people's needs], we get hand overs and anything urgent we would be told straight away." Another informed us, "The hand overs have every detail up to date." We observed people being asked for their opinions on various matters, such as meal choices, and that staff discussed and encouraged participation in day to day activities.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs and they were listened to. People were aware of and involved in planning their care. One person told us, "My care plan, it's on the wall there." A relative explained how they were kept involved in their loved ones care, stating, "They tell me if she's had a fall or anything … they phone me straight away." Another relative said, "It's a very good service. I'm very happy, the communication is excellent." They continued by telling us they were kept involved with any appointments and staff contacted them by phone for more urgent matters.

Staff identified and planned for people's specific needs through the care planning and review process. We saw people had individual care plans in place to ensure staff had the correct information to help them maintain their health, well-being and individual identity. When people had moved to Brierton Lodge Care Home an initial assessment of their needs had been undertaken. Their needs had been reviewed and re-assessed since that time. From these re-assessments a number of areas of support had been identified by staff and care plans developed to outline the care needed from staff. There was evidence to show that people's care and treatment was reviewed and re-assessed in response to changes. For example, staff acted on feedback from people, or instances where people's needs had changed or risks increased. Areas included changes in people's behaviour, nutritional risks and personal care needs.

Staff developed care plans with a focus on maintaining people's wellbeing and independence. They covered a range of areas including; physical health, psychological health, leisure activities, and relationships that were important to people. Care plans were evaluated regularly to ensure there were meaningful, evidence based updates on the progress made in achieving identified goals, such as helping people to gain weight or manage distressed reactions, such as verbal or physical aggression. We saw that care plans were reviewed periodically, taking into account monitoring records and evaluation notes. If new areas of support were identified, or changes had occurred, then they were modified to address these changes. For example, we saw one person's health had improved dramatically since being admitted to the home. As a result safety measures that had been put in place to stop the person rolling out of bed were no longer needed. The care plan and staffs' practice were therefore reviewed and updated to reflect the change in this person's needs.

Care plans were sufficiently detailed to guide staffs' care practice. Staff detailed the advice and input of other care professionals within individual care plans so that their guidance could be incorporated into care practice. For example, where people had swallowing difficulties, the input of a Speech and Language Therapist had been sought. Their advice and guidance was retained on file and incorporated into the relevant nutritional care plan and choking risk assessment.

Progress records were available for each person. These were individual to each person and written with sufficient details to record people's daily routine and note significant events. Such records also helped monitor people's health and well-being. Additional monitoring records helped evidence the care and support provided, for example with activities, diet and fluid intake. Areas of concern were recorded and these were escalated appropriately, for example to the GP, or to mental health and community healthcare professionals, such as the dietitian.

Staff had a good knowledge of the people living at the home and could clearly explain how they provided support that was important to each person. Staff were readily able to explain people's preferences, such as those relating to health and social care needs, personal preferences and leisure pastimes.

The people living at Brierton Lodge Care Home accessed activities in the service. Activities included aromatherapy, one to one time, movie afternoons, and manicures. On the day of the inspection there was a visiting bible group. Several areas of the home had been re-developed to offer alternative spaces for activities to take place in, including a library, bar and hair dressers salon. We saw people were able to accept visitors throughout the day and could receive their guests in private or shared lounges.

People using the service expressed a good understanding of to whom and how to complain. Most said they would speak to a member of staff and the registered manager if they had any concerns. One relative said, "There's a notice board where they say what people have said and what they've done about it." We saw information about making a complaint was available on the service's notice board. There were seven complaints recorded within the service during 2016. Records showed the complaints were acknowledged, investigated, an outcome communicated to the person concerned and apology offered where appropriate. A record of compliments was also kept, as well as numerous thank you cards, where people expressed thanks and gratitude for the care given and approach of staff. Comments from compliments included; "It was the best thing we did moving [name] to Brierton Lodge", "Brierton Lodge is one of the best homes in Cleveland" and "Excellent care, dad's always happy."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. They had been registered in respect of this service since 1997. People told us they were happy at the home and with the leadership there. One person told us, "The manager sees how things are going." A relative commented to us, "I've had a talk with the area manager." When asked if they would recommend the service all the people we spoke with, their relatives and staff said, "Yes." A relative elaborated, saying, "I would definitely recommend it." A staff member said, "I've recommended it."

Staff were complimentary about the leadership of the service. One staff member said, "Firm but fair, efficient but approachable." Another commented, "We have a good leadership." Staff also told us about how they were involved in the operation of the service and that events and incidents were discussed openly.

The registered manager was on extended leave during our inspection and arrangements were in place to ensure the smooth day to day management of the home during this time. The deputy manager was present and assisted us with the inspection. They appeared to know the people using the service and the staff well and had a visible presence within the service. Paper records we requested were produced for us promptly and we were able to access care records we required. The deputy manager acting on behalf of the provider and registered manager was able to highlight the priorities for the future of the service and was open to working with us in a co-operative and transparent way. They were aware of the requirements to send the Care Quality Commission notifications for certain events and had done so. The deputy manager and staff were clear about the underlying values they saw as important, including ensuring people were treated with dignity and respect. A staff member said, "We're expected to be professional, but also friendly and approachable."

To ensure a continued awareness of current good practice the managers attended on-going training and had networked with other managers within the provider group and more widely. They had supported the learning and development of colleagues. For example, the deputy manager had attended a course of study at Bradford University to enable them to provide training and coaching for staff in relation to the care for people living with dementia. The managers sought the advice and input of relevant professionals, including in relation to people's general medical and mental health needs. In addition, the care provider undertook an annual awards process to recognise the work of individual staff and teams. In 2014 the home was awarded a 'team of the year' award and in 2016 the deputy manager won Bupa's 'Nurse of the Year' award. In a separate clinical awards ceremony, a nurse employed in the home won the 'Caring and Compassionate Award' for their work on end of life care.

We saw the registered manager, their deputy and senior staff carried out a range of checks and audits at the home. A representative from the provider organisation also visited to carry out a quality check on care and staffing issues, and staff confirmed senior managers attended the service periodically, seeking their views and those of the people living at Brierton Lodge Care Home.

Staff said they were well informed about matters affecting the home. The deputy manager told us there

were staff meetings and meetings for people living in the home. Records confirmed this was the case, although resident and relative meetings were not well attended. As an alternative, out of hours surgeries were offered and feedback sought by questionnaires. There was a broad range of topics discussed at the staff meetings. The team meetings included discussions of care related, policy, safety and personnel issues. This gave the people using the service, their relatives and staff the opportunity to be involved in the running of the home and to be consulted on subjects important to them.