

Preston Bethany Care

Bethany House

Inspection report

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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 unannounced inspection at Bethany House on 28 and 29 March 2017. The first day was unannounced.

Bethany House is a residential care home for older people. It is owned by Preston Bethany Care, a Christian charity. It is a purpose built, single storey home. The home is situated within its own grounds, close to local shops and other community facilities. There are 26 single rooms. 13 have en suite facilities. There were 25 people who lived there at the time of our inspection.

The service was managed by a registered manager. 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.

At our last comprehensive inspection on 17 December 2015 and 6 January 2016, we found the provider was not meeting three regulations. We therefore asked the provider to make improvements to safeguarding people from abuse and improper treatment, safe care and treatment and seeking people's consent. Following the inspection, we asked the provider to complete an action plan indicating how and when they would meet the relevant legal requirements.

During this inspection, we found improvements had been made in order to meet the regulations. We saw that significant work had taken place since our last inspection to improve the management of people's medicines and to improve the systems and processes for seeking people's consent to receiving care.

Feedback from people and their relatives regarding the care quality was overwhelmingly positive. Views from the visiting professionals we spoke with were positive.

People who lived at Bethany House told us that they felt safe and there was sufficient staff available to help them when they needed this. Visitors and people who lived at the home spoke highly of the registered manager and the staff. They told us that they were happy with the care and treatment.

There were up to date policies and procedures in use by staff. We saw copies of satisfaction surveys that had been completed by people who lived at the home. These surveys demonstrated people thought their care and the staff who supported them were excellent.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found there were policies and procedures on safeguarding people. Staff had received up to date training in safeguarding adults; they showed awareness of the signs of abuse and what actions to take if they witnessed someone being ill-treated.

Safeguarding incidents had been reported to the relevant safeguarding authority. Staff had documented the support people received after incidents. Staff had sought advice from other health and social care professionals where necessary. Risks associated with people's care were identified and assessed. Plans to minimise or remove risks had been written and analysed for patterns and trends. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and according to the records seen people received their medicines as prescribed by health care professionals.

The level of staffing on the day of the inspection was sufficient to ensure that the current number of people who lived at the home had their needs met in a timely manner. Systems were in place for the recruitment of staff and to make sure the relevant checks were carried out before employment.

Staff had received regular training in the safe management of medicines. On the day of the inspection we observed that medicines were administered safely and in a person centred manner. Records for medicines and audits had been completed. Minor improvements were required in respect of recording for medicines such as topical creams where we found some gaps.

People were protected against the risk of fire. Staff had received fire safety training; regular fire safety inspections and evacuation drills had been undertaken.

There was an infection control policy and the environment had been kept clean and decorated to a high standard. People's bedrooms were personalised to their tastes to reflect their choice.

Staff had completed an induction programme when they started work and they were up to date with the training appropriate for their role. Staff had received induction, supervision and appraisals. The provider had provided staff with appropriate support, training and professional development.

The registered manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation. This was an improvement from our last inspection. There were appropriate arrangements in place to support people to have a varied and healthy diet. People had access to a GP and other health care professionals when they needed them.

Care records were written in a person centred manner. People who lived at the home and their relatives told us they were consulted about their care. The provider had sought people's opinions on the quality of care and treatment being provided. This was done through relatives and residents meetings, annual surveys and quality monitoring visits by the board of trustees.

Staff treated people in a respectful and dignified manner and people's privacy was respected. People living in the home had been consulted about their care needs and some had been involved in the care planning process. We observed people were happy, comfortable and relaxed with staff. Care plans and risk assessments provided guidance for staff on how to meet people's needs and were reviewed regularly. People were encouraged to remain as independent as possible and supported to participate in a variety of daily activities.

The environment within the home had been adapted to make it as enabling an environment as possible for people who lived at the home.

Systems were in place to monitor the quality of the service provided and ensure people received safe and effective care. These included seeking and responding to feedback from people in relation to the standard of care.

The visions and values of the service had been shared with staff, people and their relatives. The organisation's own policies had been followed to guide practice.

We found the service had a policy on how people could raise complaints about care and treatment.

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 received their medicines when they needed them and as prescribed.

There were sufficient staff to meet people's needs. Recruitment processes were safe and ensured only suitable staff were employed.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about the procedures to follow to help keep people safe.

Risks to people's health and well-being were appropriately assessed and managed.

Is the service effective?

Good ●

The service was effective.

Staff were appropriately supported to carry out their roles effectively through induction and relevant training.

Staff understood the main provisions of the Mental Capacity Act 2005 and how it applied to people in their care.

People were supported to have a sufficient amount to eat and drink. People received care and support which assisted them to maintain their health.

Is the service caring?

Good ●

The service was caring.

People were involved in day to day decisions and given support when needed.

Staff knew people well and displayed kindness and compassion when providing care.

Staff respected people's rights to privacy, dignity and

independence.

Is the service responsive?

Good ●

The service was responsive.

People had plans of care which included essential details about their needs and outcomes they wanted to achieve. Care plans reflected people's needs.

The provider had gained the views of people who used the service and their representatives.

People had been provided with appropriate meaningful day time activities and stimulation to keep them occupied.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment.

Is the service well-led?

Good ●

The service was well led.

There was a quality assurance programme in place to ensure the service was monitored. Feedback on the running of the home was obtained from people, their relatives and staff on a regular basis.

There was oversight on management and running of the service. Clear lines of accountability had been maintained.

There were up to date policies to inform practice and meet regulations.

Bethany 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 28 and 29 March 2017, the first day was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we had asked the provider to complete 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.

Before the inspection we sought feedback from health and social care professionals who visited the service. Two professionals provided us with feedback. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the registered provider about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us. We reviewed information from the local authority and also information that had been shared with us from other professionals.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We observed people's care and spent time talking with 10 people who lived at the home and two relatives to gather their views on their experience of the care and support provided by the service. We also spoke with the registered manager and five care staff including a care manager and an activities coordinator. We reviewed records and management systems and also undertook observations of care delivery.

We looked at care records of six people, four of which we pathway tracked. Pathway tracking is where we

look in detail at how people's needs are assessed and care planned whilst they live at the home. We also looked at a variety of records relating to the management of the service. This included staff duty rosters, medicine administration records, five recruitment files, the accident and incident records, policies and procedures, service certificates, minutes of residents and staff meetings, and maintenance records.

Is the service safe?

Our findings

All people spoken with told us they felt safe and secure in the home. Comments included, "I feel safe because of the atmosphere, if I didn't feel safe I wouldn't be here", "I'm safe because of the environment, staff check on me every hour at night", "Everything's is alright here; you couldn't find anywhere nicer to live." And; "Everybody's nice to you, you get looked after and nobody raises their voice to you."

Relatives felt that their family members were safe. Comments included; "Everybody is so kind and lovely." Another visitor told us, "There are no issues about people's safety at all." A visiting professional told us; "They are proactive and will refer people if they find any concerns", "I'm confident with the staff they will act on concerns."

At the last inspection, we found the provider's arrangements for managing medicines did not protect people against the risks associated with medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found people were not protected because the service had not always made safeguarding referrals in line with their policy and procedure. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to send us an action plan which set out the action they intended to take to improve the service.

During this inspection we found that Bethany House had made a number of improvements in medicine handling, stock management and administration and managing safeguarding concerns. Minor improvements were required in respect of recording for medicines such as topical creams where we found some gaps.

The provider had taken suitable steps to ensure staff knew how to keep people safe and protect them from abuse. We found there was an appropriate safeguarding policy and procedure in place which included the relevant contact number for the local authority. The staff understood their role in safeguarding people from harm. They were able to describe the different types of abuse and actions they would take if they became aware of any incidents. All staff spoken with said they would report any incidents of abuse and were confident the registered manager would act on their concerns. Staff were also aware they could take concerns to organisations outside the service if they felt they were not being dealt with.

The provider had a whistleblowing policy. Staff knew they had a responsibility to report poor practice and were aware of who to contact if they had concerns about the management or operation of the service.

We saw from the staff training records that all staff had completed safeguarding training when they began working for the service. Safeguarding procedures were discussed regularly during individual supervision and group meetings and information on how to raise concerns was displayed prominently around the home. This helped staff to make the correct response in the event of an alert. Our records showed the registered manager was aware of her responsibilities and had reported any safeguarding concerns appropriately to the local authority. One member of staff had been appointed as a 'Safeguarding Champion', they were

responsible for attending meetings and workshops with the local health commission group and share best practice with other staff in the service.

We looked at the arrangements in place for managing people's medicines. People were satisfied with the way their medicines were managed and were supported to administer their own medicines wherever possible. Staff designated to administer medicines had completed a safe handling of medicines course and undertook competency tests to ensure they were competent at this task. Staff had access to a set of policies and procedures which were readily available for reference. We saw staff administered medicines safely, by checking each person's medicines with their individual records before administering them. This ensured the right person got the right medication.

As part of the inspection we checked the procedures and records for the storage, receipt, administration and disposal of medicines. We noted the medicines administration records for oral medicines were well presented and organised. Medicines audits (checks) were in place and we saw monthly checks carried out by the care managers and annually by an external pharmacist. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to reach their medicines safely.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the home's policy.

We found there were suitable arrangements for the management of creams such as topical creams. Cream charts and body maps had been introduced which guided care staff on where to apply the creams. In majority of the cases staff had recorded and signed when they had applied the creams. We found three records that had missing signatures however; we checked records for skin care for these people and found that risks of skin damage had been identified and staff were aware who needed creams. There were no concerns or deterioration in the three people's skin conditions. The registered manager assured us that they would take immediate action to monitor all records related to topical creams.

People who were able to manage and keep their own medicines had been supported to ensure they maintained their independence to do so. Staff had completed self medicine administration risk assessments to ensure that people could keep and manage their medicines safely.

Medicines errors had been identified and the registered manager had taken action to address these with staff involved. Staff told us they were not permitted to administer medicines unless their competence to administer medicines safely had been checked and signed off by the registered manager and the care managers.

We looked at how people were supported following significant incidents or accidents such as falls. We found accident and incident forms had been completed following incidents and medical attention was sought in a timely manner. Staff had carried out observations following falls. The records were overseen by the registered manager to check whether staff had followed the correct procedures in response to the accidents or incidents. A system for analysing patterns and trends was in place which allowed the staff to identify ways to reduce the incidents.

Risks to people's individual safety and well-being were assessed and managed by means of individual risk assessments and risk management strategies. This helped ensure guidance was in place for staff on minimising risks to people's wellbeing and safety. Everyone had individualised risk assessments in their care

files covering areas such as, mobility, personal care, mental health, risks of malnutrition, falls, the use of profiling beds and moving and handling. Each risk assessment offered an overview of the person's risk, triggers and the assistance required. Records we reviewed demonstrated that people's risk assessments had been reviewed every month and more often where required. The risk assessments we saw were in date and held detailed information you would expect to see in such a document so that staff had clear strategies for managing individual risks and behaviours.

We looked at the risk assessments in place concerning fire safety and how people would be supported in the event of an emergency. We saw the service had contingency plans in place and personal emergency evacuation plans for people who lived there should people ever need to be moved to a safer area in the event of an emergency. These documents gave guidance to care staff on how people needed to be supported in an emergency including the closest fire escape to their room. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. Records showed that staff had been involved in fire safety practice drills. Maintenance records showed safety checks and servicing in the home including the emergency equipment, water temperatures, fire alarm, call bells and electrical systems testing. Maintenance checks had been done regularly and records had been kept. We could see that recommendations made by the local fire safety authority had been followed. Faults and repairs had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment.

We found there were plans in place to respond to any emergencies that might arise and these were understood by staff. The provider had devised a continuity plan. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

We looked at how the provider managed staffing levels and the deployment of staff. We requested a month's staffing rotas including the week of the inspection. We found the rotas indicated there were sufficient staff available for the 25 people who lived at the home. The registered manager was on duty five days a week to oversee care and senior staff or the care managers were on the day shift across the week and at the weekend to help supervise staff. There were two staff on duty at night.

The registered manager told us that the staffing levels were kept under review and were flexible in response to the needs and requirements of the people who lived at the home. This monitoring of staffing against dependency would be essential when people's needs changed and more staff were needed to meet people's individual needs.

We looked at the records of five staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the home.

We looked at how the service minimised the risk of infections and found staff had undertaken training in infection prevention and control and food hygiene. The premises were kept clean and maintained to a high standard. No malodorous smells were present in the premises. There were policies and procedures for the management of risks associated with infections. People told us staff wore their uniforms and gloves and disposed of used gloves appropriately. A member of staff had been designated as an Infection Control

Champion. This member of staff was responsible for sharing good practice around infection control and carried out infection control audits.

Is the service effective?

Our findings

People and their relatives told us they felt the staff were appropriately trained and had the necessary skills and abilities to meet their needs. Comments included; "They know what they are doing and will check with someone if they are not sure", "I think the food is reasonable, if you don't like what's on the menu, they will give you something else", "It's excellent, I get enough (food) and they make you toast in the middle of the night if you want it." And; "The food is adequate, it's always nicely prepared, the porridge is especially nice." Comments from relatives included, "If they do rice which he (relative) doesn't like, they'll do potatoes instead."

A visiting health care professionals told us; "They are a caring team who are willing to seek advice, engage and follow our guidance." And; "It's one of the best homes, I will always judge on whether I can put my parents in there and with this one I will."

At our previous inspection of Bethany House in December 2015, we found the service had not taken effective action to ensure people's capacity to consent to care was taken into consideration. This was because staff had not kept records of how they had considered people's mental capacity. Staff lacked an understanding of the principles of the Mental Capacity Act, 2005 (MCA) and had not received training. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We also found the service had not taken action to protect people against abuse and improper treatment because we found people had been deprived of their liberty without lawful authorisation. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). After our last inspection we asked the provider to send us a report telling us the actions they had taken to ensure they met the regulations.

During this inspection we checked to see what improvements had been made to ensure compliance with regulation 11 and regulation 13 (5) of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We could see that significant and productive work had been done by the registered manager and staff to assess people's ability to consent and to apply for authorisations to restrict people for their own safety. This demonstrated that they had met the requirements of the regulations.

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 make 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 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager and staff had a clear understanding of their responsibilities under this legislation. Staff said they

always asked for people's consent before providing care. They had received training in assessing and working within the principles of the MCA 2005. The registered manager understood when an application for a DoLS should be made and how to submit one. We looked at people's records and saw that the registered manager had applied to relevant supervisory authorities for deprivation of liberty authorisations for four people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible.

We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. Some people were not able to make some important decisions about their care or lives due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision.

The service had procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests. The records on the process that had been followed showed how relatives, health professionals and senior care staff had been involved when needed to make sure decisions were only being made in that person's best interest.

We looked at how people who lived in the home were supported with eating and drinking. All of the care plans we looked at contained information on specific dietary needs, preferences and any intolerances. People who lived at the home had an individual nutritional assessment and records were made of people's weight in order to monitor for changes or fluctuations which may require medical advice. Recommendations from professionals had been followed to support people identified to be at risk of malnutrition. There was also information on people's dietary needs such as diabetic diets and soft meals. People told us they enjoyed the food and were given a choice of meals and drinks. One person said, "The food is as good as I've had in many a good hotel, it's freshly made."

Weekly menus were planned and rotated periodically and were flexible to allow people to have choice. We noted information about the meals was displayed and information on people with special dietary needs had been shared with kitchen staff. We observed the lunchtime period and observed staff supported people appropriately to eat their meals. Staff ensured people had drinks and these were topped up when required. People were offered more food if they needed it. Everyone we spoke to said they thought the meal times were well spaced. The tables in the dining area were dressed with place settings, tablecloths and condiments.

We looked at how the provider trained and supported their staff. We found all staff completed induction and training when they commenced work in the home. This included an initial orientation induction, training in the organisation's policies and procedures, training required for the role and the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. New staff were also given copies of pertinent policies and procedures, for instance the whistleblowing and safeguarding vulnerable adult's procedures.

There was an ongoing programme of training available for all staff, which included safeguarding vulnerable adults, moving people, safe handling of medicines, health and safety, Mental Capacity Act 2005; end of life care and dementia awareness. We looked at the staff training records and noted staff completed their training in a timely manner. The variety of training offered meant that staff were supported to have the correct knowledge to provide effective care to people. All staff spoken with told us their training was beneficial and relevant to their role.

Staff spoken with told us they were provided with one to one supervisions with the registered manager or the care managers. We saw records of supervision during the inspection and noted a variety of topics had been discussed. The registered manager explained staff were offered an annual appraisal of their work performance in line with the provider's policy and procedures. We noted staff were invited to attend meetings and told us they could make suggestions as they wished. We saw detailed minutes of the staff meetings during the inspection and noted a broad range of topics had been discussed. Staff told us they were required to attend at least four meetings per year.

Staff told us they felt that the team at the home worked well together. One staff member told us, "It's a second family we have here and we all get on well." We noted that there was a low staff turnover and the majority of staff had been employed at the home for more than 10 years.

People were supported to maintain good health and had access to health care support. Where there were concerns, people were referred to appropriate health professionals. We spoke with a healthcare professional during the inspection who told us staff were knowledgeable about people's needs and they made prompt medical referrals as necessary.

Records looked at showed us people were registered with a GP and received care and support from other professionals, such as the district nursing team, physiotherapists, occupational therapists and speech and language therapists. We noted a nurse clinician visited the home twice a week to provide support to people who had been referred by staff. The professional told us; "We are here twice a week to check people they refer. They ask for our advice and follow our recommendations."

People's healthcare needs were considered as part of the care planning process. We noted assessments had been completed on physical and mental health and there was a detailed section in each person's care plan covering people's medical conditions. This helped staff to recognise any signs of deteriorating health. Staff had been provided with guidance on people's conditions and how these conditions affected people and how staff were to support people. One person had requested information on their health condition and the registered manager contacted a national support organisation that provides information on that condition and obtained booklets for the individual. Medical reviews had been requested for people with long term health conditions. From our discussions and review of records we found the staff had developed good links with other health care professionals and specialists to help make sure people received prompt, co-ordinated and effective care.

We looked at the premises and people's bedrooms and found they were clean, warm and well presented. People had personalised their bedrooms with their own possessions. The provider had adapted the premises and environment to ensure it was suitable for people who lived at the service. There was an ongoing refurbishment programme.

Is the service caring?

Our findings

People told us the staff treated them with respect and kindness and were complimentary of the support they received. Comments included; "You feel at home with them, they go out of their way to build up a good relationship with you", "They're all very good and seem to know what they're doing, they're very caring and very kind." And; "One of the carers came to see me every day when I was in hospital. I have a great relationship with the staff."

Comments from relatives included, "I would say residents matter, and they come and sit and chat to them." And "They are very patient."

Relatives spoken with confirmed there were no restrictions placed on visiting and they were made welcome in the home. We observed relatives visiting throughout the two days of our inspection and noted they were offered refreshments.

We found Bethany House had a friendly and welcoming atmosphere. We observed staff engaging with people in a warm and friendly manner. All professionals we spoke with told us the staff were caring and that they would place their parents in this care home if they needed to.

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. A visitors' lounge was provided to ensure people could spend time with their visitors privately. People told us and we saw from the records, that people were able to follow their own beliefs. There were regular church services held at the home and people were free to attend.

People's privacy was respected. Some people chose to spend time alone in their room and this choice was respected by the staff. One person commented, "Staff always knock before entering bedrooms and bathroom doors are always closed when occupied."

People's bedroom doors were fitted with suitable locks to help promote privacy of personal space. Staff described how they upheld people's privacy, by sensitively supporting people with their personal care needs and maintaining confidentiality of information. We observed staff knocked on bedroom doors before entering and ensured doors were closed when people were receiving personal care.

We spoke with some people in their bedrooms and saw these had been made into personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things. One staff member told us; "I would ask people first if they want me to provide them with personal care." One professional said, "I have observed privacy offered when people have visitors."

We observed people being as independent as possible, in accordance with their needs, abilities and preferences. We observed people being encouraged to do as much as they could for themselves. For example we saw one person walking with staff following them closely and another person had asked to keep their own medicines and they were managing independently. Staff explained how they promoted

independence, by enabling people to do things for themselves. One staff member said, "We encourage people to do as much as they can, we don't just take over."

We observed that people were encouraged to express their views and opinions during daily conversations. Residents meetings were held; this provided the opportunity for people to make suggestions, be consulted and make shared decisions. A member of the board of trustees visited the home every three months and spoke to people about their experiences. Records kept of meetings showed various matters had been raised and discussed with people. We saw copies of satisfaction surveys that had been completed by the people. These surveys demonstrated people thought their care and the staff who supported them were excellent.

There were notice boards and displays at the service which provided information about forthcoming events, activities, meetings, the complaints procedure and other useful information.

There was a statement of purpose of Bethany House displayed in the home and on the website. This provided people with brief information about the services and facilities available, including; the staffing arrangements, and the aims of the service. The aims of the service made reference to involving people with all aspects of daily living, maintaining people's rights to privacy, dignity, choice, independence and meeting people's spiritual needs.

The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people who lived at the home. They had been trained in providing care with dignity and respect. Staff were aware of the need to treat people as equals and recognised people's human rights.

We found evidence of end of life care plans in people's records. Staff had been provided with training on how to care for people towards the end of their life. Where possible people had been assisted to make decisions regarding how they wished to be cared for in the event of a life threatening illnesses. This meant that people could be assured they would receive end of life care in line with their wishes.

Is the service responsive?

Our findings

People made positive comments about the way staff responded to their needs and preferences. One person told us, "I was involved in writing my care plan initially, but there hasn't been any need to review it. If there's an issue I raise it and it's sorted.", "I read books, and you can do what you want. I play dominoes, there's something to do every day at 2 p.m." And, "I chat to friends, we have craft days and exercise, we're never lonely or bored."

Relatives felt that staff were approachable and had a good understanding of people's individual needs. They told us people were supported to continue to follow their interests. One relative said, "(Relative's) main hobby is church, and there's a lot of involvement here. I take him to church every week."

One professional told us; "The staff in the home are very caring and responsive to the needs of those residents in their care. The documentation and communication is excellent and this care home in particular is one I would recommend."

We reviewed how the service aimed to provide personalised care. We looked at the way the service assessed and planned for people's needs, choices and abilities. The registered manager and care manager described the processes in place to assess people's needs and abilities before they used the service. We saw examples of the assessments. The assessment involved gathering information from the person and others, such as their families, social workers and health care professionals. Where possible people were encouraged to visit, to see the facilities available and meet with other people and staff. This would help people to become familiar with the service before making a decision to move in. Some people had experienced the service by staying on a short term basis. During the inspection we saw one person who had previously stayed on a short stay had returned to live at Bethany House on a long term basis.

There was a significant improvement in people's care plans since our last inspection. We looked at six people's care plans. The care plans were kept on an electronic computer system. They were organised, detailed and clearly written. They also included people's personal preferences, life histories, and aspirations. Care staff had full access to this information through handheld computers. People's care plans, were supported by a series of risk assessments. The plans were split into sections according to people's needs and were easy to follow and read.

All files contained a profile with details about people's life history and their likes and dislikes. The profile set out what was important to each person and how they could best be supported. We saw evidence to indicate the care plans had been reviewed and updated on a monthly basis or in line with changing needs. We noted that one individual requested to have their health needs reviewed by a specialist consultant and care staff took appropriate action to ensure that this happened.

There were ongoing discussions about people's needs and well-being; this included regular staff 'handover' meetings.

We checked whether people had been involved in the development of their care plan. Majority of the people could not remember. A relative also confirmed they had been consulted about their family member's care. The relative said, "I was involved initially, but there hasn't been any need to review it. If there's an issue I raise it and it's sorted." We spoke to the registered manager and they informed us, staff would use the handheld computers to sit down with people and review their care plans however this was done in a casual manner and some people would not recognise they were reviewing their care.

Daily reports provided evidence to show people had received care and support in line with their care plan. We noted the records were detailed and people's needs were described in respectful and sensitive terms. We also noted records were completed as necessary for people who required any aspect of their care monitoring, for example, weight, falls and behaviour.

People had access to various activities and told us there were things to do to occupy their time. The provider had employed an activities coordinator and we noted a schedule of activities was posted on the wall. Forthcoming events were advertised well in advance to allow families to plan. The activities included dominoes, armchair exercises, quizzes and pampering sessions. There were planned activities three times a week; in addition, there were three Christian fellowship sessions which included songs of praise and some ad hoc activities that staff organised. We saw people had access to reading materials including books from a visiting library service. Some people attended local churches.

People told us they enjoyed the activities. One person said; "You talk to your friends, nobody would stop you reading a book. A minister comes in, I couldn't fault the activities, and if I did I'd tell you." And; "I always seem to have quite a lot to do. I go to some of the services and the exercises." On the two days of the inspection, we observed people getting involved in activities.

During the inspection three people informed us they would prefer to have a television in the main lounge. We looked at minutes of residents meetings and found that people had made the request in two meetings. People had shared this with us during our inspection in December 2015. We spoke to the registered manager who informed us that they will consider this request with the wishes of people who did not want the television. This would demonstrate that the service is responsive and take peoples' views into consideration.

We looked at how people were supported to maintain local connections and important relationships. People were actively encouraged and supported to maintain local community links. For example two people had been supported to maintain contact with their family relations who lived abroad using Skype and other social media technology. This was an innovative and resourceful way to support people to maintain regular contact with their family and friends.

People were assured they would receive consistent coordinated, person centred care when they used, or moved between different services. We found evidence of information that had been completed to facilitate information sharing when people moved between services. These are sometimes referred to as Hospital Passports.

We reviewed how the service responded to complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. People had been fully informed on how to make any complaints and were given detailed information on how or who to contact. The procedure was on display on the notice board. People we spoke with confirmed they knew how to make a complaint. We also saw evidence of a complaint that had been received and how it had been dealt with. The registered manager had carried out investigations and shared the outcome with the complainant. This

meant that people could be assured that their concerns had been received and dealt with properly.

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). We received overwhelmingly positive feedback from people and their relatives regarding the management and the provider. Comments from people included; "The home is very well organised. When my son took the wrong clothes to the charity shop, the manager took me to buy them back, but they'd already gone", "We've just been asked to pick new wall paper for the hall, every so often we have residents meetings, and you can speak up." One relative said, "Management is very well organised." And; "If there are ever any issues [name removed] sorts it out."

We also received overwhelmingly positive feedback from staff. Comments included; "The manager is good, she is accommodating and listens to you", "They are supportive and we are encouraged to speak up." Staff told us there was a positive culture within the service and everyone got along well. They informed us they felt supported to do their job and were equipped with the skills and knowledge as required. We noted that there was a very low staff turnover at the home. The majority of staff had worked at the service for more than 10 years.

Our observations were that the provider was committed to provide a high standard of care. They had maintained high standards of hygiene and adaptations within the home and were willing to take further action to improve the service.

We found the registered manager was familiar with people who used the service and their needs. When we discussed people's needs the manager showed good knowledge about the people in her care. For example, the registered manager was able to identify people with very complex needs and the risks associated to these individuals. This showed the registered manager took time to understand people as individuals and ensured their needs were met in a person centred way.

We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager and the two care managers were experienced and had an extensive health and social care background. They were experienced, knowledgeable and familiar with the needs of the people they supported. The care staff had been delegated individual responsibilities such as a Safeguarding Champion and an Infection Control Champion. Each person took responsibility of their role and had been provided oversight by the registered manager who was in turn accountable to a board of trustees.

There were up to date policies and procedures relating to the running of the service. These had been reviewed annually. Staff had access to up to date information and guidance procedures were based on best practice and in line with current legislation. Staff were made aware of the policies at the time of their induction and when new changes came into place. This ensured that staff had adequate guidance on the impact of their actions.

The registered manager told us she was committed to improving the service. For example they told us they

had achieved Investors in People (IIP) accreditation. They also told us in their PIR; 'We are reviewing our quality accreditation ISO9001:2008 as this is due for re-certification in January 2017. We are working to achieve the new revised standard ISO9001:2015 and achieve a smooth transition to its requirements. This quality standard has a new emphasis on identifying risks and opportunities for improvement. We aim to improve the use of non-conformances identified during audits to improve our service. We will improve our recording of non-conformances and the time taken for improvements to be made.' IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management. ISO 9001:2008 is an accreditation which is focused on meeting customer expectations and delivering customer satisfaction it encourages organisations to pay attention to the customer.

The registered manager used various ways to monitor the quality of the service. This included monthly visits by the chairperson from the board of trustees and three monthly quality inspections by the trustees. There were audits of the systems to manage medicines, staff supervision and training trackers, infection control and checks on commodes and fire systems audits. The audits and checks were designed to ensure different aspects of the service were meeting the required standards. We saw completed audits during the inspection and noted action plans were drawn up to address any shortfalls. The plans were reviewed to ensure appropriate action had been taken and the necessary improvements had been made. It was evident that significant effort had been made since the last inspection in December 2015 to improve the service and ensure compliance with regulations.

The registered manager and the care managers were visible and active within the home. They regularly worked alongside staff and had a detailed knowledge of people's needs, preferences and backgrounds. They were observed to interact warmly and professionally with people, relatives and staff. People were relaxed in their company and it was clear they had built a rapport with them. The registered manager operated an 'open door' policy which meant people and members of staff were welcome to go into the office to speak with her at any time. Staff told us they felt confident in the management of the home. The staff members spoken with said communication with the registered manager was good and they felt supported to carry out their roles in caring for people.

Management were committed to their own learning and development to achieve high standards. For example we noted the registered manager had written on their PIR; "Amongst the senior care staff, one has completed level 5 Diploma in Health and Social care and a further three are currently working towards their level 5 Diploma in Health and Social care. All other senior care staff are qualified to level 3 Health and Social care. In addition, the registered manager keeps up to date with best practice by use of media and internet as well as attending conferences and workshops organised by the Lancashire Care Association and local NHS bodies. She is also a member of the local Registered Managers' network which meets every six weeks to share and learn with other managers."

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication was described by staff as being "excellent", with regular staff meetings, handover every day, group supervisions, a communication book and notice board. We looked at the minutes of a recent staff meeting. Topics discussed included reminders for staff to ensure people were offered their medicines; bedrooms kept clean and signing medicines administration records appropriately.

People were actively encouraged to be involved in the running of the home. We saw residents meetings were held and minutes of recent meetings showed a range of issues had been discussed. People commented on the quality of the service, food and their environment. We saw changes that were made following suggestions by people.

We saw evidence to demonstrate that the management and leadership at the home worked in partnership with other agencies to improve the quality of the care they provided. For example we noted the registered manager had arranged a meeting with other local care home managers and deputy managers. They told us that these meetings were very informative and covered a wide range of useful topics that played a part in the running of a care home.

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities. Incidents and accidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. Maintenance checks were being done regularly by staff and records kept.

The service had a contingency plan to show how they would deal with unplanned events that affect the delivery of regulated services.