Benvarden Residential Care Homes Limited

Benvarden Residential Care Homes Limited

Inspection report

110 Ash Green Lane
Exhall
Coventry
West Midlands
CV7 9AJ

Tel: 02476368354

Date of inspection visit:
20 December 2017

Date of publication:
29 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Benvarden Residential Care Home on 20 December 2017. The inspection visit was unannounced.

Benvarden provides personal care for up to 14 older people, including people living with dementia. The accommodation is on two floors. There were 12 people living at the home when we inspected the service.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 and the associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection visit who was also the provider. We refer to the registered manager as the manager in the body of this report.

Since our inspection on 14 January 2016 we have reviewed and refined our assessment framework, which was published in October 2017. Under the new framework certain key areas have moved, such as support for people when behaviour challenges, which has moved from Effective to Safe. Therefore, for this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

At our previous inspection we found Effective was rated 'Requires Improvement'. This was because where people did not have capacity to make certain decisions, the records to support decisions made on their behalf were not sufficiently detailed. There was also a risk that some people may have been deprived of their liberty because the provider's application of the deprivation of liberty safeguards was inconsistent. At this inspection we have rated Effective as 'Good' because the manager and staff followed the principles of the MCA. However, paperwork around the MCA still required improvement to ensure people's decisions and decisions made on their behalf were recorded.

We found Individual risks to people's health were not always documented, however, risks were being managed appropriately to ensure people were protected. Risk management plans had been updated to ensure the environment and premises were managed safely.

There was enough staff to keep people safe. All necessary checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there. People were supported by a staff team that knew them well.

Staff received training and had their practice observed to ensure they had the necessary skills to support people. Staff treated people with respect and dignity, and supported people to maintain their privacy and independence.

People had been consulted about their wishes at the end of their life. Plans showed people's wishes about the interventions they had agreed to.

People received their medicines as prescribed to maintain their health and wellbeing. People were supported to access healthcare from a range of professionals inside and outside the home, and received support with their nutritional needs. This assisted them to maintain their health.

People were supported to take part in social activities, although feedback we received from relatives indicated that more could be done to stimulate and engage people. People made choices about who visited them at the home, which helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. People who used the service and their relatives were given the opportunity to share their views about how the service was run; action was taken in response.

Quality monitoring procedures identified some areas where the service needed to make improvements, for example, in record keeping. Where issues had been identified in checks and audits, the manager took action to address them to continuously improve the quality of care people received. However, quality procedures and checks had not identified that incidents were not always recorded when they occurred.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe living at Benvarden and staff had been recruited safely. However, the manager and staff did not consistently report and investigate accidents and incidents when these arose, to minimise the risk of such incidents happening again. People did not always have up to date written risk assessments and risk mitigation plans in place, to provide staff with the information they needed to minimise risks to people. However, staff knew people well and there was a consistent team of permanent staff employed at the home to ensure people were cared for safely. Medicines were administered to people safely.

Is the service effective?

Good

The service was effective.

Staff completed an induction and training so they had the skills they needed to effectively meet people's needs. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with health professionals. People were supported to see healthcare professionals when needed. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

Staff knew people well and respected people's privacy and dignity. Staff treated people with care and kindness. People were able to have friends and relatives visit them when they wished.

Is the service responsive?

Good

The service was responsive.

People had personalised records of their care needs and how these should be met. People were able to raise complaints and

provide feedback about the service. There was end of life care planning to involve people in decisions that took into account their wishes and preferences. People were supported to take part in social activities.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance procedures were in place to assess areas where the service could improve. However, quality assurance checks did not always identify where improvements were required. Records required improvement to ensure they were always up to date, and were easily accessible. The management team was approachable and there was a clear management structure to support staff. People were asked for their feedback on how the service should be run, and feedback was acted upon.

Benvarden Residential Care Homes Limited

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 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 comprehensive inspection took place on 20 December 2017. The inspection visit was unannounced and was conducted by one inspector.

Benvarden accommodates 12 people and specialises in providing care to people living with short term memory conditions and dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Before our inspection visit we reviewed the information we held about the service. We looked at information within the statutory notifications the provider had sent to us and from the commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. However, during our inspection visit we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke to one person who lived at the home and ten people's visitors or relatives. We gathered feedback from several members of staff including the registered manager, a director, and four members of care staff. We also spoke with an electrical engineer/maintenance worker.

We looked at a range of records about people's care including three care files. We also looked at other records relating to people's care such as medicine records. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager/provider made to assure themselves people received a quality service. We also looked at recruitment and supervision procedures for members of staff to check that safe recruitment procedures were in operation and that staff received appropriate support to continue their professional development.

Requires Improvement

Our findings

At our previous inspection the service was rated 'Good' in Safe. At this inspection we have rated the service as 'Requires Improvement' in Safe. This was because we found accidents and incidents that occurred at the home were not always recorded, to ensure future risks to people could be identified and mitigated against. Not all risk assessments were up to date, and described to staff how they could consistently mitigate against risks to people.

We found accidents and incidents were not always recorded when these occurred. For example, when people showed aggression to staff this had not been documented according to the provider's procedures, to identify whether any triggers for this type of behaviour could be avoided in the future.

Incidents and accidents that were recorded were monitored to show when and where accidents happened in the home, and whether risks could be mitigated to reduce the number of future accidents.

Risks to people's health and wellbeing were not always identified in writing in people's care plans, and risk management plans were not always written down to instruct staff on how they should care for people safely. For example, one person had recently moved to the home and they were being treated for two wounds to their skin. This person was at risk of their wounds deteriorating or developing further skin damage. There was no risk assessment or risk management plan to advise care staff how they should assist the person to prevent further skin damage.

However, although staff did not have written information to refer to, staff were acting appropriately to manage the risk. The person was being attended by the district nursing team daily to manage their wounds. Staff told us they moved the person frequently and encouraged them to spend time resting in their room each afternoon to elevate their legs and relieve the pressure on their skin. Pressure cushions were in place for the person, and a specialist pressure relieving mattress had been requested by the district nursing team. Following our inspection visit the manager confirmed the person was being re-positioned every two hours, which had been added to their care records along with the appropriate risk mitigation plans.

All the people we asked told us with nods or gestures they felt comfortable and safe at the home. People's relatives told us, "[Name] is happy here, and chose the home themselves", and, "[Name] tells me they are happy here daily."

People were protected against the risk of abuse. Care staff told us they completed regular training in

safeguarding people. Care staff were knowledgeable about the procedures for identifying and reporting any abuse, or potential abuse. Staff told us they were comfortable with raising any concerns they had with the manager, and were confident any concerns would be investigated and responded to. The provider had procedures in place to report safeguarding concerns to local authorities for investigation, and to CQC.

Staff told us and a director confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff. All prospective staff members had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

We found the home was clean and well maintained. Infection control procedures were in place to prevent the spread of infection. The home was regularly cleaned to keep communal areas and people's rooms clean. The manager checked on the cleanliness of the home through regular daily walk rounds, and also monthly auditing. Care staff adhered to current infection control guidelines to prevent the spread of infectious diseases. Care staff wore the correct personal protective equipment (PPE) such as gloves and aprons to protect people from cross contamination and infection, for example at lunch times when serving food to people.

We looked at how the maintenance of equipment and the premises was managed. We found there was an electrician on site during our inspection visit who was responsible for checking all electrical appliances, the CCTV monitoring system, and the fire alarms around the home. The electrical engineer explained how regular checks of the premises and equipment were completed to ensure people were safe. Records confirmed checks were up to date including an up to date fire risk assessment and regular testing of fire safety and fire alarms so people and staff knew what to do in the event of a fire.

During our inspection visit, there were enough staff to care for people safely. Staff were available all day in the communal areas. People and their relations told us there were enough care staff at the home to meet their needs.

The manager told us staffing levels were determined by the number of people at the home, their needs and their dependency level. Also, senior staff worked alongside care staff daily and monitored whether staffing numbers were adequate to meet people's care needs.

We asked the provider and manager about staff vacancies at the home. They told us they were in the process of recruiting more staff. This was to allow more flexibility to cover staff absences. They explained they did not use agency staff and were always able to fill the staffing rotas from their permanent staff team.

All care staff administered medicines and received specialised training in how to do so safely; they had regular checks on their practice to ensure they remained competent to do so. We found medicines were mostly stored safely and securely. On our arrival at the home we found one medicine storage trolley, and a medicines fridge, contained everyone's medicine. The medicines trolley was positioned next to a radiator, and the medicines in the trolley were not monitored to ensure they remained below a recommended temperature, to ensure they remained effective. During our visit the provider told us they would immediately begin recording daily temperatures of the medicines storage trolley, to ensure the contents were stored below a recommended 25 degrees centigrade. They also turned the heating off near to the trolley, to ensure temperatures were reduced. We were confident medicines were stored safely following our inspection visit.

Each person at the home had a medication administration record (MAR) that documented the medicines

they were prescribed. MARs contained a photograph of the person so that staff could ensure the right person received their medicines. The MARs we checked confirmed people received their medicines as prescribed.

Some people required medicines to be administered on an "as required" basis. There were protocols (plans) for the administration of these medicines to make sure safe dosages were not exceeded and people received their medicine consistently. This supported care staff to make consistent decisions about when people needed the medicine. Daily and monthly medicine checks ensured people received their prescribed medicine when they should.

Good

Our findings

We last inspected this service on 14 January 2016, when we rated Effective as 'Requires Improvement'. This was because procedures around protecting people's rights under the Mental Capacity Act 2005 (MCA) needed to be improved. At this inspection we rated Effective as 'Good'. Although paperwork around the MCA still required improvement, we were confident people's rights were protected and people were supported to make decisions where they could.

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. 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 are called the Deprivation of Liberty Safeguards (DoLS).

The manager and staff were able to describe the principles of MCA and DoLS. However, paperwork did not always show where people could, they had been asked to sign consent to certain aspects of their care. For those people who lacked the capacity to make all of their own decisions, people's relatives or advocates told us they were involved in planning their care, and making decisions in people's 'best interests' along with health professionals. However, paperwork was not up to date in people's care records to show how 'best interests' decisions had been made, when they had been made, and by whom. The manager told us they would review people's care records following our inspection and update the paperwork they used to record consent and decisions.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties, or their care involved any restrictions. Several people at the home had a DoLS application made to the local authority and were awaiting a decision.

Staff asked people for their consent and respected people's decisions to refuse care where they had the capacity to do so. For example, if one person refused to take their medicine, staff would respect their decision and offer their medicine later in the day.

We looked at meals provided to people and people's meal time experience. People chose whether they ate in their room, the dining room, or the lounge area. The dining room was a calm space designed to enhance people's mealtime experience and make it a social event. There were sufficient staff to assist people to eat

their meal at their own pace.

People told us they enjoyed the food on offer at the home, and could make choices each day about what they wanted to eat from freshly prepared food. People were able to choose from a range of options and staff asked people for their food choices before their meal was prepared. Comments from relatives included; "The food is very good, everything is fresh and homemade" and, "On Sunday there is always a very nice roast dinner."

However, we saw some people had forgotten what they ordered for lunch or tea when they were given their meal. We noticed there was no visual menu on display at the home, such as a blackboard or picture board, to remind people of the food choices each day. We brought this to the attention of the manager, as this might be helpful for people with short term memory loss or dementia. However, staff verbally reminded people of their food order if this was required, and people were able to choose alternatives if they didn't like what was on offer.

Kitchen staff knew people's dietary needs and ensured they were given meals which met those. For example, some people were on a soft food diet to prevent them from choking. Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People were offered a choice between cold or hot drinks several times during the day and at mealtimes to maintain their hydration.

We saw staff used their training and skills effectively to support people. For example, some people required assistance to move around the home safely. Staff used their skills to assist people with the correct equipment when moving them from chairs to standing positions, and also from standing positions into seated positions.

All staff received an induction when they started work at the home which included working alongside experienced members of staff. Induction courses were tailored to meet the needs of people who lived at the home, and the different roles each member of staff performed. One staff member explained they had been supported to achieve a vocational qualification since starting work at Benvarden. They said, "I am also building on these skills, with the support of senior care workers, to do further training. I intend attending a course next on how to support people with dementia."

Staff told us they received regular support and advice from their immediate supervisor which enabled them to do their work. There was an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. Regular team meetings and individual meetings between staff and their managers were held at Benvarden. These gave staff an opportunity to discuss their performance and any training requirements.

Staff met daily to discuss the running of the home and any ideas they had to improve things, as well as to discuss people's care and support needs. As the home was small, with a small staff team, formal meetings were only organised when a need arose.

Staff and people told us the provider worked in partnership with other health and social care professionals. Care records included a section to record when people were seen or attended visits with healthcare professionals, and their advice. The manager told us the doctor and other health professionals visited the home whenever they were needed and records confirmed people had been seen where required. For example, one person at the home was receiving regular daily care from the local district nursing team.

Staff could describe people's individual support needs, which matched what people told us and the information in their care plans. This was because everyone's needs were assessed when they moved to the home.

People had decided how their personal space was furnished and arranged. People's rooms included photographs of family and friends, pictures on the walls, ornaments and furniture personal to them. This was important as Benvarden was people's home, and people told us having personal items around them helped them to feel comfortable in their surroundings.

The environment at the home was not specifically designed to assist people with finding their way around, and to meet the needs of people who suffered from short term memory loss or dementia. For example, the corridors, bedroom doors, and communal areas were not marked with directional signage to assist people to find their way. The manager told us one person did get confused, and sometimes could not find their room. This meant they could enter other people's room by mistake. The manager told us they had considered this and were introducing 'memory boxes' at the home in the near future. These boxes would be located outside people's rooms and contain pictures and items familiar to them, to help identify their room.

Good

Our findings

At this inspection, we found staff continued to be caring and engage people at the home. People were encouraged to maintain and develop their independence. We continue to rate 'Caring' as Good.

Comments from people and their relatives included; "Staff are nice, the senior care staff are the backbone of the home", "[Name] is very happy here" and, "The staff and home provide fantastic care."

Benvarden had a homely atmosphere and people were happy and relaxed in their environment. People and their relatives indicated to us they felt happy to be staying at Benvarden. One relative commented, "We chose the home because we had previously had a relation stay there. [Name] also liked the homely atmosphere when we came to see it." Another relative said, "We now have trouble getting [Name] to come home for a visit, as they like to be at their home [Benvarden]."

We observed good relationships between people and staff, such as staff sharing jokes with people, telling stories about activities or trips, and chatting about their environment. People did not hesitate to request assistance from staff, which indicated they felt safe around staff.

Staff told us they liked working in the home. One staff member told us, "I really enjoy my role here. I enjoy the interaction with people who live here. Some people are here a long time and we get to know them really well."

Staff were thoughtful and patient. One person called out every few minutes to ask the time, day and month. Care staff always patiently replied to the person to remind them what time and day it was, or when they could expect their next meal. They engaged the person in conversation about something they were interested in to distract them and alleviate any anxiety.

We spoke with the manager to see whether a different type of communication such as reminder cards, or a noticeboard telling people the day of the week and time of year, might help people remember themselves. The manager agreed to look into different types of communication techniques to assist people with their short term memory.

The provider had a procedure in place that described to staff how people could be supported with accessible communication aids. For example, the procedure encouraged staff to consider the use of braille, large print, use of text messaging systems or translators if people had communication or sight impairments.

People's individual needs were catered for, as people's ability to communicate with staff and each other was assessed at Benvarden. We found some people with disabilities used specialist communication tools, to assist them. For example, one person wore hearing aids which required 'long life' batteries, which needed to be changed every week. This was noted on the person's records to ensure staff did not forget to change the batteries.

The provider had developed some technologies around the home to assist people with their environment. For example, some people at the home suffered with hearing loss. Whilst they were provided with hearing aids, including digital aids, people also had strobe lighting located in their bedrooms. This had been designed to flash in the event of an emergency, so that people who could not hear the alarm were alerted to any danger in the home.

People's care and support was planned in partnership with them and people who were important to them, which enabled staff to deliver person centred care. A relative said, "The staff know people really well, and we are always involved to answer any questions they have, or help with planning care."

Records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs and their personal preferences. Records also provided staff with brief information on people's life history. Care reviews took place every six months, or when people's needs changed.

Staff promoted people's independence and encouraged them to do things for themselves where possible. For example, staff encouraged people to eat and drink independently. Where people could, people attended to their own personal care needs unless staff were requested to assist them. A relative told us, "This helps [Name] maintain their dignity and independence."

There were a number of communal areas, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. This included a conservatory/lounge area and a dining area. People made choices about who visited them at the home and were supported to maintain links with friends and family. One visitor told us, "I can visit anytime."

People's dignity and privacy was respected by staff. Staff knocked on people's doors and announced themselves before entering. Care records were kept securely at the home, so that these could only be accessed by authorised people.

People were assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person they supported, ensuring their social and practical needs were met. Keyworkers also helped to maintain accurate care records for people to ensure they reflected people's current needs. We found keyworkers knew people well.

Good

Our findings

At our previous inspection Responsive was rated as 'Good'. At this inspection we continued to find people had the support they needed from staff, to respond to any changes in their health. People were able to raise complaints if they wished. We continue to rate Responsive as 'Good'.

Relatives told us care staff were always available to meet the care needs of their relations when they visited. Staff responded to people's requests for assistance in a timely way. One person asked for a drink, which was brought to them straight away. Other people gestured when they wanted assistance, and staff approached them to ask what they would like.

One person asked for staff to help with their legs as their skin felt dry. The staff member checked with the person whether they wanted a certain cream on their legs, which they did. The person did not want to move to a private space, so the staff member knelt down and rubbed cream on to the person's lower legs. The person smiled their acceptance.

Staff told us care records were usually kept up to date and provided them with the information they needed to support people responsively. Staff knew people well. One relative said, "The care staff know people's needs, it's a small home and everyone knows each other well."

We found care records had been devised using recognised tools from a leading authority on how people should be supported with dementia or short term memory loss. Information was held about each person in their care records on a form called 'This is me' which was designed by the Alzheimer's' Society. The document provided information on who the person was, the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality. The document was available in different formats to assist people with different levels of communication and was designed to enable staff to see the person as an individual and deliver person centred care tailored specifically to the person's needs.

Staff were able to respond to how people were feeling, and to their changing health or care needs because they were kept updated about people's needs at a handover meeting at the start of each shift. The handover meeting provided staff with information about any changes in people's needs since they were last on shift. Staff explained the handover meeting was recorded so that staff who missed the meeting could review the records to update themselves.

The home did not employ anyone specifically to support people with activities, hobbies and interests, but care staff supported people with what they wanted to do each day. People told us they enjoyed the activities and events offered at the home. Activities that people regularly took part in included chatting to staff and each other, crafts, pamper sessions, quizzes and listening to music and the television. Seasonal events were also organised at the home around Christmas, Easter, and other special occasions. People were also offered the opportunity to attend church or religious services each month.

A list of planned activities was not on display in the communal area of the home for people to refer to, which meant people were not able to get excited or anticipate activities that were planned that day. We raised this with the manager, who agreed to improve the information provided to people.

Relatives told us they had no complaints about the home, but they would like to see more activities and stimulation for their relations organised at the home. One relative said, "More stimulation for people is important to keep their mind occupied." A relative told us whilst one of their relations was at the home, they felt, "[Name] required more mental stimulation. Without the mental stimulation we found their condition worsened, care staff do try their best, but more stimulation would be good." Other comments from relatives included; "People could do with more to do, but sometimes it's clear they don't want to do anything except sit and chat." One staff member said, "There could be more to do. Sometimes people are looking forward to relatives or the vicar visiting."

Staff had held a meeting with people during the summer and discussed some of the activities they liked to do. This included arts and crafts, cake making, and quizzes. Staff were able to offer these types of activities for people most days, when there was time to do so.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. A typical response from people we spoke with was that they had never needed to make a complaint. Systems were in place to investigate complaints' however, the provider explained they had received no complaints in the last year.

We found people had some end of life care arrangements in place. The arrangements included decisions that had been made regarding whether people should be resuscitated following a cardiac arrest. These records were reviewed to ensure they had been discussed with people and their relations, and whether they remained valid as people's health changed.

The provider told us they aimed to make the home a 'home for life'. This meant wherever possible people were supported to stay at the home for as long as possible, rather than being transferred to a nursing home or hospital, if they became ill at the end of their life. People at the home had been consulted about their wishes where they wished to discuss these arrangements. We reviewed care records which documented people's preferences. Care staff told us this was to provide good quality care to people nearing the end of their life. One relative told us about the support they received when their relation was at the end of their life. They said, "The care was very good. We were well supported as a family, and we could stay overnight at the home if we wished to be there."

Requires Improvement

Our findings

When we last inspected the service we found Well-led was rated 'Good'. We found on this inspection, record keeping required improvement to ensure risk assessment documents and risk management plans were always up to date. Auditing procedures required improvement to identify where improvements were needed. At this inspection we have rated the service as 'Requires Improvement' in Well-led.

We found some people's care records were not always up to date, as people did not always have identified risk assessments and risk management plans in place. In addition, some people's care information was not filed so that it was immediately accessible. For example, during our inspection we found the manager and senior care worker needed to search to find some information we requested. This meant key information about people's care needs was not accessible immediately to refer to, or in emergency situations.

Recent checks and audits had identified that improvements to record keeping was required. The provider had recognised the need to amalgamate some people's care records, to complete some archiving of records, and to transfer some records to an electronic system at the home. This was to improve the accessibility of information, and to allow for quicker updating of care records. On the day of our inspection visit a Director was at the home, and had begun the transfer some paper records to the computerised system. The provider's intention was to expand this facility during 2018. The changes were planned over a phased programme, to ensure staff were trained adequately before systems were implemented.

Audits had not identified that accidents and incidents records were not always updated by staff, to provide a centralised record of accidents and incidents that could be reviewed. This would help to establish any patterns and trends that were occurring at the home, or preventative measures that could be adopted, to reduce risks to people. The manager told us, "Record keeping is where we need to make improvements." They added, "We recognise this is an area we need to work on."

People's relatives told us they felt the home was well-led. One relative told us they would be happy to approach the manager with any concerns they might have. Another person said, "The manager and staff are quite approachable." However, one person's relative told us they would like to see more of the manager around the home, involved in people's care.

The manager, who was also the provider, was part of a management team which included three senior care workers. There was a senior care worker on shift each day at the home, which provided management support and advice to any other staff members on duty. The senior care workers reported directly to the

manager and oversaw the day to day running of the home, and people's care needs. The manager was involved in all the administrative duties of running the home, as well as completing audits and assessments of people coming into the home.

People or relatives could give feedback about the home, to the manager or staff at any time, as they were on site and operated an 'open door' policy. We saw during our inspection visit the manager was available to speak with visitors and relatives throughout the day. Several people and their relatives visited the manager in their office during our inspection visit.

The manager organised some meetings, approximately twice yearly, for 'residents' and relatives at Benvarden where people were asked for their feedback. However, these were not frequent. The manager explained this was because the home was small, and people could talk to staff at any time about the things they liked and if they had any problems.

The manager also told us people were able to provide feedback regarding the service in an annual customer satisfaction survey; the most recent customer satisfaction survey was undertaken in November 2016. The results detailed that people were satisfied with the home and would recommend Benvarden to others. The only area people said they would like to see improved was more social stimulation for people, which had been discussed in subsequent meetings to establish what people preferred to do. Care staff were encouraged to organise daily activities for people at the home according to their preference.

The manager/provider completed regular checks on the quality of the service they provided. This was to highlight any issues and to drive forward improvements. For example, the manager conducted regular checks on care records, medicine administration and infection control procedures. The management team produced quarterly reports about how the home was performing against key indicators to the local authority commissioners. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. For example, a recent audit of medicines had highlighted where the home could reduce wastage of medicines. The provider was able to demonstrate wastage had been reduced in response.

The manager told us how they worked in partnership with other agencies such as commissioners of services and health care organisations to support people when they first came to the home, making sure their needs were fully assessed to get the right care in place.