Bupa Care Homes (CFChomes) Limited

Highfield Care Home

Inspection report

London Road
Halesworth
Suffolk
IP19 8LP

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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

The inspection took place on the 1 August 2016.and was unannounced. It was last inspected on the 23 October 2015. It was rated as inadequate overall and inadequate in safe and well led. There were two breaches of regulation 12: Safe care and treatment and regulation 11, Need for consent. . Following this inspection the Local Authority placed an embargo on the service which meant they would not place any funded clients in the service. The service is registered for 40 people but at the time of our inspection there were 29 people using the service. Following the last inspection in October 2015 the manager provided CQC with a detailed action plan which stated what actions they were taking to comply with regulations.

There is a registered manager in place: 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 2008 and associated Regulations about how the service is run.

We found there were enough staff to meet people's needs and we observed staff providing timely, respectful care. Staff were familiar with people's needs and provided personalised care around their individual needs.

We did not identify any hazards to people's safety other than when people were mobilising and had the potential to fall. Staff did not stifle people's independence but put things in place to reduce their risk of falls. We also found inadequate storage of large items of equipment which could potentially be a hazard.

We have made a recommendation about the management of risk.

Staff had a good understanding of safeguarding and what actions they should take if they suspected a person to be at risk of harm of abuse.

Staff recruitment was sufficiently robust to try and ensure only suitable staff were employed to work in care.

People received their medicines as prescribed and medicines were administered by staff who were trained to give them.

Staff induction and training could be improved upon to clearly show staff had achieved the necessary competencies.

Staff had a good understanding of legislation relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People were supported to eat and drink and this was closely monitored to ensure it was adequate to people's needs.

People's health care needs were met by the staff and other health care professionals where appropriate. We observed care being provided which was appropriate to people's needs, respectful and dignified. Staff supported people in a way they wanted to be supported and in consultation, gaining their consent before providing care.

Care plans were in place for people and demonstrated how they should receive their care in accordance with their needs and wishes. These were kept under regular review to ensure they accurately reflected people's needs. Social activities were organised around people's individual needs and helped to alleviate social isolation. However not everyone was seen to participate and it was clear that there was insufficient engagement for some people.

There was a robust complaints procedure and staff involved and consulted with people.

This was a well led service. Staff felt the manager listened and was responsive. They were adequately supported by a deputy and senior team of staff. Audits were in place to assess and monitor the standards of care and support provided to people using the service and to help identify and reduce risks. There were regular audits for record keeping, care and safety and maintenance of equipment. Action plans showed how the service resolved any service deficiencies.
It was clear there were a lot of changes occurring to improve the overall service delivery but we felt in order for these changes to be managed effectively staff needed to be adequately supported. The number of audits potentially could overwhelm the service.

The manager had good systems in place to assess people's needs and ensure they were being met. However the organisation did not have an effective dependency tool to help demonstrate and ensure that staffing levels at the service were adequate for the needs of people using the service. We also felt that there had not been sufficient consideration of how many activity hours should be in place to ensure people received sufficient social stimulation. We have made a recommendation about this.

Quality audits were completed through head office, surveys were sent to people annually and results collated and sent to the managers. However we saw low response rates and felt this was not an effective means of engaging with the majority of people using the service many of whom had dementia. Across the whole service we saw poor evidence of active engagement with relatives and with the local community

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 always safe.

Risks to people's safety were assessed and steps taken to reduce the risks. However we identified a few concerns throughout our observations.

Staffing levels were adequate but the allocated number of hours for activities was insufficient. The service did not have an effective staff dependency tool so we could not see how the service adequately assessed the number of staff it needed.

Medicines were given safely by staff trained to do so.

The service had a robust staff selection/recruitment procedure to help ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were supported and trained to give effective care.

People were supported to make decisions about their care and welfare.

People were supported to eat and drink in sufficient quantities for their needs.

Staff monitored people's health care needs and make referrals to other health care professionals as appropriate.

Is the service caring?

Good

The service was caring.

Staff promoted people's choice and independence.

Staff were respectful of people's needs and provided care and support in a dignified way.

People were consulted about day to day decisions but the

overall way in which the service engaged with people required improvement.

Is the service responsive?

Good

The service was responsive.

Staff were familiar with people's needs and met their needs in a timely way. Initial needs assessments and care plans demonstrated how care was planned, implemented and reviewed to ensure people's needs were met.

Activities were planned to help alleviate social isolation and activities were held regularly but there were not always enough staff to support people to engage.

There was a complaints procedure and the service took into account and acted upon feedback to improve people's experiences.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager was experienced and knowledgeable about people's needs.

There were systems in place to judge the quality and effectiveness of the service provided. However these did not always take into account the views of people using the service who might be unable to articulate or complete a survey. There was also a lot of repetition and the number of audits made it difficult to see how other aspects of the service could be delivered effectively.

There was poor engagement with the local community and other stake holders and it was not always clear how the service were enhancing people's quality of life.

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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.

The inspection took place on the 1 August 2016 and was unannounced. The inspection was undertaken by an 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 care service. Our expert had experience of older people care.

Before the inspection we looked at information already held about the service including previous inspections and notifications which are important events the service is required to tell us about. We carried out observations of care, looked at records, we spoke with seven people using the service, 12 staff, including domestic staff, maintenance, activity staff, care staff, senior staff, and catering staff two visitors and we looked at two care plans. We looked at other records relating to the management of the business

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2015 we rated Safe as inadequate. This was because medicines were not well managed and risks to people's safety were not always managed effectively. At this inspection we found risks to people's safety were well managed and improvements had been made in relation to how medication was administered.

Medicines were well managed and administered by qualified staff. We looked at recent medication audits which were completed weekly, and monthly. There were also spot checks in between. These showed good compliance but also identified any discrepancies which were then followed up with an action plan put in place. For example the medicines room floor needed replacing. We did not observe medication administration but saw that the trolley was secure at all times and the medication rounds had been completed in a timely way. Staff administering medication were knowledgeable and had received training and their competencies assessed on a number of occasions.

People had medication records showing all their prescribed and occasional use medication. There was clear guidance for staff as to when to administer medication especially medication for occasional use such as pain relief. There were protocols in place for this. The use of sedatives was monitored and we saw good evidence of GP involvement and medication reviews. Records did not contain gaps so we were assured medicines were given as prescribed. This included pain patches and creams, which were recorded and body maps were used to show where creams should be applied.

No one administered their own medication but there was a risk assessment the service used to assess people's capacity to do so safely if they wished to. Staff administering medication completed medication training and were subject to regular competency checks to ensure they were able to give medicines safely. When we asked how often staff would be observed we were told until they are confident and competent.

There was a clear medication policy and systems for checking in and returning unwanted medications. Cream were dated when opened and disposed of at the end of the cycle as required. Medicines were stored safely and at the correct temperatures.

The supplier of the medicines had recently changed a decision taken at regional level. This meant the service had moved from local supplier to a more remote one which had caused a few teething issues.

Risk assessments for people showed what actions staff took to keep people safe and we saw regular referrals to other health care agencies particularly the GP and falls prevention team. The manager regularly audited the number of falls people were having and said they had altered their staffing levels at night because more falls were occurring then. They also said they had introduced hourly checks for everyone during the day.

We observed a number of people unsteady on their feet and one lady going into the garden holding on to the wall. There were no hand rails outside her room and their door led directly into the garden. Another lady

was balancing tea and her frame and staff offered to help.

People's care plans documented any risk to their health and safety and included actions taken to minimise risk. These included manual handling risks and manual handling plan, falls risk and risks associated with poor diet/fluid intake and maintaining skin integrity.
Staff spoken with had a good understanding of risk and what actions they should take if they believed a person to be at risk of harm or abuse. All staff were confident that if they had any concerns these would be listened to and acted upon. Staff were familiar with records they should be using to document any concerns, including body maps. Not all senior staff were familiar with the computer systems where risks, accident, and incidents were recorded and sent to head office.
Everyone we spoke with, including visitors, told us the home was a nice environment and people living there told us they felt safe.

Staff received training to help them deliver safe care. The environment people were cared for in was free from hazards and specific equipment such as hoists, profiling beds and bed rails were used to help deliver safe care. Only one person had a sensor alarm which would help alert staff when they were moving about and the service had a second spare alarm. There was a call bell system which was regularly checked and where people were unable to use call bells there were frequent monitoring checks.

The service had individual fire evacuation plans for people and there was equipment to help evacuate people using the stairs in the event of a fire. We noted the rear conservatory and part of the first floor landing by the lift were used to store spare wheelchairs. These do have the potential to become hazards, and an alternative storage space should be found.

We recommend that equipment is safely stored to minimise risk to people's safety.

The service appeared clean and the manager completed health and safety and cleaning audits. We did note however an odour on entering the service which gave a poor first impression and a number of the hard back chairs had an odour. We observed good hygiene practices and there was hand sanitizer around the service.

Staff recruitment was sufficiently robust. Staff records showed staff were only recruited once all the necessary checks had been completed to confirm they were suitable for employment such as a checkable work experience, references, proof of identification, address and work status and criminal records checks. Interviews were recorded to show how the candidate's knowledge was tested prior to a job offer being made in line with the job specifications.

There were enough staff to meet the needs of the people using the service. On the day of inspection the service did not have a full complement of staff. A number of staff were training leaving them one short on the floor. The receptionist and the administrator were both on leave. However the shift ran smoothly and both the manager and deputy manager were available to support staff. We observed staff working cohesively and delivering care in a timely way.

In addition to care staff there were ancillary staff who worked efficiently and the service was clean and well ordered. There were also catering staff and a kitchen assistant who assisted with drinks and meals which worked well and ensured that t care staff could assist people with their personal care. There was also an activities member of staff who went round to people individually and then organised a group activity. This was cake making for a person's birthday that day and there were further planned activities that day. However a lot of people were not engaged in activity and staff, although vigilant, did not spend a lot of time

with people.

We looked at staffing rotas and were satisfied that staffing levels were adequately maintained throughout the week. The manager told us that they did not use either bank or agency staff so all the staff employed were regular staff who were familiar with people's needs. Some staff had set shifts and were able to pick up overtime. The team leader advised us they were moving over to a different shift pattern which they felt would be easier to forward plan and although the shifts were slightly longer would give care staff more days off.

We looked at the dependency tool which did not give us a break down of individual needs so we could not establish if the number of staffing hours allocated to the service was always sufficient. We were also concerned about how the service would staff the home if they had additional residents as they did not have bank staff.

We recommend that that provider aligns the dependency tool to the individual needs of people using the service and also take into account required activity hours to positively impact on peoples well being.

Staff we spoke with felt there were enough staff for the number of people currently using the service, several staff members said there was cohesiveness amongst the team, morale was good and staffing levels were maintained throughout the week and the weekend.

Good

Is the service effective?

Our findings

At the last inspection in October 2015 we rated Effective as requires improvement because staff were not supporting people lawfully around decision making. At this inspection we found that consent to care and treatment was sought from people before being provided and staff acted lawfully. In people's records was some helpful information for staff to follow if they were unsure about someone's capacity to make decisions. We saw both mental capacity assessments which had been reviewed and showed who had been consulted and best interest decisions which contained a clear rationale and processes involved in making the decision. Best interest decisions were kept under review and were specific to each area of need. We noted that where people had dementia the service had ensured the person was regularly seen by health care professionals to see how the dementia was progressing and its likely impact on the person's decision making.

We saw that the manager had made deprivation of liberty applications to the Local Authority when appropriate, (DOLS) when people could be at risk if they left the service unaccompanied. The environment was as least restrictive as it could be for the people living there and security had been reviewed after a number of incidents which had occurred. This was to help ensure people were kept safe but were able to live as freely as they wished.

People received effective care because staff had sufficient knowledge and the right skills for the job. We saw the training matrix which showed what training staff had completed and what had been booked. Refresher training had been booked to ensure staff received regular updates.
Staff received training essential to their role. The manager was a manual handling trainer and was able to assess and support staff with their manual handling. We observed manual handling practices and they were well done with staff reassuring and explaining what they were doing the whole time and working well as a team.

Staff all said that they received regular training and supervisions. Supervisions were with the Manager and they said they were confident that they could raise any issues with them. The shadowing of permanent staff carried out during the induction period, was felt to be effective as they could "get to know each individual resident and their preferences" whilst they trained.

Staff induction included a week long induction which was not held at the service. New staff would then go to their service and be shadowed by more experienced staff, observing their practice and being observed to ensure they had the necessary competencies. They were also required to work through a BUPA induction booklet which provided evidence that staff had understood key elements of their role and practice. A probationary review was completed at the end of this. The manager was in process of updating all staff competencies and using the forms provided by BUPA to spot check staffs performance so they could provide more robust evidence of how they assessed staffs competence. We were unable to see for some staff how the manager had assessed their performance in the past as records were patchy but were confident going forward that they had the right tools in place. However the timescales given to the manager

to assess all staff competencies in key areas of practice were unrealistic.

People were supported to eat and drink enough and maintain a healthy diet. We spoke with the chef who was experienced and knew people's needs well. They told us about special diets and how they accommodated the needs of people with diabetes. They had an updated list of people's needs including anyone losing weight. They told us they fortified their foods to increase the calorie content and also made home-made smoothies and snacks. One person had a food allergy and staff were aware of this and ensured they had food with was free from food they were allergic to. They confirmed they had received relevant training for their role and also additional training other care staff completed such as safeguarding people from abuse. The chef told us they had completed training on using the malnutrition universal screening tool, which is used to determine people's risk of malnutrion without the need to weigh people. This is because some people are not able to use conventional scales. The chef told us a number of staff had also completed this training and there was a nutritional champion in the service. They said they ensured people were regularly weighed and communicated to other staff if anyone had lost weight and needed to be monitored.

One potential risk not identified by the service was the risk of aspiration. A number of people were on special diets and staff were aware of this but the risk of aspiration had not been considered. We noted a number of people had all meals in their rooms so it is advisable to assess the risk to individuals

The service employed a kitchen assistant both in the morning and evening and they were responsible for supporting the chef and care staff by giving out regular drinks and snacks. This ensured people had adequate fluids throughout the day and care staff had more time to assist people with their personal care needs.

We observed lunch time and although this was a bit later than planned it was well supported and staff were attentive to people's needs. They offered people appropriate support and choices. Menus were both typed and picture menus, to help people make choices. One person required assistance with their meal. This was well managed with care staff pulling up a chair, to be at the right level, and taking their time to assist the person according to their needs. Drinks were readily available in the lounges and in people's rooms.

People were supported to maintain good health and access health care as appropriate to their needs. People's records demonstrated this with regular entries about people's health and health care professionals involved in their care such as regular input from the chiropodist and also the doctor, district nurses, optician and dentist.

The manager told us everyone was registered with the local GP surgery and they had a good relationship with the GP who they said visited every Friday and any other time needed. They said there was a set meeting with them every six months. The manager informed us that one person currently had a pressure sore but this was not acquired at the service. They were receiving regular visits from the District nurses and had equipment in place to promote their skin integrity.

The service provided high quality care. Care plans were updated and reviewed regularly and demonstrated staff were responsive to people's changing needs. For example we saw how a person was restless at night and there was a care plan in place to try and promote a better night's sleep. When this was ineffective staff contacted the GP and the person was prescribed medication but this had an adverse effect on the person and increased their risk of falls so it was discontinued. This showed staff were continuing to try and meet a person's needs. In addition there was further documentation about how they were at risk of falls, how this had been minimised and why some options had been considered but discounted such as the use of bed

rails. The service had systems in place to identify and manage risk such as wound care, pressure relief, hydration/weight loss and falls.

Good

Is the service caring?

Our findings

Positive and caring relationships were developed with people using the service. We used mainly observations as we found there were not many people who were able to tell us about their experiences of the service. We saw that people looked well groomed and well dressed. A number of men were unshaven but when we asked them they told us this was their choice. One relative told us, "Staff make great efforts to understand my family member's needs. Nothing was too much trouble for them."

Interaction between staff and people using the service was positive. Staff were polite and considerate, constantly checking that what they were doing was correct and that people knew what was happening. We considered care was given around people's needs and staff were responsive and flexible in their approach.

Visitors all said that they were not subjected to any restrictions on visits. They also said that they could raise any issues they felt needed airing with the manager and any of her staff.
The manager informed us that there was a 'Residents wish list.' This was created from what people had said they had always wanted to do either for the first time or something they had enjoyed in the past. For example one person had always wanted to sit on a Harley Davidson and this had been arranged.

People were supported to make decisions about their care, treatment and support. We observed care staff asking people what they wanted to eat. Staff were very patient with people and gave them opportunity to respond. Drink choices were offered and staff asked people if they wanted sugar. The only concern we had is some drinks such as squash were served in plastic glasses and some people were given hot drinks in plastic cups which were stained and not very dignified. The manager told us some of the more traditional tea sets were too heavy for some people to lift. We would like this to be reviewed. In addition we noted there were not enough occasional tables for people to put their drinks on.

We looked at care plans and they clearly told about people's needs and what people needed help with and what they could do for themselves. We saw people mobilising and being encouraged to do what they could for themselves.

People's privacy and dignity was respected and promoted. We saw staff asking people for their consent and giving people the time they needed. Staff knocked on doors and waited to be invited in. Staff asked people discretely about their personal care needs.

Good

Is the service responsive?

Our findings

People receive personalised care that was responsive to their needs. Most people using the service were not able to tell us about their experiences because many had advancing dementia. We carried out some observations to help us make a judgement about the quality of care provided to people. We saw people were relaxing and staff were attentive to their needs. People sitting in the main lounge were periodically supervised by staff to ensure their safety and well- being. Staff promoted people's fluid and there was quiet, old time music playing and a number of people were tapping away to it. Another lady was singing, later she went into the office and staff sat talking to her. We also saw a number of people enjoying the weather in the garden.

We observed one person with a severe speech impediment. Staff took their time and, were familiar with their needs and were able to understand them. They did not finish their sentences and waited for them to finish speaking, before checking their understanding with them. It appeared to be too natural to have been behaviour encouraged by our presence, so is commended.

We looked at two people's care plans and found the documents to be very informative, well written and regularly evaluated. They clearly told us what people's needs were and how staff should meet them and taking into account how the person wished to be cared for. People were only admitted to the service after an assessment of their needs was completed. On admission staff observed the person and recorded how much they ate and drank for a period of two weeks to ascertain if they were at risk from malnutrition/dehydration. Care plans were actively reviewed and daily notes were informative and showed how staff were delivering effective care.

The service routinely listened and learnt from people's experiences. We reviewed the complaints and saw actions were taken to ensure people were listened to and their experiences were taken into account as to how future care would and should be delivered. The service also took into account compliments and these were shared with staff where appropriate.

On the day of our inspection it was a person's birthday and activity staff were making a birthday cake. They did this with the help and involvement of about seven people using the service as a planned activity. We met the designated activity person who was full time and also worked every other weekend. They showed us what activities were planned throughout the week. This included cooking, painting, carpet bowls and local trips out. There were also bigger events such as fetes and recently jazz in the garden. They also recorded who participated in activities and if people had enjoyed an activity to see if it was worth repeating. They took into account people's wishes by going round to everyone to tell them what was planned, giving them an activity schedule and asking people if they wanted to participate. In addition the activity co-ordinator told us about the resident's wish list and how they tried to link people's experiences with planned activities. For example they told us about one person and their previous employment. They had arranged for a person to visit them who had the same profession so they could discuss what they did and what had changed in the industry.

Throughout our observations we saw that most people were up and dressed and finishing breakfast by ten and then having lunch by about twelve thirty. Most people did not join in a planned activity and were observed sitting unoccupied throughout the morning and again in the afternoon. We spoke with the activities coordinator about this and they said in addition to organising group activities they also offered one to one activities which most people needed and benefitted from. However they said it was very difficult to meet the needs of everyone within their current hours. We noted, when observing, that care staff did not support the activities coordinator and although staff were very kind and did chat to people most people were without adequate stimulation throughout the day. There were outside entertainers but this occurred about twice a month and the staff organised events throughout the year which were well received by people.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection this service was rated as inadequate in well led. This was because we felt the systems in place to assess and measure the quality of the service were ineffective because they had not identified the concerns we had in relation to the management of medicines and risks which made the service unsafe. During our inspection in August 2016 improvements have been made since the last inspection. For example we saw how risks were effectively being managed because care plans were updated and reviewed regularly and demonstrated staff were responsive to people's changing needs. We saw how a person was restless at night and there was a care plan in place to try and promote a better night's sleep. When this was ineffective staff contacted the GP and the person was prescribed medication but this had an adverse effect on the person and increased their risk of falls so it was discontinued. This showed staff were continuing to try and meet a person's needs. In addition there was further documentation about how they were at risk of falls, how this had been minimised and why some options had been considered but discounted such as the use of bed rails. The service had systems in place to identify and manage risk such as wound care, pressure relief, hydration/weight loss and falls.

Improvements to the service were further demonstrated through the audits carried out, some were daily, weekly and monthly some of which directly looked at care practices, others at care records and others at health and safety and the environment. We sampled a few and saw that where things had been identified an action plan was put in place stating how the issues would be addressed. There were a large number of audits being done and we were concerned how the manager would keep up with these alongside her other duties. They said each week she has an afternoon free to hold a clinical risk meeting. During the risk meeting she and her deputy review any known risks in the service or anyone whose needs are changing and a clinical risk tracker was completed which clearly shows how the risk is being managed. Whilst this was thorough we saw some overlapping of audits. For example each care plan was reviewed at least monthly, there was also resident of the day where a person's needs were reviewed on that particular day. There were also care audits. There were monthly dining room experience audits and spot check audits as well as meetings at ten am each day to review risks. Whilst the systems of audits were robust it was difficult for us to see how the manager was able to keep on top of everything they were being asked to do which included new paperwork for staff induction and new medication systems.
The service demonstrated good management and leadership. The manager had been in post for many years as had many of the staff. They knew people well and were observed interacting with people in a kind, appropriate manner. On the day of our inspection a number of staff were on leave but ordinarily the manager was supported by a full time receptionist who was there to meet and greet people and there was also administrative support for the manager. This helped free up some of the manager's time so they could support staff in providing care.
The leadership was strong but the service was constrained by the organisation overall and the manager was not able to operate with the autonomy expected to manage the service in the interest of the people using it. For example when we spoke with the chef they told us BUPA had a rolling menu which they had in all of their services. This gave people adequate choice but did not take into account people's food preferences or cultural differences. Food was sourced and purchased from national companies and the manager could not

source local products which might help to improve the service's relationships within the community. Another issue was that the service had used a local pharmacy and this had worked well with the pharmacy carrying out audits and providing support. However BUPA changed pharmaceutical companies which meant the service lost their local links.
Staff were supported to develop and senior staff had the opportunity for role specific training such as National vocational courses and specific dementia training. The manager was able to give examples of service specific training staff had done around people's individual needs. Most training was commissioned through BUPA which meant the service were not often tapping in to local training

Staff told us engagement with the local community was quite poor and there were no volunteers and poor family contact. We discussed this with the manager in context of activities as people were not sufficiently stimulated. This was in part attributed to budgetary considerations but also the amount of time allocated to the provision of activities which staff told would us would not increase if the service was full. The activities coordinator although experienced did not have specific training in the provision of activities which might assist them in providing activities for people who experienced cognitive impairments. A number of recent events held at the service were poorly attended by family members. The service has a newsletter but did not routinely circulate this to relatives; neither did they have a distribution list which would help inform people of forthcoming events and what was happening in the service. Relative meetings were held but not frequently and were poorly attended. The manager was not able to show they had explored the reasons for this but said they felt it was because they had an open door policy and anything brought to their attention was addressed immediately.

We felt engagement with people using the service could also be improved upon as most people had a cognitive impairment and would find it difficult to complete questionnaires which were the main way BUPA communicated with people asking for their feedback as part of an annual survey. The manager was able to analyse the overall results of the feedback.. There was no dementia champion in the service and no specific quality audit tool to measure the effectiveness of the dementia care provided.

The service promoted a positive culture which was person centred but not always inclusive. Feedback from people was sought and saw that every three to four months written feedback was sought from people using the service about the quality/quantity of the food. There were also dining room audits to ensure people were appropriately supported with their meals.
Staff told us there was a written handover after each shift and this involved care staff and kitchen staff who updated care staff on anyone who had not eaten or drank very much so they could be encouraged, this ensured continuity of care.