Benridge Care Homes Limited

# Benridge Residential Care Home

**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 |

## Overall summary

An unannounced inspection took place on 5 and 6 November 2014.

Benridge Residential Care Home provides accommodation and personal care for up to 27 people who need support with personal care and who are living with dementia. The home is a large converted property providing accommodation over four levels. Nursing care is provided by the local district nurse team when needed. The care home is situated close to close amenities provided by the town. At the time of our inspection 22 people were living there.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law.

# Summary of findings

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 was a relaxed and friendly atmosphere and staff support was given in a kind, respectful and gentle manner. We observed positive and warm interactions between people living at the home and staff throughout the inspection.

People living at the home were kept safe from abuse because the staff understood what abuse was and the action they should take to ensure actual or potential abuse was reported. Relatives told us they thought the home was safe.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People and their families told us there was generally sufficient numbers of staff on duty at all times.

Family members told the home communicated well with them and they were kept informed of any changes regarding their relative's care and support. People were able to see their families and friends when they wanted. There were no restrictions regarding the times when people could visit.

People were supported by external care professionals to maintain their optimum health and referrals were made at the appropriate time. A number of external care professionals were visiting during our inspection and the information from the visits was shared with the staff team.

People and family members told us the staff were polite, caring and respectful. Staff had a good knowledge of people's care needs, wishes and preferences. We observed staff assisting people in accordance with individual need and we saw the staff positively engaging with the people they supported. Some people displayed behaviours that were challenging and unpredictable. We observed the staff supporting them to ensure their safety and wellbeing. This support was provided in a respectful manner. Family members told us they felt the home was safe.

Care records we looked at showed a range of risks assessments and plan of care to support people depending on their individual needs. It was recognised that the development of documentation around pain management and also more detailed recording of behaviours needed to be addressed.

The menu provided a good choice of hot and cold foods at different times of the day. People told us they liked the food and we saw staff offering alternative choices. Snacks and drinks were available throughout the day and special diets were catered for.

At the time of our visit sufficient numbers of staff were available to support people. Staff were skilled and trained to provide care to people at the home. A training programme was in place which included dementia awareness. Staff told us they were supported through induction, team meetings, supervision and appraisal. There was a high percentage of staff with formal qualifications in care which evidenced a good knowledge base for their role. Staff told us they had access to a good training programme.

Medicines were safely administered to people and were monitored and reviewed. Input was provided by a community pharmacist to ensure medicines were reconciled and reviewed appropriately.

The principles of the Mental Capacity Act (2005) (MCA) were adhered to for people who lacked mental capacity to make their own decisions. We saw examples where care and treatment had been carried out in people's best interest and this had included assessment of the person's mental capacity. Deprivation of Liberty Safeguarding (DoLS) authorisations had been applied for around restrictions that were currently in place to keep people safe. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the manager and senior staff knowledgeable regarding the process involved.

Audits and checks of the environment were undertaken to ensure it was safe and well maintained. On-going work was evident with regard to upgrading the fire prevention system in the home. As part of ensuring fire safety, we saw Personal Emergency Evacuation Plans (PEEPs) were not in place for people at the home. The home are currently working with the local fire authority regarding the implementation of these under the Regulatory

# Summary of findings

Reform [Fire Safety] Order 2005 and its relevant legislation. This will help fire evacuation to optimise the safety of people living at the home. Following the inspection the manager informed us PEEPS had been implemented.

Consideration had been given to ensure the environment promoted people's safety and independence. Contrasting colours were evident and pictorial signs to help orientation, as well as a clutter free environment and sensor and pressure mats in people's rooms. We found the home to be clean and tidy.

The culture within the service was person-centred and open. This meant people's care and support was planned individually to meet their needs. A process was in place for managing complaints and the quality of care was monitored to ensure it was safe and in accordance with 'best practice'.

People who lived at the home and their family members were able to give feedback about the home through meetings and day to day discussions.

A service user guide provided information about the service and the manager informed us this was reviewed and updated as required. The manager continues to send statutory notifications to us to identify key events in the home. We were aware that there were people in the home who were subject to Deprivation of Liberty Authorisations from the local authority. We had been notified of these.

# Summary of findings

## 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.

Risks to people safety were assessed to protect people from harm or abuse.

Medicines were administered safely and there were effective systems for checking and monitoring on-going medication management.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults. There were enough staff on duty to support people safely and in accordance with their individual needs.

As part of ensuring fire safety, we saw Personal Emergency Evacuation Plans (PEEPs) were not in place for people at the home. The home are currently working with the local fire authority regarding the implementation of these under the Regulatory Reform (Fire Safety) Order 2005 and its relevant legislation. This will help fire evacuation to optimise the safety of people living at the home. Following the inspection the manager informed us PEEPS had been implemented.

**Is the service effective?**

Good

The service was effective.

Staff understood and were following the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions. .

People had access to health professionals to continually monitor and assess health care needs.

Staff received training and were supported through induction, supervision, appraisal and the training programme. Staff told us the training programme was good.

The home was warm and well lit. Orientation aids were available to help people maintain their independence.

**Is the service caring?**

Good

The service was caring.

People told us they were happy with the care they received. We observed warm interactions between the staff and people they supported. People were treated with respect and dignity.

Staff had a good understanding of people's needs and made sure people were comfortable and well cared for. Staff encouraged people to engage in social activities and people enjoyed taking part during our visit.

Family members told us the staff communicated well and they were advised of any changes regarding their relative's needs or care provision.

**Is the service responsive?**

Good

The service was responsive.

People's care was planned in a way that reflected their individual needs and wishes.

# Summary of findings

Following a recent safeguarding incident the need for recording information on pain control had been highlighted. The manager informed us they were implementing documentation around pain management for people.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

**Is the service well-led?**

Good

The service was well led.

Systems were in place to assess the quality of the service provided in the home. This included a number of audits and checks on the environment and care practices. 'Best practice' and research based guidance was followed by the home to support people who had a dementia.

There was an open and positive culture in the home. Systems were in place to seek people's opinions and to get formal feedback about the service provision.

A registered manager was in post and staff advised us the manager was supportive and approachable.

# Benridge Residential Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

We visited the home on 5 and 6 November 2014. Our first visit was unannounced and the inspection team consisted of a Care Quality Commission inspector and a Specialist Advisor. This is a person who has experience and expertise in health and social care. The Specialist Advisor attended the home on the second day of the inspection and the inspector completed the inspection on the second day.

Before our inspection the provider completed a provider information return [PIR] which helped us to prepare for the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Prior to the inspection we reviewed the information we held about the home, looked at the notifications the Care Quality Commission had received about the service and took into account the local authority contract monitoring reports. We also contacted commissioners of the service and three external professionals to share their views with us about the service.

The inspection was carried out with the manager and deputy manager. During our inspection we spoke with three people who lived at the home, eight staff, including care and ancillary staff, three relatives and a visiting health professional. We looked at the care records for three people [to track people's care], three staff recruitment files and other records relevant to the quality monitoring of the service. We undertook general observations in the communal areas and we looked round the home. This included viewing some bedrooms, bathrooms, dining room, two lounges and the grounds. Following the inspection we conducted telephone interviews with two relatives.

During the inspection we used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who use the service who could not talk with us.

Good

# Is the service safe?

## Our findings

People who were able to share their views with us told us they liked living at Benridge Residential Care Home. A person said, "I am really happy here, you can tell."

The family members we spoke with during the inspection said their relatives were looked after safely by the staff. A relative said, "I do feel it is safe" Another relative told us they would happily speak up if they felt anything was unsafe at the home.

Throughout the inspection we observed the staff supporting people in a discreet way ensuring their safety at all times. For example, we observed staff supporting a person going out for a walk. We were made aware that all of the people living at Benridge Residential Care Home had some level of support when going out into the community to ensure their safety. We saw staff supporting people to move between rooms and also staying with people whilst they took their medicines. The staff checked to make sure people had taken their medicine before moving on to the next person. People were able to move around the home freely with or without staff support. Corridors were kept clear from equipment and the floors had no raised edges to reduce the risk of trips or falls.

We found the home to be clean and tidy; this included the kitchen and the laundry room where there was segregation of clean and dirty linen. The home had been awarded a five star rating food hygiene rating in April 2014 by the local council. Internal infection control audits were carried out quarterly and and the home achieved 99% following an external infection control audit of the home by a community health team.

The staffing rotas we looked at and our observations during our visit demonstrated there were sufficient numbers of staff available to meet the needs of the people who lived at the home. A person told us if they needed help they only had to ask. Relatives told us there could be very busy times in the home when people presented with behaviours that challenged the service though generally there were enough staff on duty to help. For the 22 people living at the home there were two care staff, a care manager, shift manager (with a care background) and ancillary staff available on the day of our inspection. This was in addition to the manager. We found the staff had the skills, experience and knowledge to support people. This was confirmed by family members we spoke with and also by looking at staff files.

We observed several people asking for help and this was provided immediately by the staff. A staff member stayed in each of the lounges and the dining room. This presence ensured people's safety, providing extra support for people who were moving around frequently or who were agitated. We were shown a staffing level assessment tool which helped the manager determine staffing levels. The manager informed us they were looking to provide more staff support early morning, as people's dependencies had increased and it had been identified this was a particularly busy period of the day. The manager had therefore responded positively to a change in people's needs.

During our inspection we saw a number of people displaying behaviours that were challenging and unpredictable. These had the potential to affect their own and other people's safety. Staff provided support by using diversional techniques to help reduce these potential risks. Staff offered comfort and support maintaining people's dignity at all times. For example, assisting people to the bathrooms. Family members told us the staff had a good knowledge of people's needs and described to us how the staff used their expertise and knowledge to keep people safe and comfortable.

Staff gave us examples of how they supported people who were not always able to verbally communicate their needs. They had a good awareness and knowledge of people's facial expressions and body movements which had the potential to indicate pain, hunger, assistance needed. People who were not able to communicate verbally appeared comfortable and relaxed with the staff. We observed two staff supporting a person who wanted to go for a walk. In light of the behaviour the person displayed, the need for two people had been risk assessed to ensure the safety of the person and staff.

The care files we looked at showed how risks to people's safety were assessed and how this information was used to record a plan of care. Risks assessments identified possible risks and the level of support required to help protect people from unnecessary hazards, thus ensuring people's safety and promoting independence where possible. Examples of these were risk assessments relating to access

Good

# Is the service safe?

the community, challenging behaviours, falls, nutrition and the use of bed rails. These had been discussed with family members and they and the staff were aware of the risks and the measures in place to help keep people safe.

Staff supported people with their finances where needed. Electronic records were held of people's expenditures. The administrator advised us these were audited on a regular basis, as part of monitoring the safe handling of money and accuracy of the financial records held.

We looked at how incidents and accidents were recorded. This included discussions with staff, family members and viewing incident and accident reports. A person suffered a minor injury during our inspection and staff provided first aid and completed an accident form. We looked at incident reports where people's behaviours had been challenging. These were subject to review and on-going monitoring through the home's quality assurance processes. These reviews(audits) enabled the manager to identify any possible causes or trends and put measures in place to minimise the risk of reoccurrence. We saw examples where a change in medication or altering the time of day when a medicine was administered had helped reduce risks. A family member advised us they were always informed if their relative had been involved in an accident or incident. This they found reassuring.

Staff we spoke with had a good knowledge about what constituted abuse and how they would report it. Training records confirmed staff had undertaken safeguarding training and this training was also covered in staff induction. A safeguarding report was available in some of the care files we looked at to show the actions taken following incidents.

People did not have a plan of care for pain management. Following a recent incident the need for recording this information had been highlighted. The manager informed us documentation around pain management was being implemented and the staff had been made aware of the importance of assessing and providing adequate pain control. This was confirmed when talking with staff.

The home was subject to regular safety checks to make sure it was safe and well maintained. Environmental risk assessments were in place and specific safety checks were undertaken. For example, checks of the hot water temperature and fire safety. As part of ensuring fire safety, we saw Personal Emergency Evacuation Plans (PEEPs) were not in place for people at the home. The home are currently working with the local fire authority regarding the implementation of these under the Regulatory Reform (Fire Safety) Order 2005 and its relevant legislation. This will help fire evacuation to optimise the safety of people living at the home. Following the inspection the manager informed us PEEPS had been implemented.

Following a recent safeguarded incident in the home the manager discussed with us the person's current safety measures and how these were being reviewed to optimise the person's safety. The changes needed had not been actioned as yet though the manager informed us these would be in accordance with advice from environmental health following their visit to the home. We saw the use of sensor and pressure mats in people's rooms to alert staff when people had got out of bed unaided.

We looked at personnel files for three staff, this included newly appointed staff. Recruitment checks had been carried out to confirm prospective employees were suitable to work with vulnerable adults. An application form, photograph for identification, DBS checks and two references were in place. DBS is the Disclosure and Barring Service which provides a recruitment check to help ensure people are suitable to work with vulnerable groups.

We observed, for short periods, a staff member administering medicines safely to people. The staff member gave out the medicines from a locked trolley which was kept in the staff office. They signed for the medicines once they had administered them to people on an individual basis. This helped reduce the risk of errors occurring. Medicine administration records (MARs) we saw were fully completed and accurate showing people had been given their medicines properly. This included the application of prescribed creams. Staff wore a 'do not disturb' apron when giving out medicines to lessen the risk of them being distracted. There was a medicine fridge and medicines were kept at the correct temperature. The home had a controlled drug cupboard (drugs liable to misuse). This was not attached to a wall. This was brought to the manager's attention and rectified immediately to ensure the cupboard was secure. No one was receiving a controlled medication at the time of our visit.

Staff who administered medicines were trained and their competency observed by senior staff.

Good

# Is the service safe?

Medicine audits were completed to check medicines were managed safely. Any shortfalls identified had been actioned. A visiting community pharmacist was undertaking a review of a number of people's medicines during our visit. These measures helped to ensure medicines were reconciled and reviewed appropriately.

A number of people were receiving regular or as required (PRN) painkillers. Staff were knowledgeable regarding the pain management for the people discussed.

Three people were receiving their medicines covertly. This is when medicines are disguised in food or drink for example, without the person knowing. External agencies had been involved with risk assessing this practice along with discussions with family members. The use of covert medicines was subject to regular review to make sure it was in the 'best interests' of the people concerned. Care plans for covert medication did not record the medicines to be given covertly or what to do should people refuse their medication. Talking with staff confirmed they were aware of the required actions. Following discussion with the manager they informed us they would record this information.

Good

# Is the service effective?

## Our findings

We asked people to tell us what they thought about the care and support they received. A person living in the home said, "They look after me very well." A family member informed us the care was excellent and their relative's health had improved.

Family members we spoke with told us the staff were good in keeping touch and advising them of any changes or incidents that affected their relative. Their comments included, "They always give me a call" and "When [family member] had a fall, I was notified immediately."

From looking at care records, talking with staff, relatives and visiting health professionals we could see a multi-disciplinary approach to supporting people with their care needs. This included referrals and visits to the home by a community psychiatric nurse, district nurse team, occupational therapist, GPs, chiropody and optical service. At the time of our visit a GP, district nurse, community psychiatric nurse and optician who specialised in supporting people with dementia were visiting to conduct reviews and carry out a medical procedure. Following a recent safeguarded incident the need to seek prompt medical attention had been reinforced with the staff. At the time of our visit staff told us about the importance of seeking medical advice at the appropriate time. Care records we viewed showed these visits had been conducted in a timely way; a visiting health confirmed this with us.

We looked at number of staff training records and also the home's staff training plan. This showed the staff attended a number of courses including courses relevant to the client group they supported. New staff received an induction and part of the induction was role specific. A staff member told us during their induction they initially worked with a senior member of staff to support them in their role. New staff were also given a staff handbook.

A number of staff held a formal qualification in dementia care (dementia award) or were working towards this qualification. Staff also held or were working towards a qualification in care such as NVQ [National Vocational Qualification] or a Diploma. 88.8% currently hold a formal qualification in care. Staff told us they felt supported in the work place and that they received training and also attended supervision, appraisals and staff meetings. The training programme and support offered to staff helped to ensure they had the skills, experience and knowledge to support people at the home. Staff told us they had access to good training.

We asked people who lived at the home and their family members what they thought about the food. People were complimentary about the meals. They told us, "Sometimes the meals are very nice", "I like it all" and "Everything is lovely, but if don't like it I can ask for something else." We saw people were offered regular drinks and sweet/savoury snacks throughout the day.

The dining room tables were laid for lunch and tea. White crockery was used against a dark tablecloth for easy recognition and people had access to adapted cutlery, crockery and plate guards to help maintain independence.

Lunch was well attended in the dining room and this was seen as a sociable time for people to get together. Some people chose to have their meal in the lounge or to move from room to room. Staff supported them serving lunch on a tray. In the dining room lunch was served from individual serving dishes and people were able to choose what they wanted to eat and the portion size. There was a four week rotational menu which provided a good variety of hot and cold foods to meet people's dietary needs. The manager informed us the menus would be changing and would include details about the calorific value to help monitor people's dietary intake. We saw the staff had received training on the use of thickening agents for drinks. This helped to ensure the correct consistency for people who had problems swallowing. Staff provided people with lots of encouragement to eat their meals and they made sure people had sufficient time to eat their lunch. We saw the staff and the chef asking people what they 'fancied to eat', offering alternatives and lunch at a later time if people were not hungry when lunch was served. People's dietary preferences and requirements were recorded therefore kitchen and care staff had the information they needed to support people with their diets. Special diets, for example diabetic and meat free diets were catered for. Staff kept a record of how much people had to eat and drink if they were concerned about their diet and fluid intake.

For people who required a special diet for medical reasons, this was recorded in a plan of care.

Good

# Is the service effective?

People had a nutritional risk assessment to identify whether they were at nutritional risk and people's weights were monitored for weight gain or loss.

The Mental Capacity Act (2005) is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. We looked at how people's mental capacity was assessed in relation to 'day to day' decisions and specific treatments. Mental capacity assessments had been completed and decisions made in the 'best interests' of people recorded. Relatives and external multi health care professionals (including GPs) had been involved in this process. For example, we reviewed a person who had bed rails in place. They were unable to give an informed consent and therefore this decision was made by the home in conjunction with family and external health care professionals. This was deemed in the person's 'best interest' to help keep them safe. This was backed up by plan of care which was subject to regular review.

DoLS (Deprivation of Liberty Safeguards) is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. For the people who lived at the home the manager had applied for DoLS authorisation where a restrictive practice was in place. An example of this authorisation was the use of a key coded lock on the front door which was in place to keep people safe through restricting them from leaving the home without staff supervision. We had been informed via a statutory notification of four DoLS authorisastions for specific restrictive practice in accordance with our regulations. The Care Quality Commission (CQC) has a duty and responsibility to judge these safeguards are being met. We found the manager and senior staff knowledgeable regarding the process involved.

Where a person had requested their own room key for security and dignity purposes this had been provided. The person told us they had a key.

We looked round the home and found it was well lit and generally warm. We saw a number of bedrooms and the communal areas. Consideration had been given to ensure the environment promoted people's safety and independence. Contrasting colours were evident and pictorial signs to help orientation, as well as a clutter free environment and sensor and pressure mats in people's rooms. We found the home to be clean and tidy.

The manager informed us people were involved with choosing their own colour scheme and we saw people had personalised their rooms with photographs and ornaments. We saw bedrooms were individually decorated and people had their name on their bedroom door. Bathrooms and toilets were signposted and the toilets had bright coloured seats. Armchairs had different coloured piped edges. These initiatives helped to orientate people in their surroundings. Adapted baths and shower rooms were available.

Good

# Is the service caring?

## Our findings

We asked people if they thought they received good care and support. A person said, "Yes, the staff are great, I get help and also have a nice time with them." Relatives told us the staff were very caring and were aware that with a recent change in staff, new staff were having to 'get to know' people's needs and how to respond to them.

Relatives told us they were able to visit their family member in private and the staff were always polite. People could see their family and friends at any time. There were no restrictions when people could visit. We observed staff knocking on peoples' doors before entering and also using the preferred name of address when talking with people. This helped show people were treated with respect.

Throughout the inspection we saw people at the home being cared for in a kind, sensitive and respectful manner. There was a relaxed and friendly atmosphere and we observed warm positive interactions between the staff and people they supported. This had a positive effect for people and their relatives.

When staff assisted people we heard them explaining things clearly in a way they understood. We observed a staff member kneeling down to maintain eye contact when talking to people and holding their hands. They provided plenty of reassurance to the person, checking on their comfort and wellbeing at all times.

There was plenty of laughter and chatter between people and the staff and this was particularly evident during the social activity sessions. This included circular dancing which staff were trained to deliver. Lots of people joined in with the social activities and the sessions appeared to be enjoyed and enhanced people's moods. Several people did not wish take part and wanted to sit quietly. Staff accompanied them to the other lounge. Some people were being nursed in bed due to frailty. We saw staff carrying out regular checks and offering drinks to ensure their health and wellbeing.

We discussed a number of people's needs with the staff. A staff member gave us a detailed over view of a person's preferred routine, likes and dislikes, past history and favourite colour. It was evident the staff member knew the person as an individual and this was observed in the positive interaction we saw. The staff member said, "I don't feel like I'm at work, I look forward to coming here every day. Everyone is different, different types and needs." Relatives told us the staff had a good understanding of people's needs and wishes. For example, the meals they preferred and music they enjoyed listening to.

Daily reports recorded the activities people had taken part in. The manager informed us they were looking to implement individual activity records to better evidence people's inclusion and enjoyment.

An activities board was displayed in the main hallway for people to see. In respect of other information available to people, we saw a laminated poster in people's rooms with pictures prompts. This recorded information such as people's preferred name, preferred social activities, whether they wore glasses, dentures or a hearing aid. Staff said this was a good communication tool for the people they supported. A person told us they liked the board as it helped them to remember things.

The home's service user guide, brochure and complaints procedure were available. The manager advised us these documents could be printed off in large print or alternative formats on request. A person told us they knew what 'the home was about' and only had to ask if they needed further information. A relative said they had received lots of information when choosing the home, which they found very useful.

We saw that people's care records and other personal confidential was held securely in the manager's office.

Good

# Is the service responsive?

## Our findings

Due to the nature of the service people at the home were not always able to be involved with planning their care though staff told us how they spent time with people and their families to get to know their care needs. We observed staff seeking consent from people before undertaking an activity or task with them. An example of this was obtaining a person's consent before helping them to the dining room for lunch. The person wanted to go later and the staff respected this wish.

The manager told us that the pre-assessment of care was completed with the prospective resident where possible. Family members and care professionals who knew the person and were involved in supporting them were also included. We looked at the care files for three people who lived at the home. The care files held information such as past medical history, preferences, medication, family involvement and likes and dislikes. A life history had been completed for some people though we noted that people's care plans did not always hold detailed information about people's past history. The inclusion of this information would help to provide a richer over view of people's past life before coming to live at the care home. We discussed this with the manager during our visit.

We saw that people's risk assessments were also used for recording the plan of care and this provided information for the staff on how to support people in accordance with individual need. Care plans were subject to monthly review and these reflected any changes over the past month. There was evidence that plans had been discussed with family members. A family member told us they were involved with their relative's plan of care and had attended care reviews conducted at the home. Family members also said the staff communicated information about their relative in a timely manner.

During our visit we saw people could sit where they wanted and where possible staff sat chatting with people. A person wanted some 'quiet time' as they were tired. The staff responded to their needs by assisting them to a comfortable chair and placing blanket over them. The person appeared comfortable and was able to rest. Prior to lunch several people wanted to assist with laying the dining room tables and folding napkins for lunch. The staff supported them to do this.

The home employed activity co-ordinators and they had completed dementia training. They therefore had knowledge of dementia and associated behaviours. During our visit an activities co-ordinator was discussing the day's news and people engaged in a wide range of activities such as, icing biscuits, a quiz, musical 'sing a long' and circle dancing. An activities co-ordinator told us about the outings that had taken place. This included a trip to see Blackpool lights with a fish and chip supper and also taking part in a health and wellbeing event in Southport. An activities co-ordinator told us how some people now preferred music from the 50-60's era rather than war time music and therefore this choice was respected. This showed the staff had listened to what people preferred and adapted the social activity accordingly. Staff were preparing to honour armistice day and the activities organiser told us people would be asked if they would like to make a poppy.

People had access to the garden and were involved with garden based activities. During our visit social activities were carried out in the lounge and there was an activities/ reminiscence room on the lower ground floor. Staff told us this was often used for 'one to one' sessions or if people wanted some 'quiet time'. People were able to access the kitchen with staff support.

We saw the home had links with the community and this included attending community based events held in the town centre. A person at the home told us how much they enjoyed attending these events. The manager informed us families were involved in social activities and fund raising events. A newsletter for them was also available.

On occasions people at the home require 'one to one' support. This provides a higher level of staff observation over a set period of time. We saw this support being offered to a person during our visit though the care plan held limited information regarding this.

When people required assistance if staff were not able to attend to them immediately, they said they would be back in a few minutes. Staff did not leave people waiting which would cause undue anxiety. For people who were agitated staff stayed with them providing reassurance until more settled.

Family members we spoke with told us they were able to go to the managers if they wished to raise a complaint. A family member told us the staff did their best to put things

Good

# Is the service responsive?

right and the manager was working with them to ensure their relative's care needs were being met. A person told us they had no concerns but would speak to 'the staff' if they needed to.

The home had a complaints policy and procedure. Care files held discussions with family members where the manager had been informed of any initial concern and actions taken were recorded. The manager informed us they had no on-going complaints or had received any since the last inspection in 2013. They told us that if a complaint was received this would be investigated in accordance with the home's policy. The complaints procedure was stated in the service user guide and details were available at the home. Family members told us they attended relatives' meetings and felt confident in raising issues at this forum or in private.

Six monthly relative satisfaction questionnaires were available and these provided positive feedback about areas such as, the food, activities and listening skills of the staff. We saw a relative comment which the manager stated needed to be explored; they confirmed they were in the process of doing this. The manager said that comments received were used to make changes to the service. Feedback surveys for external health care professionals were not currently being sent out.

Good

# Is the service well-led?

## Our findings

The service had a registered manager in post and they were supported by a compliment of senior care managers. This provided a good management structure. We discussed with the registered manager the overall management and development of the service and also the home's vision, values and culture. The manager told us about how they strived to develop the service using 'best practice' and research based guidance for people who have a dementia.This included signing up to a number of organisations who specialise in supporting people with dementia and attending a quarterly dementia forum. Good practice guidance for dementia was available for the staff and the home had an appointed dementia champion. Attendance at dementia forums was on-going. The manager was aware of the importance of supporting staff with health and safety and formal care and dementia qualifications to support their learning and development. The organisation's health and safety advisor oversaw the training programme to ensure it was in accordance with current legislation.

The home had gone through a number of staff changes and the manager was very aware of the need to build up strong working relationships between the team members and also the people they supported. Staff told us the manager was supportive and approachable. A relative thought the staff team worked well together and there was an effective management structure in place.

Care plans were 'person centred' and work was in progress to enhance them further to reflect the nature of the service. Person centred care planning meant the care was centred on an individual rather than being task led. Staff told us the service was very much centred on people they supported and at all times their needs and wishes came first. We observed this in practice during our visit.

An external health professional with a background in dementia care (with recent input into the home) advised us that the staff had a good understanding of the principles of dementia care. We observed the staff interacting positively with visiting health professionals and information was shared with the staff team so they were aware of the actions taken.

Staff told us communication was good at the home and they received hand overs (meetings to discuss people they supported and issues in the home) at each shift change. Staff told us the handover and communication books gave them current information which we saw during our visit.

Staff and managers attended meetings and this provided an opportunity to share their views about the service and also identify any training needs. Staff told us the meetings were informative. Resident and family members' meetings were held and a family member said they were able to share their views about the home. We were informed the manager involved families in training information, such as DVDs on the subject of dementia. This was to provide assurance around the home's commitment to providing a good standard of dementia care. Family members were invited to attend a dementia day at the home. The aim of the day was to provide support for family members and also to enjoy a Victorian tea party with their relative and staff.

We looked at how the quality of the service was assured. We saw a number of audits or checks on the service and these helped to monitor the service provision. The manager discussed with us the care plans which were being implemented for monitoring pain and also ways of better recording people's behaviours and how these were managed. These actions helped demonstrate committment by the home to drive forward improvements and ensure a quality service.

A comprehensive health and safety auditing system included infection control, the environment and key safety certificates for services. For example, gas and electric and these were in date.

The management team completed clinical audits around care plans and medicine audits. Statistics for accident and incidents were monitored and staff looked at ways of decreasing risk where a pattern or theme had been identified. A provider audit was carried out in May 2014 and this looked at the overall management of the service. The need for dementia training for some staff had been highlighted and this was being arranged for the staff. A member of staff was appointed the role of dignity champion to monitor standards of dignity in the home. A dignity day was held earlier in the year and staff had a good understanding and an awareness of how to promote dignity and respect in the care setting.

Good

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A service user guide provided information about the service and the manager informed CQC this was reviewed and updated as required. The manager has sent in statutory notifications to notify us of key events in the home. This is in accordance with our regulations.

In relation to some recent safeguarding incidents that had taken place within the home, the manager was working closely with us and the local authority to support the care provision. Any actions or recommenations made by the agencies involved were being actioned by the manager.