Blackberry Hill Limited

Bridgeside Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Overall summary

We carried out an unannounced inspection on the 14 May 2015. Our previous inspection took place on 22 April 2104 and we found the provider met the regulations inspected. Bridgeside Lodge Care Centre provides nursing care primarily for people with cognitive impairment, including dementia and other neurological conditions including spinal injuries. The service provides care and support for 64 adults of all ages.

There was a registered manager in place at the time of the inspection. 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 that the registered manager and staff worked in partnership with local health and social care teams to provide a person-centred service that encouraged independence. There were strong links with the local community and an emphasis on creating opportunities for people to maintain interests and build friendships.

Summary of findings

Activity programmes were detailed on a weekly activity board and arranged by the activity co-ordinator. We saw activities planned for the week that included poetry, movies, memory box, exercise to movement, card games, yoga, cinema and massage. People had designated one to one time with staff in order to pursue their interests; one example was a monthly cinema visit and shopping trips which people told us they looked forward to and enjoyed.

We saw innovative projects and initiatives in place to promote connectivity between people who use the service, relatives, friends and the local community. This included a new project called; 'People like Me' that had brought together people, staff, relatives and friends through their experiences, beliefs and interest. Outcomes were good and we saw that a number of people had developed friendships and rekindled the interests they had before coming to the home.

A volunteering project and partnership had been set up between Bridgeside Lodge and local university students. The aim of this initiative was to reduce isolation in the community by offering activities like gardening, baking and games. People were positive about the initiative and the opportunities that they had been given to interact again with the local community. They told us they missed the connections with the community and were happy to be once again doing the activities that they loved. This was another excellent demonstration of the emphasis the service put on creating opportunities for meaningful activities to take place and this ethos was at the heart of promoting and enhancing wellbeing for people, relatives and staff at the home.

Another positive development was the appointment of a dementia specialist. This person is the lead person for the company on setting up the "Who am I" document which is a passport to ensure people's unique information and life stories are written down in one place, including choices and preferences and how they wished to be supported.

A 'Carers Network' had also been established to support families and friends as a result of feedback from families saying they sometimes feel alone. Relatives reported feeling less isolated and more connected to others in a similar position since the setting up of the network.

Staff had a good understanding of safeguarding adult's procedures and keeping people safe. They knew how to recognise and report concerns appropriately and understood how to 'whistle blow'.

Medicines were stored and administered correctly and staff had completed the appropriate training to ensure they were competent to administer medicines safely.

Risk assessments and care plans for people using the service were effective. They were person centred and recorded all the required information. People and their relatives were involved in the care planning process.

Staff had the knowledge and skills to enable them to support people effectively. They had undertaken induction training and currently thirteen staff had completed the new care certificate training, which are a set of standards which aim to give confidence that workers have the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People consented to their care and treatment and staff had a good understating of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

The staff team were caring and promoted positive caring relationships. People's dignity and privacy was maintained. They were supported with personal care and other tasks and were encouraged to do as much for themselves as possible in order to maintain and increase their independence.

The provider had invested in a training package devised by a renowned actress to support staff awareness in the area of dignity and compassion. DVD's from the package were also used during staff induction to ensure dignity and compassion were embedded at the start of the employment process.

Three were excellent practices in place to support people and their relatives around end of life care which was

Summary of findings

described by people and their relatives as being sensitive and supportive. Policies and procedures were in- depth and included information on cultural and religious customs.

There were innovative systems in place involving the robust and timely sharing of information between health and social professionals to support people achieve a dignified pain-free death.

There was a clear management structure in place and people, who used the service and staff, were fully aware of the roles and responsibilities of managers and the lines of accountability. Improvements were seen at the home and this was attributed to the extensive activity programme as well as the excellent management of the service.

People were given a service guide on how to make a complaint and other information about the service. Complaints were logged and addressed appropriately.

The registered manager conducted a number of regular audits at the service to ensure the service was delivering high quality care. Actions were carried through and discussed with the staff team for learning and improvements.

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. Staff knew how to report concerns or allegations of abuse to ensure appropriate procedures were used to keep people safe. People and their relatives were given information on how to report concerns.

Individual risk assessments were prepared for people and measures put in place to minimise the risks of harm.

There were sufficient staff on duty throughout the day and night to meet people's needs.

There were suitable arrangements for the safe recording, storing and administering of medicines, in line with the provider's medicines policy

Is the service effective?

Good

The service was effective. Staff received induction training and received advice and guidance from visiting professionals.

People were assisted to receive ongoing healthcare support.

People's food preferences and any requirements around being supported to eat and drink were detailed in their care plans to ensure people were supported safely to maintain a balanced diet

Staff had a good understanding of the Mental Capacity Act 2005 and how to support people using the principles of the Act.

Is the service caring?

Outstanding

The service was caring. Staff understood people's individual needs and they demonstrated patience, kindness and respect.

Staff ensured they used information from assessments as well as finding out about people's beliefs, preferences and history to ensure equality and diversity was upheld.

Policies and procedures were in place to guide staff on issues relating to death, dying and bereavement, including dealing sensitively and observing religious and cultural custom.

There were innovative systems in place to support a dignified pain- free death

Staff encouraged positive caring relationships amongst people using the service and went the extra mile in demonstrating kindness

Is the service responsive?

Outstanding

The service was responsive. People received personalised care that met their needs.

The service used innovative ways to ensure people's needs were met, including offering a wide range of activities and prompting community partnerships and projects to connect people with the same interests.

Summary of findings

People and their relative were involved in care planning, including providing information for reviews to ensure care and support was appropriate to them and delivered safely.

People's voices were heard through a number of ways including meetings between staff and people using the service. Feedback was considered and acted upon.

Is the service well-led?

Good 

The service was well-led. The service promoted a positive culture which demonstrated strong values and a person centred approach.

There was a focus on continual improvement and best practice to ensure the service was offering high quality care.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided.

Bridgeside Lodge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 May 2015 and was unannounced. The inspection team included two inspectors, a specialist nurse advisor with experience of dementia care 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.

Before the inspection we reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

We spoke with nine staff including three care workers, two nurses, a dementia specialist, domestic assistant, the registered manager and the chief executive, During the inspection we spoke with fifteen people using the service, thirteen relatives and a volunteer. We also gained feedback from health and social care professionals who were involved with the service as well as commissioners.

We reviewed eight care records, four staff files as well as policies and procedures relating to the service. We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

Good

Is the service safe?

Our findings

People told us service they felt safe and relatives we spoke with said they thought it was a safe service. One person said "I feel safe here; I know that staff are here if anything happens to me." Another relative said "The security is good. When we first started visiting, before they knew us, people would always ask who we were." The inspection team noticed we were also challenged by staff who we had not met, several times during our visit, making us feel the building was safe. People were given information in the service guide about how to report concerns and abuse.

Staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. One care worker said "It's our job to protect our residents, who are very vulnerable." They explained that if they saw something of concern they would report it to the nurse on duty. The nurse would document the issue, take photographs if necessary and record on a body map as appropriate. Another said, "Safeguarding policies and procedures are kept in the nurses station and we can look at them at any time". Staff understood how to whistle blow and told us that there was a whistleblowing hotline and email address which they could use to report any concerns.

There were comprehensive risk assessments on each of the care records we looked at. Baseline risk assessments were completed and they related to the person's medical diagnosis. These assessments were specific to the individual, for example, where a person's was at risk of malnutrition, we saw a completed Malnutrition Universal Screening Tool form (MUST). (MUST is a five-step screening tool to identify adults, who are malnourished, or at risk of malnutrition.) In another, where the person was at risk of pressure ulcers, there was a completed Waterlow assessment on record. A Waterlow assessment is used to assess the risk of a person developing pressure ulcers. Other risk assessments included the safe use of bed rails; falls assessment and call bell assessments. Nutritional risk assessments were completed with details of diet, positions for eating weight and height. Risk assessments were reviewed monthly, or when there had been a change in a person's condition, in line with the policies and procedures at the service.

We saw there were adequate staff on duty during the day and night. During the inspection we noted an air of calm around the building and staff did not appear to be rushing from task to task. One relative told us, "I feel it is very well staffed. My relative gets lots of one to one time, which has helped them tremendously."

One care worker told us "When we are fully staffed, it works well. Weekends can be a problem as this is when we are most likely to be short staffed if a care worker rings in sick." They told us that the provider does not use agency staff, so they ask if a care worker from another floor can cover." Another told us that if there short at the weekends, some staff let the manager know that they are happy to be called in to cover at short notice. They told us it was about managing time, for example, taking shorter breaks or getting cover from another floor. "We're all here for the residents, they must come first."

We discussed the matter of apparent shortages of care staff at weekends with the registered manager and the chief executive and they acknowledged that cover at weekends had been an issue but they had always managed to find cover. Records of past rotas confirmed this was the case. They also told us there was a new system of bank workers being introduced, made up of permanent staff from across the organisation who had chosen to join the bank.

We looked at four staff files and saw that recruitment practices ensured staff were appropriately checked prior to employment to ensure they were suitable to work with the people using the service. They included criminal record checks, two written references, interview records and an application form detailing the staff member's employment history. Their right to work in the United Kingdom was also checked and verified and included supporting documentation.

Medicines were administered safely. During the inspection we saw that medicines were being administered correctly to people by a registered nurse. There were individual Medicine Administration Records (MAR) for each person using the service, their photographs, details of their GP, and information about any allergies they may have. There were abbreviations used on some MAR charts i.e. NKDA which stands for No Known Drug Allergy. We discussed with the nurse and registered manager that abbreviations should be avoided as this may lead to avoidable errors. We saw that a memo was sent out immediately to all floors asking staff not to use abbreviations. Records of medications received

Good

Is the service safe?

into the home were recorded on the MAR chart. The MAR sheets were up to date, accurate and no gaps were evident, our checks confirmed that people were receiving their medicines as prescribed by health care professionals.

Medicines were stored safely. Each bedroom was fitted with a lockable cabinet, in which their medication was stored. There was also a medicines trolley which was taken to each room, and once the medicine round was complete the trolley was secured in the clinical room. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator. The temperature in the refrigerator had been checked and recorded on a daily basis and the room temperature was recorded daily.

Kept in the file along with individual MAR charts was a pain assessment tool for staff to use to identify levels of pain. This was used in assessing whether a person was in pain, particularly for people with communication difficulties and if it was necessary to administer pain relief.

There were safe systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use. We saw two registered nurses had checked, administered and signed for a controlled drugs and the practice was safe and followed the prescribed procedures.

A medicines audit had been undertaken by the registered manager in May 2015. During the inspection we spoke with the pharmacist who confirmed they undertake a monthly check of the prescriptions. We saw medicines policies, procedures, audit tools and guidance in place for staff to refer to and evidence of medicine training and competency testing for the three staff.

The home was clean and we saw the home being cleaned throughout the day. Infection control measures were in place and we saw staff using gloves and protective clothing appropriately.

The fire risk assessment had been reviewed February 2015, and was conducted on an annual basis. We saw that over 90% of applicable staff had completed in date fire training. The fire plan was on display clearly indicating fire exits and escape routes. The fire exit on the ground floor was clear of hazards.

Good

Is the service effective?

Our findings

People we spoke with and their relatives told us they thought the service was effective. One person said, "The service is good. If you're sick, the doctor comes." One relative said, "After my relative came here from hospital, they trained staff to give him exercises, but he wouldn't do them. I don't blame the staff here at all." Another said, "Our relative has done so well since she came here; putting on weight and everything. We've decided to keep her here, it's a fantastic home"

Staff had the knowledge and skills to enable them to support people effectively. They had undertaken induction training and thirteen staff had completed the new care certificate training via Whittington Health. Staff also had access to guidance and advice from visiting professionals and this was usually around supporting people effectively and safely. We spoke with health and social care professionals who told us staff were very receptive to training and always had an interest in working through things with them to ensure good outcomes for people.

We saw evidence on care records of multi-disciplinary work with other professionals and in particular a consultation with the speech and language therapists around concerns about a person's swallowing reflex. There was also evidence of engagement with the palliative care team, dentist and chiropodist.

Health and social care professionals told us that they worked closely with the registered manager and staff to ensure the support offered was person centred and that the provider encouraged this approach. We saw that the care of the elderly consultant conducted a monthly review of people known to them, where any issues were discussed. In addition there were multi- disciplinary team (MDT) telephone conferences, which included members of the palliative care team, occupational therapist and the GP. There was also evidence of regular input from the tissue viability nurse, dentist, chiropodist and pharmacist.

Staff told us they received regular supervision, both one to one and in groups and this was confirmed on the staff files we saw. Appraisals were conducted annually. The service offers placements for student nurses and one nurse we spoke with confirmed she had received induction and was always supervised in her work. She felt confident to raise any issues with her supervisor who was the registered manager. She said "[The manager] manages to resolve most of them." Staff also told us they are encouraged to consider their own professional development and request additional training, one said "I have done recent courses on the use of a defibrillator, better pressure ulcer care and tissue viability." Another told us they felt the supervision was supportive, "It's good to have space to talk about the work I am doing." We saw a senior staff supervision plan on display in the ground floor office.

Staff we spoke with were familiar with the Mental Capacity Act 2005, and the need to obtain consent from those who used the service. We walked past a closed bedroom door and could hear a care worker explaining to the person what they were about to do, they paused to give the person time to respond. We also heard the care worker offering choices to the person they were supporting. One care worker told us of a time when a best interest meeting was held in respect of a person's poor level of hygiene, they told us "I contributed some information to the decision making because there was a real health and safety issue." A person who used the service told us, "Staff always ask my permission before they carry out any task, they are so respectful."

The registered manager had made referrals to the local authority with regards to deprivation of liberty safeguards (DoLS). DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. It also allows people's movements to be restricted for their own safety. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way. We saw evidence of DoLS authorisations on the care records we looked at as well as detailed instructions around how a person should be supported in relation to this.

We saw signed and dated consent forms on the records we looked at. These related to medication, use of wheelchair strap, the taking of photographs and care, treatment and diagnostic tests. Another record we looked at related to a person who lacked capacity and their consent forms were signed by a family member who had Power of Attorney, and was documented as such. We saw fully completed Do Not Attempt Resuscitation (DNAR) forms on three records and evidence of a discussion around this with a third person, who had capacity and chose not to complete a DNAR form.

Good

Is the service effective?

There were menus displayed in the dining rooms .Catering was provided by an external catering company. A folder kept in the dining room provided staff with the information they needed relating to peoples eating, drinking, specific diets, associated risks and other key information. For example, it was clear which people required one to one support and who had swallowing difficulties. Individual guidance prepared by the speech and language therapists was available for staff to refer to. Staff notified the kitchen immediately when a new person was admitted and when there are any changes to an individual's dietary needs. This was to ensure that people's nutritional needs and preferences were catered for and they were supported to maintain a balanced diet. Policies and procedures relating to nutrition, diet and dysphagia had been prepared and reviewed within the past year.

At lunch time we saw there was a choice of drinks for everyone and a full condiment set on every table. There were two choices of main course, which people had chosen in advance. People were well supported by staff if they needed assistance. We observed a person being brought in a wheelchair and settled at the table. The care worker took great care to position the chair, removing the footrests so it could be moved in closer to the table. She spoke quietly to the person, bending to do so and then fetched her food and supported her to eat one to one, in an un-rushed manner, talking to her as she ate. Throughout most of the morning and lunchtime one person had been asleep on the sofa. A care worker roused him gently to ask if he was hungry and he said he wanted some fruit and this was brought to him. We received mixed feedback about the food, one person said "It's average food. Always two choices. Their sandwiches are good. And when I say sandwich I mean a sandwich, packed with tuna." Another said "The dinners they have here are not very good, the smell does make me feel not hungry." The registered manager told us that the external food company they use and the menus are always under review and they encourage people to give their feedback so they can address any problems.

Food and fluid intake charts were in place for those people who required them. We saw frequent and appropriate entries relating to this. However, information, relating to the food a person had eaten and fluid intake were not totalled at the end of the 24 hour period to ensure the person has had an adequate fluid intake for that day. This was discussed with the registered manager and the nurse on duty and immediate action was taken to ensure this was rectified. The care plans we saw around nutrition had some good information referring to the person's food preferences, weight and any assistance needed.

Staff worked closely with relatives of people using the service around their health needs to ensure they were supported to maintain good health, access to healthcare and received on- going healthcare support. Any actions and outcomes from appointments were recorded in people's case files. During our visit we saw an occupational therapist and a diabetic nurse visiting and we saw evidence on care records of multi-disciplinary work with other professionals. On one care record there was evidence of a consultation with speech and language therapists where there had been concerns about a person's swallowing reflex. There was also evidence of engagement with the palliative care team, dentist and chiropodist.

Outstanding ☆

Is the service caring?

Our findings

People told us that the staff were caring. One person said "It's very nice. They are very kind." Another said "The carers and nurses look after me when I am asleep and when I am awake. I am doing marvellously. These people are the best in the world." Another person told us that her husband was living in another care home and that the staff support her to talk with him on the phone when she wants to do so. A relative we spoke with told us they thought the staff were excellent. They also commented on how good it was that the same care workers supported their relative, so much so, their relative recognised them more than their own family. We saw from the interactions we observed that the staff team were thoughtful and promoted positive caring relationships between people using the service, their relatives and friends.

We were told by people who use the service, staff and volunteers of consistent improvements at Bridgeside Lodge. All spoke highly of the staff and many spoke of the family atmosphere that had been created. We heard positive comments about the activity coordinator as well as the entertainment and activities provided for everyone, including people who could not always come out of their rooms.

We noticed how staff took time to engage with those who used the service, whilst at the same time getting on with tasks. All members of staff we observed demonstrated a depth of knowledge of the person and would, for example, ask how their relative was or if they wanted their favourite snack. We heard them explaining their actions before carrying them out. One person told us "Staff are always ready to assist me when I want it. They respect my privacy and always close curtains and doors when helping me in the shower. A relative said "I am so impressed with how staff deal with those who have challenging behaviours, including my own relative. They are so patient and kind." They added "the personal care is wonderful, that is because the staff really care for the people." Another said "staff respond immediately if my relative needs to be changed. If I had to mark them I would give them 200 out of 100!" Throughout the day we were impressed by the amount the registered manager and other staff and volunteers knew about the people living at the home. The manager was able to give us detailed stories of several people she introduced us too.

The positive feedback and caring culture reported from people and their relatives was attributed by managers and staff to the focus on motivating and inspiring staff to deliver kind and compassionate care, through bespoke training and creative initiatives, in particular around improving dignity and compassion and end of life care.

We heard from the registered manager and chief executive that dignity and compassion training had been delivered by a renowned actress and trainer who had produced award winning films and training packs, specifically designed to improve empathy and compassion. We saw from training records that there had been four training sessions so far in 2015. We were also told that the DVD materials that underpin the training were used in the new staff induction programme to ensure dignity and compassion were embedded from the start of the employment process.

Signs of wellbeing were apparent amongst people who were smiling, engaging with one another, expressing their opinions and occasional differences. We saw people moving independently between floors without restriction and they were able to spend time where they wanted to, for example in their bedrooms, communal areas, dining rooms etc. Visitor and relatives told us they were encouraged to visit at any time and we saw lots of people coming and going throughout our inspection.

We were told a story and saw a recent newspaper cutting about a lady who had recently celebrated her 100th birthday. The registered manager and staff had managed to trace a long lost grandson who had lost touch with his grandmother. He was found to be in Hong Kong and travelled back to join the surprise celebrations at Bridgeside Lodge.

Staff completed life histories for people and used the information to ensure equality and diversity was upheld. There was a policy in place and staff had a good understanding of the ways in which this could be achieved. One care worker told us that Halal meals were provided for Muslim people at the home and a visitor told us they were pleased that their relative, who was Italian, was given pasta when they requested it, as this is what they were used to before they came to the home.

Outstanding ☆

Is the service caring?

As a result of feedback from relatives a carer's network' had been set up by the registered manager that puts relatives in touch with each other via e-mail. Relatives told us "this is a source of great comfort as we can share and get support from each other. I don't feel as isolated as I used to."

Policies and procedures were in place to guide staff on issues relating to death, dying and bereavement, including dealing sensitively and observing religious and cultural customs. We saw that this was discussed with people fairly early on in their stay at the service. Bridgeside Lodge had also introduced red escalation folders which included current resuscitation forms, escalation plans, to be used if a person's condition worsened, advanced care plans, out of hours doctor contact details and other relevant medical notes to ensure that all parties had easy access to relevant information at critical times.

Another initiative called 'Co-ordinate my Care' had been introduced at Bridgeside Lodge which involved the service working closely with the palliative care team to ensure any professionals, for example, out of hours doctors, ambulance services and hospitals, who may need access to information at the end of a person's life had information quickly and efficiently and people's wishes were fulfilled.'

We spoke with a nurse about End of Life Care. They told us "This is always upsetting; however, we make sure we respect any directives that have been recorded. We are really clear that the person is kept comfortable right up to the end." They said that peoples' advance wishes about how their end of life care should be managed to support a dignified and pain- free death. This was clearly documented and easily accessible. We saw confirmation of this on care records where people chose to make certain stipulations for their end of life care.

People we spoke with and their relatives told us that end of life care had been discussed with them and this was done in a sensitive and caring way. We were told by one relative that they found the process had been supportive. They told us that after a few hospital admissions, arrangements had been put in place to ensure their relative had no further admissions to hospital and that they would end there life at Bridgeside Lodge as this is what the person wished. They also noted that staff would always support their relative by accompanying them during the process of hospital admissions, which they found reassuring.

Outstanding ☆

Is the service responsive?

Our findings

The care and support people received was responsive to people's needs. One person said "If you ask anything, they do it straight away; you don't have to ask twice." Another said, "There are plenty of people around so you never feel lonely. I do like to go out when someone can take me and there's entertainment every week. I'm not the sort of person who mixes very easily but it's all there if I want to." A relative told us "It is as good as one could get, I'm always made welcome and can come here anytime. There is nothing I can't ask and they leave me to form my own opinion. I think I know him best, but life changes and in some ways he has more in common with them than me."

The registered manager told us how the staff team as a whole "look beyond the illness." She said this helped them to respond to needs other than those health related. We observed how people using the service were very varied in age across all the floors and the registered manager said "I don't segregate or differentiate on the basis of age or illness. Everyone has something to offer to others and we can all learn from each other." A relative told us how "the range of ages is wonderful. My relative is so stimulated by this and much more responsive and settled as a result."

Care records contained a comprehensive pre-admission assessment, which a nurse told us "formed the basis of the person's care plan." We saw consent forms covering photography, flu vaccines and medicines. In addition the record headed "life stories" provided an insight into a person's life, likes, work, family and social lives. Care plans were detailed and personal and provided good information for staff to follow. In one care plan there were specific instructions to communicate with a person who was deaf in one ear which included the need to speak into the other ear, keep sentences short and reduce background noise.

Relatives were involved in the development of care plans and family members told us that staff always explored the relevance of certain behaviours in their relatives to better understand and support them, particularly for those who were living with dementia. They explained how the knowledge helped staff to work more effectively with their relative and helped them to be more understanding of the changes they saw.

The registered manager and staff told us that people's care plans were developed using the assessment information. The care plans included information and guidance to staff about how people's care and support needs should be met. They were retained safely and kept in individual care files. The information was easy to locate, as the files were separated into individual sections for ease of access. Clear care plan guidance is located in the front of the files. In the clinical room on the first floor we saw a prompt list reminding staff of who needed to have monthly checks on weights, Malnutrition Universal Screening (MUST) and vital signs.

A recent development at Bridgeside Lodge was the appointment of a dementia specialist. This person is the lead person for the company on setting up the "Who am I" document which is a passport to ensure people's unique information and life stories are written down in one place, including choices and preferences and how they wished to be supported. We were told that the information was used extensively by visiting health and social care professionals as well as when people were taken to hospital. This ensured that people were supported in a safe, effective, person centred way, regardless of whether they were at the home or in hospital. It was especially useful for people with communication difficulties and dementia as it minimised the risk of people receiving inappropriate care.

People who use the service, relatives and staff told us of a new innovative project called, 'People like Me' that aims to bring people, staff, relatives and friends together through their experiences, beliefs and interest. Posters were displayed on the walls telling people about the project and people were supported to write something down on a branch about their interests and things they like and place it on the 'Silver Tree'. This would prompt likeminded people, staff and visitors to connect. We saw that people had developed really strong 'friendships' with others through the connections and relationship building this project evoked. We heard of one person and a staff member becoming good friends because of their love of tattoos. We were also told of a person who had been quite withdrawn and didn't engage very much with other people or staff at Bridgeside Lodge. They had been supported along with others to share their interest around football. Staff reported a considerable improvement in wellbeing and interaction with the person and others and some people had bought football memorabilia including duvet

Outstanding ☆

Is the service responsive?

covers and posters to reflect their rekindled love for their team. We saw that the 'Silver Tree' was starting to grow and people were using it to break down barriers and start new friendships

Another recent initiative saw the development of a volunteering project and partnership between Bridgeside Lodge and local university students. We saw a newspaper cutting reporting on its success. The aim of the initiative was to reduce isolation in the community by offering activities like gardening, baking and games. People we spoke with were positive about the initiative. Some spoke of the opportunities they had been given for them to interact again with the local community, which they missed but also to be involved with activities that they love. This was another excellent demonstration of the emphasis the service put on creating opportunities for meaningful activities to take place and this ethos was at the heart of promoting and enhancing wellbeing for people, relatives and staff at the home.

Activity programmes were detailed on a weekly activity board and arranged by the activity co-ordinator. Activities planned for the week included poetry, movies, memory box, exercise to movement, card games, yoga, cinema and massage. One person told us that they had visits from an external group and they supported her to go to a gym to exercise. People who stayed in their rooms told us they had one to one interaction sessions with staff as well as activities like, foot and hand massage, reading, board games and even table tennis as there was a portable set that people use. We saw that activities were not always structured and planned but there was lots of interaction between staff in groups and one on one. The registered manager told us that people had designated one to one time with staff in order to pursue their interests; one example was a monthly cinema visit and shopping trips which people told us they enjoyed. The registered manager told us that families were very much involved activities at the home, for example they recently had someone come and play the cello and another family regular bring in a young baby who has become part of the home's community and brings people lots of joy.

Regular meetings took place for people and their relatives to express their views and receive up to date information. One person told us they attended a weekly morning coffee and some staff also attended. They said "This is an opportunity to raise any issues or ideas we might have." We asked if they had ever raised something which was then acted upon and they told us they had and they were very pleased with the outcome.

Information regarding how to make complaints was given to people as well as a leaflet was available and visible. People we spoke with and their relatives told us they knew how to make a formal complaint and staff were clear about how to support people to do so. The complaints log gave details of the complaint and the outcome. We also saw ten compliment letters offering thanks to staff for the care and support given to their relatives.

Good

Is the service well-led?

Our findings

People and their families and friends told us they thought the service was well run and that management and staff were open and honest. A person who used the service told us “The manager is good. She cares for all the staff as well as residents. She listens to us all.” A relative told us “This feels like a well-run home and I have prior experience to judge it against. It comes from the top, the manager is very available and present and staff feel this and pull together.” A visitor said, “The manager is a force in nature. She is always on it.”

There was a clear management structure in place and people, who used the service and staff, were fully aware of the roles and responsibilities of managers and the lines of accountability. We saw that the rota for senior staff on duty was posted next to the visitors’ signing in book. This was excellent practice and gave visitors and staff coming into the building information about who was leading the shift.

We saw that the registered manager promoted a positive culture. The values of the service were demonstrated clearly in what we saw throughout the day as well as from the feedback we received from people, staff and relatives. Staff showed respect for people as individuals and supported them to continue their chosen lifestyles. People told us they were listened to and felt they had a say in the way the service was run.

It was clear from our discussions with staff that morale and motivation was high. One care worker we spoke with said “From the first time I met the manager, I felt confidence in her and it’s a transparent environment.” Another said “the CEO and the Chief Compliance Officer come in very often. They are always checking out how things are for me and that means that they care about staff.” A volunteer told us, “If I spot anything wrong, I tell the management and it gets acted on. The manager doesn’t let anything go.” Managers spoke of the importance of motivating and supporting staff to promote their values, through training, supervision and strong leadership.

Staff told us the management team had an open door policy and staff felt confident they were listened to and actively involved in the development of the home through various forums including staff meetings, one to one and monthly group supervision and regular staff surveys. The registered manager felt well supported and told us of recent training organised by the provider around the implications of the Care Act 2014.

The chief executive told us that they had recently sourced external management coaching for the registered manager that was delivered over a six month period. The coach had a long history of managing health and social care services. It was specifically designed to ensure that the registered manager had additional support specifically designed around her needs in order to assist her to achieve excellence in leading the service.

The inspection was received positively by managers and staff and we saw from previous inspection reports that any matters arising had been addressed, for example reviewing the layout of care plan records. This had been done and we noted that access to information had been made easier and the general layout of the care plans was very clear.

We saw opportunities for people to provide feedback and for their voices to be heard, through meetings arranged for people using the service and their relatives. People told us of one to one meetings with staff who were their keyworkers and there were also weekly coffee mornings which generated lots of discussion and feedback.

Relatives' questionnaire had been undertaken at the end of 2014 and analysis had been delayed due to changing IT systems. The registered manager told us how in response to concerns regarding relatives feeling isolated, she facilitated the setting up of a ‘Carers Network’. The service had introduced several initiatives where meaningful activities were integrated into people’s daily lives and to further develop the service to be more person centred and led by people using the service their friends and relatives. People using the service and their relatives told us they had seen great improvements in their relatives since they had been at the home. Many commenting on the extensive activity programs and initiatives introduced, and the way they had been tailored to the interests of people using the service. They felt that this and the excellent management of the service played a major part in the improvements in wellbeing seen for their relatives living with dementia and other illnesses at the home

The registered manager conducted monthly audits .She explained that the audit systems had been revised from April 2015 to include the five CQC domains: safe, effective,

Good

Is the service well-led?

caring, responsive and well-led. Any actions identified from audits were followed through and any learning shared with the staff team. The senior operational team also completed a monthly home review which is linked to the provider's key performance indicators. Monthly clinical quality monitoring reports are sent to the local authority and clinical commissioning group, detailing information on the clinical management at the service as well as concerns and progress seen. Following receipt of the clinical quality monitoring data, the registered manager attends regular good practice groups led by the local authority to ensure that good practice is shared and learning takes place.

Currently the service is renewing its membership to the National Activity Providers Association (NAPA) which is an organisation that promotes meaningful activities as being the heart of care for older people. This was to ensure that the staff team and people using the service continue to benefit from best practice and advice that this association provided.