Maria Mallaband Properties (5) Limited

The Belvedere

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

This inspection was unannounced and took place on 13 October 2014. A second day of the inspection took place on 20 October in order to gather additional information. The home was previously inspected in November 2013 when it was found to be meeting all the regulatory requirements which were inspected at that time.

The Belvedere is a purpose built care home located close to Alderley Edge. It offers permanent or respite nursing and dementia care for up 41 older people. All bedrooms have en-suite facilities.

Lounges and dining rooms are accessible to all residents and there is a garden which they can also use.

At the time of the inspection there was a registered manager at the Belvedere. 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.

Summary of findings

We found that people felt safe at The Belvedere and that staff had a good understanding of how to protect people and would take action to do this if it was required. There were good arrangements for recruiting staff who were well-trained in most of the required areas. Although there were enough staff working at the Belvedere we found on a few occasions that the layout of the building meant that people were sometimes left alone for short periods of time.

Records were kept which would allow staff to provide the care that people needed and there was good access to health and other care services. More attention was needed to the arrangements for recording people's agreement to their care and for Deprivation of Liberty Safeguards.

Some people who lived in the home and relatives told us that the food was not very good and we found that there was not enough choice. The home was taking action to improve this. The Belvedere was well-led with a proactive management that was keen to listen to the relatives and people who lived in the home.

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 because staff had a good grasp of how to safeguard the people in the home and what to do if they suspected abuse. They had confidence that their concerns would be listened to and acted upon. Staff training in safeguarding was up to date.

Although there were sufficient staff employed in the home the design of the building and the requirements of the people living there meant that sometimes people were left unattended in the lounges for short periods of time and it was not always possible to find a member of staff easily.

Although we found some discrepancies in two records we found that the provider had undertaken risk assessments so that they could take steps to protect people from harm. We found that medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not effective because staff did not have good understanding of the Mental Capacity Act or the Deprivation of Liberty Safeguards.

Some people and their relatives were unhappy about the standard of food at the Belvedere. There was no real choice of either dish or portion size at the main meal.

Staff were well-trained and people living at the Belvedere received good access to health care from the various professionals who visited the home.

Is the service caring?

Good

The service was caring because staff took the time to understand the needs and preferences of the people who lived in the home. They involved them in the care they were providing by explaining what they were doing so that people would understand what was happening to them.

Staff had a good grasp of the need to care for people with dignity and in ways that promoted their privacy. Staff demonstrated this by the way they spoke about the people who lived in the home and by their care practices. Although we did not see evidence of involvement by people in their care reviews we saw that the provider was changing the way they undertook this.

Is the service responsive?

Requires Improvement

The service was not responsive because the physical environment was not sufficiently adapted to help people living with dementia. There was little evidence that people's backgrounds and life histories had been taken into account when planning their care such as activities.

Summary of findings

We saw that when staff were available they responded to people's immediate needs with care and attention. Records were maintained which would allow staff to meet these needs on a day to day basis. However on some of the files we looked at routine reviews of care were overdue.

There were systems in place to respond to complaints although none had been registered in the period since our last inspection.

Is the service well-led?

Good

The service was well led because there was a registered manager. Although the registered manager was not present during our inspection it was clear that her style of management promoted transparency, openness and involvement.

There were effective systems of audit in place so that the service could be monitored and developed. There were arrangements for people who lived in the home and their relatives to be consulted about their opinions and the manager was proactive in seeking this. Staff told us that they found the management of the home to be approachable.

The Belvedere

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 13 October 2014 and was unannounced. A second day of the inspection took place on 20 October in order to gather additional information.

The inspection was undertaken by two inspectors, a specialist adviser regarding services for people living with dementia 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, in this case of people living with dementia.

Before the inspection the provider sent us a provider information return which we reviewed in order 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 improvements they plan to make.

We looked at all of the information which the Care Quality Commission already held on the provider. This included previous inspections and from contact around any incidents the provider had to notify us about. We invited the local authority safeguarding, quality assurance and commissioning functions to provide us with any information they held about The Belvedere. We also contacted the local branch of Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

After the site visit we contacted the Clinical Commissioning Group, Tissue Viability Service and Infection Control specialists. We took any information they provided into account.

During the site visit we talked with eight people who used the service and four of their relatives and visitors. We talked with ten care and nursing staff as well as the cooks who were on duty. We met with the quality assurance manager for the company of which the home is part. We spent time with people in the communal lounges and at mealtimes. The expert by experience joined one group of people for lunch. We also visited people in their bedrooms. We undertook three Short Observational Framework for Inspection (SOFI) observations one in each unit of the Belvedere. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records including five care plans and six staff files as well as minutes of meetings and audit documents.

Good

Is the service safe?

Our findings

The relatives of people who lived at the Belvedere told us that they felt that the people who lived there were safe and that they had no concerns about the way that their family members were treated. They told us "I have no worries about ill-treatment here. I trust them" and "I feel Mum is safe".

When we spoke to staff they were clear about the meaning of safeguarding and knew what to do if they suspected a person was being mistreated. They told us that they would report anything untoward to their supervisor and that if they felt this did not result in the appropriate action they would continue to report it through the management structure until their concern was acted upon. One member of staff told us about an occasion on which they had had concerns of this kind and said that when they had reported it management had been quick to act and the situation had been resolved. We saw that responses to safeguarding were tested as part of the interview procedure for care staff prior to their being appointed.

We checked the records of staff training and saw that training in safeguarding was up to date. More than 98% of staff had completed this training within the last twelve months and those requiring refresher training were clearly identified. When we talked with staff they confirmed that they had received this training and new staff told us that it was included in their induction.

When we looked at the care plans for people who lived at the Belvedere we saw that they contained risk assessments relating to key areas of care relevant to each person. We found that most of these had been updated regularly so that staff were aware of current risks for people who lived in the home and the action they should take to manage them.

However we found some discrepancies. In one instance when we looked at audit records kept in the home we saw that an analysis was undertaken of falls within the home. There had been 171 incidents recorded of which 41 related to one person. We could see that this person's placement within the home had been changed so as to allow a higher level of nursing care. However this had occurred after the person had already fallen 39 times in the current year. We did not see evidence within the care file that more detailed risk assessments had been put in place nor changes to the person's care in respect of the falls other than more frequent observation.

We saw that the provider weighed and recorded people's weights on a weekly basis so as to identify any nutritional risks. However on one care plan we saw that a person had been recorded as losing weight whereas a day later the care plan recorded a different increased weight. In another care plan we saw that there was conflicting information about a person's skin condition which had originally been identified as a risk but most recently had been recorded as not at risk without any evidence of how this change had come about.

We checked staff rotas which confirmed what we were told throughout the inspection about the numbers of staff on duty. Staffing levels had been set by the service at one registered nurse and seven care staff for the service. We found no occasions where staffing had fallen below this level. The number of nursing staff was increased to two in the mornings. This was further increased where required such as during our inspection when the registered manager was not present in the home. These staffing levels allowed for two care staff to work on two of the units with three care staff working on the third unit where there was a higher level of nursing need. We were told that at night the home had five care staff with one nurse.

During our inspection we noticed that there were occasions when there were no staff present with the people in the lounges. When we went to look for staff in the corridors they were not visible and we could not find them. In one instance we met a relative who was also looking for staff to assist the person they were visiting with toileting. We used the alarm system to summon staff who then responded promptly. We realised that because both staff were attending to people who required help in their rooms they could not also be present in the lounges. We were concerned that on some occasions people might not be able to summon help quickly enough. The provider undertook to look at this issue following our inspection. The home had a call system but during our inspection this was rarely used. We saw that staff responded promptly to it when required.

We looked at a sample of staff files to see if the provider undertook checks to make sure that the people employed at The Belvedere were suitable. In most records we found

Good

Is the service safe?

that there were application forms, references, and proofs of identity including photographs. In appropriate instances there was evidence that Nursing and Midwifery Council personal identification numbers had been checked to ensure valid nursing registration.

In one instance we could not find documents which established a person's identity. We were told that these were sent to head office in connection with Disclosure and Barring Service checks which were undertaken from there. We were told that this was why we could not find any evidence of a DBS check on another file for one new starter. We were assured that the company's payroll system would prevent anyone from being paid unless such a check had been received.

We noted that more than a third of the staff who worked on the rotas we looked at were bank staff. These are staff employed by the provider but who do not have a contractual guarantee of work. We were surprised at this proportion because bank staff do not usually afford the provider the same level of security in providing cover as permanent staff. We were told that some staff preferred the conditions of service for the bank which were different for those of permanent staff and allowed staff greater control over when they worked. We saw that some bank staff had worked for The Belvedere for some time and offered the same level of consistency as permanent staff. We also saw that using the staff bank was one means of managing an induction period prior to accepting a member of staff onto the permanent establishment.

We checked the arrangements for medicines in the home. We checked training records and found that all staff who undertook medicines management had received current training. We also checked that there were appropriate and recently reviewed policies in place around the administration of medicines. Whilst the most recent policies were available to staff administering medicines and were retained in the policies and procedures manual we saw that there were still out-of-date copies of this and other information displayed on a notice board.

During our inspection we observed the administration of medicines by a nurse. We saw that drugs were stored appropriately in a locked cabinet and then dispensed from a trolley. We saw that there was a working medicines' refrigerator, the records of which showed that the temperature was usually checked regularly although we noticed that it had not been checked over the weekend prior to our inspection.

Most medicines were supplied to the home by the pharmacy in a monitored dosage system. This meant that medicines were pre-packed by a pharmacist into the correct doses for each time of day and supplied to the people for whom they were prescribed in a sealed tray. This reduced the risk of too much medicine being taken or of medicine being taken at the wrong time. We saw that a record of administration was completed in each instance on the medicines administration record (MAR). We checked the arrangements for the storage and administration of controlled drugs and found that this was satisfactory with registered nurses undertaking audit checks twice a day.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they had received training mainly in the form of e-learning which they could complete at work and for which they would be paid. We checked the records of training and found that there was a high level of completion although there were some gaps notably in relation to mental capacity and adults at harm.

We talked to some staff who had recently started to work at the Belvedere. They told us that they had received an induction which covered the mandatory areas such as safeguarding and moving and handling. They told us that like other training at the home that this was made available through online packages although the moving and handling training was supplemented by a practical session. We noted from job specifications that the minimum qualification required for a care assistant post was a National Vocational Qualification (NVQ) Level 2.

The training records in the home showed that all appropriate staff were up to date with training in manual handling, fire awareness, Control of Substances Hazardous to Health (COSHH) and first aid, and most were up to date in other areas such as infection control, dementia, and health and safety. Care staff were recorded as having completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. We saw that there was a policy relating to the Mental Capacity Act 2005 but this was two years old and did not make reference to DoLS requirements or to recent changes in the requirements relating to these.

We looked at care records to see if the provider had obtained the consent of the people using the service to the care being provided for them or by another person authorised to do so. On two of the files we looked at consent forms had been included but they had not been signed by anyone including the person themselves. This meant that there was no record that this person's care had been agreed by that person or someone authorised to do so on their behalf. One of these people had been assessed as having the capacity to consent for themself. The provider told us that this might be because new forms for consent were being introduced.

On most of the files we looked at we saw that there were mental capacity assessments. Where these showed that a person did not have the capacity to make certain decisions then various agreements had been given by relatives. We saw that "best interest" decisions were recorded in relation to such matters as using bed rails which might be viewed as a form of restraint. These decisions were made by involving other people such as relatives or professionals who knew the person, taking into account any previous wishes expressed by the person, and making sure that the proposed course of action was the least restrictive option.

In the information provided before the inspection we were told that there was one person living in the home who was subject to Deprivation of Liberties Safeguards (DoLS). These are safeguards provided within the Mental Capacity Act 2005 which apply where a person is unable to take certain decision for themself. When we asked staff if they knew who was subject to these arrangements they were unable to confidently identify who this was. Staff confirmed that they felt some uncertainty about this given recent judgements which had changed the circumstances in which DoLS are applied. This uncertainty meant that these safeguards might be applied to the wrong person or might not be applied correctly.

We looked at the documentation relating to the DoLS to make sure that this was complete. We saw that a standard authorisation was in place for one person. However there appeared to be an error on the date of application which preceded the date the standard authorisation was required by some weeks.

We saw that there were two people living in The Belvedere who had been subject to a DoLS in the past. In one instance these safeguards were no longer necessary as the staff in the home had helped this person to settle in to the home environment. We talked to the relative of this person who told us that they were happy with the way that this had been dealt with so as to support them at a stressful time. They told us that they were very happy with the treatment provided to their relative. We saw that this person was able to relax in the home and was enjoying the company of visitors.

We checked with the local authority which has responsibility for authorising standard requests for DoLS and were told that an application for another person had been refused by them. We checked this person's file and saw that papers relating to this application were still present and there was no indication that the application had been refused.

Requires Improvement

Is the service effective?

We asked staff if they had received training in the Mental Capacity Act 2005 and the arrangements for DoLS in the home. One member of staff told us that DoLS training had been cascaded to staff by the manager. Staff were able to explain to us clearly about the importance of consent and what they would do if someone withheld consent to something. They were clear that people could not usually be forced to accept something that they did not want. During our inspection we saw a person refuse their medication. The nurse told us that this was not unusual and that they would approach them again at a later time when they might accept it.

When we checked the policies and procedures at The Belvedere we saw that there was a policy relating to the covert administration of medicines. This might be required where a person does not have the capacity to agree to a course of treatment. In the care files we examined we saw that mental capacity assessments had been completed and that the decision to support covert administration of medicines had been supported by best interest meetings involving the general practitioner and the person's partner or other relative.

Each of the separate units at the Belvedere had a dining and small kitchen area adjoining the lounge. Each of these kitchen areas were served by a service lift through which food could be sent from the central kitchen. When we visited each of these kitchen areas we saw that the preferences and special dietary requirements of the people living in that unit were readily available to staff. We saw that food was served to people in accordance with these special requirements.

Menus were displayed in the corner of each room. This meant that they were mainly out of reach and out of sight for most people who lived in the home. We could not see how it was possible for people to express a preference about their meals if they were unable to see the menu. In one unit we saw that there was an alternative menu displayed but this was in a broken display frame and inaccessible to the people living there. However we were told that there was no choice of main hot meal which was served in the middle of the day, other than a sandwich.

We saw a main meal being served and noticed that there was little conversation with people about what was being served or about the portion size that they might prefer. Overall the portions were large and there was considerable wastage. Staff told us that people could exercise some choice over breakfast and that the meal in the evening was made up of different dishes (always including sandwiches) from which people could choose. The menu was spread over two weeks after which time the same dishes would feature again. We noted that the menu provided the "five a day" recommended food groups.

We saw that drinks were provided with each meal and that care staff made frequent offers of drinks to people who lived in the home. On one instance we saw care staff contact the kitchen to make a request for extra fruit on behalf of a person. It was clear to us that staff knew people's individual preferences of this type. We visited the kitchen and saw that individual dietary requirements were clearly displayed for the cook to follow. We checked that in two instances the requirement for a soft diet was being followed. One relative confirmed that where food needed to be pureed before serving, efforts were made to keep the individual components separate so as to preserve the different colours and smells.

Some people told us that the food in the home was "adequate" or "alright". One person said "It's horrible. It has no taste". Some relatives we spoke to said that they did not think the food was good. They said "We'd give …. the food three out of ten marks". Another relative told us that there had been some variation in the standard of food over the last year. The regular cook had returned from absence to duty on the first day of our inspection and relatives told us they expected that the former standard of food would be restored. We looked at the kitchen and saw that it was well-organised although a recent local authority hygiene inspection had reduced its rating by one star.

We saw documents which indicated that the cook was working to improve standards and the kitchen and was arranging to meet with people who used the home and their relatives to discuss menu changes.

We saw that where required staff took food to people's bedrooms and assisted them to eat there. Relatives told us that they felt able to visit in order to assist with mealtimes. We saw that staff helped people to eat their meals where assistance was required. However on one occasion we saw that even with the assistance of a relative and an additional member of staff from outside the unit concerned and with staff helping a person in their own room only one member of staff was available in the dining room where most people were eating.

Requires Improvement

Is the service effective?

Staff told us that the home received primary medical services from a single local practice. We were told that the same doctor visited each week and that nursing staff decided who to refer for a consultation. The doctor was usually present for one or two hours each week. We saw that staff could refer people to see the doctor and the results of any consultation were written into a log book. We checked that where a change in medicines or a routine was made that this transferred into the person's care file. The surgery also followed this up with a faxed copy of the doctor's entry on to their patient record which was also filed. Because these notes from the doctor were available this meant that care staff could take people's changing requirements into account when providing care. One relative told us that the doctor had taken considerable care to research the most appropriate treatment for a person living in the home. We saw a number of references to and recommendations from other health professionals in the case files. These included Tissue Viability Nurses as well as Speech and Language Therapists (SALT).

We saw that a number of the people living in the home had completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. We saw that these included details of the reasons why resuscitation should not be attempted in certain circumstances and recorded that there had been consultation with an appropriate other person where people did not have the capacity to make this decision on their own.

We recommend that where an application of a DoLS authorisation has been refused that the person's file is clearly marked to show this.

Good

Is the service caring?

Our findings

One person who lived in the home told us "We're happy here". Another person said "They have been very good here, they are excellent". When we asked one person if anything could be improved in their care they replied "Nothing!"

Relatives of the people who lived at the Belvedere spoke highly of the care provided. One said "It's very good – I can't fault the care. I can't complain. The staff are very compassionate and gentle. This is not a miserable place, there is no smell and my relative is always warm, fed and clean". Another relative told us "I cannot commend (the staff) too highly. All the other relatives we spoke with were complimentary about the care provided saying "it's by far and away the best home (my relative) has ever been in" and that their relative appeared "well looked after, clean and well dressed".

We spent time with people and staff on each of the three units in the home on each of the days of the inspection. We saw that staff related to people in a way that was friendly, addressing them in person and speaking directly to them with a tone of voice that was appropriate. We saw that where staff were involved with helping people to eat that they took time and did not hurry. We saw that where necessary they allowed people to take a break so that they could digest their food before continuing with and completing the meal. Throughout staff spoke to people in a way that was reassuring so that the meal would be as enjoyable an experience for people as possible.

Staff told us that they gained a good knowledge of people's likes and dislikes by spending time with them particularly in the lounge. They told us that this was how they gained an appreciation of what was needed to help each person and how they would like this to be done. We saw that they found out about the care required by looking at the care plans and other documentation. We saw that staff were familiar with people's routines when they asked them if they wanted to do something at a particular time of day such as going to their bedroom for a rest in the afternoon. People's regular choice and preferences such as for bathing were recorded in a file which was kept readily available on each unit.

We saw staff providing assistance to people who needed to use stand aids and hoists. In each instance staff asked the person if they wished assistance with the particular action they proposed. If the person agreed then at least two members of staff would assist the person with using the equipment. Throughout the process the care staff provided information and encouragement to the person so as to reassure them. We could see from the expressions and reactions of people that they were comfortable and relaxed throughout the process.

We saw that in this way staff involved people in their own care as far as possible. One member of staff described it as "We think resident – not task. We involve people in their own care". Another member of staff told us "We treat people like our own grandparents". A relative told us "They explain what is proposed. I feel fully involved. I am consulted about things".

However when we looked through the care files we did not see evidence that people were more formally involved in planning or agreed to their care. We did not see any evidence of periodic reviews with either people who used the service or their relatives. Although the NHS and the local authority provided their own reviews for some people the majority of people living in the home were not funded by these agencies and so would not benefit from their reviews. The provider told us that the absence of these reviews largely related to the form of care planning documentation that was in use and that plans were in hand to change this. We confirmed that this was the case from reading reports of past quality audit visits which showed the action being taken. We noted from the recent quality audit questionnaire however that all eight of the respondents felt they had been given the opportunity to be involved in care planning and to review care packages.

We asked staff how they promoted dignity and privacy when providing care for the people who lived at The Belvedere. They told us that they did this by treating people as individuals. "We don't shout at people across the room. If they need something like help with going to the toilet then we do this quietly." Our observations confirmed this. We saw that staff knocked on bedroom doors before entering. In one instance we saw that staff helped a person to remain independent by offering only the level of help required when they needed assistance. Staff told us that they attempted to match the gender of carers to people when undertaking personal care tasks so that a female would be attended to by a female carer as far as possible and vice versa.

Good

Is the service caring?

We saw that on one of the units each of the bedrooms was locked when not occupied and staff had access to a master key. This prevented people who might be confused about where their own room was from entering another person's bedroom. We saw that relatives and visitors could collect a key from the foyer so that they would have access to their family member's bedroom.

Requires Improvement

Is the service responsive?

Our findings

Many of the people living in The Belvedere were living with dementia. During our inspection we met one person and heard of another who had transferred to The Belvedere from other homes because it was thought that the home could provide care more tailored to their needs. Dementia can cause memory loss, confusion, mood changes and difficulty with day-to-day tasks.

The environment and care routines of a home can be adapted in a number of ways to support people living with dementia. We saw that each unit had a noticeboard which correctly displayed the current date as a reminder. There were other examples of the environment being adapted to provide a more homely atmosphere. For example in one unit a wall had been decorated with a countryside scene with comfortable seating. In another unit there were wooden items which could provide people with tactile experiences. We saw that an area of one unit had been decorated to appear homely with a fireplace, pictures and an old radio.

Toilets were identified by red signage with blue signs for a bathroom. Beyond this, however, there was little evidence that the home had been physically adapted for people living with dementia. In particular bedroom doors were indistinguishable from each other than by a nameplate. This would be unlikely to be sufficient to help some people living with dementia to find their own room. From the outside of the bedroom there was little that distinguished one bedroom from another. Decoration throughout the home did not help people to orient themselves by the use of contrasting colours.

On the second day of our inspection we undertook a SOFI observation in each of the units at The Belvedere. In each instance we found that care staff interacted positively with the people who lived there. They took care to acknowledge each person who was present and attempted to engage them individually in conversation.

We saw that there was a programme of activities at The Belvedere and that a member of staff was employed as an activities organiser. We saw that on the day of our inspection they organised poetry readings for the people who lived in the home. One relative told us that they felt it was difficult to organise activities because the design of the home divided people into three units. The activities organiser could not attend them all at the same time and people's needs and interests across the home were very varied. Another relative told us that they thought the activities were good but that the activity organiser did not have enough time.

When we looked at the care files we found that there was little information which described people as individuals in terms of their background, where they came from, and what other experiences they may have had which might be relevant to their lives now. The exception was one file where detailed information appeared to have been provided by a friend or relative of the person. On two other files we saw that "life story" forms had been completed by the home but these appeared to date from a period some time before our inspection and did not appear to be in use on other case files. Apart from these we did not see any more systematic method of recording personal information which would support and inform the care of people.

Care files were divided into information relating to different domains such as behaviour, cognition, psychological, communication and mobility. The domains included detailed accounts not only of the care to be provided but also information about how that care should be offered taking account of people's individual differences. Records were also included of relative support which meant that concerns by and enquiries from relatives could be seen by staff. We saw that in most files these domains had been reviewed by staff on a monthly basis with the date for the next due review entered. However on three of the care files we looked at this date had passed and there was no record that the planned review had taken place.

We also saw that for each person who remained in bed during the day there was a positional chart kept in the bedroom so that staff could record the times they turned people to avoid bed sores. The two positional charts we looked at recorded that people had been turned but on one it was difficult to identify what the correct interval should be for this to take place or that this had been observed. Staff told us that they thought it was two hourly but we could not see a record of this and staff could not tell us where we would find such a record.

We saw that in each kitchen/lounge area a file was maintained so as to allow staff to record information which might have more immediate relevance to the provision of care than the care files. These included records (where appropriate) such as blood glucose levels, dietary matters

Requires Improvement

Is the service responsive?

and food intake, weight and any other visual observations or notes about behaviour. The notes about behaviour were designed to help staff to understand people's behaviour particularly where there might be communication difficulties. Staff were asked to note what had led up to a particular piece of behaviour as well as the consequences of it. We saw that these records were kept up to date and saw staff completing and referring to them at various points during our inspection.

We reviewed the complaints file and noted that there had been no complaints for the current year. All complaints outside of this time had been handled according to the complaints procedure in the home. Relatives told us that they would not hesitate to complain to the manager if they needed to. One relative said "It is most unusual to feel unhappy about anything. I can complain and I get a response and I am not made to feel uncomfortable".

We recommend that the service considers the latest guidance available on the adaptation of the physical environment for people living with dementia.

Good

Is the service well-led?

Our findings

Although the registered manager was not present during our inspection her influence on the home was evident throughout the inspection. For example at a number of points in the home the manager had posted prompts to staff about the need to maintain care standards and provide people with care in a dignified way. The manager had pointed out an article about poor care standards which she had left in the staff room for staff to read. Staff referred to the manager by her first name which reinforced that there was a friendly relationship between them and a commitment to an "open door" policy from her.

All of the relatives of the people who lived in the home spoke positively of the manager. One described her as "top notch" and another said "The manager is very good and the staff are well-chosen". Another relative said they would "award the manager ten out of ten marks and the care staff eight of out of ten". Staff consistently identified that they would have no hesitation in approaching the manager about any matter, gave us examples of when they had done this, and confirmed that when they had done so appropriate action had resulted quickly. We saw that there was a whistle blower policy available and on display where staff could see it. No whistle blower concerns had been received by the Care Quality Commission (CQC) in the past twelve months nor had the Commission received any negative comments or complaints about the home.

The manager had facilitated strong links with a major university school of nursing so that the home could benefit from what a recent commendation from the university described as "a partnership between clinicians in practice and university education". It went on to say "The contribution of all colleagues at the Belvedere is highly valued". This meant that the home was able to keep in touch with and influence developments in modern nursing practice for the benefit of the people living in the home. The manager sought to offer herself as a role model to other staff in terms of professional practice and providing a high standard of care.

We saw that there was a system of audits in place. These were constructed by the manager supplying information routinely to the company's quality assurance manager who compiled a monthly report. This was combined with a report of the quality manager's monthly visit to the home. We saw records of these visits for the last three months and saw that they included both early morning as well as day time visits. The audit reported on feedback from people who lived in the home and their relatives, quality comments and analysis of staff trends, an inspection of the environment including infection control, and analysis of complaints and other documentation. The report concluded with a clear action plan. We saw that the action plans were reviewed so that progress could be monitored. We were able to see the impact of this monitoring in terms of developments such as in relation to developing documentation and responding to the recent food hygiene rating.

In addition to this the manager had a series of her own audits such as mattress checks, health and safety audit, night visit reports and care file audits. There was evidence of action plans resulting from audits. We saw the results of a recent quality audit dated July 2014 where relatives had rated various aspects of the home and the way it treated the people who lived there. The home had been rated consistently highly across areas such as laundry, environment, food and other care items.

We saw the minutes of staff meetings which had taken place at three-monthly intervals. Topics discussed included dignity, independence and confidentiality. This reinforced the positive culture towards the care of people who lived in the home. Staff told us that they received both "on the spot" and routine supervision. We did not look at the content of individual records of this but saw that the format included a review of job description, identification of training needs, staff perceptions and comments on the working environment. Each record was signed by the supervisee, the supervisor and the manager. We saw from a notice in the staff room that every member of staff had been allocated a supervisor. Staff told us that they received supervision at between three monthly and six monthly intervals together with an annual appraisal. We were unable to verify this from the records provided to us.

Relatives told us that the home held regular meetings with them called the "families and friends forum". We saw from the minutes of these meetings that the most recent of these had been held in August, had been well attended and the next was scheduled for November. The manager was proactive in using these meetings to meet concerns which had either been or might be expressed by people

Good

Is the service well-led?

and their relatives. These included about staff changes, and where appropriate moves amongst people who lived in the home. Recent changes to the Deprivation of Liberty Safeguards arrangements were explained to those present.

The agenda and minutes for the meeting suggested that the manager was transparent and honest in her dealings with people who used the home and their relatives. In the information provided to us before the inspection the manager had described how she had sought to increase the involvement of relatives in the running of the home. This had already taken the form of influencing decoration. A relative had also helped with a recruitment initiative.

The registered manager is required to notify the CQC of certain significant events in the home. We saw that the manager kept a careful log of these notifications. We checked our records and found that the manager had taken a proactive approach to communication with the CQC sometimes alerting the Commission before information was received through other routes. Where the Commission had been notified of safeguarding concerns we were satisfied that the manager had taken the appropriate action. This meant that the registered manager was aware of and discharged the legal responsibilities attached to her role.