Bentley Lodge Care Home Ltd

Bentley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 November 2017 and was unannounced. Bentley Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. It is registered to provide accommodation and nursing care for up to 41 older people. At the time of the inspection there were 34 people living there.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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.

People were safeguarded from the risk of abuse; staff understood both their role and duty to protect people and had access to relevant guidance. Staff recognised people's rights to take risks, where they had the capacity to make these decisions. Risks to people were assessed, identified and managed safely. Staffing levels were based upon an assessment of peoples' needs. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider. Processes were in place to ensure people received their medicines safely as prescribed from trained staff. The service was clean and staff had undergone relevant training to enable them to understand how to protect people from the risk of infection. The clinical lead investigated and reviewed incidents to ensure any relevant learning took place for people's future safety.

People's needs were assessed prior to their admission and their care was based upon best practice guidance to achieve effective outcomes for them. Staff told us they felt well supported within their role and staff that were new to care underwent an induction to their role. Staff at all levels were encouraged to undertake professional development to further enhance their knowledge and skills and ensure people received effective care. Staff understood the importance of ensuring people received sufficient food and hydration that met their individual needs and this was provided. Records demonstrated that when people moved between services, staff ensured they had access to relevant information to enable them to provide the person's care effectively. People were supported to access a range of healthcare professionals in order to promote their welfare. The registered manager had instigated a project to promote sound oral health care for people, in order to improve their dental health. The physical environment provided met people's needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People, their relatives and representatives told us the service was caring. Staff were observed to care for people in a kindly and compassionate manner. Staff understood, listened to and acted upon people's preferences about their care. Staff ensured people's privacy and dignity was upheld during the provision of their care.

People, where they could express their views, or relevant others, were consulted about their care. They had individualised care plans that reflected their needs and which were understood by staff. People were provided with a range of opportunities for social stimulation. Processes were in place to ensure people were informed of how to make a formal complaint. Any feedback received was investigated to ensure any required improvements in the quality of the care provided were made for people. People were appropriately supported with their end of life care. People's own needs in relation to bereavement had been recognised, acknowledged and met.

The provider had a stated purpose, aims and objectives for the service underpinned by clearly defined values which staff were observed to apply in their work with people. There was an open and self-scrutinising culture, which enabled staff to drive improvements for people. Processes were in place to ensure staff understood their responsibilities and legal requirements were understood and met. People's views were sought and acted upon to improve their experience of the service. Changes to the service had been made at peoples' preferred pace. People had benefited from the links that had been forged with the local community. Processes were in place to enable staff to continuously evaluate the quality of the service provided. Health and social care professionals told us there were good, strong working relationships with the service.

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.

People were safeguarded from the risk of abuse through the processes and staff training, which were in place to protect them.

Potential risks to people were identified, assessed and managed for their safety.

There were processes in place to ensure there were sufficient, suitable staff rostered to meet people's needs.

People's medicines were managed safely within the service.

The processes in place protected people from the risk of acquiring an infection.

Processes were in place to ensure incidents were analysed and reviewed for people's safety.

Is the service effective?

Good

The service was effective.

People's needs were assessed and their care was delivered in accordance with best practice standards.

People were supported by trained and knowledgeable staff.

Staff supported people to eat and drink enough to maintain a balanced diet.

Staff worked with other services to ensure people received effective care.

People were supported by staff to access healthcare services as required.

People's needs for space and independence were met by the design and decoration of the service.

People's consent to their care was sought and where they lacked

the capacity to consent to a decision, legal requirements were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion by the staff that provided their care.

People were supported to express their views and to make decisions about their care.

People's privacy and dignity were promoted within the service.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Processes were in place to enable people to raise issues with the service and any concerns raised were used as an opportunity for improvement.

People were appropriately supported with their end of life care.

Is the service well-led?

Good

The service was well-led.

People's care was provided within a positive culture and care provision was based on clear objectives.

Processes were in place to ensure staff understood their responsibilities and that requirements were understood and managed.

People, staff and the community were engaged and involved with the service.

Processes were in place to enable staff to continuously evaluate and improve the quality of the service provided.

The service worked in partnership with other agencies to provide people's care.

Bentley Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 14 November 2017 and was unannounced. The inspection team included two inspectors 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. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). 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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection, we requested and received written feedback on the service from: a social services team manager, four social workers, a specialist nurse and the ambulance service. During the inspection, we spoke with seven people, four relatives and a person's representative. We spoke with two nurses, two care staff, the chef, an activities coordinator, the registered manager and the clinical lead for the service.

We reviewed records which included four people's care plans, four staff recruitment and supervision files and records relating to the management of the service.

This service has not been inspected since the legal entity providing the service and the name of the service changed.

Good

Is the service safe?

Our findings

People, their relatives and representatives told us the service was safe. Their comments included, "I'm happy and not frightened of anything. When I'm in bed I've got my bell to call for someone," "There are enough staff," "The nurses give them to me (medicines)" and "It's a nice looking place and it's very clean which is important."

Staff completed face to face safeguarding training which was updated annually. The registered manager told us they tested staff's understanding of safeguarding, which records confirmed. Staff were able to describe the purpose of safeguarding, their role and the signs, which might indicate a person had been abused. Staff had access to relevant safeguarding guidance and contact numbers if required to enable them to protect people. Information about safeguarding and how to raise any concerns was displayed for people to read. Staff had correctly referred situations to the local authority safeguarding team as the lead agency for safeguarding, when they had identified that people had been at risk of harm to ensure the person's safety.

A social worker informed us the service had "Good risk assessments" in place. Staff had identified and assessed potential risks to people and measures had been implemented to manage risks for them. For example, people's moving and handling care plans described any equipment needed to support the person to move, the number of staff required and any particular guidance staff needed to be aware of to ensure the person's safety. Where people had been assessed as requiring equipment to manage the risk of them developing pressure ulcers this had been provided. Staff were instructed on how often to re-position people in bed who could not do this for themselves and documented that this care had been provided. Risks to people were managed safely.

Staff recognised people's rights to take risks. A person had declined the use of bed rails to manage the risk of them falling out of bed and had the capacity to make this decision. Staff respected their decision and alternatives were put in place to reduce this risk. The person did still experience a fall, so staff then discussed their decision with them again so they could re-evaluate their choice. Staff recognised that risk assessments evolve as new information emerges and continually involved the person in deciding whether to continue to take the risk, based on the information available.

Twenty-eight staff had completed training in managing challenging behaviour and dementia and 26 staff had completed dementia awareness training. People had relevant risk assessments and individual guidance for staff about how to manage people's behaviours, which could challenge staff. This ensured staff had the knowledge and skills to keep people living with dementia safe.

People's records were accurate, complete, legible and up to date. They were stored safely and accessible to staff in order that they could support people to stay safe.

Safety checks on service utilities and equipment were completed as required to ensure the building and equipment was safe for people's use.

Staff assessed the individual needs of people and this information informed the dependency scale. This was then used by the provider to ensure there were sufficient staff with the right skills, competencies, qualifications, experience and knowledge, to meet people's individual needs. Staff told us and records confirmed they had undergone recruitment checks as part of their recruitment and these were documented. These included a full employment history, the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had checked that nurses were registered with their professional body and had no restrictions upon their practice. People were cared for by staff whose suitability for their role had been assessed for their safety.

Processes were in place to ensure the safe ordering, storage, administration and disposal of people's medicines. Nurses who had undergone the provider's medicines training and who had their competency regularly assessed administered people's medicines. A nurse was observed to administer a person's medicines safely. The medicines were administered in accordance with the person's preferences and in an unhurried manner. Staff then signed the medicine administration record, to ensure there was a clear record. Processes were in place to ensure people received medicines that had to be administered at a specific time correctly. Where people were prescribed medicines, 'as required' protocols for their safe administration were in place.

Some people lacked the capacity to consent to their prescribed medicines. Staff had followed both legal and best practice requirements when taking the decision to give medicines in food or drink, without the knowledge of the person. Staff had requested pharmaceutical advice and in the interim, whilst this was provided, the GP had confirmed in writing that the medicines to be administered could be given safely in food or drink.

Cleanliness around the service was overall of a good standard and the service was fresh and there were no malodours. A specialist nurse reported to us, 'The environment has seen significant improvements - I have checked on several occasions the cleanliness and a high standard has been maintained.' We observed housekeeping staff cleaning the service throughout the inspection. The service was clean, minor issues required attention, such as some dust and some lime scale removal. This was brought to the attention of the registered manager who took immediate action to address this for people.

People were protected by the prevention and control of infection. Staff were trained and understood their roles and responsibilities for maintaining high standards of cleanliness and hygiene in the service. Staff had access to clear policies and procedures on infection control. There were plentiful supplies of personal protective equipment located around the service which staff were seen to use, when providing personal care or serving meals, for example. Staff were up to date with their food safety and hygiene training. One member of staff told us, they were, "The designated infection control link nurse." They were responsible for completing hand wash audits and infection control audits, to ensure infection control standards were maintained for people.

Staff were informed of incidents when they occurred both through the verbal staff shift handover and a written handover sheet. The clinical lead completed a root cause analysis (RCA) following serious incidents. This is a method of problem solving used for identifying the root cause of faults or problems. They also met with staff to discuss the results of the RCA. This ensured any relevant learning took place to reduce the risk of repetition for people.

Good

Is the service effective?

Our findings

People, their relatives and representatives told us the service was effective. Their comments included, "Very good. We've had a change of chef. I had roast pork yesterday and it was very good." "She (GP) came to see me here; the nurses got through to the doctor."

A social worker reported, 'I have also seen an improvement in the quality of care plans and I have had heard positive feedback from Hampshire County Council and Continuing Health Care nurses when they have reviewed care plans.' People's needs were assessed before they were offered a place. Where people were not offered a place, records showed the reason why the service was not suitable to meet their needs. This ensured transparency in how decisions about admissions for people were made. Once people had been admitted, there was an admission pathway to ensure the new person received the information they needed about the service and that their care plans were completed in a timely manner to ensure effective delivery of their care.

Staff shared best practice; if staff attended any external training then this was cascaded amongst the staff. Staff applied national guidance in the delivery of peoples' care. For example, a person had lost weight and in accordance with best practice guidance, staff had requested the person was referred for review by a dietician. Staff used nationally recognised tools to assess people's care needs. For example, staff used the Abbey Pain Scale where required, this is designed to assist in the assessment of pain in people who are unable to clearly articulate their needs. This ensured people's needs in relation to pain relief were assessed and met. The provision of people's care was based upon best practice guidance to achieve effective outcomes for them.

Staff told us they felt well supported and staff who were new to care underwent an induction based on national industry standards. Staff then received regular training, supervisions and annual appraisals. The registered manager had arranged relevant training for staff in collaboration with the Stroke Association, Epilepsy Action, Parkinson's Association and the local hospice to further develop staff's knowledge and skills. A specialist nurse told us staff from the service had recently attended a training session on, 'Nutrition and hydration - the challenges with dementia' and that staff who attended had engaged very well and demonstrated a good understanding of the issues. Nurses were enabled to update their skills and competencies and were supported with their professional revalidation. Staff at all levels were encouraged to undertake professional development. People were supported by well trained staff.

People were provided with a choice of meals and snacks. The dining tables were attractively presented to encourage people to want to sit down and eat their meal. Where people required adapted cutlery or crockery to enable them to eat their meal this was provided to promote their independence. Where people experienced issues with eating and drinking, appropriate referrals had been made. Professional's guidance had then been incorporated into people's care plans and the provision of their care. For example, if people required thickened fluids or pureed foods then these had been provided.

Relevant guidance was available for staff to ensure they understood the importance of ensuring people

were sufficiently hydrated and how to achieve this. People's fluid intake was recorded, totalled and monitored to ensure they drank sufficient. Staff told us they would report to senior staff if a person was not drinking enough. We observed drinks were placed within people's reach and were available for people to help themselves, in addition to staff offering people drinks.

Records demonstrated that when people moved between services, staff ensured they had access to relevant information to provide the person's care effectively. For example, they ensured that they had copies of any relevant assessments for people from other agencies. When people returned from hospital, staff checked the guidance contained in people's discharge letters and chased up any queries. A GP visited the service weekly and processes were in place to ensure the timely and effective handover of information to them. Any guidance received from external professionals was incorporated into people's care plans, to ensure staff had access to this information in order to provide peoples' care effectively. For example, we saw that in a person's records the physiotherapist had provided staff with pictorial and written guidance about how to position the person safely and comfortably. When we checked upon the person, we saw staff had positioned them in accordance with the guidance provided, to promote the person's well-being.

People were enabled to access a range of healthcare professionals, from the physiotherapist and GP who both visited weekly to a range of external health and social care professionals. Where people required transport or staff support to attend hospital appointments, this was arranged. The registered manager told us and a person's representative confirmed, staff visited people whilst they were in hospital, to both maintain contact and promote their welfare.

The registered manager had arranged with a dental practice for them to visit the service on 27 November 2017 to provide an oral health training session. This was to be delivered by a dentist and a hygienist and was aimed at educating staff about how not only to meet people's oral health care needs but also their own. This was to promote the concept of, 'Shared ownership' of the importance of good dental care between people and the staff team. The success of the session and the outcomes was to be evaluated with people and their families after the session.

There was level access entry to the service, for those with limited mobility. The front door was locked with a keypad for exit; this ensured people who lacked the capacity to leave the service safely could not do so without staff's knowledge. There were three lounges and a dining room so that people had space for socialising and eating. There were lifts for people to gain access to the first floor. People had en-suite facilities and there was discreet signage for the communal bathrooms to enable people to orientate themselves. The service had been decorated in a modern, light and airy style.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were up to date with their MCA training and understood the act as it applied to their work with people. DoLS applications had been made to the supervisory body for people where required and the applications were appropriately underpinned by a MCA assessment, to demonstrate why the application was required.

Relevant people and professionals had been consulted where decisions had been made in people's best interests. Where people used bed rails to prevent them falling out of bed, people had either given their consent or a MCA assessment and best interest decision had been made. This ensured the person's legal rights were met.

Good

Is the service caring?

Our findings

People, their relatives and representatives told us the service was caring. Their comments included, "All (staff) are lovely, including the kitchen staff and the cleaners." "They're good to me, polite and gentle."; "They're very good to you, we have a laugh." "I get up about six, nice and early because that's what I like to do." "Staff listen." "It's the little things that make the difference" and "Staff speak kindly and with respect."

Staff were observed to care for people in a kindly and compassionate manner. A staff member told us, "We are attached to them as our family." Staff encouraged people as they provided their care. We heard comments from staff such as, "Would you like a clothes protector on?" and "Would you like me to cut up your lunch?" People were pleased to see staff and appeared to enjoy warm and caring relationships with them.

Staff demonstrated concern for people's welfare. For example, if people were seated in chairs in the lounge then staff ensured that they were propped up with cushions if required and had blankets to ensure their knees were warm.

Staff understood people's individual needs. People's care records documented their communication needs and how these should be met by staff. For example, one person's care records said staff should speak in a low, friendly manner and ensure they gave the person time to respond to questions. Another person's care plan provided staff with information about how they could become distressed during personal care and the measures staff should take to allay their anxieties. This information ensured staff understood the person's behaviours.

A person's representative told us that staff recognised the person's needs as an older male. They told us, "They group the older, single men together." The registered manager told us how the men in particular had enjoyed trips to the local pub. The needs of men as well as women within the service had been acknowledged and met by providing opportunities that reflected their interests.

People were supported to express their views and were offered choices, for example, in relation to their choice of clothing or what they wished to eat and drink. Staff offered people choices about their care. For example, in relation to where they wanted to sit, whether they wanted to be assisted from their wheelchair to sit in a chair and about what they wanted to do. We observed people had their choice of breakfast at their preferred time, served either in their bedroom if they wished or the dining room. People had been supported to personalise their bedroom to their tastes. Where people had expressed a preference for female care staff to provide their personal care this was clearly documented on the staff handover sheet to ensure all staff were aware. People's preferred times for getting up and going to bed were also noted. Staff listened to and acted upon people's preferences about their care.

A person told us how important their appearance was to them as an individual. We observed staff had positioned a table in their bedroom with their make-up and a mirror on it so that they could apply this for themselves in their style. This both promoted the person's independence and enabled them to retain their

identity. People's care plans also instructed staff on what aspects of their care they were independent with and what they needed support to do.

People's privacy and dignity was upheld during the provision of their care. Staff told us how they maintained people's dignity and privacy during personal care. For example, by ensuring doors and curtains were closed and keeping the person covered. We observed that when staff were transferring people in the lounge, they closed the door and used mobile screens, thus promoting the person's privacy and dignity. Staff were observed to knock on people's bedroom doors and wait for a response before they entered. Staff confirmed to us that refresher dignity training had been booked for them to attend on 17 November 2017, to further develop their knowledge and understanding.

Good

Is the service responsive?

Our findings

People, their relatives and representatives told us the service was responsive. Their comments included, "Staff have a good understanding of (relative's) needs." "Any small issues are addressed." "We have a band visit; we have a keyboard player who is very good." "They go to the theatre. They went to some gardens" and, "A girl organises things; a pottery class, that is lovely, and she is organising things for Christmas like a little children's choir coming in to sing."

People were consulted about their care, where they could express their views. Records showed that where people had not been able to provide information about their preferences or personal history their family or relevant others had been consulted. A person's records demonstrated the registered manager had arranged for their relative to come in and meet with staff and to talk about their loved one's needs prior to them moving in, this had helped to alleviate the relatives anxieties about placing their loved one in care and enabled staff to learn about the person.

There was a comprehensive staff shift handover sheet, which provided key information staff needed to be aware of about each person, including their medical needs, care needs and personal preferences about the delivery of their care. Staff were knowledgeable about people's individual care needs and interests and how to manage behaviours, which could challenge them. The handover sheet noted where and how people preferred to spend their time and any regular visitors so staff would know who to expect to visit. There was also guidance for staff about where to source additional information, for example, where to locate information about people's personal history and potential topics for discussion.

Staff were familiar with people's preferences. Whilst, staff respected people's preferences, they were also aware of the potential risk of social isolation when people chose to stay in their room. Staff therefore encouraged people to participate in activities if they wanted to and relatives confirmed this happened.

Each person had a 'This is me' form, which is a way of recording who the person is. The form documented details about the person's background. It had been extended to include topics of conversation that might be of interest to the person based on their past and to provide information for staff to initiate conversations with them. One person liked snooker so staff had been given dates of the major snooker championships, so they could ensure the person could watch them.

Records demonstrated that people's relatives had been invited to attend reviews of their care. This ensured people and their relatives were given the opportunity to review the on-going relevance of their care plans. Following a review of a person's care, records showed the registered manager had then held a meeting with staff to collectively review how they could improve the quality of the person's life. The person's family had also been encouraged to express their views and to provide guidance to staff. As a result, various measures had been taken to enrich the person's environment for them. Staff had also met together to identify strategies to support another person, which resulted in the engagement of a befriender for them. This demonstrated how staff had recognised and worked together to respond to people's individual needs.

Although the service was not registered to admit people with dementia, they recognised that some people had developed dementia since moving into the service. We have suggested to the provider that they consider applying to add the service user band 'dementia' to their registration. This will ensure that people and their relatives are informed that the service can meet the needs of those living with dementia.

There was a varied programme of activities across the week. We observed activity staff engaged with people making shortbread. They used the activity to reminisce with people about their experiences of cooking. People appeared to enjoy this activity and then enjoyed eating the product. A range of additional seasonal activities were provided for people's stimulation. These included, for example: entertainers, external trips, crafts, music and coffee mornings. People were provided with a range of opportunities both within and outside the service for social stimulation.

People were encouraged and supported to develop and maintain relationships with people that mattered to them. The service accommodated couples; this ensured they were able to continue to live together whist receiving the care each required. People's families and friends were encouraged to visit the service at will and to attend social events with their loved ones.

The service ensured that people had access to the information they needed in a way they could understand and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers of publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Staff had obtained pictorial communication cards from the Stroke Association for a person who could not communicate verbally. The registered manager informed us and records confirmed they had produced the resident's meeting minutes in large print to ensure everyone could read them.

People were informed of the provider's complaints policy in the welcome pack provided and this was also displayed in the reception area. Although no formal written complaints had been received any concerns verbally expressed by people or their representatives had been documented, investigated and addressed in order to improve the quality of care provided. Records showed the actions taken and any meetings held in order to resolve the issues raised for the person.

The clinical lead told us that when changes were observed in a person's presentation this was reported to the GP for them to assess if the person required palliative care. Those who were nearing the end of their life had a care plan in place to meet their individual needs. The person's needs in relation to communication, family contact, medication, nutrition, skin care, hydration, oral hygiene and spiritual care had been assessed and their care plan reflected how these were to be met. Where people required anticipatory medicines for end of life care, these had been obtained to ensure people's comfort and dignity. Staff training in palliative care was booked to ensure staff had the opportunity to develop their knowledge and skills in this area. Records showed that a social worker had complimented staff on the quality of the palliative care they had provided to a person.

The registered manager told us about how staff had recognised the needs of people when dealing with bereavement. For example, people had expressed a wish to attend the funeral of a long-term resident who had passed away. The provider had arranged a mini bus so people could attend. Input from a bereavement service had been arranged for another person who required this support. People's needs had been recognised, acknowledged and met in relation to their own experiences of bereavement.

Good

Is the service well-led?

Our findings

People, their relatives and representatives told us the service was well-led. Their comments included, "The manager is a people person. She is hands on and feeds people." "She (Registered Manager) is alright. She listens and the other one (the deputy manager) listens." "She's got a good team." "It's better now. (Manager) has got different things outside, like the bird house."

The provider had a stated purpose, aims, objectives for the service underpinned by clearly defined values which staff were observed to apply in their work with people. The values of the service were: excellence, caring, integrity, teamwork, quality, honesty, professionalism, respect and thankfulness. A representative from the ambulance service reported, 'I do think things have taken a positive turn over the last 12 months.' Staff told us there was a "Very good" and "Really open" culture."

A social worker reported, 'It appears Bentley Lodge now has a good retention of staff and they appear to have good working terms and conditions.' The registered manager valued the staff and their efforts to improve the service for people and had personally written to each member of staff to thank them. Staff had also been provided with gifts of flowers and food. The registered manager cared about the welfare of staff. For example, they had planned that the forthcoming oral health care session would not only educate staff about peoples' oral heath but enable them to understand and address their own oral health care needs. People had benefited from the stable staff team and the continuity of staffing they had experienced.

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There was a registered manager registered with CQC to manage the service. They had submitted notifications as required to inform us of events at the service.

There was a clear organisational structure. Although the registered manager had overall responsibility for the service, there was also a clinical lead who was a qualified nurse to ensure oversight of the quality of the clinical care provided. They worked one day a week supporting people with their care, which enabled them to work directly with and to observe staff practice. Staff were allocated to work with groups of people across the building. A staff member commented, "All of us are responsible." Staff understood their joint responsibility and accountability on each shift for the delivery of people's care.

On four mornings, there was a clinical meeting, to ensure information was shared and any action required identified and taken for people. The daily handover sheet for nurses contained a checklist for them to ensure all of peoples' relevant records such as food and fluid charts, medicine administration records and controlled medicine checks had been completed. This helped to ensure relevant checks were made on people's records for completeness before staff finished their shift.

The provider's policies were readily available and accessible to staff, who had been required to read and sign them, to ensure they understood their responsibilities.

Staff had been appointed as champions for areas such as infection control. Their role was to undertake

additional training to enable them to share best practice with staff and ensure the quality of delivery in that aspect of peoples' care, for example, through audits.

The views of people, relatives, staff and professionals were sought via meetings, reviews of care, feedback forms and surveys. A 'You said we did,' board displayed in the reception demonstrated on a monthly basis the actions taken in response to the feedback received. For example, In July 2017 people asked for more trips out. People had since been taken to a local garden centre and to a national garden. In August 2017, people asked for more entertainment. A fun day was held and a new pottery class was introduced. In September 2017, people asked for a Memorial for a person who had passed away. In response, a Memory plaque was placed in the garden and Memory Pebbles are to be introduced. People's views on the mealtime experience had been sought earlier in the year and then a follow up meeting had taken place with people in October 2017, to review the effectiveness of the changes that had been introduced and to identify further improvements. People's views were sought and acted upon to improve their experience of the service. Staff respected people's views. For example, a number of ideas for change had been generated following the last mealtime improvement meeting. However, these were to be introduced gradually as people had also expressed the view that changes to the service were taking place too quickly.

The registered manager had strengthened links within the local community. Following consultation with people they had formed links with, for example, the local church, the parish council, two local children's nurseries and the local Age Concern village agent, who are people who offer support to older people living in their local communities. The agent had written, 'I have found Bentley Lodge very considerably transformed over the last year or so with a much warmer, friendly atmosphere and a much greater interest in local activities.' These links had opened up a range of opportunities for people: including attendance at a church tea group, visits to the pub and visits to and from the nurseries. A representative from the church visited the service weekly to promote peoples' spiritual well-being. People had benefited from these community links.

The registered manager told us that they were continually researching best practice both from national guidance and CQC published reports to identify ways in which they could improve the service. Their current service improvement action plan identified a range of areas they wished to either address or further improve. For example, they were planning to make improvements to the entrance to the service with input from people. The registered manager monitored the service provided and applied current good practice and guidance.

A range of audits were completed monthly, including: infection control, medicines, pressure ulcers, incidents, falls, first aid boxes and care plans. The infection control audit from May 2017 identified areas for improvement. In response, the infection control lead had arranged a presentation and additional training for staff. An external audit of medicines at the service was completed by the provider's pharmacy on 30 June 2017 and no action was required. These audits enabled the quality of the service for people to be monitored and areas for improvement identified.

When reviews of incidents were completed, these were often followed up with further 'bite-size' training sessions for staff to understand what had occurred and why and to further improve their practice. For example, a person had injured themselves when they walked into a wheelchair. This was identified as a hazard and staff received a training session to remind them of the safe storage of wheelchairs for people. Incidents were also reviewed to identify if there were any missed opportunities for earlier intervention. There was an open and self-scrutinising culture, which enabled staff to drive improvements for people.

Professionals told us there were good, strong working relationships with the service, across both health and social care. Records showed the service had worked in partnership with the local authority's Partnership in

Care Training (PaCT) team to identify courses for staff, such as an infection control course for managers. This will further educate the managers about good practice in relation to infection control for people.