Benridge Care Homes Limited

Benridge Residential Care Home

Inspection report

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Merseyside
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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

This unannounced inspection was conducted on 18 April 2017.

Benridge Care Home is situated in Southport close to the town centre. It is registered to provide personal care for up to 27 people who may have dementia. At the time of the inspection 25 people were living at Benridge. The service has bedrooms and shared areas over four floors. People with mobility difficulties were able to access the building by the use of stair-lifts. The service is owned by Benridge Care Homes Ltd.

A registered manager was in post. 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.

At the inspection in November 2016 we found that the provider was in breach of regulation relating to person-centred care. This was because the care provided during the early morning was not meeting people's need for social interaction and support and did not reflect personal preferences. In addition we made a recommendation regarding the safe deployment of staff in the early morning. As part of this inspection we observed the delivery of care in the early morning and throughout the day. We also spoke with staff and visiting relatives to gather their views.

We saw that people's personal preferences were met through the provision of staff in accordance with their plans of care. Staff were able to explain what time people preferred to get up and how this could change depending on the previous night.

Another concern noted at the previous inspection was that one person was not offered a drink as outlined in their plan of care. At this inspection we observed staff offering hot and cold drinks to people as they waited to go into the dining room. They were also offered a drink with their breakfast. The service was no longer in breach of regulation with respect to person-centred care.

We saw that staff were deployed in sufficient numbers to monitor people's safety. The visitors that we spoke with were generally positive about the numbers of staff and their deployment. We saw that staff were vigilant in monitoring safety and acted to protect people from harm.

The staff that we spoke with had completed training in adult safeguarding and knew what action to take if they suspected that a person was being abused or neglected. Each staff member told us that they would not hesitate to raise a concern and was able to explain how they could report outside of the service (whistleblow) if necessary.

Individual risk was appropriately assessed and recorded in care files. We saw examples of risk being regularly reviewed in conjunction with care plans and with the involvement of relatives and care staff.

However, one plan of care contained contradictory and confusing guidance for staff.

We were provided with evidence that regular checks were completed on other aspects of the service with regards to their safety. For example, electrical condition, gas safety, hoists, water temperatures and fire safety equipment. Each check had been conducted by an external professional and was supported by an appropriate certificate.

Medicines were stored and administered safely. Where errors had been identified appropriate action had been taken to improve safety and practice.

Family members told us that they felt the staff were competent to deliver their relative's care and staff spoke positively about the quality and frequency of training and supervision available to them. The records that we saw indicated that all training had been completed as required by the provider.

We saw that the service was operating in accordance with the principles of the MCA and that applications to deprive people of their liberty had been made to the local authority. Capacity assessments clearly indicated that the people living at Benridge were not able to provide meaningful consent, but we saw evidence that families and professionals had been involved in best-interests decisions regarding various aspects of people's care.

People also told us that their relatives enjoyed the food at Benridge and had a good choice. There was a choice of main meal and dessert. Relatives told us that their family members got enough to eat and drink.

Relatives spoke positively about the staff, the manner in which they provided care and the way that they treated their family members. Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff demonstrated that they knew the people living at Benridge and accommodated their needs in the provision of care.

Records contained care plans in relation to; bathing, mobility, social needs and nutrition amongst others. We saw evidence that care had been reviewed regularly and that some changes had been made as a result. We asked people and their relatives if they had been involved in their care planning and reviewing care needs. The people living at Benridge were unable to provide appropriate responses because of their dementia, but it was clear from the level of detail in the records that people and their relatives had been involved.

There was limited detail throughout the care records in relation to individual activities, but staff did inform us that there were a range of different activities taking place throughout the week which some of the residents enjoyed. The service kept a photographic record of important activities to remind people of what they had done.

A copy of the complaints procedure was displayed in the entrance hall and people told us that they knew who to complain to if they had any issues. However, records indicated that the service had not received any formal complaints recently.
Senior staff dealt with the questions and issues arising out of the inspection process openly and honestly. They were able to provide information and evidence on request and provided additional information and evidence after the inspection.

The service completed a wide range of audits covering; care plans, health and safety and cleaning. Audits were completed weekly and monthly by different staff and were checked in a comprehensive monthly

quality and compliance audit which provided a rating for important aspects of the service.

The service had recently updated the majority of its paperwork and associated systems. The new systems utilised a mixture of paper-based and electronic records which allowed staff to record important information in real-time, but also allowed senior staff and managers to access and assess other information to monitor the safety and quality of 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.

Staff were safely recruited and deployed in sufficient numbers to keep people safe.

Risk was appropriately assessed and regularly reviewed.

Medicines were safely stored and administered. Where errors had been identified, appropriate action had been taken to improve practice and reduce risk.

Is the service effective?

Good

The service was effective.

Staff were regularly supervised and trained in a range of relevant subjects.

The service operated in accordance with the principles of the Mental Capacity Act 2005.

People enjoyed the food and were given choice in accordance with their individual preferences and needs.

Is the service caring?

Good

The service was caring.

Staff demonstrated that they knew people well and spoke to them in a caring and positive manner.

People were consulted about the provision of care and given information in a way that made sense to them.

People's right to privacy and dignity in care were understood by staff who acted in a timely manner when required.

Is the service responsive?

Good

The service was responsive.

Care plans contained a significant level of person-centred detail which helped staff get to know people well.

People had access to a good range of activities.

The service offered people a number of ways to express their views. No formal complaints had been received recently.

Is the service well-led?

Good

The service was well-led.

The registered manager was supported by a senior team on a day to day basis and had recently developed new systems and paperwork.

The staff that we spoke with were motivated to provide good quality care.

The service completed a range of audits which allowed effective monitoring of quality and safety.

Benridge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 18 April 2017 and was unannounced.

The inspection was conducted by two adult social care 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.

At a previous focussed inspection in November 2016 we identified a breach of regulation relating to person-centred care. At this comprehensive inspection we assessed the service's compliance with all regulations.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority who provided information. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the service and the staff. We completed a SOFI (Short Observational Framework for Inspections) to gauge the frequency and quality of interactions with people living at the service. We also spent time looking at records, including four care records, four staff files, medication administration record (MAR) sheets and other records relating to the management of the service.

On the day of the inspection we spoke with a number of people living at the service. They were unable demonstrate that they understood our questions because of their health conditions, but we did consider their views as part of the inspection process. We also spoke with five relatives, the registered manager, two care managers, a senior carer, the cook, the activities coordinator and two care workers.

Good

Is the service safe?

Our findings

At the inspection in November 2016 we identified concerns relating to the deployment of staff during the early morning. We made a recommendation that the service reviewed the deployment of staff to check that people were effectively monitored to ensure they received an appropriate level of interaction and engagement. At this inspection we observed the provision of care during the early morning and spoke with visitors and staff to assess if people were effectively monitored as required.

The visitors that we spoke with were generally positive about the numbers of staff and their deployment. Comments included; "They're very attentive the staff", "I think they do as good a job they can with the staffing they have. Sometimes you see the managers doing hands on", "They do have a good number of staff", "I'm sure they do [have enough staff], they're all over the place" and "There hasn't looked to be any shortage of staff." However, two members of staff expressed concern that there were not always enough staff engaged in direct care to help get people up in the morning. One staff member said, "It is full on". Another member of staff said, "It would be nice to have an extra pair of hands." We saw no evidence that the allocation of staff impacted on people's preferences for their morning routine. We discussed the deployment of staff in the mornings with the registered manager. It was confirmed that there were sufficient numbers of care staff on shift and that the senior carer could be allocated to provide care on request.

We asked about staffing levels and were told that, as a minimum, Benridge deployed two carers, a senior carer and a care manager from 8:00 am. A member of the night staff remained on duty until 9:00am to assist with the morning routine. This reduced to three carers (one with 1:1 responsibilities) and a floating night manager (shared across three services) later in the evening. These numbers were supplemented at various points during the day by the registered manager, an activity coordinator and domestic staff.

We saw that staff were vigilant in monitoring safety and acting to protect people from harm. The staff that we spoke with had completed training in adult safeguarding and knew what action to take if they suspected that a person was being abused or neglected. Each staff member told us that they would not hesitate to raise a concern and was able to explain how they could report outside of the service (whistleblow) if necessary.

Individual risk was appropriately assessed and recorded in care files. However, we saw on one occasion that a person showed signs of agitation by banging repeatedly on tables in the dining room. A member of staff who was completing paperwork in the dining room did not engage with the person or provide any form of support. When we checked the relevant plan of care we saw that it contained information which appeared to be contradictory. In one section staff were instructed to monitor the behaviour and not intervene because this may present additional risk, while another section suggested staff may 'try and calm' the person by 'offering a hand and introducing yourself.' The was no clear guidance indicating when which approach would be more appropriate. We discussed this with the registered manager after the inspection and requested that the plan of care was reviewed and clarified.

We saw examples of risk being regularly reviewed in conjunction with care plans and with the involvement of

relatives and care staff. In one example, risk in relation to falls had been reviewed and a referral made to a specialist falls' team. We saw evidence that risk assessments were also undertaken and reviewed in relation to; general risk, health, nutrition and skin integrity. Each of the risk assessments that we saw was sufficiently detailed to inform safe practice and was accompanied by records and charts as appropriate. Accidents and incidents were recorded in sufficient detail and subject to analysis to establish if any trends were present.

We were provided with evidence that regular checks were completed on other aspects of the service with regards to their safety. For example, electrical condition, gas safety, hoists, water temperatures and fire safety equipment. Each check had been conducted by an external professional and was supported by an appropriate certificate.

People were protected from the risks associated with the outbreak of fire because the service operated and maintained a range of safety equipment including; fire alarms, smoke alarms, extinguishers and specialist equipment to move people in the event of a fire. Each person had a personal emergency evacuation plan (PEEP) in their care record and details of their needs in the event of a fire were summarised for use in an emergency. Detailed plans of the building were held in the fire safety file.

Staff were recruited safely and deployed in sufficient numbers to meet people's needs. Each of the three staff records that we saw contained an application form, two references and a Disclosure and Barring Service (DBS) check. A DBS check is used to help establish if a person is suited to working with vulnerable adults. The service had introduced an electronic monitoring system to ensure that all of the necessary checks and training had been completed by new employees.

We checked to see if medicines were safely stored and administered. We did this by observing the administration of medicines, checking storage arrangements, checking Medicine Administration Record (MAR) sheets, checking other records relating to the storage and auditing of medicines and speaking with a senior carer responsible for administration.

We saw that medicines were stored in a dedicated locked trolley which was kept in a lockable office. Facilities were in place for the storage and administration of controlled drugs. These are drugs with additional controls in place because of their potential for misuse. None of the people currently living at Benridge were prescribed controlled drugs, but records indicated that they had been stored, administered and recorded correctly when they had been in use. However, we saw that one member of staff had failed to secure a second signature when administering controlled drugs as required. We spoke with the registered manager about this. The concern had already been identified and reported to them. Appropriate action had been taken including re-training and disciplinary action to reduce the risk. The service had PRN (as required) protocols in place for pain relief for people who were unable to alert staff. We saw evidence that covert medicines were being administered at the time of the inspection with the knowledge and consent of the GP and pharmacist and family. Covert medicines are medicines disguised in food or drink and administered in a person's best-interests.

The MAR sheets that we saw had been completed fully and correctly with the exception of one missed signature. We checked the stock level relating to this medicine which indicated that it had been administered as required. The stock levels of the other medicines that we checked were accurate.

The service monitored the temperature of the office where the medicines' trolley was stored and the refrigerator used to store some medicines. Each was maintained within a safe range.

Good

Is the service effective?

Our findings

Family members told us that they felt the staff were competent to deliver their relative's care and staff spoke positively about the quality and frequency of training and supervision available to them. The records that we saw indicated that all training had been completed as required by the provider. Training was a mix of e-learning (computer-based) and classroom-based as required by the subject. Staff were trained in subjects which were appropriate to their roles including; health and safety, dementia, adult safeguarding and infection control. Staff told us that they could request additional training as required. New staff were given a comprehensive induction into the service. They were also required to complete the Care Certificate within 12 weeks of starting their employment. The Care Certificate requires staff to complete a programme of training and be assessed as competent by a senior colleague. Staff were given formal and informal supervision on a regular basis. They were also given an annual appraisal.

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 saw that the service was operating in accordance with the principles of the MCA and that applications to deprive people of their liberty had been made to the local authority. Capacity assessments clearly indicated that the people living at Benridge were not able to provide meaningful consent, but we saw evidence that families and professionals had been involved in best-interests decisions regarding various aspects of people's care.

People also told us that their relatives enjoyed the food at Benridge and had a good choice. One relative said, "[Family member] has a diabetic diet, I know [family member] has a dedicated pudding and they only give plain biscuits." Another relative told us, "I've only seen the Christmas dinner, but I feel confident about it (the food)." The service operated a four week rolling menu which was made available with photographs to support people in making choices. The menu was also displayed on a monitor in the reception area. The majority of the people that we spoke with were very positive about the provision of food and drinks. There was a choice of main meal and dessert. Relatives told us that their family members got enough to eat and drink.

We observed lunch in the dining room. The tables were well-laid with matching crockery, cutlery and condiments. However, our observations of the lunchtime experience revealed that the process was rushed and not particularly well-organised. The activities coordinator was stationed in the dining room and offered assistance to those who needed it. Carers were seen to place food in front of people without speaking with

them and move quickly to another task. In one instance a person complained that their plate was excessively hot. With their permission, we checked the temperature of the plate which was hotter than expected. Staff had not warned any of the diners that their plates may be hot. Two people were seen to enter the kitchen while lunch was being eaten. These behaviours may have presented a risk to the health and safety or wellbeing of people living at Benridge. We reported our concerns to the registered manager and other senior staff. They were aware of the two people who entered the kitchen and assured us that the preparation of food was completed before the lunch was served and that arrangements were in place to manage the risk. We were provided with an example of one person who only went into the kitchen to get biscuits. A supply of biscuits was made available near the entrance to the kitchen so they didn't enter a high-risk environment. We were subsequently provided with evidence that the risks associated with these behaviours was known and assessed as part of their individual care plans.

The people that we spoke with did not have a good understanding of their healthcare needs and were unable to contribute to care planning in this area. The majority of people had identified a named relative to communicate with. We asked if people could see healthcare professionals when necessary. Staff confirmed that this was the case and showed us evidence in their care records that people had engaged with healthcare services on a regular basis. Benridge made use of the 'Telemed' system which gives immediate access to a healthcare professional for consultation and advice via an electronic tablet. Staff spoke positively about the impact of the system.

Because of the structure of the building Benridge could not be specifically adapted to meet the needs of people living with dementia. However, we did see that parts of the home were decorated with pictures of old film stars and objects of reference. These could be used to stimulate conversation or remind people of positive experiences. There was also directional signage displayed around the home. Consideration for the needs of people living with dementia had also been given in the provision of lighting, flooring and the use of colour. We spoke with the registered manager about the restrictions of the building and the changing needs of people living in the service. They explained that people's suitability was regularly monitored and that people had been moved on to more appropriate environments when their needs changed.

Good

Is the service caring?

Our findings

Relatives spoke positively about the staff, the manner in which they provided care and the way that they treated their family members. Comments included; "I really think they are very caring", "I've never seen them be nasty, they speak to them [people living at the service] as though they're speaking to their own family. They pick the good staff", "They're lovely, they're really good" and "They always say hello and they're kind". One relative told us how they were made to feel welcome. They said, "They're very helpful, they've always got a smile on their face. You're not in here long, before someone offers you a coffee."

With the exception of the early morning and lunchtime routines, we saw that staff generally had time to speak with people as well as completing their care tasks.

Staff spoke to people in a respectful way and used positive, encouraging language. Staff took time to listen to people and responded to comments and requests. Written information was supported by the use of photographs and familiar images where appropriate. This helped people living with dementia to understand their choices and engage in conversation.

Staff demonstrated that they knew the people living at Benridge and accommodated their needs in the provision of care. For example, when we asked staff which people would be most comfortable speaking with us, they were able to explain who would be most comfortable and how their understanding of our questions would be limited. In another example, staff explained how one person became anxious in the dining room and preferred to eat their meals in the lounge. Staff were also able to tell us about people's personal histories. We saw that this information was recorded in people's care plans.

We saw that people living at the service were encouraged and supported to be as independent as possible. Throughout the inspection we saw people using the facilities within the service independently. We also heard staff providing encouragement and guidance to people rather than completing tasks for them.

People's privacy and dignity were respected throughout the inspection. We saw that staff were attentive to people's need regarding personal care. For example, on two occasions we noticed a strong odour in one of the lounges. Staff were quick to intervene and provide personal care which resulted in the odours dispersing. People living at the home had access to their own room with washing facilities for the provision of personal care if required. The home also had shared bathing and showering facilities. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity in the provision of care. Staff said they would always seek permission before entering people's rooms or coming into their personal space, when we asked why this was important one staff member said, "Out of respect, I wouldn't like to be treated like I didn't matter." Information about promoting people's dignity was displayed throughout Benridge.

We spoke with visitors and relatives at various points throughout the inspection. They told us that they were free to visit at any time and always made to feel welcome. Staff and managers confirmed that this was the case.

We were told that none of the people currently living at the home was making use of the services of an independent advocate, but they had in the past. The contact details of a local advocacy service were displayed in the reception area. We saw from care records that people had nominated a family member to act on their behalf.

Good

Is the service responsive?

Our findings

At our last inspection in November 2016 we identified a breach of regulation because people's needs for social interaction and support were not being met in the early morning. At this inspection we observed the delivery of care, checked care records and spoke with staff to see if sufficient improvements had been made and sustained.

We completed a SOFI (Short Observational Framework for Inspection). The SOFI allowed us to record the frequency and quality of interactions between staff and people living at Benridge. Over a 15 minute period we observed that staff were regularly present in, or in a position to monitor, each of the main lounges and the dining room. There were a total of nine interactions recorded between staff and the five people in one of the lounges. Each of the interactions was categorised as good or neutral. However, two of the people slept in their armchairs for the majority of the observations and there was a five minute period when there were no interactions between staff and any of the people in the lounge. In addition to the interactions noted during the SOFI, we observed that a member of staff helped to prepare the dining room for breakfast and supported people from the other lounge to take their seats. The SOFI was stopped after 15 minutes because people were being moved to the dining room in preparation for breakfast.

We asked staff about people's individual preferences for their morning routines. Staff were able to explain what time people preferred to get up and how this could change depending on the previous night. For example, we were concerned about one person who was still in bed after 11:00 am. We asked why this was the case and were told that the person had a disturbed night and had not gone to sleep until after 2:00 am. We checked the care records for this person which indicated that the person was in bed before 10:00 pm. We asked the registered manager and other senior staff about this. Further checking confirmed that the person had got back out of bed and spent a number of hours with the night staff. This information had been relayed to staff during the verbal handover at 7:45 am. Another concern noted at the previous inspection was that people were not being offered drinks as outlined in their plan of care. At this inspection we observed staff offering hot and cold drinks to people as they waited to go into the dining room. They were also offered a drink with their breakfast. The service was no longer in breach of regulation with respect to person-centred care.

We saw that records contained care plans in relation to; bathing, mobility, social needs and nutrition amongst others. We saw evidence that care had been reviewed regularly and that some changes had been made as a result. For example, one person had been referred to a specialist falls team following a review of care. Other people had been supported to improve their nutritional intake and take their medicines consistently in conjunction with input from staff and healthcare professionals.

We asked people and their relatives if they had been involved in their care planning and reviewing care needs. The people living at Benridge were unable to provide meaningful responses because of their dementia, but it was clear from the level of detail in the records that people and their relatives had been involved. For example, one care record contained extensive personal details including; where the person met their partner and the fact that family photographs had been lost during the war. Other care records

contained family trees and a history of addresses. All of this information helped staff in getting to know the person and would be useful to help orientate people if they became confused. People's rooms were filled with personal items and family photographs that reflected their preferences.

We observed that care was not provided routinely or according to a strict timetable. There were sufficient staff to respond to people's needs and provided care as it was required. We asked people living at the home if they had a choice about who provided their care. The majority of people were unable to understand the question or provide a meaningful response. However, none of the people that we spoke with expressed concern about any of the staff and some were able to identify a favourite carer.

There was limited detail throughout the care records in relation to individual activities, but staff did inform us that there were a range of different activities taking place throughout the week which some of the residents enjoyed. The service kept a photographic record of important activities to remind people of what they had done. The relatives that we spoke with confirmed that the activities took place regularly. Comments included; "[Family member] likes to sit in the bright room, there are activities most times" and "[family member] tries to take part in the activities and loves singing."

We asked if people living at Benridge went out. One relative said "They are going to do trips out; they are going to go to Mecca Bingo." While another told us, "They go out in the summer, but don't know if anything is planned. The service employed a dedicated activities coordinator to facilitate the activities which were clearly scheduled and displayed in the reception area. Activities included; skittles, board-games, jig-saws, hairdressing and hand-massage. People were also supported to complete 'household chores' as part of a therapeutic approach to living with dementia. People had access to television and radio if they preferred. The service also made use of an orientation board which displayed basic information about the day including the date and a description of the weather.

The service distributed questionnaires to relatives and visiting professionals. The most recent questionnaires generated primarily positive comments with the majority rating their response as satisfied or very satisfied. The service also held resident's meetings. We saw evidence that the décor had been discussed as well as staffing, menus and activities. In one example two people had said that their favourite meal was a burger. We checked with staff and were told that burgers had been added to the menu as a result of these comments. Benridge also had a comments box located in a prominent place in the reception area. The service displayed a 'You Said, We Did' notice which detailed some of the changes made following requests.

A copy of the complaints procedure was displayed in the entrance hall and people told us that they knew who to complain to if they had any issues. However, records indicated that the service had not received any formal complaints recently. Each of the relatives that we spoke with said that they could approach the acting manager with any concerns and had not felt the need to lodge any formal complaints. One relative gave an example where they raised a concern which was quickly dealt with to their satisfaction.

Good

Is the service well-led?

Our findings

A registered manager was in post. The registered manager held responsibility for two other services in the area and was supported by senior staff with the day to day management of Benridge. The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission and had submitted notifications as required. The ratings from the previous inspection were displayed in the reception area as required.

Senior staff told us that the service had a vision and values which focussed on providing high quality care within a homely, family environment. They acknowledged the restrictions placed on the provision of complex care by the structure of the building, but stated that it was their aim to keep people at Benridge for as long as it was safe and suited their needs.

Senior staff dealt with the questions and issues arising out of the inspection process openly and honestly. They were able to provide information and evidence on request and provided additional information and evidence after the inspection.

People living at Benridge, their relatives and staff spoke positively about the registered manager and senior staff. Comments from relatives included; "I like [registered manager] very much, I think [registered manager] is fair and honest. Sometimes you see the managers doing hands on", "[Registered manager] is brilliant, they're all exceptionally good. If anything happens they let me know. She's on the floor all the time" and "I don't know who the manager is, but they [senior staff] are always about and they're all very good." The registered manager and other staff were well-represented on specialist forums and shared best-practice approaches with other services.

During this inspection we looked at records of audits and saw that they had been completed regularly. The service completed a wide range of audits covering; care plans, health and safety and cleaning. Audits were completed weekly and monthly by different staff and were supplemented by a comprehensive monthly quality and compliance audit which provided a rating for important aspects of the service. We saw evidence of issues being identified and corrective action taken. For example, in a cleaning audit four areas of the building had achieved a score of less than 60%. This was in contrast to an external infection control audit score of 100% and an environmental health five star rating. In another example, an audit from February 2017 had identified the need for minor repairs and purchases to improve infection control measures. It was confirmed that the actions had been completed. Other audits focussed on more subjective aspects of care like dignity. The dignity audit from April 2017 looked at the promotion of dignity in relation to; the environment, privacy, personal care, communication and meal times.

The service had an extensive set of policies and procedures which had been recently reviewed. Policies included; adult safeguarding, MCA and whistleblowing. Policies were sufficiently detailed and offered staff guidance regarding expectations, standards and important information. The staff that we spoke with understood how to access information through the relevant policy and other sources of information. The service had a policy of the month process that promoted a particular policy. Recent policies featured

included; absence and dignity and privacy.

The service had recently updated the majority of its paperwork and associated systems. The new systems utilised a mixture of paper-based and electronic records which allowed staff to record important information in real-time, but also allowed senior staff and managers to access and assess other information to monitor the safety and quality of the service. We spoke with the registered manager about this and in particular the pressure that completion of the new paperwork might place on staff. The registered manager assured us that the introduction of the new systems and paperwork had been time-consuming, but said that once this had been completed and reviewed staff would have more time to spend with people using the service.

Staff understood what was expected of them. They told us that they enjoyed their jobs and were motivated to provide good quality care. Staff were encouraged to recognise their colleagues by recommending them for a prize when they had done something exceptional. We were provided with examples where staff had raised concerns. For example, in relation to staffing levels. The staff that we spoke with said that they would not hesitate to raise other concerns and would be prepared to report outside of the service (whistleblow) if they thought it necessary.