Cuerden Developments Ltd

Cuerden Developments Limited - Berkeley House

Inspection report

Berkeley House
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Date of inspection visit:
05 January 2016

Date of publication:
14 April 2016

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 was unannounced and carried out on the 05 January 2016.

The service was last inspected on 30 August 2013 and we found action was required with regards to the old essential standard 'supporting workers'. We re-inspected on 15 November 2013 and found the home had met all the actions and was compliant with the regulations.

Berkeley House is a purpose built acquired brain injury, learning disability and mental health unit; located in Pemberton, near Wigan. The unit has 18 en-suite bedrooms across three floors with lift access to all floors. The service offers short respite and long term care for adults between the ages of 18 and 65 years.

There was a registered manager 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.

People, relatives and visiting healthcare professionals without exception spoke positively about the staff and management at the home. It was clear throughout the inspection; staff knew and understood people's needs well and went out of their way to provide flexible, tailored support. Staff went through a robust recruitment process before starting work. Sufficient staff were deployed which was responsive to people's needs and preferences and enabled people to lead busy and fulfilled lives.

People had comprehensive risk assessments which were reviewed regularly and changed timely to meet people's needs. People and their relatives were involved in the assessments and planning of their health and social care. Regular reviews were undertaken collaboratively and relatives expressed feeling involved. People's views and decisions they made about their care were listened and acted upon.

We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. The management of medications, promoted people's safety. Medication records were well maintained and detailed policies and procedures were in place.

Staff were trained and the management demonstrated a commitment to continued professional development to maintain skills and deliver best practice. Staff were supported through induction, supervision and training to promote better outcomes for people.

People's healthcare needs were regularly assessed and monitored. Contact was made with other health care professionals timely and links were established with; community nurses, social workers, Huntington's team, opticians, specialist learning disability services, dentist, tissue viability nurses and GP's.

Staff understood the Mental Capacity Act 2005 (MCA) regarding people who lacked capacity to make a

decision. They also understood the Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily.

We saw staff assessed peoples' nutritional needs and varied menu's had been developed. People were offered choice and the dining experience was interactive and relaxed. People's records were accurately maintained and completed timely.

We saw genuine relationships between staff and people who used the service. Staff were caring and compassionate. We noted frequent, appropriate physical contact between staff and people which were natural and symbolised the familiarity and relationships that had developed between people and staff. People were put at ease and we saw staff approach people's distress with empathy and provide appropriate reassurance and contact to provide support. People were supported by staff that were compassionate and treated them with dignity and respect.

The home was warm and welcoming. It was clean, free from offensive odours and was decorated and maintained. People had personalised the environment with murals and pictures of activities and outings. People chose the colour of their bedroom and furnishings.

There was a positive atmosphere throughout the home and people spoke positively about the support provided. We were consistently informed by people who used the service, relatives and health professionals that the care provided was of high quality and person centred. Staff were repeatedly described as committed, thoughtful and dedicated.

People were active members of their local community and led busy and fulfilling lives. There was evidence of positive outcomes for people, and that people had pursued new opportunities, progressed over time, gained new skills and increased their independence.

We saw the home had received compliments from relatives and healthcare professionals since our last inspection. People told us they knew how to make a complaint and felt comfortable to do this should they feel the need to.

Staff told us the management was open, supportive and approachable. Staff felt they had an influence over service development and how care was provided. Feedback was sought from people, relatives and staff through meetings, surveys and suggestions.

Leadership within the home was strong. Managers had a clear vision of what was required of a quality service and this spread throughout the home. All staff were respectful of management and demonstrated a commitment to working towards the shared values.

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.

The service had safeguarding and whistleblowing policies and procedures which staff demonstrated they knew in order to keep people safe.

Risk assessments were comprehensive, reviewed regularly and changed timely to meet people's changing needs.

We found sufficient skilled staff to meet people's needs. Robust recruitment ensured only suitable people were employed.

Processes were in place to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had received extensive training. The registered manager encouraged continued professional development in a supportive atmosphere.

People had access to healthcare services when they needed them. Management and staff were proactive in referring to health care professionals and demonstrated excellent working partnership with them.

People were supported to make decisions about their lives in a way which maximised their autonomy. The registered manager and staff were fully aware of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were regularly consulted about their meals and their preferences were accommodated. Mealtimes were relaxed and inclusive. People's nutritional needs were met and closely monitored.

Is the service caring?

Good

The service was caring.

Without exception, people and relatives praised the staff for their caring and professional approach.

Management and Staff had high expectations of what people could achieve and people were empowered by staff that encouraged independence. We saw compassionate staff that consistently treated people with kindness, dignity and respect.

We saw positive relationships between staff and people using the service and there was a genuine fondness expressed by staff when speaking about people.

People were provided with care and support in line with their wishes and preferences.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and consistently reviewed. Staff responded promptly when people's needs changed. External professionals were consulted timely and appropriately when people's needs changed to promote better outcomes for people.

The management had an ethos of continuing improvement. They engaged with people living at the home and were proactive in seeking feedback from relatives and visiting professionals to drive improvement.

Complaints were taken seriously and responded to timely and effectively.

A range of social, leisure, occupational and educational activities were provided; which were based on people's choices. People were encouraged to make friends, learn new skills and be involved in their local community.

Is the service well-led?

Good

The service was well led.

We found the service promoted an open culture, was person centred, inclusive, open and transparent.

People's safety was monitored and the provider had systems for checking the quality of the care.

The provider ensured statutory notifications had been

completed and sent to CQC in accordance with legal requirements.	

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 05 January 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a specialist advisor (SPA). A SPA is a person with a specialist knowledge regarding the needs of the people in the type of service being inspected. Their role is to support the inspection. The SPA was a registered mental health nurse (RMN).

At the time of the inspection there were 18 people living at Berkeley House. The home provides single occupancy rooms, across three floors. As part of the inspection, we spoke with six people who lived at the home, six of their relatives and five healthcare professionals. We asked people for their views about the services, care, staff and facilities provided.

Throughout the day, we observed care and treatment being delivered in communal areas; including lounge and dining areas. We also looked at the kitchen, bathrooms and external grounds. We looked at five people's care records, four staff files, supervision and training records, medication administration records (MAR) and the quality assurance audits that were undertaken by the service. We spoke with seven staff members, the registered manager and the team leader.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us
by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key

information about the home, what the home does well and improvements they plan to make.

We also liaised with external professionals including the local authority, local commissioning teams, infection control and Healthwatch. Healthwatch Wigan works with Healthwatch England to share local people's experiences of health and care. No issues of concern were raised by external professionals contacted. We reviewed previous inspection reports and other information we held about the service.

Good

Is the service safe?

Our findings

A person told us; "Yes, I feel safe." Relatives told us; Staff work on all the floors which is good. The staff get to know everybody and know how to keep people safe." "I've no concerns about [person's] safety; there is always enough staff to meet people's needs." "I've never had any concerns. [Person] is completely safe."

We looked at how the service managed risk. We found individual risk assessments had been completed for each person and recorded in their care plan. There were detailed management strategies documented to guide staff on how to safely manage risks in order to help keep people safe. We saw risk assessments had been developed in conjunction with people and their relatives. Risk assessments were reviewed on a regular basis and in response to a person's changing needs. We observed a person sleeping on a mattress on the floor. We looked at their care file and found risk assessments had been conducted and alternative means to keep the person safe had been considered. We saw discussions had been conducted with the person and their relative and a rationale for the decision was documented in the care plan. This demonstrated to us that risk management was a shared decision which incorporated people and family views.

We found pictorial guides to convey risk assessments. For example; people who required the aid of a hoist had a comprehensive plan documented in their care record. The plan contained a picture of the hoist and its accessories; the sling to be used and outlined the circumstances in which it was to be used. The plan detailed; the size and weight of the person, instructions on how many people were required to use the equipment and instructions on assessing the condition of the equipment prior to use. This meant all staff had clear guidance when supporting the person to transfer.

We saw the care plans were detailed and provided comprehensive information for staff to follow. A healthcare professional told us the care plans for the person they supported were excellent and the person had progressed significantly since moving to Berkeley house.

We observed furniture in bedrooms and communal areas were easy to manoeuvre to encourage people's independence. The stairwells had coded locks and people who were not subject to restrictions had the codes in order to come and go as they pleased. People had appropriate mattresses and seating to promote pressure relief and we saw nurse call alarms were located near to the bed and in reach of people receiving care in their bedroom.

People were protected against the risks of abuse because the service had a robust recruitment procedure in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection, we looked at four staff personnel files. Each file contained a job application form, interview questions, photo identification (ID), a minimum of two references and evidence of either a CRB or DBS (Criminal Records Bureau or Disclosure Barring Service) check being undertaken. This helped to keep people safe and ensure appropriate recruitments decisions were made when employing staff to work with vulnerable adults.

We looked at whether the home had sufficient numbers of staff to meet people's needs and keep them safe.

During the inspection we saw the registered manager, team leader, two nurses, six care staff were consistently busy but we found the service had sufficient skilled staff to meet people's needs. The registered manager told us; staffing numbers were frequently reviewed and adjusted to respond to people's choices, routines and needs. Several of the people who used the service had challenging behaviour and complex needs but we saw staff were able to meet their needs. We observed staff diffuse potential incidents, preventing them escalating and putting vulnerable people at risk. We noted people were accompanied by staff to day centres, education and there were sufficient numbers of staff allocated to ensure people attended their community activities as planned.

Everybody we spoke with told us they didn't have concerns regarding the staffing at the home. Relatives told us; "I've no concerns with staffing. I visit at different times and I've no concerns about anything." "I've never felt the home was understaffed when visiting. There are enough staff around." A health professional told us they frequently visited the home unannounced, the door was always open to accommodate the visit and they were made to feel welcome. They told us there had always been enough staff on duty when they had visited the home. Staff told us they felt there was enough staff when there were two staff on each floor, the nurse was not included in the numbers and there was an additional staff member to go between the floors assisting when needed.

During our inspection, we checked to see how the service protected vulnerable people against abuse. We found suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We looked at the service safeguarding adult's policy and saw how the service managed safeguarding concerns. We found all the staff had completed training in safeguarding vulnerable adults, which we verified by looking at training records. We spoke to six staff members about safeguarding procedures. All the staff spoken with told us they had received appropriate safeguarding training, had an understanding of abuse and were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice.

Staff said, "A safeguarding could involve staff and service users, unidentified marks on somebody's body and changes in the service users' behaviour. There are tiers for reporting and investigating." "Safeguarding could be physical, mental, financial, sexual, and emotional abuse. If I had concerns, I'd inform the nurse in charge and the registered manager. If I wasn't satisfied it had been addressed, I'd contact Wigan safeguarding team." "Abuse could be physical, emotional, shouting, neglect. People could have bruises or marks. People could be withdrawn or flinch when the abuser is near them. The person could also become aggressive due to fear of the abuser. I'd inform management but I'd whistleblow too. I'd contact the local authority and CQC." This demonstrated staff had a good understanding of signs and symptoms of abuse and knew what procedure to follow to protect people from harm.

We saw camera's had been installed in communal area's but were not yet operational. We looked at the consultation document which confirmed the installation of camera's had been discussed with people and their relatives. Everybody had voted in favour of the camera's being installed. We saw a policy and procedure had been developed to outline who had access to the monitors and the circumstances in which the video recordings could be accessed and viewed. We saw maintenance logs were up to date; this included testing of lifting equipment, checks of mattresses, bed rails, water temperatures, window restrictors and the fire alarm. There were up to date records of tests of the safety of gas appliances and the electrical system.

We saw people living at the home had personal emergency evacuation plans (PEEPs) in place, which provided staff the details of the level of support people required in the event of an emergency evacuation of the premises.

We found the provider had safe arrangements in place for managing people's medication. We looked at five people's medication records (MAR). We saw the home used a biodose system. Biodose is a pod system to hold the medication which has been sealed by the pharmacist using a tamper evident sealing system, removing the possibility of medication being tampered with between dispensing and consumption. All biodose packs were marked with the person's name, the person's photograph, they were also colour coded and displayed the date and time of day to be taken on the pack.

We saw the medication administration records (MAR) were kept in a large folder. Accompanying the MAR were coloured photographs and details of each medicine contained within the biodose pod. This meant staff would be able to distinguish between medicines when providing support to people. Controlled drugs were in a locked cupboard and the administration book was current and complete. We saw all the MAR had been completed correctly and there were no omissions of the staff signatures.

Each person had PRN medication, "prescribed when needed". We saw PRN protocols which detailed the rational and circumstances to offer each medicine, the dose details, route, contraindications and potential side effects. People told us they received there medicines on time and they could request homely remedies when needed. A 'homely remedies' policy was seen for over the counter remedies and provided clear guidance for staff. The protocols gave administration guidance to inform staff when the medication should and should not be given. This ensured people were given their medicines when they needed them and in a way that was responsive, safe and consistent.

Medication was administered by a nurse. Support workers who had completed the safe administration of medication training were able to sit and support people whilst they took their medicines. The medication training records were current and staff told us they felt confident in this area.

We saw detailed assessments and care plans with accompanying documentation of best interest meetings with staff, GP, person and nearest relative regarding the administration of covert medication which complied with the Mental Capacity Act (MCA) 2005. We saw discussions had been undertaken with people to assess their compliance prior to activation of the covert medication care plan.

We saw accidents and incidents were closely monitored within the service and monthly audits of accidents were undertaken by the registered manager to capture re-occurring themes. Actions had been implemented following issues arising of a similar nature for people. For example, if a person had a series of falls, risk assessments were conducted and measures implemented to mitigate the risks. We saw care plans had been updated and incidents were handed over to staff to monitor. People had been referred to other agencies to assess the cause of falls. Lessons learnt and outcomes were disseminated throughout the team to promote best practice at team meetings.

Although we were confident the registered manager had an oversight in regards to addressing accidents/incidents, tracking accidents/incidents was challenging with the documentation in use at the time of the inspection. We informed the registered manager of our experience and they acknowledged the difficulty and complexity of the recording system in use at that time. Following our inspection, the registered manager contacted us and sent a revised accident/incident audit which they had devised and implemented following our feedback. The accident/incident log had been significantly improved and recorded on one sheet who had been involved in the incident, the nature of the incident and the outcome. This would enable a more robust monitoring system that was not solely reliant on the registered manager for interpreting.

Good

Is the service effective?

Our findings

People told us they felt staff had the correct knowledge and skills. A relative said; "Staff are well trained and they know what they are doing. They have exceeded my expectations in the management of [person]. [Person] was in and out of hospital before coming to the home. [Person] continues to fluctuate but the staff identify changes in [person's] health early and respond. [Person] has not needed to go in to hospital since being at Berkeley house."

We looked at the training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. The registered manager told us the induction consisted of staff completing the care certificate and shadowing experienced staff. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control.

The new staff member remained supernumerary for up to three months until they felt confident to undertake the role. Staff told us; "Care staff shadow whilst completing the care certificate and nursing staff shadow until they feel confident." "When I commenced working here, I had an NVQ level 3 in health and social care. I completed core subjects again; moving & handling, safeguarding, infection control and shadowed for two weeks." "The induction is thorough. We are all well supported. Staff returning from maternity also shadow again until they are confident."

From discussions with staff and from looking at the training records, we found all staff received a range of appropriate training applicable to their role. We looked at the training matrix, which showed staff had access to a comprehensive training programme. We saw staff had attended mandatory training such as safeguarding, mental health, mental capacity, first aid, fire safety, medication and moving and handling. There was also a high attainment of more specialist training, such as; diabetes, epilepsy, cerebral palsy, acquired brain injuries, dual diagnosis, mobility and falls management. This provided staff with the necessary knowledge and skills to look after people with varying complex needs.

Staff training was maintained and there were clear records to indicate when refresher training had been undertaken and scheduled to enable staff to maintain their knowledge and competency. We saw when staff had not completed the annual updates; the registered manager had discussed with staff the deadline for completion. This had been followed up by a letter and staff had been informed shifts would be suspended until completion of the required training. This demonstrated the registered manager's commitment to training to ensure staff had the required skills to provide effective care.

We noted a high attainment of National Vocational Qualifications (NVQ) amongst the staff team. All the staff had completed NVQ's, diplomas or working towards them. Staff we spoke with told us they were satisfied with the training and support available to them. Staff told us; "The training is really good. We get a lot of training and we have an opportunity to influence the training we receive. We can put forward requests in

supervision." We saw Berkeley house had been nominated along with 900 nominees' and won the Alliance Learning company award for training and development in 2014; which was won as a result of the continued commitment to the training and development of staff. We also saw a member of staff from Berkeley house had been awarded the apprentice of the year award in 2015 for their contribution to health and social care.

Staff told us they felt supported and were provided with regular supervision and had an annual appraisal of their work performance. The registered manager told us they aimed to conduct supervision bi-monthly but on occasions this would not be achieved due to annual leave etc. We looked at the supervision matrix, which recorded all staff had received supervision consistently each quarter with some staff receiving supervision more frequently. All staff had an appraisal recorded. We selected four staff personnel files at random and saw supervision had been conducted. The supervision was positively written and focused on achievements and areas for growth. This enabled the registered manager to assess the development needs of their staff and we saw evidence that the registered manager had scheduled training based on these discussions.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff were able to discuss the relevance of DoLS and the requirement to apply the least restrictive approach. Staff told us which people were subject to DoLS and what the restrictions entailed. We observed challenging behaviour was addressed in the least restrictive way and care planned to reduce unnecessary restrictions being imposed. We observed a person sitting on the floor and screaming at people and staff. Staff did not attempt to move the person but reassured the person and people that things were okay. Staff gently persuaded the person to come with them by holding out there hand and sat with the person on the couch stroking their hand and talking to the person about their family. We observed the staff diffuse the situation by remaining calm and reassuring the person and other people who witnessed the outburst. Staff remained in control and worked together. The atmosphere remained relaxed and the staff continued about their duties as if nothing had occurred.

Best interest assessments were comprehensive and involved people, their nearest relative or advocate and the required professional determined by the decision to be made. We observed staff seeking consent prior to assisting people with mobilising, personal care, and fluids. This meant staff were consistently and meaningfully engaging with people throughout interventions and support to ensure it was what the person wanted at the time that they wanted it.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed their meals and were not rushed when eating. A relative told us; "I'm happy with the food [person] has. [Person] has a lot of choice and the staff encourage healthy eating. Staff get people to try different fruits and smoothies." Where people were at risk, we saw input had been sought from; community dieticians, neuro team dieticians and diabetic nurse specialists. We saw a person with specific carbohydrate needs which was documented in their care plan. We observed the care plan was adhered to during meals. Regular checks were made on people's weight and we saw discussions with people and their relatives regarding the quantity of sweets and chocolates purchased for people who were overweight and at risk of health complications as a consequence of their weight.

We observed breakfast, lunch and the evening meal and we saw people were offered sufficient amounts to eat and drink. A choice of menu was offered in the morning and people picked their choices for the day ahead. Staff described each meal to the person to assist people when they were choosing. We saw people change their mind when the meal came as they preferred the look of a different meal and this was accommodated. We saw staff and people sat at a large dining table and ate together. The food was nicely presented and the meal was not rushed. The meal was a relaxed and a sociable time with staff and residents engaged in conversation. We saw some people required assistance eating their meal and this was done in a discreet and sensitive manner. We saw one person sat with staff in a different room whilst eating their meal. We looked through the risk assessments and care plan which detailed difficulties this person had when eating with other people. This included; assaulting other people with cutlery and being verbally abusive. The room had been decorated with paintings of clowns and the circus which the person liked. We watched the person set their table for lunch and go with staff to eat their meal. We observed the person and staff talking through the meal and the person looked relaxed in staff company.

People's diet and fluid records were current and completed at the time of the meal to prevent staff completing retrospectively and forgetting what people had consumed.

We saw the home followed best practice guidance by its involvement with partners and external agencies. The home worked closely with other professionals and agencies in order to meet people's health needs. SALT (Speech and Language Therapy) referrals, assessment were in care files and care plans were devised following recommendations. Staff were able to tell us people's individual needs and requirements. We saw involvement from a variety of different professionals recorded in people's care plans which included; mental health teams, physiotherapists, falls team, district nurses, Huntington's team, opticians, specialist learning disability dentist, tissue viability nurses and GP's. People were encouraged to register with a GP and dentist within two weeks of moving in to the home. People were also able to access alternative therapies within the home. We also saw, visits to a healthcare setting were recorded. For example; attendance at hospital was noted with the date, reason for going and the outcome of the appointment documented.

We spoke to five health care professionals and without exception the feedback we received about the care provided at Berkeley house was positive. We were told; the home had done an exceptional job at supporting people's needs, communication was very good and the staff contacted professionals when required but were not inappropriately contacting. We were told; staff had the right attitude and built good relationships with people and their families which contributed to people achieving excellent outcomes. For example; one health care professional told us that one person had frequently required hospital admission prior to coming to Berkeley house. We were told staff recognised the change in the person's needs quickly and sought support from the person's family and professionals. The person had not required hospital admission since living at the home.

We looked around and found the home was clean and free from offensive odours. We saw people's photographs were displayed throughout the home of people engaged in various activities and outings. In communal areas, there was a mural painted on the wall and people's art work displayed. On each floor there was a lounge and dining area with a small kitchen that people were encouraged to use to make drinks and snacks for each other and their visitors. People told us they had chosen the colour, décor and furnishings for their bedroom. One person proudly showed us their pink bedroom and explained a member of staff had helped them to choose the pictures. Another person's bedroom had been adapted to include sensory items to stimulate them. There was no prescriptive visiting time; visitors could spend time with people in their bedroom or communal areas. There was a courtyard area through double doors from the ground floor that people could use, where there was seating, a basketball net and a small gardening area.

Good

Is the service caring?

Our findings

People told us; "The staff are great." "I love them. [Staff] are my friend." Relatives told us; "They are genuinely kind people." "The staff will do anything for people who live here to make their lives better." "I can't praise the staff/care high enough. It should be a flagship for people to see how care should be done." "The staff are really good. It's a brilliant place. I'd like [person] to spend the rest of their life at Berkeley house." "[Person] wanted to tell a staff member something so they came in early. That's going the extra mile." "Staff are brilliant. Wherever you go in the home, whatever the time; staff can have their back to you so they don't know you are there but they are speaking to people kindly and managing situations with respect. It's not for show." "When looking at homes, I immediately warmed to the staff at Berkeley house and knew I wanted [person] to come here."

During our inspection we observed staff treating people with kindness and compassion. Staff spoke to people in respectful tones and listened and responded to people. We observed people embrace staff and the natural reaction from staff was to appropriately place their arms around the person. Staff were not uncomfortable with people's displays of affection and appropriately responded during these interactions.

We observed one person throughout the inspection becoming distressed, crying out and shouting at other people. Staff responded promptly but calmly to diffuse the situation on each occasion. Staff were not distracted or flustered by our presence and approached the situation calmly, speaking softly and showing empathy. One staff member distracted people whilst the other staff member calmly provided reassurance and used distraction techniques to diffuse the situation. We saw the staff approach successfully overcame these situations and we saw the person positively respond to staff and hold their hand seeking comfort. The staff sat with the person following this outburst stroking their hand and offering continued reassurance. Staff enquired whether the person was in any pain or discomfort and offered pain relief.

We observed interactions between people and staff to be compassionate and caring. Management and staff were able to demonstrate a comprehensive understanding of people and their needs. We observed staff skilfully diffuse difficult situations and empower people to promote positive engagement. We observed staff distract another person from shouting out by engaging them with a jigsaw. The person had initially declined but staff persisted by starting the jigsaw and positively encouraging the person to participate. We saw the staff member voice that they were struggling to complete the jigsaw and would benefit from the person's help. The person was observed to pick up a jigsaw piece and pass it to the staff member. Positive engagement in the activity was then observed and the person was observed laughing and smiling throughout the activity.

We saw repeated examples of staff providing choices and placing a strong emphasis on empowering people and seeking people's wishes before doing things for people. Staff were confident and caring. Their interactions with people promoted an emphasis on person centred care and involving people in their own decisions. We saw one person in a wheelchair with limited communication that was not self-propelling. Staff knelt down in front of the person, gained the person's eye contact and slowly asked whether the person would like to sit at the table for lunch. The person shook their head to signify 'No'. Staff remained knelt in

front of the person, took their hand and whilst gently stroking it asked where the person would like to sit. The staff slowly identified different parts of the room until the person nodded. But before moving the person, the staff clarified again if the person wanted staff to move them to where they had identified.

We noted throughout the inspection positive staff engagement with people, staff didn't rush people and there was no time restraints imposed upon people when making decisions. Staff remained calm, pleasant and polite. We noted frequent, appropriate physical contact between staff and people which was natural and symbolised the familiarity and relationships that had developed between people and staff. We found the management and staff demonstrated a strong positive person centred ethos at the home which was delivered by highly compassionate staff who valued people as individuals. Staff demonstrated a comprehensive understanding of people's care needs, preferences and a passion in ensuring that people received care representative of their wishes. There was a constant dialogue between staff and people which reflected staff knowledge and understanding of people and their favourite foods, clothing, things they liked and didn't like, what they were doing and when, when family were visiting and upcoming activities people were engaged with.

We saw care plans were personalised and the documentation supported discussion with people and their relatives to ensure people were involved in decisions about their care. We saw people were provided with easy reading and pictorial leaflets explaining their medications, symptoms and experiences. We saw laminated books were available in the communal lounges with Makaton signs to facilitate conversation and support communication between staff and people.

Staff spoke fondly of people and treated them with dignity and respect. We observed staff close bedroom doors when administering injections or providing personal care. Staff described how they protected people's privacy and dignity; One member of staff said; "make sure people are covered up when providing personal care, knock before entering people's bedrooms and wait to be invited in, close the blinds or curtains before providing personal care and don't use the hoist when it's not necessary." A staff member told us; "One person talks about taking their top off in communal areas but we are vigilant and manage the situation by distracting the person and others so not to draw any attention."

We observed staff that were highly motivated to empower people and promote people's independence. Staff used positive encouragement to engage people and involve them in daily tasks. We saw one person set the table for lunch and another person asking people what they would like to drink and assisting staff to make the drinks. We heard one person ask for a sandwich and the staff member encouraged the person to go with them to pick it. The person left holding the staff members hand and returned smiling and proudly showed us the sandwich they had chosen. Relatives told us; "[Person] helps staff to prepare drinks, fruit smoothies and fruit salad."
They work with [person] and encourage [person] to do as much as they can for themselves." "When [person] asks for something, staff say to them, why don't you come with me and do it. [Person] asked for an omelette and they just stood back and encouraged [person] to do it. They cajole [person], they do it in the right way and [person] responds. They don't push it." Staff told us; "We learn what people can do but we also gently encourage people to challenge themselves."
"We encourage people to do what they can. We are here to help or do it when people can't." "We don't do everything for people or people will lose their skills." "It's important to say; what would you like to do rather than influence."

Throughout the inspection, we saw positive engagement and outcomes for people living at the home. We spoke to the management and staff, who consistently demonstrated a commitment, high motivation and verbalised a dedication to delivering person centred care and improving people's experiences and lives.

Good

Is the service responsive?

Our findings

People's care and support was planned proactively in partnership with them and their relatives. Without exception, everyone we spoke with told us they had been involved in an assessment before moving in to the home. Relatives told us; "We were involved in an assessment with [person] before they moved. [Person] also visited Berkeley house before accepting it." "[Person] was in hospital before moving to Berkeley house and management visited [person] a few times to get to know them. [Person] also visited Berkeley house before they moved in so staff were familiar to [person]. It was good transitional support."

People received personalised care that was responsive to their individual needs and preferences. We looked at five care records. The care plans captured people and relative's contributions to the assessment process. People's personal histories were detailed. We saw what people liked and disliked, who was important to the person and how they would like to be supported on a daily basis. People had expressed a preference for which staff supported them with their personal care. Staff were able to identify who they were responsible for supporting with their personal care. We corroborated this information with the documentation and by confirming with people this occurred.

We saw people's care had been reviewed regularly. Relatives told us; "We are continually involved with reviews, care and support. I feel if I wanted a meeting for any reason, I could have one. We feel lucky like that." "I'm involved with assessments and attend reviews regularly." Healthcare professionals confirmed multi agency reviews were conducted regularly and the home requested earlier reviews if there was a notable change in a person's needs.

We saw on people's bedroom walls, people had compiled a wish list with staff of things they would like to achieve in 2016. We saw one person had listed; chocolate, cake, going to Blackpool/Southport, new clothes, bigger bed and attending rugby. We spoke to the person and saw from there care records they had already achieved some of the items listed. They also told us they had achieved all their wish list in 2015.

People had detailed what bad and good care looked like to them and some people had chosen to put these visual signs on their walls. The registered manager explained that although they had not used agency staff for over three years, it was a snap shot of what was contained within people's care files. It served as a reminder to current staff and a prompt for unfamiliar staff as to what good care looked like to each individual person. We saw one person had detailed good care as; supporting them to cook, liking their own company, and enjoying talking about their previous job, being offered choice and smoking on the ground floor. Poor care was; not knocking before entering their room, not being patient, not respecting their privacy, disturbing them when doing a crossword, staff pressuring them and not giving them clean sheets. The person told us they had no concerns about the care provided and they were only occasionally interrupted when doing the crossword. This demonstrated the management were using innovative means to highlight to people what poor care was and how they would recognise it. This would help empower people to recognise poor care and promote an open culture where poor care is challenged.

People and their relatives expressed being happy with their daily structure and involvement with their local

communities. We saw people were encouraged by staff to pursue educational, training and employment opportunities. One person told us; "I'm looking forward to going back to college tomorrow. I enjoy it. I'm doing my NVQ." The person was smiling whilst telling us this and embarked on a conversation with a member of staff about what they were doing at college. It was evident from the engagement observed between the person and the staff member that attending college had positively enriched the person's life. Staff told us engagement with college and mixing with other people outside the home had improved the person's self- esteem and they were more confident in social situations and there engagement with others.

We saw another person was waiting to attend college but required a specialist bathroom being available which management was pursuing with the college to provide. Staff had made links with the local community and people had been encouraged to be involved in voluntary work at the local coffee and charity shops. We saw people were supported to attend Zumba, drama, art and day centres daily in their local communities. We saw the management had arranged for a person who had become increasingly withdrawn to receive a visit from an organisation that was of particular relevance to them through previous employment. The person had previously undertaken work related to the forces and was visited by somebody who had served alongside them. We were told by staff that the person had spoken about the visit for days following it occurring. This showed staff and management valued people's experiences and were committed to promoting engagement and fulfilling people's lives with the things that they were interested in and enjoyed doing.

We saw people had been supported on holidays of their choosing; one person had been supported to Florida for two weeks. People had been to Wembley, local team games, the theatre, dream boys, meals and to Blackpool. We saw people engaged with relaxation, reflex and art classes. People's birthdays were celebrated and parties were arranged for other celebrations, For example; Easter, Halloween and Christmas. People spoke of paddling pool parties and summer barbecues. Following staff suggestion, the registered manager had implemented a "special person day", each person took it in turns and it would be their day every 18 days. The day entailed the person doing whatever they chose and receiving attention and time from staff like it was there birthday. The person's bedroom would be given extra attention and the person would be pampered and made to feel extra special. We were told the special person day had initially been a trial but people had responded positively so it had been implemented permanently. This demonstrated that staff actively thought about new ways to enrich people's lives and we found management promoted a culture in the home which placed a strong emphasis on people's engagement and experiences.

We saw the management were committed to supporting people to maintain and develop relationships with people that matter to them. A relative told us; "Staff managed to get [person] to come home and visit us for the day. We never thought [person] would come home again." Another relative told us; "Seeing [person] arrive at my 80th birthday party was the best surprise of my life. I could never thank staff enough."

We saw the home had received over thirty compliments from friends, relatives and healthcare professionals since our last inspection. The compliments were all dated and comments from friends and relatives included; ""Berkeley House in my opinion should be a flagship, a role model for others." "What can I say, amazing, amazing, amazing, thank you for caring and looking after my hero." "The service is outstanding. Every member of staff goes above and beyond. Berkeley House is an amazing place." "There is nothing more you could do; You are truly dedicated and caring. I cannot praise you enough. You are angels." "I am overwhelmed by the love and care you provide." "Upmost care and dignity by staff which makes my family happier." "You are an extended family to us all."

Visiting professionals had also sent compliments. These included; "What you are doing at Berkeley House is an excellent example of maintaining contact with people and empowering all parties to improve their self-

worth and well- being." "Staff are extremely welcoming and helpful. Most open and friendly place." "Communication has been exemplary."

There were effective systems in place to investigate and respond to people's complaints. The home had a complaints policy, which gave clear guidance and timescales on how to manage complaints. The registered manager told us the process they would use to investigate complaints and we found they had applied the policy when managing the three complaints received.

The issues raised were low level complaints regarding maintenance of an extractor fan, making beds and staff had raised an issue regarding people's diet. The registered manager had investigated the complaints, taken the required action and responded in writing to the complainant detailing the outcome within 24 hours of all the complaints being received. The registered manager maintained records to demonstrate the investigation and actions.

Relatives told us; I've never had to make a complaint but I have no concerns to do so if I needed too." "I've never needed to make a complaint. If I did, it would get sorted. [Person] is well cared for. It's really good." "No concerns. I'm scratching to think of anything. I've had no concerns to raise a complaint."

Good

Is the service well-led?

Our findings

There was a registered manager 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. The registered manager and team leader were available throughout the inspection.

People and their relatives spoke highly of the home and the management team. Relative comments included; "The manager is wonderful, when somebody is getting it right, they should get the praise they deserve." "I would definitely recommend this home; this is how things should be done." "I could live at Berkeley house; I'm happy with everything and would recommend this home." "Brilliant manager, they're really helpful, pleasant and approachable. Good service. All I've got to say is positive." We spoke to both the registered manager and team leader. They demonstrated a strong emphasis on people and relative involvement.

Staff described an open and transparent culture promoted by the registered manager and team leader. Staff told us they were able to raise concerns or make suggestions. Staff comments included; "I can't fault how supported we are. It's such a friendly place. Management is really good; they have an open door policy. We can talk to them anytime." "I'm happy here; We can have an influence over things. Management ask you if you are you okay, they'll help on the floor when needed." "The management are approachable. It's a good structure and I feel supported." Management will help us with anything, anything we ask for. They'll help on the floor and the door is always open to provide support." This meant that staff were empowered to make suggestions and we saw how staff had influenced change in the home through the implementation of 'special person' day.

We were told by staff that meetings were conducted monthly, at different times to enable staff the opportunity to attend. A staff member told us; "Regular meetings once a month but if we wanted a meeting earlier, I'm confident it would be accommodated. The minutes of the meeting are sent to us and we sign to say we've read them." We were told the team meetings provided the team with an opportunity to discuss people's specific needs and achievements, raise issues about the premises, put forward ideas, and consider new legislation, good practice and policy updates. The agenda was devised by the management and staff which ensured everybody had an opportunity to suggest areas for discussion. This enabled staff to share in an environment of continuous learning and influence the direction the service.

We saw meetings had been conducted consistently each month with people living at the home. Topics discussed across the meetings included; Living at the home, thought's on the daily menu choices, activities, staff support, upcoming events, visitors and any other issues. We saw people signed to say they had attended the meeting. We saw the home had recently instigated family coffee mornings. The registered manager explained it was an opportunity for relatives to informally get together, speak with people of similar experiences and determine the direction of the meeting. We saw the feedback received from the first meeting was extremely positive. A relatives told us; "it's good to get together over coffee and a cake and just

chat. We appreciate it."

We also saw that a staff recognition award was in place where two staff members were chosen each month and received a £10 voucher.

We saw surveys were sent bi-annual and the ten surveys returned in September 2015 were extremely complimentary. The surveys indicated strongly agree across all the questions asked. There were no suggestions made for improvements to the home. A survey had documented in the suggestion box; "I do not see any opening for improvement in the last two years."

The registered manager had also placed a suggestions box in the entrance to the home to capture feedback from visitors, relatives, staff or visiting health care professionals. This would be used to drive improvement of the service in conjunction with staff and relative surveys.

We looked at the homes policies and procedures. The policies had been reviewed and maintained to ensure staff and people had access to up to date information and guidance. Staff were made aware of the policies at the time of induction. We found accidents; incidents and safeguarding had been appropriately and timely reported. We saw that the registered provider ensured statutory
notifications had been completed and sent to CQC in accordance with legal requirements. The registered manager kept a file of all notifications sent to CQC. The home kept all personal records secure and in accordance with the Data Protection Act.

The registered manager had systems in place to assess and monitor the quality of the service. We saw the registered manager conducted monthly and bi-monthly audits. For example; incidents, nurse call alarms, medication was audited monthly. Whilst; Health and safety checklist, infection control, training, clinical files, kitchen, first aid and maintenance were reviewed bi-monthly. There were robust quality assurance and governance systems in place to drive continuous improvement. Where shortfalls were identified an action plan was devised specifying what action had to be taken, by whom and by when.

Learning through reflective practice was encouraged. Nurses were offered clinical supervision with the psychologist which is a formal process of professional support and learning that addresses practitioner's developmental needs. The process enables staff to learn from their experience and develop their expertise. This demonstrated a commitment to continued learning and showed the management were utilising community links to promote best practice. The home also offered student placements which would enable nursing staff to remain up to date with changes in practice.