Burlington Care Limited

Bessingby Hall

Inspection report

Bessingby
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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

Overall summary

Bessingby Hall is a care home that provides a service for up to 65 older people, some of whom may be living with dementia, as well as people with a physical disability. There is a separate unit for people who are living with dementia and require nursing care. Most people have a single room although there are three double rooms, and most rooms have en-suite facilities. The home is situated within its own grounds and accessed via a private road; there are ample car parking facilities.

We inspected this service on 29 October 2015 and the inspection was unannounced. We last visited the service on 5 June 2013 and found that the registered provider was compliant with the regulations we assessed, apart from in respect of record keeping. We carried out a follow up visit on 19 August 2013 and found that the service was compliant.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted an application for registration. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

During this inspection we found that the service was safe. People's needs were assessed and comprehensive risk assessments put in place to reduce the risk of avoidable harm.

Staff had received training on safeguarding adults from abuse and any safeguarding concerns had been identified and appropriate action had been taken.

People were supported to make decisions and their rights were protected in line with relevant legislation and guidance.

The service had an effective recruitment process and this ensured only people considered suitable to work with vulnerable people had been employed. There were numerous staff vacancies but new staff had been recruited and were due to start work at the home when their safety checks had been received. We saw that there were sufficient numbers of staff on duty on the day of the inspection.

Staff told us they were happy with the training provided for them, and we saw that there were effective induction training and refresher training programmes in place.

People's nutritional needs were met; their likes, dislikes and special diets were known by staff and were catered for. People were supported to access healthcare services. We saw that advice and guidance from healthcare professionals was incorporated into care plans to ensure that staff provided effective care and support.

People using the service were positive about the caring attitudes of staff. We observed that staff were kind, caring and attentive to people's needs and that they respected people's privacy and dignity. Staff encouraged people to make decisions and have choice and control over their daily routines.

We saw that there were systems in place to assess and record people's needs so that staff could provide personalised care and support. Care plans were updated regularly and information shared so that staff were aware of people's changing needs.

People told us they felt able to make comments, complaints or raise concerns and we could see that feedback about the service was used to make changes and improvements.

The manager was proactive in monitoring the quality of care and support provided and in driving improvements within the service. There was clear organisation and leadership with good communication between the manager and staff on both units. We observed that records were well maintained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

Good

People's needs were assessed and risk assessments put in place to reduce the risk of harm.

There was a safe recruitment process in place to ensure only people considered suitable to work with vulnerable people had been employed.

There were systems in place to safely manage and administer medication to people using the service.

Is the service effective?
The service was effective.

Good

There was an effective recruitment, induction and training process to equip staff with the skills and experience they needed to carry out their roles effectively.

People were supported to make decisions and their human rights were protected in line with relevant legislation and guidance.

People were supported to have their nutritional needs met and to have access to healthcare professionals when needed.

Is the service caring?
The service was caring.

Good

People who lived at the home told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?
The service was responsive to people's needs.

Good

Visitors were made welcome at the home.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for their care, and these were being followed by staff.

There was a complaints procedure in place and people told us they would be happy to speak to the manager if they had any concerns.

Is the service well-led?
The service was well-led.

Good

The manager was not registered with CQC but they had commenced the registration process.

Summary of findings

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Care Quality Commission

Bessingby Hall

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 29 October 2015 and was unannounced. The inspection team consisted of one Adult Social Care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses this type of service. The Expert by Experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

As part of this inspection we spoke with five people who used the service and four visitors who were relatives or friends of people living at Bessingby Hall. We also spoke with the registered provider, the manager and five members of staff. We observed interactions throughout the day between staff and people using the service; this included the serving of lunch. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People using the service told us that they felt safe living at Bessingby Hall. One person said, "Yes, you can buzz if you need attention" and another told us, "There are people to look after me at night if I need them."

We asked staff how they kept people safe and they told us, "Follow the care plans, monitor people and check on them" and "We have risk assessments in place and we explain what we are doing." Visitors also told us they felt people were safe at the home. One visitor told us, "Yes, they had falls at home but here there are staff around to look out for them – the room is safe – I have no fears for them."

We saw that there were risk assessments in place that recorded how identified risks should be managed by staff. These included individualised risk assessments for falls, the use of bed rails, care needed following a head injury and choking, plus a general risk assessment to assess the risks involved in moving and handling and recording safe systems of working. We saw that risk assessments had been updated on a regular basis to ensure that the correct information was available to staff providing care. This helped to keep people safe.

Where people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. Staff told us that they tried to diffuse situations and use distraction techniques, and that restraints were never used at the home.

The registered provider had policies and procedures in place to guide staff in safeguarding adults from abuse and the safeguarding monitoring log included details of alerts that had been submitted to the local authority. We noted that the log also included some complaints that had been received by the manager; the manager told us they investigated these in the same way they investigated safeguarding issues. The home provided training to equip staff with the skills and knowledge to appropriately identify and respond to signs of abuse; this included training for nurses, care workers and ancillary staff.

The information we received from the local authority indicated that they had received eleven alerts about safeguarding concerns during 2015. We found evidence that appropriate action had been taken by the manager on each occasion to ensure people were kept safe from harm, and that CQC had been notified of the incidents. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

The staff who we spoke with were aware of the whistle blowing policy and told us they would not hesitate to use it if needed to ensure any unsafe practices at the home were identified and dealt with.

We observed safe moving and handling practices throughout the day and saw that people were supported to mobilise independently around the home. We saw that, when needed, doors were locked with a key code system, but otherwise doors were left open for people using the service to move freely between their rooms and shared communal areas.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned. The documents we saw recorded the details of the accident, witness statements, details of the injury sustained, whether hospital treatment had been required and any action taken by the manager. This information was also recorded in the person's care plan. Body maps were used to record details of the injury and where on the body the injury had occurred; this helped staff to monitor the person's recovery. We saw that, when people had regular falls, a referral was made to the falls team to ask for advice on how to keep the person as safe as possible and protect them from the risk of further harm.

We looked at two staff recruitment files. An application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We noted that recruitment files recorded a start date for new staff and that these dates were sometimes before written references and a DBS check had been received. The manager assured us that people completed induction training and shadowing shifts whilst they were waiting for these checks to be received but did not work unsupervised. They agreed that this information would be recorded in recruitment records in future to provide more robust evidence about safe recruitment practices at the home.

Good

Is the service safe?

The date that each nurse's registration with the Nursing and Midwifery Council (NMC) was due to expire was recorded on the training matrix. This was to remind the manager that they needed to check that nurses had active registrations to practice.

The registered provider told us that people's dependency levels were used to determine staffing levels. They told us that the standard staffing levels were two nurses on duty each day and one nurse on duty each night. There were between six and eight care workers on duty each day and four care workers on duty overnight. The deputy manager and the manager were also trained nurses and one or both of them were on duty each day, Monday to Friday.

There were ancillary staff on duty in addition to care staff; this included chefs, kitchen assistants, domestic assistants, laundry assistants and a maintenance person. In addition to this, there was an activities coordinator on duty each day, Monday to Friday. This meant that care workers and nurses were able to concentrate on providing support to people who lived at the home.

We heard that call bells were responded to quickly on the day of the inspection. Feedback from people who lived at the home varied. Two people told us they never had to wait for assistance. One person said, "Staff will do anything for me. I have never waited for anything and they answer the call button - usually quickly." Two people told us that they sometimes had to wait for assistance when staff went off sick and staffing levels were reduced; however, one of these people told us this had never affected them adversely. The same applied to visitors; two visitors told us they had observed that there were sufficient numbers of staff on duty, whereas another two visitors told us that their relative or friend sometimes had to wait for assistance. One visitor told us, "I visit at random times and I have seen that between 6.00 and 7.00 pm there are occasionally no staff present." Staff told us that staffing levels had improved. One member of staff said, "Days when short staffed – odd days at weekends - but they are looking at employing staff just for the weekends" and another told us, "Rotas are always covered – we use agency staff if there are vacancies. It is really about quality rather than quantity and we usually have 'the right team on'."

The manager told us they had interviewed potential members of staff but they had turned down many of them as they did not "Fit in with the family" of Bessingby Hall. On the day of the inspection there were seven people waiting to start work at the home when their DBS clearance had been received. In the meantime the manager was using agency staff to fill staff vacancies. The long term plan was for the home to be over-staffed so that, when people were absent due to holidays or sickness, there were still sufficient numbers of staff employed to safely provide a service. We found that there were sufficient numbers of staff working at the home on the day of the inspection and that action was being taken to improve staffing levels in the long term.

People using the service told us that they always received their medication on time. We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, stored, recorded, administered and returned when not used.

We looked at medicines, medication administration records (MARs) and other records for people living at the home. We spoke with the manager and a nurse about the safe management of medicines, including creams and nutritional supplements within the home. We observed that medicines were stored safely and securely. The temperature of medicines storage areas was monitored regularly. Only nurses or senior care workers supported people living in the home to take their medicines. We found that medication records were clear, complete and accurate.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in a biodose system; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The system was colour coded to identify the time of day the tablets needed to be administered and the same colour coding was used on MAR charts; this reduced the risk of errors occurring.

We observed that medicines were administered in line with guidance on best practice, that people were given a drink of water to help them swallow their medicine and that staff ensured medication had been taken before recording this on the MAR. We saw that information was accurately recorded on the MAR and further information recorded on the back of the form to record additional information. There was a policy in place for the use of 'as and when required' (PRN) medication; this included that if the person did not require this medication for a week, staff would contact the GP to seek advice.

Good

Is the service safe?

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. Controlled drugs are medicines that require specific storage and recording arrangements. There was a note on the CD cupboard door as a reminder that two staff needed to sign both the CD book and the MAR chart when CD's had been administered. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We also saw that CD's were audited each week to ensure no recording or administration errors had been made.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment. These records showed us that agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the passenger lift, bath and mobility hoists and slings, the fire alarm system, the emergency call bell, the electrical wiring system, portable electrical items and gas systems.

Records evidenced that the fire risk assessment was reviewed in October 2015 and that weekly fire tests and periodic fire drills were carried out. Clear records were maintained of weekly checks carried out by the maintenance person on water temperatures, window opening restrictors, and fire safety. These environmental checks helped to ensure the safety of people who used the service.

We saw the registered provider's business continuity plan. The plan identified the arrangements made to access alternative accommodation and emergency telephone numbers that might be needed in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. The manager acknowledged that staff names and details of people who lived at the home and their relatives would be a useful addition to the business continuity plan so that all emergency information was held in one folder.

People who lived at the home had personal emergency evacuation plans (PEEPs) in place. These documents record the assistance a person would need to leave the premises, including any equipment that would be required and the number of people that would be needed to assist.

Good

Is the service effective?

Our findings

People who lived at the home and visitors told us that staff seemed to have the skills they needed to carry out their roles. One visitor told us, "I have lots of confidence in the staff." Staff who we spoke with confirmed that they had completed a thorough induction programme and that they were happy with on-going training that was provided for them.

We reviewed training files and saw that care workers had attended a three day induction programme; topics included health and safety, infection control, the control of substances hazardous to health (COSHH), food hygiene, safeguarding adults from abuse, dementia awareness, manual handling theory and practical, duty of care, roles and responsibilities, equality and diversity, person-centred care, communication and basic life support. Staff also told us that they shadowed experienced care workers as part of their induction training; this was before they worked unsupervised. This showed us the service had an effective induction programme to support and develop new staff.

The registered provider had identified the training that was considered to be essential for different groups of staff. Essential training for care workers was fire safety, moving and handling, infection control, safeguarding adults from abuse, safe handling of medicines, dementia awareness, first aid and health and safety. This training was considered to be essential for nurses but they also attended additional training such as Percutaneous endoscopic gastrostomy (PEG) feeding.

We reviewed individual training records and saw that these contained certificates of courses completed. We also asked staff what training they had done in the last year and they mentioned training on health and safety, use of a syringe driver, dementia awareness, food hygiene, moving and handling, end of life care and Parkinson's awareness; this showed us that staff were receiving on-going training to support them in their roles

The staff who we spoke with told us they were well supported by the supervision systems in the home. They said they had supervision with a manager and that they were able to discuss their concerns at these meetings.

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 MCA 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. We saw that the five principles of the MCA were listed on the staff notice board as a constant reminder for staff.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that documentation had been completed appropriately by the manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. The DoLS applications and authorisations we saw in care plans were accompanied by best interest documents and capacity assessments.

We saw in care records the staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. One person who we spoke with told us they acted as Power of Attorney (POA) for their relative in respect of finances, but not health and welfare. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. People told us that they were consulted about their care and that staff asked for consent before assisting them. We saw that some people had completed forms to record their consent to dental treatment, photographs being taken and flu vaccinations.

We saw that people's personal preferences, dietary requirements and support needs were documented in their care plan. Staff told us that they checked care plans to find out about people's dietary needs and that, if people were losing weight, they would make a referral to a dietician. Staff also told us that they recorded food and drink intake for people when they were at risk of malnutrition so they could monitor their daily intake.

People who lived at Bessingby Hall told us they were happy with the meals provided and that their dietary

Is the service effective?

requirements were met. One person told us, “I am a diabetic so I cannot have sweet things” and another person described a very specific dish that they liked to have for breakfast; they told us this was always provided.

A Malnutrition Universal Screening Tool (MUST) was used to identify risks around nutritional intake. Entries in the care records we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. This showed us that there was a system in place to ensure that people using the service were supported to eat and drink safely and in sufficient quantities.

The manager told us that they had moved the main meal of the day from lunchtime to tea time, following consultation with people who lived at the home and staff. This was because many people only ate a light tea as they had eaten a large lunch. The manager was concerned that this meant people had a long gap between eating their tea and their breakfast the next morning. Two people told us they liked the new arrangement. They said, “I eat so much, good choices, couldn’t do better.” However, two people told us they did not like the main meal in the evening as they did not like to go to bed on a full stomach. We noted the evening meal was at 5.00 pm so this would only be a concern for people who decided to go to bed in the early evening.

We observed the serving of lunch and saw that there were sufficient numbers of staff in dining rooms to assist people who required help with eating and drinking. There was a wipe clean menu board with the choices for lunch recorded; we noted there were no picture menus. Picture menus would help people with a cognitive impairment to choose a meal. People were offered a choice of different food and drink and people were asked if they required assistance. Staff checked that people had finished their meal before they cleared away crockery and cutlery. Staff chatted to people and this made lunchtime a pleasant experience.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home’s kitchen. Five is the highest score available.

People told us they could have access to their GP and other health care professionals when they asked. One person said, “Easy, I just phone him and I have also seen the district nurse recently” and another told us, “You can ask for a GP to come and a district nurse monitors my insulin.” Relatives told us they were kept informed of any events in respect of their relative’s well-being such as hospital appointments. Staff told us they would speak to a nurse if they were concerned about someone’s general health and they would contact the GP if they thought a visit was required. We saw evidence that individuals had input from their GP’s, district nurses, chiropodists and dieticians. There was also evidence that other health professionals such as the Speech and Language Therapy team, dietician, tissue viability nurse and respiratory nurse had been contacted appropriately. All individual health needs, visits or meetings were recorded in the person’s care plan with the outcome for the person and any action taken as required.

Staff told us that communication at the home was good and that they had ‘handover’ meetings each time a new group of staff started their shift. They discussed medication, diet, personal care and general well-being for each person who lived at the home. We discussed with the manager how it would be useful for staff to look back over previous day’s handover sheets if they had been absent from work and the manager told us they would introduce this.

We saw that there was appropriate signage in the dementia unit to support people using the service to identify toilets, bathrooms, dining rooms and to find their way around the home. In the dementia unit, people’s bedrooms had either a photograph or name on the door to help them identify which was their room. The manager told us that this was ‘work in progress’ and that they were working towards having pictures on bedroom doors that might be more appropriate than names or photographs. We discussed that it might be useful for some additional signage to be provided in the residential unit to help people to find their way around the premises.

Good

Is the service caring?

Our findings

We asked people if they felt staff cared about them and everyone responded positively. One person told us, “Yes, they put their arms around and cuddle me.” Visitors agreed with this view. Comments included, “They seem to adore (name)”, “It is the one thing I have noticed. They attend to people straight away” and “They are marvellous staff – I have watched them with other residents as well and they are very considerate. Staff genuinely care – they go the extra mile.” A staff member told us, “Yes, we have got a really good staff – even domestics are great.” On the day of the inspection we observed that staff were caring and kind.

We observed that staff interaction with each other and with people who used the service was respectful. One member of staff told us, “We encourage them to do things for themselves – one person came out of hospital saying they couldn’t walk any more, but we have encouraged them to walk again.” We observed that care being delivered was not restrictive and people were supported to maintain their independence. For example, we saw people leave the home to take part in activities in the community and that people chose to sit in a quiet area of the home to spend some time alone.

We noted that care plans contained information about people’s wishes and views and we observed staff supporting and encouraging people to make decisions and have choice and control over their support. Comments from staff included, “We talk and explain things to them (people who live at the home) and their family”, “We give them choices – let them speak. Give them choice about whether they want to stay in bed” and “We get people involved as much as possible – give them choice.”

We asked people if staff shared information with them appropriately and took time to explain things to them. Most people responded positively; one person said, “They talk to me throughout the day, always somebody about” although one person said that staff did not have enough time to talk to them apart from when they were helping them to get dressed in a morning. The relatives we spoke with were happy with the level of communication between staff at the home and themselves. We saw that there was a newsletter produced that kept people informed about events at the home.

We saw that there was information displayed on the notice board about the role of an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who supports a person so that their views are heard and their rights are upheld. IMCA’s are independent: they are not connected to the carers or services that are involved in supporting the person. There was no information available to people who lived at the home about other advocacy services and the manager told us they would ensure this information was made available to people.

People we spoke with felt their privacy and dignity were respected, and this was supported by visitors who we spoke with. Staff explained to us how they respected privacy and dignity. One care worker said, “We ask if they want to stay in their room when using the toilet. We knock on doors – we get permission before we do anything” and another told us, “Be discreet, and we ask and get permission. Always keep people covered when doing personal care.”

Good

Is the service responsive?

Our findings

All of the people we spoke with told us they thought their care was centred on them. Assessments were undertaken to identify people's support needs and comprehensive care plans were developed outlining how these needs were to be met. The manager told us that they were accompanied by a member of staff when they carried out initial care needs assessments and only offered the person a place at Bessingby Hall if they "Fitted in with the family." He told us it was important for the needs of people who were already living at Bessingby Hall were taken into consideration when admitting new people.

The care plans we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes in a 'This is Me' document. Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. Records evidenced that the information had been gathered from the person themselves, their family and from health care and social care professionals involved in the person's care where possible.

People told us that they had been involved in developing their care plan and one person told us that their care plan was updated when their needs changed. People had signed their care plans to show they agreed to the contents when they were able to do so. Staff told us they got to know people's individual needs by talking to them and their families as well as looking in their care plans.

Care plans were reviewed on a monthly basis and any changes to care were implemented straight away. For example, a medication care plan had been updated as the GP had recently visited to change that person's medication. We saw that another person with recent weight loss had been referred to their GP who prescribed high calorie drinks and a high protein diet and extra snacks. This person's care plan had been updated to reflect this and to support staff to provide responsive care to meet these changing needs.

We saw that visitors were made welcome and that people were supported and encouraged to maintain contact with their family and friends. On the day of the inspection one person was visited by their extended family, including the family dog. A room was made available for them and staff brought them tea and cake. This showed that staff tried to make the family feel welcome and it was clear the family were enjoying spending time together. We saw that drinks were available in the reception area for people who lived at or visited the home.

People told us they were supported to keep in touch with family and friends. Staff told us people could use the homes telephone if they did not have one of their own, and that staff would make telephone calls on behalf of people or help them to write letters if this is what people requested. People who lived at the home also had access to Skype so that they could contact their family and friends via the Internet.

We saw that the home was decorated ready for Halloween celebrations and that people were taking part in activities on the day of the inspection; four people in the dementia unit were sitting at a table with a member of staff doing one activity, and the activities coordinator was in another lounge encouraging people to take part in a different activity. One person told us, "We have ball games and I love the Church visits here on a Wednesday – that is my favourite." Visitors told us that their relatives took part in activities although one person said their relative would like to have more. There was an activities board to inform people about the activities that would take place each day.

The activities coordinator told us that they provided a variety of activities, including quizzes, reading poetry and exercise, and that they also spent one to one time with people who did not wish to join in group activities. Care staff described a variety of activities that took place, including entertainers that visited the home and trips out to local gardens.

The registered provider told us in the PIR document that they planned to have a garden area for people to use. The stated, "The garden will not be sensory or staged, but will be a working garden incorporating a greenhouse for growing vegetables, raised beds for planting herbs, a bird aviary and chickens. It is hoped that, even for short periods, people will be able to contribute to the garden." This showed that the registered provider and manager were continually thinking of ways to provide meaningful activities for people who lived at the home.

One social care professional told us about a person who had stayed at the home for a short period of time. They

Good

Is the service responsive?

spoke highly of the individual care package that was provided for this person and this included them being accompanied by staff whenever they asked to go into the local community. The social care professional told us, "They thrived in the environment." Staff kept in regular contact with the social care professional who felt there had been a joint process in place to improve this person's quality of life. They said, "I don't think the home could have done anything better." However, another social care professional gave us negative feedback about a placement they were involved in; this had been prior to the current manager being appointed and the person no longer lived at the home.

Staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and ability to make decisions. Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift and by reading the care plans. We saw the sheet that staff used to record information discussed at handover meetings. This evidenced that every person who lived at the home was discussed to that staff had up to date information about everyone's care needs. Where someone had been unwell during the night, this was handed over to the day shift to monitor and vice versa. Information was passed from nurse to nurse, and the nurse passed the information to the team of staff on duty that day. This system ensured that carer workers had up-to-date information enabling them to provide responsive care as people's needs changed.

There was information displayed within the home about the home's complaints procedure; this explained what people should do if they were unhappy with any aspect of their care.

The people who lived at the home who we spoke with told us they would not hesitate to speak to the manager if they had any concerns or a complaint, but they had never needed to. Visitors told us that they would not hesitate to complain. One person told us, "I'd see the manager – would feel comfortable to do so but have never had to" and another said, "I would see (name of manager). I once complained about the radiator in (my relatives) room as it couldn't be adjusted and it was sorted immediately."

We checked the home's complaints log and saw that there had been six complaints received since January 2015. The records included the details of the complaint, the investigation carried out and the outcome, plus any action needed to make improvements to the service.

People told us they attended 'resident' meetings and that this kept them informed about events at the home, and that they were happy to share their views with the staff and the manager. One person told us, "Yes, I do go to residents meetings and we tell them" and another said, "Yes, I go to every residents meeting. We keep asking for a shower to be fitted and we want a tuck shop." The registered provider told us they were aware that some people preferred a shower and that one would be commissioned by the end of 2015. This showed that people's opinions had been listened to and acted on.

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Our findings

The registered provider is required to have a registered manager as a condition of registration. There was a manager in post on the day of this inspection and they had applied to CQC for registration; this meant the registered provider was meeting the conditions of registration. The manager was supported by a deputy manager.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

Staff spoke positively about the culture of the service. Comments included, "There have been a lot of changes for the better recently", "Management is brilliant" and "The manager asks residents and their views are listened to." The staff notice board in the home recorded the home's values; these were listed as compassionate, approachable, respectful and enabling. We asked visitors about the culture of the home and we received positive responses. One person told us, "I would definitely recommend it. The location is delightful, staff are very good and efficient, and (the manager) is excellent."

We observed that there was a calm atmosphere within the service and care and support was provided throughout the day in a professional but relaxed manner. We observed that the manager was a visible presence within the home and was positive, proactive and focused on the needs of the people using the service and on delivering a high standard of care and support. The manager was knowledgeable about the needs of people who were living with dementia and told us they were promoting "Re-mentia" within the service. This is a Stirling University model of dementia care and is based on "Helping people to be all that they can."

We observed that there was a good level of organisation at all levels within the service; staff we spoke with knew what they were doing and what was expected of them. We saw that there were clear lines of communication between the manager, the deputy manager and staff. The manager knew what going on within the service at an organisational level and about the specific needs of people using the service.

There was a quality assurance folder in use that included a meeting planner; this showed the frequency that meetings would be held for people who lived at the home and for different groups of staff (nurses, care staff and ancillary staff). Visitors who we spoke with were aware of relatives meetings and some people told us they had attended them. One person told us, "Yes, I have attended. One relative mentioned pot holes in the drive and this was sorted out" and "The chef was present and he said he would work around dad's diet and offer more variety."

Staff told us they attended meetings and that these meetings were a 'two way process'. They were given information but were also able to ask questions and make suggestions. The minutes of the 'resident' meeting in October 2015 recorded that relatives had also attended the meeting, and that a change to mealtimes had been discussed, as well as staffing levels and shift patterns. We also checked the minutes of the governance meeting held in June 2015. These evidenced that discussions had been held about recent complaints and incidents at the home, and any lessons learnt.

The quality assurance folder also included an in-house audit schedule. This included the dates that a variety of audits had been or would be carried out, including health and safety, recruitment and selection, complaints, staff training, medication, infection control, care plans, dignity, daily charts, meals / nutrition, food safety and safeguarding adults from abuse. The audit schedule also recorded the frequency of audits, either monthly, two monthly or three monthly. The aim of the quality monitoring system was to identify any patterns or areas requiring improvement, and we concluded that the home had an effective system for monitoring the quality of care and support provided, and for driving improvements within the service. A mystery shopper had been used to enquire about a placement at the home; they gave positive feedback about their experience, with a score of 91.67%

The outcome of the staff survey was displayed on the staff notice board. We saw that there was very detailed analysis of the responses, but no action plan. The manager told us that they believed the responses were no longer relevant to the staff who worked at Bessingby Hall, as the survey had

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been carried out when morale was low. They intended to carry out a new survey to measure the current opinions of the staff group so that they could compare the responses. The manager told us that they had introduced 12 hour shifts but not all staff were happy about this; they said that shift patterns were now therefore more flexible. This showed that staff opinion was listened to.

We asked if there were any incentives for staff. We were told that staff received an increase in pay when they achieved a NVQ award and that the home operated an Employee of the Month system. Staff were nominated by their colleagues and by people who lived at the home, and the chosen member of staff received a voucher for £20, and got a mention in the home's newsletter. The registered provider told us that they encouraged staff to gain qualifications and to view care work as a career.

We saw numerous thank you cards on the staff notice board and noted that the manager had responded to these. When a particular member of staff had been mentioned, the manager had ensured the thanks were passed on to them.

The registered provider told us that they had appointed a staff advocate. It was intended that this person would be able to support staff with any problems they had, and that this would result in a more positive working environment for staff. This evidenced that the registered provider was proactive in making improvements to the experience for staff who worked at the home.