Bupa Care Homes Limited

Bereweeke Court Care Home

Inspection report

Bereweeke Road
Winchester
Hampshire
SO22 6AN

Tel: 01962878999

Date of inspection visit:
27 March 2017

Date of publication:
11 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Bereweeke Court Care Home is a nursing home registered to provide accommodation for up to 50 people, including people living with a cognitive impairment. At the time of the inspection 38 people were being accommodated. The home is based on four levels, but the top level was closed at the time of inspection as it was being refurbished.

The inspection was conducted on 27 March 2017 and was unannounced. There was a registered manager in place. 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.

We received mixed views from people about staffing levels and some told us they sometimes had to wait for staff to support them. At mealtimes, we saw staff struggled to support everyone who needed help to eat at the same time; however, at other times, we found staff responded promptly to requests for assistance. Following the inspection, the registered manager wrote to us detailing alternative arrangements they had made to help ensure there were enough staff available at mealtimes.

People felt safe and felt able to raise concerns. Staff understood their safeguarding responsibilities and knew how to prevent, identify and report abuse. People were protected from individual risks in a way that supported their independence and environmental risks were managed effectively.

People were supported to take their medicines safely. Suitable arrangements were in place for ordering, storing, administering and disposing of medicines, including topical creams.

The process used to recruit staff was safe and helped ensure only suitable staff were employed. Plans were in place to deal with foreseeable emergencies. Fire safety equipment and procedures were tested regularly and staff were trained to administer first aid.

Staff underwent a comprehensive induction and training programme. They were knowledgeable and skilled at meeting people's needs. They were suitably supported in their role through the use of supervision and appraisal processes.

Staff acted in the best interests of people and followed legislation designed to protect people's rights. They also involved people or their relatives, where appropriate, in discussing and planning the care and support they received.

People were offered a choice of meals and their dietary needs were met. They were encouraged to drink often. People were supported to access other healthcare services.

People were offered a choice of meals and their dietary needs were met. They received appropriate support to eat, when needed, and were encouraged to drink often.

People were supported to access other healthcare services and staff worked well with external professionals. Staff had the necessary skills to help ensure people received appropriate end of life care in a dignified way.

Staff cared for people with kindness and compassion, respected people's privacy and treated them in a dignified way. They interacted positively with people to build meaningful relationships and supported people with their spiritual needs.

Staff were committed to meeting people's needs in a personalised way according to their individual needs. Care plans contained comprehensive information to enable staff to support people in a consistent way and care plans were reviewed regularly.

People were encouraged to make as many choices as possible. They received mental and physical stimulation through a range of suitable activities in a group setting or on a one-to-one basis.

The provider sought and acted on feedback from people. There was a suitable complaints procedure in place and people were confident any concerns would be addressed.

People and their families felt the service was run well. They had confidence in the management, as did the staff. There was a clear management structure in place. Staff understood their roles and worked well as a team.

There was a robust quality assurance system in place that focused on continual improvement. A wide range of audits was conducted, together with effective oversight and support by the provider.

There was an open and transparent culture at the home. Visitors were welcomed at any time, CQC were notified of significant events and positive links had been developed with the community to the benefit of people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We received mixed views from people about the staffing levels. We found there were not enough staff deployed at mealtimes to ensure people received appropriate support to eat. However, at other times, we saw staff responded promptly to requests for support. Following the inspection, the registered manager wrote to us detailing how they had addressed the issue. More time is now needed to ensure these changes are effective.

People felt safe at the home; they trusted staff and staff knew how to identify, prevent and report safeguarding concerns. Appropriate recruitment procedures were followed and helped ensure only suitable staff were employed.

Potential risks to people were assessed and managed effectively in a way that respected people's independence. Medicines were managed safely and administered by staff who had been suitably trained.

There were plans in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and on-going training to enable them to meet the needs of people using the service. Staff were supported appropriately in their role and encouraged to continually develop their skills.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People's dietary needs were met. They had access to health professionals and other specialists if they needed them.

The environment was being developed and re-decorated to make it more supportive for older people living with dementia.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion.

Staff protected people's privacy and dignity at all times.

People and relevant family members were involved in planning the care and support they received.

Staff had the necessary skills to help ensure people received appropriate end of life care in a dignified way.

Is the service responsive?

Good

The service was responsive.

Staff were committed to delivering personalised care that met people's individual needs. Care plans contained detailed information to support staff to deliver care in a consistent way. Care plans were reviewed regularly in conjunction with the person.

People were supported to have as much choice and control of their lives as possible. Staff responded promptly when people's needs changed.

The provider sought and acted on feedback from people to help improve the service.

Is the service well-led?

Good

The service was well-led.

People and staff praised the management of the service. Staff understood their roles and worked well as a team.

There was a suitable quality assurance process that focused on continual improvement. These included audits of key aspects of the service.

There was an open and transparent culture. CQC were notified of all significant events. Positive links had been developed with the community to the benefit of people.

Bereweeke Court Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on 27 March 2017. It was conducted by an inspector, an inspection manager, a specialist advisor with a background in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with eight people who used the service and five relatives. We spoke with the provider's Director of Quality, the registered manager, four nurses, five health care assistants, the chef, a housekeeper and an activity coordinator. We looked at care records for six people. We also reviewed information about how the service was managed, including staff records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

This was the first inspection of the home since the provider re-registered as a new legal entity in January

2017.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Bereweeke Court and that it provided a secure environment. When asked if they felt safe, one person said, "Yes, very much so." A family member told us, "I'm confident [my relative] is not going to come to harm here." Another said the home provided a "good, safe environment" for their relative.

However, we received mixed views from people about the staffing levels. For example, one person told us, "I think they could do with more staff", and two people said they did not always receive prompt support from staff because they were "busy". One person said they often had to ask several times before non-urgent tasks were completed. They said, "At times you can see a staff member and ask for something to be done and it is, straight away; other times you need to ask several times for a staff member to do something for you." Family members, though, all felt there were enough staff to meet their relative's needs.

At mealtimes, we found staff struggled to provide appropriate support for people to eat. At lunchtime, everyone was served their meal at around the same time. A high proportion of people needed support to eat and all available staff members, including kitchen staff and the registered manager, helped with this. However, some people but did not receive support on a one-to-one basis. In one dining room, a staff member was seen supporting two people to eat at the same time until a supervisor advised them to stop. One person's meal was then put away in a food warmer to keep it hot, while the staff member focused on supporting the second person.

In the second dining room, two other people were being supported to eat by another staff member who had to alternate between supporting one person and then the other. Halfway through the meal a second staff member took over from the first, so neither person received consistent support to eat. During the evening meal, we saw a further staff member supporting two people to eat in adjacent rooms; they were going alternately from one room to the other helping each person to eat in turn. This meant neither received appropriate support to eat in a dignified way.

Staff had mixed views about the adequacy of staffing. While some felt additional care staff were needed, others felt the staffing levels were adequate. All agreed that when there was a "floater" on duty, there were enough staff to meet people's needs at all times. A floater is a health care assistant who is free to support people wherever and whenever it is needed. A nurse told us, "Many clients need a lot of assistance with breakfast, so it means sometimes we are not starting patient care until 10:00am."

We discussed staff availability at mealtimes with the registered manager. They acknowledged that it was not appropriate for a staff member to support more than one person at a time. Following the inspection, they wrote to us detailing alternative arrangements they had made to help ensure there were enough staff available to support people appropriately at mealtimes. More time is now required to ensure that these alternative arrangements are fully implemented and regularly reviewed to ensure sufficient staff are always deployed at mealtimes.

With the exception of mealtimes, during the inspection we found there were enough staff to meet people's needs in a timely way; staff were not rushed and responded promptly and compassionately to people's requests for support. The registered manager told us staffing levels were based on people's needs; where additional staff were needed, for example to provide one-to-one support to a person who was particularly unwell, they had the flexibility to do this. Staff absence was covered by existing staff working additional hours or by using a small pool of agency staff to cover shifts; the agency staff had all worked at the home previously, so were familiar with operating procedures and understood people's needs

The registered manager monitored call bell response times on a daily basis. Their aim was to answer all call bells within four minutes and records confirmed this had been achieved in all but a handful of instances each week. People had been given call bells to summon staff assistance. These were plastic boxes with several highly coloured buttons. Some people living with dementia did not know what the boxes were for and none understood what the different coloured buttons did. However, for those people who were not able to operate their call bell, staff carried out regular checks to enhance their safety. Observations recorded by staff confirmed these checks were taking place frequently.

Appropriate recruitment processes were followed and staff were checked for their suitability before being employed by the service. Staff records included an application form, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Where a staff member had a previous conviction, we saw a thorough assessment had been conducted by the provider's Employment Compliance Advisor to consider whether they posed a risk to people and, if so, how it could be managed. Checks were also conducted to confirm that the person was entitled to work in the UK. In addition, the registered manager checked that nurses were registered with their professional body and had a system in place to help ensure their registration was renewed before it expired. Staff confirmed these processes were followed before they started working at the home.

Staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety and were aware of people who were at risk of abuse. When people came to harm, the registered manager conducted thorough investigations. For example, one person had broken a bone in their arm. A detailed enquiry was conducted to identify the cause and the local safeguarding authority were kept informed throughout. A relative of another person told us, "[My relative] had a bruise and [the registered manager] looked into it. It was all recorded, with photographs as well, and there was a perfectly reasonable explanation."

All of the staff, including those not in a care role, had received safeguarding training. They knew how to raise concerns and were confident that managers would take appropriate action. A staff member told us, "If I had any concerns, I'd report them to the nurse and escalate them to the manager or further if needed. There's a clear protocol to follow." The contact number for the local safeguarding authority was prominently displayed in the nurses' station to make it easy for staff to access.

People were protected from individual risks in a way that supported them and respected their independence. For example, one person was at risk of harm from alcohol, but had agreed with staff a daily alcohol limit that would accommodate their preference whilst keeping them safe. Staff were clear about how much the person could safely drink and records confirmed they received exactly this amount each day. Staff took a proportionate approach to safety to help ensure that the least restrictive option was considered. For example, one person had a "crash mat" by their bed in case they fell out of it and this gave them the freedom to get out of bed safely when they wished to. However, for another person, this was not adequate, so bed rails had been put in place to keep them safe and the risks associated with these had been assessed.

Senior staff had assessed and recorded the risks associated with providing care to each person, along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, the risk of people developing pressure injuries had been assessed using a nationally recognised scale. Where this indicated people were at high risk, appropriate measures had been taken, including providing them with pressure-relieving cushions and mattresses. The mattresses had to be set to the individual weight of each person and there was a clear process in place to check the mattresses remained at the right setting at all times.

The home experienced a low level of falls (less than one per month on average), but when any fall occurred, the registered manager reviewed the person's risk assessment to identify any additional safety measures that could be taken. The provider's Director of Quality told us how they analysed the incidence of falls in the provider's other homes, but said this was not needed at Bereweeke Court as so few falls occurred. However, they were clear about the action they would take if any patterns were identified.

Senior staff had also identified and assessed risks relating to the environment and the running of the home. They had taken action to minimise the likelihood of harm; for example, cleaning trolleys contained locked boxes where cleaning products were kept securely to prevent people accessing them when the trolleys were in use around the home.

People were supported to receive their medicines safely. There were appropriate arrangements in place for obtaining, storing, administering and disposing of medicines. A family member told us, "[My relative] seems to get all her medicines and her eye drops in the evenings." Staff were suitably trained to administer medicines and had their competence assessed every six months by one of the managers. Medication administration records (MAR) confirmed that people received their medicines as prescribed. A random check of a sample of medicines showed the number in stock tallied with the number shown on the medication administration records (MARs).

Comprehensive information was available to guide staff when administering 'as required' medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way. There was also an effective process in place to help ensure topical creams were not used beyond their 'use by' date. Refrigerators were available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturers' instructions and the temperature of these was checked daily.

When necessary, an appropriate procedure was followed for the covert administration of medicines. This is when essential medicines are hidden in small amounts of food or drink and given to people. The procedures protected people's legal rights and ensured that all relevant people, including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines in this way. Staff followed best practice guidance by offering medicines to people in an open way first and only reverting to covert administration if the person declined to take them.

There were plans in place to deal with foreseeable emergencies. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place for day staff and night staff. Fire safety equipment was maintained and tested regularly. Personal emergency evacuation plans were in place to help identify the support each person would need if they had to be evacuated in an emergency. These were colour coded to make it easier for staff to identify people who would need more assistance in an emergency situation.

Good

Is the service effective?

Our findings

People's needs were met by staff who were skilled and suitably trained. A family member said of the staff, "They are very conscientious and seem to know what they are doing." Another praised the "good care" their relative was receiving.

All staff completed the provider's 'mandatory training', which included safeguarding, moving and handling, infection control, dementia and fire safety. Further training, specific to their role, was also available to each staff member. This included regular training in dementia by a specialist from a national charity who worked with staff and provided practical feedback, together with training by a speech and language therapist. A staff member said of the training, "We have proper training here [not just eLearning] and all mine is up to date; also the nurses give us guidance when we need it."

Staff were also supported to obtain relevant vocational qualifications; most had obtained level two or level three qualifications, whilst senior staff had obtained, or were working towards, management qualifications. Trained nurses told us they were supported to complete additional training and personal development to meet the requirements of their registration. This included in-depth training in end of life care to meet best practice guidance and training in the use of syringe drivers. A syringe driver is a pump used to continuously administer medicines to people to keep them comfortable and pain free; they are often used in end of life care when the person is no longer able to take medicines orally.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This included completion of a training programme that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Following this, they spent a period of time working alongside a more experienced member of staff while their competence was assessed.

Staff demonstrated an understanding of the training they had received and how to apply it. For example they were able to describe how they repositioned people who were cared for in bed, were aware of reporting procedures for safeguarding and were clear about how they supported people living with dementia. While supporting a person to drink, a staff member asked the person with advanced dementia, "Would you like some coffee? That's a drink." This helped the person understand what was being offered and to make an informed choice, which they did.

People were cared for by staff who were appropriately supported in their role. Individual meetings were held between staff and their line managers on a regular basis. These meetings were used to discuss progress in their work, training and development opportunities, and other matters relating to the provision of care to people. Staff told us that these meetings were useful and supportive. One staff member said, "I feel listed to." Another told us, "[The registered manager] is a real source of support; they've been a massive help."

Annual appraisals were carried out to assess staff performance and to consider further personal or professional development. We were told, and observed, that the registered manager had an open door

policy. Staff spoke highly of the registered manager and described a supportive atmosphere where members of the management team could always be approached for advice and guidance.

People received the personal and nursing care they required. A family member told us, "I have been extremely happy with the care [my relative] has received here, especially over the last few days." Another family member told us they were happy with the way their relative's personal care needs were met as their loved one always looked "well-groomed" and received "regular baths". Staff recorded the personal care they provided to people, including if people had declined care, such as a shower or bath.

One person was receiving end of life care and a clear plan was in place to support the person in their last few days. Anticipatory medicines were in stock and ready for use if needed; the person was receiving regular mouth care as they had stopped eating and drinking; and they were being turned regularly to keep them comfortable.

Another person had a catheter, which is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters are prone to blockages and infections if good fluid throughput is not maintained. Staff were clear about how and when the person's intake and output was monitored and there was a clear plan in place to support this. Staff were also clear about the support they provided to people with diabetes; where necessary, they administered insulin or medicines and monitored people's blood sugar levels to check they remained within a safe range. There were appropriate plans in place to help ensure people received effective diabetes care.

There were also wound management plans in place where needed. These specified the care people required with their dressings and the frequency of changes. Where necessary, staff could seek advice from a tissue viability nurse specialist, although the registered manager told us they had not had to do this recently as it was rare for people at the home to experience skin breakdown.

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Following a comprehensive assessment that followed the principles of the MCA, some people had been assessed as lacking the capacity to make specific decisions. During the care planning process, senior staff had, therefore, made decisions on their behalf and documented why the decisions were in the person's best interests. These included decisions relating to the care and support people received, the use of bed rails and the administration of their medicines. Family members had also been consulted and their views had been taken into account. One person did not have any family members to act for them, so the registered manager had arranged for an Independent Mental Capacity Advocate (IMCA) to support the person with decision making, including whether or not to be vaccinated against the flu.

Where people had capacity to make decisions, this was recorded in their care files, which most people had signed to show their agreement with the care and support that was being delivered.
One person had full capacity, but had asked for a family member to be involved in all decisions about their care. The person confirmed that staff respected this and liaised closely with the family member whenever needed.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS authorisation had been granted for those people who needed them and there was a clear system in place to help ensure renewal applications were made before the authorisations expired.

Most people praised the quality of the food. One person said, "The food is very nice and well cooked." Another person told us the food was "of a very good standard". A family member told us, "[My relative] needs a pureed diet and it's always presented well and looks like a meal. It looks nice and she gets extra pudding if she hasn't eaten well."

People's dietary needs were met. Menus were set by the provider, to help ensure people received a varied and balanced diet, but kitchen staff told us they had the flexibility to change these to meet people's individual needs and preferences. People were supported to choose their meals through the use of photographs but were also able to ask for alternatives if they did not want anything on the set menu. Kitchen staff kept records of people's individual dietary needs to help ensure they received suitable meals in an appropriate format; these included pureed, low sugar and low fat options. They also kept details of people's food preferences, which allowed staff to tempt people with food they enjoyed, particularly if they were not eating well. All meals, including those that had been pureed, were pleasantly presented. A variety of drinks, including hot drinks, fruit squashes and water, was available throughout the day and staff prompted people to drink often.

Care staff monitored the amount people ate and drank through the use of food and fluid charts. These showed most people were supported to eat and drink enough each day. Staff took action if people started to lose unplanned weight. This included fortifying the person's food with extra calories, providing additional snacks and referring them to their GP for advice. One person, who had full capacity, declined to see the GP, so staff had had conversations with them over a number of weeks to try and identify appropriate ways that the person could be supported to eat a suitable diet. The registered manager told us, "We have to report weight loss to [the provider] as part of our [quality assurance process]. By identifying it early, we've usually addressed it by the end of the [reporting] period."

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. These included doctors, palliative care specialist nurses, chiropodists, opticians and dentists. One person told us they were supported to see a doctor "within 24 hours", unless there was an urgent medical need, in which case it was arranged immediately. The home was also working with staff from the Clinical Commissioning Group (CCG) on a project to reduce unnecessary admissions to hospital. As part of this, they had developed advances care plans with people specifying their preferred place of treatment.

The home's environment was being developed to make it more suitable to the needs of older people and those living with dementia. A programme of re-decoration was in progress, together with the purchase of new furniture for people's bedrooms. Handrails were provided in all corridors and in most were painted in a contrasting colour to make them easier for people to spot and use. Age-appropriate pictures were hung at an appropriate height to make them easy for older people to view.

Good

Is the service caring?

Our findings

People told us staff were caring and had developed positive relationships with them. One person said, "Of course I would rather be at home, but they [staff] are all very kind." A family member said of the staff, "They have been very kind to [my relative] and myself." Another family member told us, "[My relative] gets on well with staff. She has a good rapport with one of the nurses in particular; they get on together and talk about [a mutual interest]. The nurse even got her a book about [the subject] and showed it to her."

We observed positive interactions between people and staff. When a staff member passed by one of the lounges, they looked in, waved at the people sat there, smiled warmly and complimented one person on their mode of dress. The person smiled, responded positively and returned the compliment. Staff used people's preferred names and approached them in a friendly and relaxed manner. When supporting people to take their medicines, they did so in a safe, gentle and respectful way. They also explained the medicines they were giving in a way the person could understand. They used touch, appropriately, to calm and reassure people when they became anxious or upset. Staff told us they had taken part in a "talent show" the week before the inspection. Each staff member performed "a turn" which people enjoyed watching. We were told that as well as providing a source of entertainment, it also provided a topic of conversation and amusement between people and staff which had further helped build relationships.

Staff also supported family members of people living at the home. For example, one family member told us they were provided with meals which allowed them to spend more time with their loved one. A specialist from a national charity had also been invited to a relatives' meeting to help family members gain a better understanding of dementia and the way their loved ones presented as a result. The registered manager told us family members had found this very helpful and reassuring.

Staff spoke fondly of the people they cared for and talked of the "privilege" they felt being entrusted with the care of a loved one. The registered manager told us, "[Relatives] give you a lot of trust [looking after their loved ones] and we respect that. I ask staff to think how they would feel if they were taken out of their homes and put to live with strangers. It can be heart-breaking, so we have to make it feel like home and help [people] to lead a comfortable life." People's birthdays were celebrated in the home and they received a birthday cake. Other special events were also marked; for example we saw flowers had been provided for Mothers' Day, together with arrangements to involve family members on the day.

People were treated with dignity and respect at all times. Staff were reminded of the need for this by posters about the principles of 'dignity in care'. Reviews posted by people on a national care website consistently rated the area headed 'Treated with dignity?' highly.

People confirmed their privacy was maintained during personal care. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking the person was ready and willing to receive the proposed care and support.

Confidential information, such as care records, was usually kept securely, either in a locked office on the ground floor or a locked filing cabinet on an upper floor. On the day of our inspection, the key to the cabinet had been misplaced, so the cabinet was not locked; however, following the inspection we were assured that the key had been found and the cabinet was secure. Any information which was kept on the home's computer was also secure and password protected.

People and, when appropriate, people's families were involved in discussions about their care and treatment. Family members confirmed they were always kept up to date with any changes to the health of their relatives. A family member described how they had been involved in discussions with staff and their relative's GP to determine the best place for their relative to receive care and support. The registered manager told us they had also involved people in decisions about the design and colour schemes of areas being re-decorated and said people had chosen the colour of new chairs that had been supplied.

When people arrived at the home, a staff member was assigned to have a 'welcome conversation' with the person to gain information about the person's life, including their family, past occupation and interests. This Information was included in their care plans and used to enable staff to get to know the person and provide topics of conversation.

People were supported to meet their spiritual and religious needs. Representatives of two local churches visited the home each week and the registered manager was aware of how to contact other religious leaders if required. A staff member told us, "People get a lot of comfort from the [church visits]. One person has low moments and the [visits] have helped her mood. She has really picked up and now goes to [a local] church most weeks."

At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death. Nursing staff had attended training to enable them to better manager symptoms people may have at the end of their lives. The registered manager was aware of who they could contact for additional support if required. Nurses were aware of how to obtain and administer symptom management medicines should these be required. Where necessary medicines to manage symptoms were held within the home so they would be immediately available should the need arise. Information about people's preferences for their end of life care was included within care files. For example, one person had specified a wish to remain at Bereweeke Court; when they experienced an unexpected seizure, a decision was made (in conjunction with their GP) not to transfer the person to hospital as this would have been against their wishes.

Good

Is the service responsive?

Our findings

People consistently told us staff were "supportive" of their needs. They said they received highly personalised care from staff who understood their care and support needs.

Assessments of people's care needs were completed by one of the managers before people moved to the home. This information was then used to develop appropriate care plans in conjunction with the person. People's care plans were well organised and provided comprehensive information to enable staff to deliver care and support in a personalised way. They were centred on the needs of each person and took account of their medical history, their skills and abilities, their preferred lifestyle, daily routines and how the person wished to receive care and treatment. For example, one person had epilepsy; their care plan included information about the signs and symptoms they presented when experiencing a seizure, the action staff should take at each stage and the person's preference to remain at Bereweeke Court for post-seizure monitoring. For another person, who became anxious when receiving personal care, there was clear guidance in their care plan to advise staff how to respond and reassure the person.

All staff we spoke with showed a shared commitment to putting people at the heart of the service and meeting people's needs in a personalised way in accordance with their preferences and wishes. They demonstrated a good understanding of people's needs and how each person liked to receive care and support. For example, they were able to describe the support people required to meet their personal care needs, their nutritional needs and how they should be supported to move and reposition. Records of care delivered confirmed that people received the care, support and treatment identified in their care plan.

A process was in place to ensure care plans were reviewed within 72 hours of the person moving to the home and every month thereafter, or when people's needs changed. The person and, where appropriate their relative, was consulted during the process. Care records confirmed that people had been cared for in accordance with their individual needs. For example, charts kept in people's rooms showed they had been checked hourly, supported to reposition regularly and received personal care and mouth care when needed.

Nursing and care staff responded appropriately when people's health needs changed. Care plans contained clear information for staff as to the action they should take in various situations. For example, one person had a diagnosis of diabetes; their care plan detailed the specific action staff should take if monitoring of blood sugar levels showed these to be higher or lower than was safe for the person.

Nursing staff were kept up to date about people's needs through a handover meeting at the start of each shift. Nursing and care staff also had access to a typed 'handover sheet' which provided relevant and individual information to help ensure changes in people's needs were identified, recorded and met.

People told us they were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. This helped promote their independence. A staff member said, "Every day at 10:00am, we start seeing residents and build conversations about the day and what they would like to do. We change things

according to mood and their wishes on the day. It's a nice way to start the day; we get a lot of feedback as they are awake and switched on at that time."
Throughout the inspection, we heard staff offering people choices by giving simple options. For example, after supporting a person to use the bathroom, the staff member asked the person, "Do you want to go back to your room or stay in the lounge."

People were provided with appropriate mental and physical stimulation through a range of varied activities. Bereweeke Court employed three activities co-ordinators who were responsible for organising activities, both in groups and individually. People who remained in their bedrooms, by choice or through care needs, were given the opportunity to receive one to one activities of their choice. Care plans included information about people's previous hobbies, interests and life histories meaning staff could incorporate these into activities and in conversation when talking to people. In addition, some family members had provided 'reminiscence books' containing photographs and information about the person's life which helped staff to prompt the person's memories.

People were able to choose which activities they took part in and suggest other activities they would like to undertake. These included arts and crafts, singing, exercise classes, flower arranging and film afternoons. The activities co-coordinator told us, "One person used to make models, so we built a model together. It provoked some fantastic details [from the person] about their life and their past, talking about colours and people." People were also supported to take part in activities outside the home. These included regular trips to the library, to local shops, garden centres, cafes and other local attractions. In addition, external entertainers attended weekly to perform people's favourite songs from the past in a variety of styles.

The provider sought feedback from people, relatives, staff and external professionals including through the use of questionnaire surveys. People said they felt listened to and responses showed a high level of satisfaction with the service. We saw a summary of the findings was displayed on the home's notice board, together with the service's response. Comment made were used to change or improve the service. For example, some people had indicated a wish to see a wider range of activities and these had been provided. Some menus had also been changed as a result of feedback; for example, bananas and custard had replaced treacle tart, as people had found treacle tart too hard to eat.

People knew how to complain or make comments about the service and the complaints procedure was displayed in the entrance hall. Relatives and people told us they had not had reason to complain, but would contact a staff member if needed. A family member told us, "If I needed to complain, I would talk to [the registered manager] first as she is approachable." The registered manager told us, "If we have a problem, we always try to resolve it straight away; we don't leave it overnight as it just gets bigger."

Good

Is the service well-led?

Our findings

People told us the service was well-led. A family member told us, "The [registered manager] checks in every now and then and asks how we are. She runs a tight ship; I've heard her telling nurses what to do." These comments were echoed by other family members who told us they had confidence in the management of the home.

There was a clear management structure in place, comprising the registered manager and members of the provider's management team. The deputy manager had recently left the service, but interviews for a replacement were planned for the day after our inspection. Nurses were responsible for running each shift and deployed staff effectively to help ensure people were supported appropriately throughout the home.

Staff were organised, understood their roles and worked well as a team. They told us they enjoyed working at the home and spoke positively about the support they received from management on a day to day basis. They described the registered manager as "visible", "approachable" and "on the ball". Other comments from staff included: "The [registered manager] is very supportive; we work well as a team"; "I like working for [the registered manager], she runs a tight ship. If you [work hard], you are alright; but if not, then you're down the road [let go]"; "[The registered manager] is very good, I like her. She is easy to talk to, but tells us if [anything] is not right"; and "Everyone is helpful and hard-working; it's a nice company to work for". We observed positive interactions between the registered manager, staff, people and relatives; they appeared comfortable discussing a wide range of issues in an open and informal way.

Staff felt managers listened and acted on their comments. For example, a housekeeper told us they had made a suggestion to improve the cleanliness of people's beds. They said, "I asked [the registered manager] if I could ask the nurses to delay making beds so I could clean them daily. She agreed this was a good idea and spoke to the nurses and now this is what we do." A health care assistant confirmed the benefits of this initiative; they said, "Cleaning is really good now; the beds are all stripped and cleaned properly every day."

A programme of staff and management meetings was also in place to aid the flow of information and provide opportunities for staff to give their views of the service and make suggestions for improvement. This included a 'ten at ten' meeting which we attended on the day of the inspection. People's individual needs were discussed, together with wider issues, such as the arrangements for repairing a hoist that had broken and a reminder about a trial of new paperwork. The meeting was effective and time managed.

The registered manager told us they were "proud of the home and the staff". They said their vision was to create a "friendly, family orientated place." They added, "I stress [to staff] that we are there for the residents. I strongly believe we have to continually work towards better service." Staff expressed a shared commitment to this vision and a desire to create a "family atmosphere" in which people felt comfortable and relaxed.

The registered manager said the standard of care delivery was helped by a low level of turnover of trained nurses; they told us that even an agency nurse on nights had worked at the home for three years. This meant people received care and treatment from a consistent team of registered nurses who understood their

needs well. The registered manager added, "Good support and sharing experiences has helped us to keep staff. We spend a lot of hours investing in them with training; they also do reflective accounts to think about what they can do better."

The registered manager told us they had access to appropriate advice and support from the provider. The managers of each of the provider's homes in the region met regularly to share good practice, discuss ideas and learn from one another. In addition, the registered manager attended a 'learning forum' operated by the provider and received weekly updates about current issues in the adult social care sector.

A robust quality assurance system was in place that focused on continuous improvement. This operated at different levels and included oversight of the service by the provider's senior management team and the registered manager. Each had a part to play in assessing and monitoring the quality and safety of the service and driving improvement. This included monthly visits by the provider's Director of Quality to assess and monitor specific aspects of the service.

A systematic programme of audits was conducted throughout the year, focusing on key aspects of the service, such as care planning, medicines, health and safety and infection control. Where changes were needed, specific action plans were developed and implemented. For example the "first impressions" audit had identified the need for re-decoration of some areas of the home and this was in progress; and the infection control audit had identified repairs that were needed to the sluice room that we saw had been completed. The registered manager, who was a registered nurse, told us they also completed a "clinical walk of the floor" every day and chaired a "clinical risk meeting" every week. These were used to help ensure people's nursing needs were being met in an effective way. Nurses also conducted daily checks of the medicine stock and of people's daily records. To support a culture of continuous improvement, the registered manager had created a 'home improvement plan' which they shared with us. This confirmed that action was taken promptly when improvements were identified.

There was an open and transparent culture at the home. Visitors were made welcome at any time and could stay as long as they wished. The registered manager told us families were important to them and were involved as much as possible in the running of the home. This included helping to organise events, such as the summer fair.

There was a duty of candour policy in place which required staff to act in an open way when people came to harm and the registered manager provided an example of when this was used appropriately. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the safeguarding authority or CQC if they felt it was necessary.

Positive links had been developed with external organisations and these had benefitted people directly. These included visits by children from a church group, a girl guide group and volunteers from a local college who spent time interacting with people. The registered manager told us, "Residents get a lot of stimulation when they see kids around, their faces light up; it brings normal life to us." Other links included a volunteer who supported people with gardening and a choir group from another local college. The activity coordinator told us, "The choir come in every Wednesday in April and May for a choir session; then they buddy-up with the residents and share experiences. The residents love it."