The Orders Of St. John Care Trust

OSJCT Bartlett House

Inspection report

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27 April 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Order of St John Care Trust, Bartlett House is registered to provide personal care for up to 49 people. On the day of the inspection there were 31 people living at the service. The registered manager informed us they recently chose to reduce the number of rooms to 36. We were told this was to make sure there were sufficient staff numbers in relation to the needs of people using the service. The service provides care for people with dementia, learning disabilities, autistic spectrum disorder and older people.

Bartlett House consists of two floors with access to the upper floor by a lift or stairs. There are some shared bathrooms, other shower facilities and toilets. Communal areas include a lounge, other smaller seating areas, a dining room and an outside garden with patio.

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A registered manager was employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 26th and 27th April 2016 and was unannounced.

People told us they felt safe when receiving care. Some relatives said they felt at times there were not enough staff but they did not feel that people's safety was compromised by this as agency staff were deployed. The registered manager was in the process of recruiting a number of new staff. Safe recruitment practices were followed before new staff members started working at the home. Checks were made to ensure staff were of good character and suitable for the role. During the inspection there were enough competent staff on duty who had the right mix of skills and experience to ensure they could safely meet the needs of people using the service. People who use the service and their relatives were positive about the care they received and said staff had sufficient knowledge to provide support and keep them safe.

Staff received regular training in relation to their role and the people they supported. Staff received regular supervisions and an appraisal where they could discuss personal development plans. This meant staff received the appropriate support to enable them to provide care to people who used the service.

Medicines were managed safely and administered by trained staff.

People and their relatives told us they had access to health services and there was a weekly visit from their GP.

The registered manager and staff we spoke with were passionate about providing care which was tailored to people's needs and choices. Throughout our visit we saw most people were treated in a kind and caring way and staff were friendly, polite and respectful when providing care and support to people.

Staff understood the needs of the people they were providing care for. Some care plans were individualised and contained information on people's preferred routines, likes, dislikes and medical histories. However, other care plans were not person centred or specific to people's needs. Individual risk assessments were in place and staff we spoke with knew what to do if they were concerned about the safety and well-being of any of the people using the service.

The registered manager and staff acted in accordance with the requirements of the Mental Capacity Act 2005. Where people did not have the capacity to make decisions themselves, mental capacity assessments were in place and records showed that decisions been made in line with the person's best interests. Where required, Deprivation of Liberty Safeguarding applications had been submitted to the appropriate authority by the registered manager.

People had access to a range of foods and drinks, with their preferences being noted and shared with kitchen staff. Where required, specialist diets were available such as soft or fortified food. People and their relatives spoke positively about the food choices explaining alternatives were always available should they not want what was on the menu.

We saw staff assisting people with their meals although this was not always done according to people's needs.
Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit, we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours.

People who live at the home and staff were encouraged to be involved in regular meetings to share their views and concerns about the quality of the service. The registered manager also sought the views of relatives and professionals. The provider and registered manager had systems in place to monitor and improve the standard of care provided. The registered manager worked with external services and organisations to share best practice and support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures.

People were supported by staff who understood how to provide and meet their individual care needs safely.

People received their medicines in a safe way.

Is the service effective?

Good

The service was effective.

Staff received training, supervision and appraisal which enabled them to effectively support and care for people.

People were supported to maintain good health and to access healthcare services.

People who needed support with making decisions were assessed to ensure their best interests were protected in a lawful way.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and the support they received. This was supported by what we observed.

Most staff were caring in their approach and had a good understanding of people's needs and how best to support them.

Staff understood how to respect people's privacy and dignity, protect their human rights and provide care that met their needs.

Is the service responsive?

Good

The service was responsive.

People were treated as individuals. Staff knew people's preferences and how to deliver care to ensure their needs were met.

Care plans provided descriptions of people's care needs and guidance for staff to meet those needs although care plans were not always person centred or specific to people's needs.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously.

Is the service well-led?

Good

The service was well led.

Systems were in place to review incidents and monitor performance to help identify any trends or lessons to be learned.

People benefited from a management team that regularly monitored the quality of care and sought to continuously improve.

Staff told us they understood the values of the provider. This included keeping people safe, promoting their independence and ensuring people received care which met their needs.

OSJCT Bartlett House

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 carried out by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At our last inspection in March 2014 we did not identify any concerns.

Before we visited we looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required by law to send to us, to inform us about incidents that have happened at the service, such as an accident or a serious injury. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit, we spoke with six people who use the service, three relatives, the registered manager and ten support workers. We spent time observing the way staff supported and interacted with people throughout the day. As part of our observations 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 lived at the home.

We also reviewed a range of records which included people's care plans and risk assessments, staff training records, staff duty rosters, staff personnel files, policies and procedures, complaint files and quality monitoring reports.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and they did not have anything to be concerned about. Comments included "They are very good here. All the staff make me feel safe and "I feel safe and very looked after". Relatives also confirmed they had no concerns about the safety of their loved one.

Policies were in place and up to date in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken.

Staff we spoke with could explain what keeping people safe meant. We saw from staff records that they had received training in safeguarding adults from abuse and whistleblowing. Staff knew the different types of abuse and said they were confident the registered manager and senior staff would act on their concerns. Staff were aware they could take concerns to agencies outside the service if they felt they were not being dealt with.

People were protected from the risks of potential abuse or harm. There were a range of individual assessments which identified potential risks for people. We saw this information was documented for each person and included how to manage the risks including the risk of falling, malnutrition, pressure ulceration and the safe moving and handling of people. One member of staff told us how they had assessed someone who was at risk of falls and what had been put in place to help prevent this.

Sufficient staff were available to support people and call bells were answered promptly. During the inspection, an emergency call bell was pressed and we saw staff responded to this immediately.
People told us they were able to access help whenever they needed it. One person told us "I have one (a call bell) in my room. I've used it and they come very quickly".

Although a few of the staff had been in employment at the service for a number of years, due to the location of the home where people are sometimes only temporarily based in the area, there was a higher than average turnover of staff. The registered manager told us they had been advertising and recruiting more staff but with limited success.

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people. The registered manager told us all new applicants were subject to a formal recruitment process. They were given a tour of the building and their interaction with people was assessed before they attended a formal interview. We reviewed four staff personnel files and saw appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People's medicines were managed so that they received them safely and as prescribed.

All staff who administered medicines received training and undertook refresher training and regular supervision. There were processes in place to ensure that staff were competent in administering medicines prior to doing this unsupervised. One person said "they give me my medication that's why I feel safe".

We observed part of a medicines round. We saw staff supported people to take their medicines; they explained what they were taking and sought consent before they administered them.
There were good processes in place to ensure the safe administration of medicines. We saw pictures that identified what people's prescribed medicines looked like and also details on how to handle the medicine safely. People were clearly identified on the medication administration record with details of their name, date of birth, GP and any allergies. Medicines were correctly signed for and we saw they were only signed for when the medicine had been taken. Medicines trolleys were kept secure and locked when not in use and medicines were stored in conditions as appropriate to the labelling. We did not see people self-administer their medicines but staff told us they gave people the choice to self-administer and explained how they would support people to do this. There was a record in the medicines file for each person which detailed individual choices such as whether they would like to self-medicate and how they would like to take their medicines. Staff were aware of what to look out for when new medicines were given. We saw in the medicine file for one person who had been prescribed antibiotics, what side effects to look out for and instructions to observe this person in relation to these and the condition they were being treated for.

There were clear policies in place for the management of medicines. We saw documentation on how medicines were ordered and disposed of. Systems were in place which included procedures to enable stock rotation and prevent the use of expired medicines. There were records for the storage temperature of drugs and this was monitored and recorded on a daily basis. Staff knew what to do in the event that storage temperatures went too high or low. A register which detailed the storage of specific drugs was seen. Of the medicines we saw recorded in this register, these tallied with what was in storage.

There were systems in place to reduce the risk and spread of infection. The service had a comprehensive policy in place to promote food infection control. There were processes in place to maintain standards of cleanliness and hygiene in the home. For example, there were cleaning schedules which all housekeeping staff completed each day to ensure all areas of the home were appropriately cleaned. On the days of our inspection the home was free from odours and appeared visibly clean with evidence of ongoing cleaning during our visit. We looked at the records of infection control audits undertaken by senior staff. These detailed what was checked, any actions arising and when these were completed. Staff we spoke with were clear about their responsibility with regard to infection control and the procedures they needed to follow for transporting laundry and the wearing of protective clothing. We observed that personal protective equipment (PPE) such as gloves and aprons were available for staff usage.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to carry out their roles and responsibilities effectively. New staff had an induction period which included core training and a period of shadowing a more experienced staff member. One staff member told us about their induction. They had ongoing support and shadowed staff prior to working under supervision prior to being assessed to work independently. They told us about the mandatory training which they completed and also read care plans and spoke with people to get to know what support they needed.

Mandatory training as set by the provider was completed by staff to ensure they had the appropriate skills and knowledge to provide the individual support and care people needed. They were also able to describe training they had completed and what this had involved. Training included safeguarding vulnerable adults, infection control, safe moving of people, the Mental Capacity Act 2005 and condition specific training such as dementia awareness. Staff training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when it was due to be refreshed. Staff told us that training needs were also highlighted during supervisions which they received every three to six months. We saw there were systems in place to identify when supervisions were due.

People had been assessed in terms of their risk of malnutrition. Where required people had access to specialised diets for example pureed or fortified food. Where required, care staff monitored people's weight and their food and fluid intake. This was to ensure people had enough to eat and drink and to put into place preventative measures if there were concerns about a person's weight.

People told us they were happy with the food in the home. Comments included "I think the food is good here and the choice", "The food is very good and if you don't like something, they will get you something else. I get a good choice of food" and "I like cakes but I eat anything that's on my plate. We can make cake mix and the cook bakes them for me". People were provided with a selection of hot and cold drinks and snacks throughout both days of our inspection. We noted people, whether in their rooms or in the communal areas always had drinks within easy reach. During our observations we saw staff confirmed people's choice of meal. This was done by using examples of the menu choice plated up as a visual prompt. People were able to choose alternatives to what was on the menu. For example, we saw one person who did not want the options available chose to have soup instead. Staff offered assistance to those people who required support to eat their meal. However, in one person's care plan we saw they required one to one support to eat their meal due to a risk of choking. During the lunchtime meal we observed this person was supported by staff to eat their main meal. They were then left unattended to eat their dessert and at one point there were no staff present in the dining room. We raised this with the registered manager who agreed to address this immediately with staff.
The cook talked to us about any special dietary needs people had and how these were catered for. This included food prepared for people who required their food to be in a softened form due to identified risks of poor swallowing and choking. They had information of all people's dietary requirements and allergies. This also included people's likes and dislikes. The kitchen was clean and tidy and had appropriate colour coded

resources to ensure that food was prepared in line with food handling guidance.
People's care records showed relevant health and social care professionals were involved in their care. People we spoke with said they have access to healthcare services which included the dentist, optician and chiropodist. Care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. Relatives told us they were always kept up to date with their family member's health needs. One person we spoke with told us when they had been unwell; staff had contacted the doctor and had kept their relative informed.

During the handover of the morning staff shift, we listened to a discussion about a person's management of pain and how they were planning to seek advice by contacting the GP. The staff also spoke about the respiratory care for another person and how they were planning to speak with the practice nurse to discuss the most beneficial method for administering medication to help them with their breathing.
We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care was sought in line with legislation and guidance. We saw people had been involved in the discussion in their care and in developing their care plans and had signed these to confirm this. Mental capacity assessments had been completed and where people had been assessed as not having capacity, best interest decision meetings had taken place. However, information on who had been involved in these best interest meetings had not been documented by the registered manager. We discussed this with the registered manager who was able to explain the process they had undertaken for one person and who had been involved in the meeting. They acted immediately to include this information in the relevant care plans.
During the inspection, the registered manager told us where needed they had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority. More urgent DoLS had been authorised, whilst others were awaiting a response. Where DoLS applications were in place we discussed with the registered manager about regularly reviewing these to ensure what was in place remained the least restrictive option.
The registered manager and staff had knowledge of the Mental Capacity Act 2005. Training in this subject had been undertaken by staff. During our inspection we observed staff supporting people to make decisions about their daily living and care. For example, people were asked if they wished to join in activities and if they declined this decision was respected. Staff sought consent from the person before undertaking any care tasks.

As part of our inspection, we observed a staff handover meeting. We listened to two discussions around people's best interests in relation to keeping them safe. These discussions demonstrated that staff understood and considered people's best interests in line with the act.

Good

Is the service caring?

Our findings

People and their relatives we spoke with were positive about staff; they told us staff were caring and kind. One person said about staff, "If I get upset, the staff give me a cuddle". Other comments included "They (staff) are very good towards me. They are very patient" and "If I'm sitting on my own, they always come and see me even if they have a lot of work on". Most staff supported people in a caring and thoughtful way. We saw two staff members assisting a person to transfer from chair to wheelchair. They offered reassurance whilst assisting them to stand with the aid of a walking frame and reassured them that the wheelchair was behind them as they sat down. When one person was crying out in pain a staff member was very responsive and sympathetic, got down to the person's level to comfort them and asked if they wanted any medication to relieve the pain.

However, we observed some interactions which were not as caring. A staff member was observed being abrupt with one person by giving them a command rather than politely encouraging them whilst assisting them to walk. Another person had been sitting at the dining table for one and a half hours after breakfast until about an hour before lunch. After they had eaten their lunch they remained in the same place for the next one and a half hours. During that time, there was some evidence of staff interaction but this was brief. As staff passed through the dining area they did not ask this person whether they would like to sit elsewhere.

We saw caring conversations between staff and people and their relatives. In the main lounge people were seated round the edge of the room which made it difficult for them to talk with other people across the room. The television was on however, some chairs were positioned so that people could not see it.

Whilst in the main people were offered choice. We observed on the first day of our inspection that one staff member only offered people tea even though there were a variety of drinks on the trolley. When we asked the staff member why they were not offering people choice they said it was because "I know what people like". This did not afford people the opportunity to request a different drink to their usual choice. However on the second day of our inspection we observed another staff member who informed people of the different drinks available on the trolley to aide their choice. People we spoke with said they were given choices. One person told us "I go to bed when I want to and I get up when I want to and am never rushed". Daily records in people's care plans showed that people were given choices. For example one care plan read "X declined assistance with going to bed and said she was not tired and would wait for night staff" and "X chose to have a lie in this morning".

We saw staff promoted people's privacy and dignity. People told us that staff knock on their door and tell them who they are before entering. Care and support was conducted behind closed doors. We saw a member of staff help someone in the dining room with their clothing to protect their dignity and they spoke to the person in a friendly and kind manner.

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment, such as walking frames, to maintain their independence. Staff ensured

people had the equipment when they needed it and encouraged people to use it. One member of staff told us how they support a person who is unable to verbally communicate by writing things down or using hand gestures. Staff told us how they give people choices and encourage independence. They knew what care and support people needed. Staff were knowledgeable about people's personal histories and interests. Care plans included people's life histories, including information on their childhood, family life, employment, holidays, pets, favourite flowers, music, television and films they liked and what hobbies they enjoyed., One staff member told us about a person who had been an active part of the community for many years and how they chatted about this. Another staff member told us "It is a friendly home and everyone knows what people want, their likes and dislikes".

People told us their relatives were able to visit whenever they wanted. Relatives told us staff were friendly and welcoming when they visited. One relative said "I can come here any time I like".

We saw that people's rooms were personalised and people had a choice of different communal rooms to spend time in.

The home was committed to providing end of life care that met people's needs. We saw in people's care plans that preferences of who the person wanted to be informed should they require end of life care, where they would like to be cared for and preferences for their funeral arrangements and resting place had been recorded. The registered manager told us there were facilities at the home for loved ones to stay and how they would support them. The registered manager explained any end of life care plan would be completed in conjunction with relevant health professionals as required including local hospices, GPs and district nurses.

Good

Is the service responsive?

Our findings

People received care and support which was responsive to their needs. People's needs had been assessed prior to them moving into Bartlett House. They had an up to date plan for their care and support. In the main, care plans were clear and were easy to read and detailed people's individual needs and preferences. However, some care plans were not person centred or specific to people's needs. For example, where guidance had been written to help people with a particular task, it had said only to encourage them to do something but didn't detail how this could be done. When we spoke with staff, they knew how to give the care required, and when we raised this with the registered manager, we were informed that this was something they were already aware of and had begun to address. Therefore, some care plans had this information but others had not yet been updated to reflect this. The information in the care plans was reviewed periodically throughout the year or as changes occurred. This ensured people had plans in place which reflected how they would like to receive their care and support.

Individual risk assessments were in place and staff we spoke with knew what to do if they were concerned about the safety and well-being of any of the people using the service. For example, we saw where a pressure mat had been put in place in one person's room to alert staff when they were mobilising as they had been identified as being at risk of falls.

We saw staff updated people's records of care throughout the day, recording for example, what food and fluids people had received and where people's positions had been changed to reduce the risk of pressure ulceration. Daily records also included what actions staff had undertaken to support people who had become distressed or anxious. This supported staff to monitor people's emotional well-being and identify if there were any changes to the care and support required.

Information about people was shared effectively between staff. We observed a shift handover meeting. During the meeting we observed that important updates were given to staff regarding people's day to day care including any medical concerns. We heard information being shared about a person who was experiencing an increase in pain. They talked about how this should be managed and how to monitor this further as well as confirming the GP involvement.

Staff had good links with other services and health care professionals. People told us they had access to services such as dentist, opticians and chiropodists. Where there were concerns or requests from people to access services, these were followed up. For example, we heard in the staff handover meeting about someone with diabetes who needed specialist foot care and how this was being managed by liaising with a podiatrist.

The home had two activity co-ordinators who organised activities throughout the week. During our visit, we observed people with staff in the lounge engaged in activities. On the first day of our inspection, four people were going to a 1940's style tea dance which had been arranged with other homes in the area. The activities coordinator was also supporting people to make hats for the upcoming celebration of the Queen's birthday. The activities coordinator supported people to choose the accessories they wanted to stick on their hat so it was their own individual design. Some people were independently knitting, reading or colouring in.

Although we saw activities in the home that day, on occasions we saw people were sat for long periods of time without having support or being acknowledged by staff. We saw a group of four people sat at a dining table for two hours before being asked whether they would like to move to a different area. During this time, they were not engaged in conversation, did not have anything to stimulate them and staff did not ask them

what they would like to do. When we asked staff about this, they told us they had previously offered to support them to move to a different area where the television was, but they had declined. On day two, we saw people were being asked what they would like to do and offered a choice of activities. A board game took place at a table in the dining room during a coffee morning. We saw from the interactions; the conversation and laughter that people enjoyed this. We were told these coffee mornings took place every Wednesday and the community were also invited to these. We spoke with the activities coordinator who told us they liaised with other homes in the area to share ideas for activities that people have enjoyed and arrange activities for groups and on an individual basis. We were also told about seasonal and topical activities that had taken place in the home. These included activities for the Grand National, Easter and Halloween and the forthcoming plans to celebrate the Queen's birthday where they would have a tea party, music group and invite the community to get involved. There were flyers around the home which included pictures of events to support some people's understanding and choices. The service worked hard to help engage people with the community. School children from the local school wrote to people who use the service and these children were invited for coffee. The local vicar visited weekly and provided a service for those who wanted to be involved. People also planted seeds in the garden and in the autumn a flower festival took place where people could arrange the flowers they had grown. Other activities included inviting a music group and visits from therapy dogs. Daily newspapers including audio newspapers, books, jigsaws and board games were also available.
People told us about activities they were involved in. Comments included "We have painting and making hats and we have two activities people here and they are very good" and "I've made things like hats and boats in a bottle and I paint with numbers and I do puzzles". One relative we spoke with told us "There are quite a few activities going on and it's always his choice if he wants to join in. They asked us what he liked doing before he moved here".
The service organised regular meetings for people and their relatives to discuss the running of the service. For example, we saw minutes which included discussion on minor issues and what activities had been and planned during a recent relatives meeting and a residents meeting which had been held in March 2016. Feedback on meetings was provided by means of a newsletter which was distributed individually to everybody living in the service.

There was a procedure in place which outlined how the provider would respond to complaints. There were notice boards around the home which displayed information for people on how to make a complaint. People told us they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the registered manager or a member of staff. We looked at the complaints file during the inspection. The last complaint had been received in March 2014. Although the complaints policy stated they should be investigated and resolved within 28 days, there was no outcome letter on file for this. However, no further complaints had been received since then and a lot of compliments had been received. Comments from people and their relatives included "I think they (staff) always listen to me", "Yes we know how to make a complaint. We once had a low level complaint and it was resolved by the manager" and "I've never needed to complain but if I did, I would take it to the one that's in charge."

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by the head of care. The registered manager was available throughout the inspection. There were many positive comments about the registered manager and staff team. Comments from people and their relatives included "Yes, I've met the manager, and she and all the staff are very good", "I like living here and the staff are very good and I would not change anything", "The staff listen to me and they talk to me about my views", "I can see and talk to her (manager) most of the time" and "She (the manager) is always available and I think it's very well run here, and I think all the staff are good".
People, their relatives and staff were encouraged to give their views about the service they received. Comments and suggestions cards were available in the front entrance of the home.
All the staff we spoke with said they had regular one to one time with the management team. They said this was helpful in their development and they had the opportunity for further vocational qualifications.

The service monitored the quality of care provided. The registered manager regularly reviewed and analysed accidents, incidents or near miss reporting forms to identify any trends or patterns and to look at how they could prevent reoccurrence. We saw documentation of quality assurance systems and audits. These included safe management of medicines, infection control and health and safety. We saw internal quality assurance visits and where issues had been identified an action plan was put into place to rectify these. For example, during an audit in January 2016 it had been identified that the number of falls had risen over the last month therefore, a falls analysis to include the times and places these were occurring was implemented. During an audit the following month in February, a trend was identified where most falls were occurring between 8am and 11am. In response to this, staff break times had been reviewed and changed to reduce the number of falls. Policies we reviewed offered guidance to staff on how to reduce the risk of falls. We saw records for accidents and incidents that had occurred which included details of any actions taken.
The registered manager told us that they networked with external services and organisations. For example, the registered manager networked with other homes in the area to look at making improvements and ensure best practice. They also had contacts with advocacy services. There were regular staff meetings, which were used to give the opportunity for staff feedback, share best practice and keep staff up to date.
The service had links with the local church, schools, supermarket and bank. The registered manager said she would like to continue to encourage the community to join in their activities to help people feel a part of their community. The registered manager said she felt privileged to work with the people they cared for and said she felt what they did particularly well was the transition for people leaving their home to the service, as she expressed "home from home".