The Orders Of St. John Care Trust

OSJCT Grevill House

Inspection report

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Date of inspection visit:
10 February 2020
11 February 2020

Date of publication:
18 March 2020

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

About the service
OSJCT Grevill House is a residential care home which has a residential reablement and rehabilitation service on the same site called Ashley Intermediate Care Centre. The care home is registered to accommodate 65 people in two separate buildings on the same site. At the time of the inspection the main care home was supporting 43 people. Ashley Intermediate Care Centre provides a service to 15 people and was full at the time of the inspection. Both services predominantly provide care and support to people aged 65 years and over.

People's experience of using this service and what we found
People told us they felt safe. People were protected from potential abuse and discrimination. People told us they received their medicines as prescribed and were given the support they needed to take their medicines. Medicines were managed safely and were available for people when they needed them. Risks to people were assessed and action taken to reduce these. The home was clean, and measures were in place to reduce the spread of potential infection.

There were enough staff with the right skills and experience to meet people's needs. Staff were recruited safely, and a successful staff recruitment campaign had already brought more stability to the staffing team by reducing the usage of agency staff.

People told us they received the support they needed. Staff received the training and support they needed to be able to meet people's diverse needs. People could access specialist and community based healthcare professionals as required.

People told us they had a choice in what they ate and drank and that they enjoyed mealtimes. People's specific nutritional and dietary needs were managed well. Specialised equipment, including some environmental adaptions were seen in both services to support people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice. The principles of the Mental Capacity Act were followed, protecting those who lacked the capacity to make independent decisions.

People told us staff were caring, helpful and respectful towards them. People's dignity and privacy was upheld. People were treated equally and as individuals. Staff knew people well; their likes and dislikes as well as their preferences when it came to their care. People were involved in planning their care, and their relatives and representatives were included in this process when appropriate.

Those who mattered to people, relatives, friends, representatives and people's pets were made welcome when they visited. People were supported to regain independence and to live as independently as possible.

Care plans recorded people's needs and gave staff guidance on how to meet these. This included information about people's end of life wishes. Care records were reviewed regularly and kept up to date so staff and visiting professionals had access to relevant information about people's needs, care and treatment.

People enjoyed the social activities provided. People's involvement in these was encouraged and supported by staff who recognised the importance of meaningful activities in people's lives. Staff did everything they could to reduce risks associated with loneliness and self-isolation.

There were arrangements in place for people and visitors to raise a complaint. Managers worked hard to remain visible and approachable so that 'niggles' or concerns could be discussed and resolved early on.

The registered manager and senior staff provided strong and supportive leadership. Staff told us communication had improved under the present registered manager and they told us they felt valued. Feedback was sought from people, their representatives and staff and used to improve the overall service. There were arrangements in place to monitor the quality of the services provided and to make improvements where needed. Staff worked collaboratively with individuals and groups from the wider community to improve people's quality of life.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 14 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

OSJCT Grevill House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector 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. In this case caring for older and vulnerable people.

Service and service type
OSJCT Grevill House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.

What we did before the inspection
We reviewed all the information we held about the service since the last inspection. This included the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed all information sent to us by the provider, about events which have taken place, and which had involved people who used the service.

During the inspection
We spoke with 13 people who used the service and six relatives to gain their views on the care and support

provided. We also spoke with 11 members of staff which included three care assistants, head of care, unit lead [Ashley Unit], an NHS Occupational Therapy Assistant [based in the Ashley Unit], clinical lead [main home], head chef, one activities co-ordinator, the registered manager and two representatives of the provider.

We also reviewed a range of records. These included five people's care records and a selection of medicine administration records. We reviewed three staff recruitment files and records relating to staff training and support. We reviewed a variety of records relating to the management of the service, including the management of falls and associated risks, admission procedures and records, use of and recording of homely remedies, quality monitoring audits and the services continuous improvement plan. We also reviewed a selection of records used for tracking various processes and referrals made by the service. We requested and were forwarded the service's fire risk assessment and medicines policy.

After the inspection
We continued to seek clarification from the provider about fire safety arrangements which we received. We sought the view of the local authority who commissioned services from OSJCT Grevill House and the Ashley Intermediate Centre.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person said, "I feel safe. I don't have to worry about anything." The provider's policy and procedures for safeguarding people were in line with the local authority's guidance. Staff worked in collaboration with other professionals and agencies to safeguard people from abuse. This included the local authority, police and the Care Quality Commission (CQC).
- Staff had been trained to recognise potential abuse and knew how to report any concerns. Senior staff acted on reported concerns and shared appropriate information with the relevant agencies.
- Daily heads of department meetings took place where any such concern was discussed and from which all staff across the service were made aware of the action required to protect people.

Assessing risk, safety monitoring and management

- People's health and safety risks, including those associated with the environment were assessed. Action was taken to reduce risks or remove them altogether. One person said, "Before I came here I fell out of bed and was on the floor for five hours. I [now] have bedsides to stop me falling." All current and potential risks were reviewed at the daily heads of departments meeting. All staff were subsequently updated so that a collective approach was taken to reducing risks. When necessary, risk management actions were altered in response to people's changing needs. One person told us they had fallen, they said, "Now I have commode [by their bed] at night."
- The provider's safety alert system kept managers informed about more widely reported risks and the action required in response to these. Information on equipment failure, near misses and community infections were included in these alerts.
- Managers reviewed information from accident and incident reports to identify possible trends and patterns. This helped them determine if changes to practice, process and policy were needed. This process was also applied when reviewing numbers and types of infections, hospital admissions and pressure ulcer development.

Staffing and recruitment

- People told us that at busy times of the day, mealtimes for example, they may have to wait a little while for staff to attend to them, but that generally, staff were available when they needed them.
- Managers reviewed people's needs and their associated risks when planning staff rosters. This was to ensure there were enough staff on duty to support people. Since the registered manager had been in post the staffing levels had increased. Staff also now worked across both sites, so each service could remain adequately staffed and responsive to people's needs.
- The provider's recruitment procedures were followed which helped managers make safer recruitment decisions. Checks, including police checks, a check against the list of people barred to work with vulnerable

people and on past employment, all took place before staff started work. Work and character references were also requested.

Using medicines safely

● People's medicines were managed safely, and they received the help they required to take their medicines as prescribed and when required. One person told us how their medicines were delivered and stored; the latter being in line with expected requirements. They told us their relative helped them with their medicines when at home and when in the care home, the staff did this. They said, "They [the staff] know what they are doing."

● Appropriate guidance was in place for staff for when medicines, prescribed for occasional use ['when required'], needed to be administered; relief of pain or distress and anxiety.

● Medicine administration records were checked after each medicine administration round to ensure these were correctly completed. Regular checking of these records had helped to reduce recording errors.

Preventing and controlling infection

● People told us the home was kept clean. One person said, "The home is cleaned, they come every day and the lounge is done before we come in." The head housekeeper ensured the cleaning schedules were followed. The washing of soiled and non-soiled items was managed safely. The head chef ensured the kitchen was cleaned and good food hygiene practice was followed.

● Care staff wore protective aprons and gloves to prevent cross contamination when delivering personal care and supporting people with their food. Staffs' hand washing practice was monitored.

● People were monitored for the signs of infection and staff worked closely with community healthcare professionals to address these. People's prescribed antibiotics were collected quickly and started immediately. People had been supported to have the Flu vaccination.

Learning lessons when things go wrong

● An open and transparent working culture had been promoted and staff felt comfortable reporting and discussing things which had not gone to plan. Managers and staff who administered medicines had collectively reflected on medicine administration practices to help identify the reasons for previously identified recording errors. Actions taken reduced the numbers of interruptions staff who administered medicines experienced whilst administering people's medicines, in turn reducing the risk of loss of concentration.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care and treatment needs were assessed before they moved into either service through the use of recognised assessment tools. Areas assessed included falls, mobility, safe ways of moving and handling, pressure ulcer development and management, weight and nutrition management, choking and inhaling of food risks, including behaviour management. One person's moving and handling assessment required the staff to use a hoist when moving them. They said, "They [staff] use a hoist, they are all right, I feel in safe hands."
- Staff sometimes needed to work closely with external healthcare professionals to ensure a full assessment of need was completed; with occupational therapists to assess people's seating needs or with speech and language therapists to assess people's swallowing needs.
- People's care and treatment was delivered following recognised pathways of care. A pathway of care sets out a process of best practice to be followed in the treatment of a person according to their condition or particular needs.
- Care plans and risk assessments gave staff guidance on how the pathway of care would be followed and delivered, also considering people's individual circumstances and their personal choices and preferences. One person's needs in one specific area of their care had been assessed by involving specialist healthcare professionals who had each given their advice and recommendations. However, the care which was planned and delivered to this person had also considered and included the person's individual choices in this matter and the potential risks which came with those choices.

Staff support: induction, training, skills and experience

- Staff received training in how to deliver care according to best practice guidance and people's personal choices. This included subjects which the provider considered necessary for all staff; health and safety, safeguarding people from abuse and equality and diversity. Update training was provided to staff during their employment and was tailored to staffs' different roles and responsibilities. Some staff were learning how to support people's enablement and rehabilitation.
- There were systems in place to check staff attendance at training sessions and to ensure staff received regular supervision. Supervision meetings were opportunities for staff to review their learning needs and progress with their manager. Nurses were provided with support to maintain registration with their professional body, the Nursing and Midwifery Council (NMC). Therapists and a community nurse, based in the Ashley unit, were employed by the NHS and therefore received this support from the NHS.
- Improved nursing and clinical advice as well as practical support was available from the head nurse; a recently employed nurse with up to date clinical knowledge and practice in primary healthcare.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food provided. One person said, "Food is very nice, choice at lunch and evening and they [staff] come around with drinks." People received the support they needed to eat and drink. One person had been sitting in a wheelchair at the dining room table, but staff had realised it was easier for them to manage when sitting on a dining room chair, so they had organised this. One relative told us about the support their relative was getting. They said, "There is a choice of food, [name] can be fussy, they [staff] are getting her to eat proper food." We observed a person receiving support to eat and drink, which was done quietly and in an unrushed way.

● People's food and fluid intake, their appetite and their weight were monitored. Relevant concerns were discussed with care staff in staff handover meetings, at the daily heads of department meetings, with the head chef and care leaders, and with the person's GP. Action was taken to address the concern.

● The action taken varied but included more assistance at mealtimes, adding more calories to people's food to help increase weight or altering the texture of people's food and drink so they could swallow safely. We observed one staff member reminding one person they needed to have their fluid thickened before making up a thickened refill for them.

● People told us they enjoyed their meals and we observed them making choices about what they ate and drank, both at meal times and in-between.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were seen by GPs, community nurses and mental health practitioners as required. They were also referred to other health related specialists when needed. This included wound specialist nurses, diabetes nurses, continence assessors and dental and optical services. They had access to regular chiropody.

● Staff in the reablement and rehabilitation unit worked closely with housing and adult social care agencies to support people's return to their own home. Prior to leaving the unit some people required adaptions to be made to their own home. Staff in both services liaised with commissioners of care to ensure people returned to their own homes safely; some required on-going packages of care to initially support them.

● Staff worked with emergency services and NHS Rapid Response teams to support people who became acutely poorly or who had an accident such as a fall. Rapid Response teams, where it was appropriate and safe to do so, could provide immediate treatment to people in the home, avoiding unnecessary or distressing admissions to hospital.

Adapting service, design, decoration to meet people's needs

● Adaptions to meet people's needs included a call bell system. Mobile devices could be put in easy reach of people, so they could summon help when needed. Bathrooms included equipment which could support people to bathe safely. During the inspection one person wanted to have their first bath since being admitted to the home. Their needs were assessed, and specialised equipment used to help them bathe safely.

● Signage helped people to locate bathrooms and toilets more easily. To support people who lived with dementia, something familiar to them, a picture or an item, was placed on their bedroom door which helped them locate their bedroom more easily.

● Both sites were due to undergo major refurbishment this year which was designed to improve the environment for people and to physically connect the two services. The registered manager told us people were going to be involved in choosing the new decoration for their bedrooms and the communal rooms. New furniture was included in the bedrooms, lounges and dining room. There were plans to increase the number of areas people could relax in and to have a bar area in the dining room where people could sit and socialise.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People's consent was sought before care and treatment was provided. Where people lack mental capacity to make decisions about their care and treatment, their legal representatives were involved in this process.
- The registered manager ensured appropriate DoLS application were made to the local authority and reviewed the level of support and supervision being provided to people who had not yet been assessed for DoLS.
- Where conditions had been added to people's authorised DoLS, these were met and reviewed with the local authority when no longer appropriate or relevant; following deterioration in health.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated as individuals and there was a zero tolerance of any form of discrimination. This was practiced towards people, their representatives, relatives and within the staff team itself.
- The registered manager told us arrangements were made to support people's diverse cultural and religious beliefs.
- Different parliamentary party candidates had been invited to visit the home and people had an opportunity to express their views and ask questions on Brexit.
- People and their visitors were welcomed. One relative said about the Ashley Unit, "They [staff] took us round and said help yourselves to tea or coffee. We are made to feel welcomed."
- People were able to spend their time as they chose to. One person preferred their own company, their own food and their own choice of entertainment. This was supported by the staff and their family. Another person told us they remained in bed most of the time and because of a fear, remained on the first floor. They confirmed they had been offered a bedroom on the ground floor, but they had preferred to stay where they were because they enjoyed the view from their bedroom window.

Supporting people to express their views and be involved in making decisions about their care

- The registered manager told us staff worked hard at ensuring care was person centred; tailored around people's individual needs and preferences. One person said, "The staff are very good, I am awake by 07.00 (used to be up early to go to work). Staff help me get dressed and washed and then I stay in my room and come down for breakfast at 08.30 (their choice). They [staff] offer a bath or shower, I like both and can have either. I chose my clothes." Another person told us about their bath, they said, "I had it at 07.00 which is the time I wanted it."
- Although people could not always remember if they had 'care plans' they were able to confirm that they had been asked how they would like their care delivered and that their preferences were met. One person liked the fact that part of their care record remained in their bedroom in a plastic folder. They said, "It's in the room and I helped with it."

Respecting and promoting people's privacy, dignity and independence

- We observed staff treating people in a respectful way, whilst maintaining what was important to people as well as their privacy and dignity. One relative said, "Spills on clothes get changed. I labelled clothes but not the ones she was actually wearing when she came in. The laundry lady picked up on this and called me, so they could sort them out. Staff put on her jewellery."
- People in the care home were supported to continue doing things they could do independently. One

person told us the staff washed areas they could not reach, and they still washed the parts they could reach. We saw people being supported at mealtimes, but staff also used their judgement on when to intervene, allowing people to remain as independent as possible without loss of dignity.

● Relatives of one person told us how their relative had been supported by the staff to start enjoying life again. They said, "They [staff] phone to say she is going out so not to visit. They have got her going out and about which she wouldn't do. We have seen a big difference since she came here, she is always in the lounge [referring to socialising]."

● People praised the laundry service which, in the service it provided, helped to maintain people's dignity. People and relatives told us how important it was to have their own clothes returned, washed, ironed and hung up ready for them to wear. One person said, "They do the laundry, very efficient, you get your own clothes back and the laundry person hangs them up."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care and treatment was planned with them and recorded in care plans which gave staff guidance on how to meet people's needs and preferences. Care plans were reviewed regularly to ensure guidance for staff remained up to date.

● Due regard was given to people's protected characteristics; age, disability, sex and religion or beliefs when planning their care and support. The focus of one person's care planning was to support their needs when living with dementia and for another person, their complex dietary needs, but also how to support their faith.

● People's representatives were involved in planning their care where the person was no longer able to do this independently, due to lack of mental capacity or frailty.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to be included in social opportunities in the home and outside of it and to maintain relationships which those that mattered to them. Information about people's life history, hobbies and interests, including what was important to them, was gathered and helped to personalise people's care plans.

● People were supported to enjoy activities and social events which had meaning to them and which they wished to take part in. Activity staff were employed and had dedicated time to support people to remain included and involved in activities, which helped to improve their quality of life. One activity assistant said, "It's about the quality of the activity. It can be a simple activity but if people start talking with each other, enjoy it and have a laugh, then that is great." They went on to say "We [the staff] get as much enjoyment out of it as people do."

● The activity and care staff were very aware of the risks associated with self-isolation and loneliness and there were daily arrangements in place, to make sure those who chose to remain in their bedrooms, or who were bed bound, were checked and spoken with regularly. One to one activity time, for people in their bedrooms, was planned into the activity assistants' weekly program.

●Musical activities were used a lot to connect with people who were no longer able to communicate effectively; people who were frail and those who lived with dementia. Both activity assistants played instruments and they took their music to people's bedrooms. When talking about how they used music to connect with people who were very poorly or who were at the end stage of living with dementia, one activity assistant said, "I get tearful when I see a reaction."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People could receive information in ways which met their needs; verbally, large print and in different languages if required. Care plans flagged up people's communication needs, and care was planned around how best to meet these.

Improving care quality in response to complaints or concerns

● The provider's complaints policy and procedures enabled people, their representatives and others who visited the home to raise a complaint. However, managers worked hard to be available and approachable so that, where it was possible, areas of concern or dissatisfaction were resolved quickly.

● Records were kept of how complaints, areas of dissatisfaction and concern were received and addressed. Where it had been necessary to investigate issues further, this had been done. Where the service had been at fault this had been acknowledged, addressed and learning had resulted from this.

● People and relatives told us, if they needed to, they would raise any concerns with the registered manager, they felt able to do this and confident these would be sorted out.

End of life care and support

● People were monitored, and staff were aware of people's increased frailty and when their health was declining. Staff worked with other healthcare professionals; GPs, community nurses and pharmacists to ensure people received the right support, at the right time, when people were nearing the end of their life.

● People's end of life wishes, and preferences were explored with them, or their representatives, so staff were aware of these and able to meet these at the appropriate time. Information was gathered about people's preferences regarding the level of medical intervention they wanted when approaching end of life. Decisions had been discussed regarding resuscitation and, where a medical decision had been made not to resuscitate, information about this readily available for staff and visiting professionals.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager had managed the service since January 2019 and in that time had altered and improved how staff worked across both services, had improved team working and promoted and achieved a more person-centred approach to care. The working culture was described as a "can do" culture by the provider.
- Staff spoke positively about the registered manager and how they had worked to make improvements. One member of staff said, "I liked how [registered manager] was focused on building relationships from the start, with staff and residents." The unit lead for the Ashley Unit described how working arrangements and levels of support, for the unit, had improved under the registered manager. They said, "We work alongside each other." This had meant that both services could remain as responsive as possible to people's needs by utilising staff across both sites to meet the needs of the whole service.
- Staff spoke positively about the improved team working and how this was now organised. One member of staff said "[Registered manager] is very organised and I feel I'm part of a very big family here." Another member of staff said, "It's a good team." They went on to say how senior staff "muck in" and help.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and provider were committed to ensuring people received a good service. They had been open with people and relatives when things had not gone to plan or when mistakes had been made. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Both provider and registered manager were clear of their regulatory responsibilities and there were systems and processes in place to ensure both services continued to perform well and remain compliant with necessary regulations. The previous inspection rating was clearly displayed, and notifications were received from the provider and registered manager as required.
- The provider's quality monitoring system provided an effective way for the provider to monitor the quality of services and care provided to people. The registered manager and staff team completed the provider's annual program of audits as well as various additional checks for example, on staff practice, so where action for improvement was required, this took place.

● Representatives of the provider regularly visited the service to follow up on planned improvement actions and to quality audit the service on behalf of the provider. They provided support to the senior staff team to meet the provider's expectations and monitored progress against the service's continuous improvement plan.
● The provider, registered manager and senior staff team were all committed to maintaining the improvements that had been achieved and to improving the service further. During the inspection, following discussion with managers about falls and how risks associated with these were managed, for people who were prescribed blood thinning medicines, a representative of the provider reviewed the current arrangements and made immediate improvements to these so that the action staff needed to take was clearer.
● Managers were keen to improve the service through lessons learnt so regularly reflected on accident, incidents and situations which had not gone to plan to learn from these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager operated an open-door policy where people, visitors and staff could speak to them at any time. The registered manager also completed a 'walk around' the home each day as part of their quality monitoring of the service but also to hear the views of people who remained in their bedrooms or who would not actively visit them in their office.
● The registered manager also held regular meetings were held with people, relatives and staff so that important information could be imparted, but also so that they could hear views and suggestions from these groups. One member of staff said, "[Registered Manager] is very good, authoritative, but also open to ideas, brings ideas to the table, listens to ours, and makes good suggestions. They don't micro-manage but offer help where it's needed."
● People's views were also sought on a more one to one basis or in small groups through general discussion. One activity assistant told us that the plans for visiting another of the provider's care homes for tea, which took place during the inspection, came about by involving people and listening to suggestions they made. People returning from this trip told us they had really enjoyed it.

Working in partnership with others
● Staff worked with commissioners of care to ensure people could access and benefit from the services provided at OSJCT Grevill House when needed.
● They worked collaboratively and in a multi-professional way to help promote people's well-being whilst people used the service but also to facilitate a safe return to people's own homes where possible.
● Links had been made in the wider community with individuals, activity groups, schools, churches and businesses which all contributed to improving people's quality of life. This had resulted in people enjoying visits from school children, visiting a local riding stable and interacting with the horses and spiritual support from church groups.
● Staff also networked with staff in other homes managed by the provider, which resulted in people attending entertainment and events in different places and meeting new people. Staff training, and staff skills were also shared between the provider's services. The activity assistants had visited another of the provider's care homes to show staff there how they took their music to people in their bedrooms and how this benefitted people.