The Orders Of St. John Care Trust

OSJCT Orchard House

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

At the last inspection in December 2017 we found people's care was not always planned and delivered in a personalised way to meet their needs. This was a breach of regulation 9 under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to complete an action plan, which we received, to show us what they would do and by when, to improve the overall rating of the service.

During this inspection, 31 October and 1 November 2018, we found improvements had been made to how people received their care and how people's care had been planned. The breach of regulation had been met. The rating for the key question 'Is the service Responsive?' has been changed to 'Good'.

The previous registered manager had left the service in August 2018 and up until a month before this inspection, there had been interim management arrangements in place. A new manager had been in post for a month prior to this inspection. They planned to become the new registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Orchard House is required to have a registered manager. 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 found the provider had continued to quality monitor the service and actions had been taken following the completion of audits by interim managers. We again rated the key question 'Is the service well-led?' Requires Improvement as a period of time was needed for the newly appointed manager to be registered with the CQC and to get to know the needs of the service. Some improvement was needed, to ensure the new communication systems were in place to ensure people's skin management plans would always be followed, and that shortfalls in staff response times to people's call bells improved so these would answered promptly. The new manager planned to complete a reassessment of the services quality performance, using the provider's existing quality review tool. They then planned to amend the existing service improvement plan to bring it in line with the findings of their quality assessment.

Although the overall rating for the service has improved from 'Requires Improvement' to 'Good' the CQC will continue to monitor the service to ensure improvements are sustained. Following this inspection we will be asking the provider to complete an action plan to show what they would do and by when to improve the key question 'Is the service Well-led?' to at least 'Good'.

What is life like using this service:

People's needs were assessed and their care planned to ensure they received the right type of support. Care plans and risk assessments were reviewed regularly and staff had access to up to date information about people's care requirements. Information about people's care and treatment was kept secure and

confidential.

People told us they felt safe. Staffing had been increased following the inspection and provider's review of the home's dependency levels. This would ensure staff were better able to meet people's physical and emotional needs.

Risks to people had been identified and action taken to reduce these, or remove them altogether. Staff had been trained to recognise potential abuse or discrimination and they knew how to manage and report such concerns. The home was kept clean, well maintained and measures were in place to reduce the risk of infection. Medicines were managed safely and people given the support they needed to take their medicines.

Improved working relationships with external professionals and agencies helped to support people's needs and wellbeing. People had access to health and social care professionals as needed. All staff, received training and support to maintain and improve their knowledge and skills. Nurses received support to maintain their registration with their professional regulator. Staff had been safely recruited. People received help to maintain their nutritional wellbeing and had a choice in what they ate and drank.

The principles of the Mental Capacity Act 2005 were followed. People were supported to make independent decisions and their care was delivered in the least restrictive way possible. 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 were supported to have maximum choice and control of their lives; the policies and systems in the service supported this practice. Any decisions made on behalf of people had been made in their best interests.

Staff were caring and kind towards people. Staff communicated well with people and we observed laughter and banter, as well as compassion and reassurance being afforded to people. Visitors were made welcome and people's representatives were kept informed of changes to people's health. People were treated equally and their diversity understood and supported. People were shown respect and their privacy and dignity upheld.

People had opportunities to take part in social activities and their more personal and meaningful interests were also supported. Plans were in place to improve the activity provision in the home by recruiting more activity staff. The new manager planned to explore more community based social opportunities for people. There were links with local church groups so people's different faiths could be supported.

Complaints were responded to and managed effectively. People's end of life wishes were met and they were supported to have a comfortable and dignified end of life.

People were benefiting from the home having a new and experienced manager in place. The new manager had already started to interview and recruit additional staff to ensure they had enough staff with the right skills and experience.

The new manager was aware of their responsibilities in relation to the homes registration with the CQC and in relation to other relevant areas of legislation. This included making sure the CQC were notified of all

appropriate events and ensuring the last rating awarded to the home was displayed.

Rating at last inspection:

The overall rating for the home, at the last inspection in December 2017, was 'Requires Improvement' and it was the second time in succession, the home had been rated this.

Why we inspected:

The inspection of the 31 October and 1 November 2018 was a planned comprehensive inspection based on the rating at the last inspection.

About the service:

Orchard House is a care home which also provides nursing care. It provides care and treatment to people with complex physical needs; also, to people who live with dementia. 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 home is registered to provide care to 50 people; during the inspection 44 people were receiving this.

Further information is in the detailed findings below.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service has improved to Good.

Improvements had been made to people's care plans so that staff had up to date information about people's individual needs, in particular, information about the care of their skin and of any wounds.

Complaints were managed effectively and managers were keen for areas of dissatisfaction to be resolved to people's satisfaction.

People were supported at the end of their life to have a comfortable and dignified death.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some necessary areas for improvement had not been identified through the provider's own quality monitoring processes, although, they were addressed once the provider had been made aware of these.

Some improvements had been made to the service by the provider but time was needed for these to embed in practice and be sustained.

OSJCT Orchard 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 as part of our regulatory functions. This inspection checked 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 team:

One inspector and an Expert by Experience completed the inspection on 31 October and 1 November 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. Intelligence gathered from this service, with regard to this review, has not been included in this report.

Service and service type:

OSJCT Orchard House is a nursing home. It provides care and treatment to predominantly older people who live with physical needs and who required nursing care. Some people also live with dementia.

The service had not had a registered manager for three months. 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. A new manager had been recruited. They had been in post for one month and intended to apply to CQC to be the registered manager.

Notice of inspection:

This inspection was unannounced.

What we did:

Prior to the inspection we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about by law. A Provider Information Return (PIR) was not requested by us as part of the planning for this inspection. We took this into consideration during the inspection and discussed with managers, the improvements which had taken place and those planned for. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from health care professionals who had visited the home, on behalf of the local authority, to review some people's care. We used all this information to plan our inspection.

During the inspection, we spoke with fourteen people who used the service and four relatives to ask about their experience of the care provided. We made observations of the support people received. We reviewed eleven people's care records which included, risk assessments, care plans and records relating to the Mental Capacity Act 2005. We reviewed records pertaining to people's social activities and meaningful interactions. We reviewed a selection of medicine administration records and other records relating to the management of medicines. We reviewed three staff recruitment files.

We spoke with the new manager and a new operations manager. We also spoke with a manager who had provided interim support to the home and to two other managers who had been allocated by the provider, to support the new manager. We spoke with three nurses, two members of care staff, the activities co-ordinator who was also the home's dementia lead, a cook and one of the housekeepers.

We reviewed a selection of audits and the home's service improvement plan. We attended one staff handover meeting, a daily head of departments meeting and a meeting between managers and a community nursing manager.

We requested a copy of the home's training record to be forwarded to us which we received.

Good

Is the service safe?

Our findings

People were supported to remain safe and were protected from avoidable harm.

Staffing levels:

- New staff had been recruited to replace those that had left. Recruitment remained on-going in order to reduce the home's reliance on agency staff.
- On the second day of our inspection the provider was reviewing the staffing levels at OSJCT Orchard House. Their revised dependency tool findings had subsequently shown that staffing numbers needed to increase. We were provided with their action plan and evidence to show that staff numbers had been increased. Further action had also been taken to identify people who required more staff interaction to improve their wellbeing.
- Recruitment records showed that staff were recruited safely in order to protect people from those who may not be suitable to care for them.

Assessing risk, safety monitoring and management:

- The environment and equipment was kept safe and well maintained to avoid potential harm to people, staff and visitors.
- Risks to people, such as falls and choking were identified and action taken to manage and reduce these. One person had previously lived on their own and told us they had not been safe, had been admitted to hospital and then moved to OSJCT Orchard House. They said, "I knew that I had to go somewhere to be properly looked after so came here. Feel safe now."
- Lessons had been learnt following a follow up by NHS health care professionals into the support given to people with pressure ulcers. People's care in respect of this was now planned well and they were referred in a timely way, if required, to other health care professionals or specialists.
- A record of incidents and accidents was kept which showed these were appropriately responded to. The action taken was reviewed to ensure this remained effective in preventing future injuries and harm to people.

Safeguarding systems and processes /Learning lesson when things go wrong:

- Staff received safeguarding training and knew what action to take if they suspected abuse or an allegation of abuse was reported to them. They knew how to report concerns about other staffs' practices.
- Managers reported and shared appropriate information with relevant agencies to help safeguard people.
- The provider's policies and procedures promoted and supported practices which helped to safeguard people and protect them from poor care.
- People's diversity was understood and accepted by staff and people were treated equally.

Using medicines safely:

•□We observed people receiving appropriate support to take their medicines safely. One person said, "The nurses are good, get my pills brought in and they help me to take them."
•□Medicines were delivered to the home in time for people's use, which included medicines used to keep people comfortable at the end of life.
•□All medicines were securely stored and returned to the pharmacy if not used.
•□Staff who administered medicines had received training and their competency to do so was checked.
•□Medicine administration records showed that people had received their medicines as prescribed. These records and stocks of medicines were checked regularly to reduce the risk of medicine errors.

Preventing and controlling infection:

•□Cleaning schedules were followed by the housekeeping staff who kept the home clean. One person said, "Cleaners are very good. They keep it all very clean."
•□Staff wore protective aprons, gloves and tabards when they delivered people's personal care and food to prevent cross contamination.
•□Laundry was managed in a safe way to reduce the potential spread of germs. One person said, "The laundry is done well just, drop it in the containers outside the door and it is back the same day."
•□People and staff had been given support to be vaccinated against the flu so that a potential outbreak could be avoided.

Good

Is the service effective?

Our findings

Improvements to people's care and treatment support good outcomes for people, promoted a good quality of life and were based on best practice.

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

- People's immediate and ongoing needs were fully assessed which included those associated with people's specific health conditions such as Huntingdon's Disease, Parkinson's Disease, diabetes and dementia. Treatment and care was planned and delivered in line with professional standards and guidance.
- Staff respected people's choices and their diverse preferences when planning their care.
- The home worked in collaboration with a range of external health and social care professionals and services. These included NHS Rapid Response teams to prevent unnecessary hospital admissions, Speech and Language Therapists for people with swallowing problems or who were at risk of choking and specialist tissue viability practitioners in the management of wounds.
- Information on best practice guidelines were sought from specialist practitioners when they visited the home and provided by the provider's policy and quality teams.

Staff skills, knowledge and experience:

- Staff received support to complete induction training, which included the Care Certificate (a set of 15 standards which sets out the knowledge, skills and behaviours expected of staff in social care). The training record also showed that staff had been provided with additional training to be able to meet people's needs safely. For example, health and safety, safeguarding adults, fire safety and safe moving and handling. One person said, "The Staff are well trained. They know me and what I need."
- The new manager was aware that more training was required to support best practice. This included training on the General Data Protection Regulation (GDPR) and the Information Accessible Information Standards. Training on care planning and an update in wound care had already been booked for some senior staff.
- Some work had been completed to provide staff with their individual meetings (called 'Trust in Conversation' – supervision) so they could discuss with a manager their training and support needs. To help review the needs of the home, the new manager planned to meet all staff, on an individual basis, to learn more about their existing skills, interests and where they needed support.
- Nurses were supported to maintain their registration with their professional regulator the Nursing and Midwifery Council (NMC).

Eating and drinking:

- The staff were skilled at supporting people at mealtimes. People who were at risk of not maintaining their nutritional wellbeing were well supported.
- People at high risk of choking were supported or supervised by staff who knew what to do if they choked.
- People's monthly weights were monitored and assessed over a three month period. Any concerns were

discussed with the person's GP.
•□The cook and their staff were aware of everyone's likes, dislikes and dietary needs. They provided meals to suit people's particular health needs. For example, food with additional calories in to support those who were at risk of losing weight and texture modified foods for people with swallowing problems.
•□Staff supported people to make meal choices and we observed them discussing alternatives with people whose appetites were poor. The cook informed us that they would prepare anything, anyone wanted if it helped them to eat. One person said, "The menus are changed every 3 months. They [staff] come round and ask us about the food; anything we would like to be included on the menu."
•□Staff supported people to eat and drink in a dignified manner.
•□Cultural and religious food preferences were met where required.

Health care support:

•□Staff worked together and with other health and social care professionals to deliver effective care and treatment. This included, community nurses, opticians and a Chiropodist. One person said, "They see to my feet, chiropodist comes in and have had my glasses looked at but didn't need new ones, just adjusted them."
•□Arrangements were in place with a local GP surgery and GPs visited on a regular and planned basis. People told us they were also able to see a GP in-between these times when needed.
•□Dental support was organised when needed.
•□People's care records showed clearly that GPs had reviewed people's resuscitation wishes and needs, either with the person or their representative. This ensured staff and emergency services were fully aware of what had been decided.

Ensuring consent to care and treatment in line with law and guidance:

•□We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•□Staff obtained consent from people before providing care and treatment in line with legislation and guidance. One person said, "Staff always ask permission before putting my eye drops in."
•□Recorded mental capacity assessments and best interest decisions had been completed where people had been unable to make independent decisions about their care and treatment.
•□Care and treatment was delivered to people in the least restrictive way.
•□Staff had sought appropriate authorisation when restrictions had been placed on people, in their best interest, to ensure they would remain safe.
•□Staff established who people's legal representatives were so that the right person/s were consulted with when decisions about people's care and heath needed to be made.

Good

Is the service caring?

Our findings

The service involved and treated people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported:

•□Staff treated people with kindness, respect and compassion. Feedback from people and relatives was positive. One person said, "Nice people [the staff] very helpful. Lots of changes of carers [staff] hope they will stay. New ones tell me about themselves and say who they are." Another person said, "Very nice staff. All very caring, nice and helpful." One relative said, "Staff are very good, very kind, they liaise with me."
•□Several people were particularly frail and staff afforded them patience and time to talk through what it was they wanted help with. Sometimes we observed staff putting their arm around someone or reassuringly touching their hand whilst talking with them.
•□Staff understood people's personal, social and religious needs. We observed the activities co-ordinator skilfully encouraged one person, who found socialising difficult, to engage in the activity taking place. There was a lot of laughing and banter between this person and the co-ordinator.
•□Links with local church groups helped to support people's different faiths. Nurses told us how they had supported one person, from a different culture, to feel supported at the end of their life.
•□We observed staff supporting people's independence, but we also saw that staff knew when to provide support. This was done respectfully and never in a belittling way.

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

•□People told us their views, choices and preferences were listened to and they received the care they needed, in a way they wanted to receive it.
•□Some people were aware of their care plans and had been involved in reviewing their care with a member of staff. One person said, They [staff] do come and ask me about my care plan; if I think that I need more help. Everything is alright" and another person said, "I know about my care plan. I'm very independent so haven't needed to change anything."
•□Relatives, where appropriate, were involved in reviewing their relatives' care and were able to express a view about this. One relative said, "I was involved in the care planning at the beginning. If issues come up they do tell me. I refer to the care plan and keep pretty good tabs on things and what is happening. They do hourly checks [on their relative] as it says in the care plan and they record them."
•□To help staff know people better and support a more personalised approach to care, staff gathered information about people's life experiences, their hobbies and interests as well as their preferences and what was important to them. The activities co-ordinator recognised that this was particularly important when supporting staff to be able to have meaningful interactions with people who lived with dementia. They had plans to improve how this information was gathered and incorporated into people's care plans, from admission onwards.

Respecting and promoting people's privacy, dignity and independence:

•□People told us their privacy and dignity was maintained when staff delivered their care. One person said, "Very respectful when they [staff] are there helping me to shower" and another person said, "I have been asked if I want a male or female carer [member of staff to attend to their personal care]. I prefer a female really. I've only had a male carer once or twice and they were very good." Care plans identified what gender of staff people preferred to deliver their personal care.
•□We observed staff supporting people's independence, but we also saw that staff knew when to provide additional support. Care plans highlighted what people could do independently.
•□Information about people's care and treatment was kept secure and confidential.

Good

Is the service responsive?

Our findings

At the last inspection in December 2017 people's care had not always been planned in a personalised way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the requirements of this regulation had been met. Care plans had been reviewed to ensure staff had the right information to be able to meet people's needs in a way they wanted and needed these to be met. In particular, improvements had been made to how care was monitored and planned for people at risk of pressure ulcers or for those who had developed these.

People received personalised care that was responsive to their needs.

Personalised care:

- People's existing care plans had been reviewed to ensure they were relevant and gave guidance to staff about how people's needs should be met. Further work was being done to improve the personalisation of people's care plans.
- The condition of one person's skin, had been recently reviewed by a visiting health care professional, on the request of the staff. The health care professional had completed the review and given some advice. We found staff had already taken remedial action to protect the skin. This person's care plans were rewritten at the time of the inspection to better reflect the support now required.
- Wound management records and records of repositioning were well maintained giving an audit trail of the care and treatment provided to people to maintain their skin health.
- Staff attended handover meetings when they first came on duty to ensure they were fully up to date with people's needs and aware of any changes in their care. The content of the handover form had been reviewed and contained a summary of everyone's care and nursing needs. This was particularly helpful for agency staff.
- Care plans included detailed guidance about people's levels of independence and support requirements. This was reflected in the care plans for people who lived with a specific degenerative condition such as dementia, Huntington's Disease and Parkinson's Disease as well as long term health conditions such as diabetes.
- People were provided with opportunities and support to socialise and take part in organised activities. One person said, "I go to the activities if I feel reasonable and there's something I am interested in. I like to sing."
- Plans were in place to improve the activities available and opportunities for one to one meaningful interactions through the recruitment of additional activity staff. Regular volunteer staff helped people to take part in activities which were meaningful to them.

Improving care quality in response to complaints or concerns:

- People, relatives and other visitors to the home could raise a complaint although those spoken with told us they had nothing to complain about.
- The provider's complaints procedure was clearly displayed. This could be provided in different formats to

meet people's needs, for example, large print or a different language.
•□Records of the complaints received showed these had been acknowledged with the complainant, investigated where needed, and responded to.
•□Managers were keen for people to feel confident enough to raise any areas of dissatisfaction so they could address these. One person said, "I've not really complained because I talk to staff and they fix things."

End of life care and support:

•□Staff supported people at the end of life to have a comfortable and dignified death.
•□No-one was nearing the end of their life at the time we visited, but staff were monitoring those who were very frail for any decline in health.
•□There were well established links with GPs, pharmacies, community nurses and the community palliative care team to support people's end of life needs.
•□Advanced care plans recorded people's end of life care and treatment wishes as well as their pastoral and religious preferences for that time.

Requires Improvement

Is the service well-led?

Our findings

The management of the home needed to remain consistent so improvements in the service were sustained and people continued to experience improved levels of care and good outcomes.

Leadership and management:

- The new manager had been employed for a month and had worked in the home for just under two weeks. They planned to apply to the Care Quality Commission (CQC) to be the registered manager of the service.
- The previous registered manager had stopped managing the home in August 2018. Since then and up until the new manager's appointment, there had been two interim managers.
- The new manager was an experienced care home manager, but needed time to get to know the service, the people who used it and the staff.
- Comments about the new manager from people, relatives and staff were positive and included words such as "supportive" and "approachable".
- The new manager told us about her priorities in managing the home, these included staff recruitment, supporting staff through more change, helping them to feel valued and building a new and effective team.
- The new manager was familiarising themselves with the needs of the home, its challenges and the provider's expectations.

Plan to promote person-centred, high-quality care and good outcomes for people:

- A collaborative way of working was being promoted and heads of department met each day for a brief meeting with the new manager. The new manager shared important daily news and each department shared any particular risks, concerns or problems they may be experiencing. This allowed the overall management team to address these together. Some areas of the home were being redecorated so the maintenance team were able to plan with the head housekeeper areas which would next require cleaning. Staff we spoke with about these meetings told us they were beneficial.
- One of Orchard House's nurses had become the lead nurse, four days prior to the inspection. They provided the clinical governance required to ensure all nursing and medical led issues were met and that best practice in these areas was maintained. The daily meetings also provided an opportunity to monitor people's clinical needs for example, in relation to people's wound management.
- Care leaders understood their responsibility for organising and supporting care staff and monitoring the quality of care provided.
- Both nurses and care leaders focused on the personalisation of people's care and organised the staff in such a way which supported this approach.

Managers were clear about their roles and responsibilities in relation to quality performance, managing risks and regulatory requirements. However, some improvements were required to the provider's quality monitoring processes to ensure all necessary improvements were always fully identified, that prompt action was taken in response to these and that improvements were sustained.

•□Earlier in the year, a lack of communication and poor care planning around the integrity of people's skin, had resulted in a delay in appropriate care. We found the provider had since taken action to ensure this did not reoccur. They had reviewed people's individual skin care requirements and ensured staff had the guidance they needed to care for people's skin. Wound management systems were reviewed so that a clear audit of the treatment provided to people, in the management of their wounds, would be available to staff.
•□We found some time was still needed to fully embed the provider's revised communication system so that reviews or changes [to people's skin care], made by a visiting health care professional, would always be communicated promptly and effectively to all relevant staff. This would ensure they remained up to date with people's skin management plans and could provide care in accordance with current best practice.
•□The provider was reviewing the staffing levels in all of their homes using their revised dependency tool. They were assessing staffing levels at OSJCT Orchard House at the time of our inspection. They had taken immediate action to increase staffing levels after the review showed that more staff were needed. During the inspection one relative said, "Staff are very good but there is less than there should be." One person said, "The staff take too long to get to us."
•□On reviewing the electronic records, within the home's call bell system, these indicated that there had been delays in staff responding to people's call bells; over a period of time. However, prior to the provider's review of people's dependency levels, and the staffing numbers by use of their new tool, the provider's audit processes had not identified these delays and prompt action had not been taken to address these. Some improvement was needed to the on-going monitoring of staffs' response time to people's call bells and how staff were used to assist people when needed.
•□The new manager was aware of the audits which had been completed and of the home's existing service improvement plan (SIP). However, they needed time to develop a full understanding of the improvements required. The new manager and an operations manager were planning to review the SIP and to reassess the services performance against the provider's full service quality audit tool (last completed April 2018). This would provide them with updated information for the SIP
•□Prior to the new manager starting audits had been completed by one of the provider's experienced interim managers and we found several examples of how these had been effective in driving improvement. Two staff members now checked and recorded the stock levels of all medicines when received. The checking of people's medicine administration records (MARs) had been increased after an audit had found that people's MARs had not been properly maintained (predominantly by agency staff). We found this had led to improvements in the correct maintenance of people's MARs. Following a recent infection control audit, the same interim manager had implemented a schedule for the night staff to clean people's equipment, such as wheelchairs, hoists and crash mats. A new body fluid spillage kit had also been purchased and staff made aware of where it was kept and its purpose.
•□The interim manager had also reviewed the way staff categorised accidents as they had found previous categorisation had made identifying and auditing falls risks difficult. Once staff had followed the new categorisation falls audits had been more accurate and showed that there were less falls taking place in the home than previously thought.

Engaging and involving people using the service, the public and staff:

•□The views of people and their relatives had been sought by the provider in a recent survey. The new manager was awaiting the provider's collation of the feedback to determine whether any improvement actions were needed.
•□People's comments and views were sought and collected by staff daily about their care, activity opportunities and the food provided. This was seen in the cook's increased attempts to accommodate people's food choices and in the plan to recruit more activity staff.
•□Regular feedback meetings with people, relatives and staff had been held in the past but needed to be

fully reinstated by the new manager. It was the provider's expectation that these were held regularly, but it would also help the new manager meet relatives, communicate their ideas and plans and receive feedback on how the service could improve.

- Managers were open to receiving feedback and suggestions which would help improve the overall service provided.

Working in partnership with others:

- The new manager was keen to meet with representatives of other services and agencies, so as to maintain links which had already been made, and to develop new working relationships. We saw an example of this when they met with a community nursing manager to discuss the improvements made to communication between the two services during our inspection.
- The new manager had knowledge of the local community and planned to make new links with community based groups. They wanted to provide people in the home with more local social opportunities and provide the local community with a place to hold meetings and groups; aiming for more integration.
- Links with local schools already promoted and supported integration between older and younger people.

- Close working arrangements with NHS hospitals and commissioners of health and social care helped people access and sustain the support they required.