Bupa Care Homes (BNH) Limited

Hutton Village Care Home

Inspection report

Hutton Village
Brentwood
Essex
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Tel: 01277261929

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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 inspection took place on 23 February 2018 and was unannounced.

Hutton Village 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. Hutton Village provides accommodation and nursing care for up to 40 older people including those living with dementia. Accommodation is located over two floors. There were a total of 37 people living at the service at the time of our inspection with two further people due to be admitted on the day we inspected.

There was a registered manager in post. 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.

At the last inspection, the service was rated as Good overall but was rated as Requires Improvement in the domain of safe. Areas identified as needing improvement included infection control practices, medicine management and water safety. At this inspection we found the service had addressed the concerns we had raised and the rating has now improved to Good in all domains.

Medicines were managed safely however improvements were still required with regard to the recording practices regarding administration of creams and lotions. We made a recommendation that the service review its systems and processes for administering topical applications.

At the previous inspection people did not have their own slings which represented an infection control risk. This had been rectified, people now had their own equipment and good infection control practices were adhered to. Regular checks of the environment and equipment were undertaken to ensure the premises were clean and safe.

Robust systems and processes were now in place to ensure water safety and prevent the risk of legionella. The heating and plumbing systems had been upgraded and regular checks of water temperatures, flushing of water pipes and quarterly water testing was completed.

Staff were sometimes slow to respond to call bells. However, the service had recognised this failing and extra staff had been deployed and an action plan put in place to address this concern.

Individual risks to people had been assessed and were regularly reviewed. Management plans were in place to support staff to keep people safe. People told us they felt safe and relatives said that their family members were well looked after. People were protected from the risk of abuse as staff had received training in safeguarding and were aware of their responsibilities and knew how to report any concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff received training to equip them with the skills and knowledge required to support people effectively. Staff felt well supported by the management team.

People were supported to have enough to eat and drink however, the recording of people's food and fluid intake required strengthening. We made a recommendation that the service review their system for monitoring food and fluid intake.

People were assisted to stay healthy and received timely support to access healthcare professionals when their health needs changed. The home environment met the needs of the people who lived there and the building was in a good state of decoration and repair.

Staff were kind and caring and treated people with dignity and respect. Staff knew people well and people felt listened to and included in decisions about their care and support. Independence was supported and encouraged. Visitors were made welcome at the service which meant that people were supported to maintain relationships that were important to them. Care plans were personalised and were regularly reviewed to reflect peoples' current needs.

The home environment was warm and welcoming. People were provided with opportunities to engage in activities of their choosing. The service had formed links with the local community to facilitate social inclusion. If people had particular wishes for end of life care these were discussed and recorded. Systems were in place to support people with symptom control and pain relief when they became unwell.

People were included in the running of the service. People's viewpoints were actively sought and the service responded positively to feedback. Quality assurance systems were in place to monitor the safety and effectiveness of the service and drive improvements. There was robust oversight of the service and clear lines of accountability at staff, management and provider level.

Further information is in the detailed findings of the full report.

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 had improved to Good.

People had their own slings to minimise the risk of cross infection and promote good infection control practices.

Systems and processes were in place to ensure water safety.

Good practice guidelines for administration of creams and lotions were consistently reinforced to develop staff performance.

Staffing numbers had been increased to improve response times to call bells.

Risks to people were well managed and staff understood how to protect people from harm.

Is the service effective?

Good

The service remained Good.

Is the service caring?

Good

The rating remains Good.

Is the service responsive?

Good

The rating remains Good.

Is the service well-led?

Good

The rating remains Good.

Hutton Village Care Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection which took place on 23 February 2018 and was unannounced. The inspection team consisted of two inspectors and a specialist nurse advisor (SPA) who had specific expertise in nursing issues including nutrition and infection control. We also used an expert by experience. An expert-by-experience is a person who has personal experience of using this type of service.

Before we visited the service we reviewed the information we held about service including inspection history, feedback from people and commissioners and statutory notifications. A notification is information about important events, which the service is required to send to us by law. We also looked at the information the provider sent us in their Provider Information Return. This is information we require providers to send us which gives key information about the service, what the service does well, and improvements they plan to make.

Over the course of the inspection we spoke with the registered manager, the deputy manager, two nurses, the activities and catering staff and six care staff. We also spoke with 11 people who used the service and six relatives. We reviewed various documents including six people's care records, four staff files and other relevant documentation such as training records, quality audits and minutes of meetings.

Good

Is the service safe?

Our findings

At our previous inspection we rated this domain as Requires Improvement. At this inspection the registered manager was able to demonstrate they were addressing the issues and the rating has now improved to Good.

During the last inspection we found poor recording practices regarding the administration of creams and lotions (topical applications) and during this inspection we found similar concerns. People did not always have medicine administration records (MAR) in place for creams. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Where MAR sheets were in place these were not always consistently completed. Therefore we could not be sure that people had received their creams as prescribed.

We discussed our concerns with the registered manager who told us they were confident that people had their creams applied as required as there were no incidents of people experiencing skin problems. However the manager was aware that recording practices were currently poor. They provided us with evidence that they had worked at addressing this issue since our last inspection. Staff meetings and supervisions had been held and letters sent out to remind staff and reinforce good practice. However, given our findings on the day, the measures put in place to improve practice had not been successful.

We therefore made a recommendation that the provider review their current systems and recording practices for the administration of topical applications.

Some people had been prescribed creams to treat pressure ulcers. Whilst written records did not reliably demonstrate that people's creams had been applied we saw evidence that people had received good pressure care. The service had signed up to the NHS SSKIN project, an initiative aimed at preventing pressure ulcers. This enabled nursing staff to pro-actively assess people's skin care needs and prescribe appropriate creams. People identified at risk of skin breakdown were regularly repositioned. Repositioning charts were kept which had been consistently completed demonstrating that people had been regularly turned. Some people had pressure ulcers but these had not been acquired at the service. These people received appropriate treatment for wound management from trained and competent nursing staff. In addition, pressure relieving equipment such as cushions and mattresses were in place to help minimise the risks. We checked the mattress air pressures and found they were on the correct settings and matched the guidance in people's care records.

Appropriate arrangements were in place for the safe storage, administration and disposal of people's liquid and solid medicines. Medicines were stored in secure trolleys inside locked rooms. Medicines that required cold storage were stored inside secure refrigerators. Temperatures for the rooms and refrigerators were recorded daily to ensure medicines were stored at the correct temperatures. People's medicines administration records (MAR) were checked and found to be accurate and up to date. There were no missing signatures and the correct codes were used. People received appropriate support to assist them to take their medicines safely and medicines were only administered by nursing staff that had been trained and

assessed as competent. Lessons had been learned to improve the quality and safety of medicine management. After each medicine round an audit was completed which included checking the start and finish times of the round, looking for any gaps on people's MAR and completing a stock count. Nursing staff told us that if a gap or error was noted this would be immediately documented and investigated to ensure people received their medicines safely.

At our last inspection we found that not all people had their own slings for moving and handling. After use slings were returned to a central storage area and used again for other people. This represented an infection control risk. At this inspection we found that the provider had taken the necessary steps to address this issue. People now had their own slings for hoisting and personal care which were clearly labelled and stored in people's rooms. The registered manager kept a 'Sling Tracker' which helped them to monitor that each person had the equipment they needed to be safely moved and positioned.

The service was clean throughout and there were sufficient arrangements in place to help ensure the cleanliness of the service. A relative told us, "It's lovely and clean here and it always smells nice. " Risks from infection had been assessed and were reduced by staff that were knowledgeable and used their training to keep people safe. Staff had access to and were observed using personal protective equipment (PPE) such as, gloves, aprons and hand wash.

On the day of inspection we observed that people had their needs met by staff in a timely manner and call bells were responded to promptly. However, we received feedback from one person that sometimes they had to wait a long time for staff to respond when they used their call bells. This person told us, "I do use my buzzer a lot, as I'm in bed all the time, but sometimes the staff do take a long time to answer the buzzer – I think they're short of staff sometimes." Some staff also commented that they were sometimes short-staffed. One member of staff told us, "We need one more person here really." Another said, "Sometimes there are three carers and sometimes two. Today there are only two of us." The service had installed a new system to monitor call response times to assess staff deployment and ensure people received timely assistance. We reviewed the data collected and saw that response times were often slow with some people waiting between fifteen and twenty minutes for staff to attend to them.

We spoke with the registered manager about our concerns regarding staffing levels and deployment. They told us that through analysis of the call bell response time data they had already identified that more staff were required and this had been arranged. We were shown a copy of the rota for the following week which demonstrated that an increase by one member of staff had been organised. After our inspection the registered manager provided us with a copy of their latest audit of the call response times which evidenced that the increase in staff numbers had had a positive impact. However, call response times were still sometimes slow, particularly at the weekend. The manager acknowledged that further work was still needed to make improvements and an action plan had been put in place to address the issue.

People were protected from the risk of unsuitable staff being employed at the service as the provider followed safe recruitment procedures. Staff files included evidence of employment history, satisfactory references, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out criminal record and barring checks on individuals who intend to work with people who use care and support services and helps employers to make safer recruitment decisions

People told us they felt safe living at the service. One person said, "I do feel safe here; it's a very calming place; nothing is rushed and the staff are very accommodating and friendly and very helpful, I couldn't be in a nicer place, it's lovely."

There were systems in place to safeguard people from abuse. Staff had received training in safeguarding, and understood their responsibilities to protect people and were confident in the management to ensure people remained safe. Staff told us they would report any concerns about people's well-being if they suspected or saw something of concern. One staff member told us, "I would report to the nurse in charge or go to the manager, if I was not happy we have a confidential whistle blowing call line to use." Staff were aware of the whistle-blowing procedure and we saw that this had been used effectively in the past to protect people from harm. Where issues of poor practice had been identified through the whistle-blowing process the registered manager had taken the appropriate disciplinary action to ensure people's safety and wellbeing.

Risks associated with people's care and support had been assessed when they had first moved into the service. Risk assessments were reviewed monthly or sooner if something changed. The risks assessed included those associated with moving and handling, nutrition and hydration and the risks of falls. Staff demonstrated a good awareness of the risks to people and knew what to do to keep people safe. Daily and weekly clinical risk meetings were attended by management and nursing staff to review people identified at risk. Key aspects explored included aspects such as weight loss, pressure care, accidents and incidents including falls. Management plans were put in place to reduce the risks and where appropriate referrals were made to the relevant health and social care professionals. This meant that whenever possible, the risks associated with people's care and support had been identified, minimised and appropriately managed by the staff team.

The service took a positive approach to managing risk which supported people to exercise choice and control and move around the service freely. For example, where a person had been identified at high risk of falls, the person's mobility was monitored using technology which was less restrictive than having to be constantly supervised by staff.

Appropriate checks and servicing had been carried out to ensure the environment and equipment was safe. This included aspects such as gas servicing, portable appliance testing (PAT) and lifting and hoisting equipment. Lessons had been learned from past failings to manage risks including the risk of legionella. Robust risk assessments and management plans were now in place which included regular checks of water temperatures and flushing of water pipes. The provider had upgraded their heating and plumbing system including water tanks, piping and boilers. In addition, quarterly water testing was completed by an external agency.

Risks to people's safety in the event of a fire had been identified and managed. For example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. The provider had an emergency plan in place and people who used the service had Personal Emergency Evacuation Plans (PEEPs). This meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation.

Good

Is the service effective?

Our findings

At this inspection we found the provider continued to provide an effective service and the rating remains good.

When people joined the service their needs were assessed in accordance with best practice guidelines. Consideration was given to people's physical needs and also their emotional, psychological, spiritual and social needs. This helped staff to form a complete picture of the person to provide effective care and support.

People we spoke with were positive about staff and the service they received. One person told us, "They [staff] really seem to know what they are doing." Another said, "I am very satisfied here, it's a really nice home."

When new staff joined the service they received an induction to support them to be competent in their role. The induction was based on the Care Certificate which represents best practice for inducting staff into the health and social care sector. A new member of staff described their induction experience. They told us, "I had a four day induction which covered lots of things, such as manual handling, duty of care and medicines. I was given an induction booklet to complete and I will be shadowing experienced staff for at least three to four shifts."

Staff were provided with opportunities for learning and development and received training tailored to meet the individual needs of people using the service, for example, training in pressure care and nutrition. Records showed that staff training was up to date or had been booked. The service had recently changed their training programme to provide a mixture of face-to-face and E-learning. A staff member told us, "We have face to face manual handling and first aid training and other courses we do on line. I think the training is adequate."

Supervisions and appraisals are a means of supporting staff and monitoring their skills and knowledge to identify any gaps in learning. Records showed that historically supervisions had sometimes been inconsistent and patchy. However, the registered manager was able to demonstrate that they had addressed the issue and showed us a plan of staff supervisions which had been booked. Staff we spoke with confirmed that supervisions were now taking place and that they felt well supported. One staff member told us, "I had supervision with the Deputy recently and there was a staff meeting two weeks ago. We are supported." Another said, "I attend the daily meeting every day with heads of departments, the Deputy is my supervisor and I feel one hundred percent supported."

People were supported to have enough to eat and drink and told us the food was good. One person said, "The food here is really nice, I have no complaints." Snacks and drinks were readily available and encouraged throughout the day. Throughout our inspection we saw staff supporting and encouraging people to eat and drink. At mealtimes people had a choice of eating in the main dining room or in their own rooms. We saw that staff went room to room to assist people to eat, where required.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to have enough to eat and drink. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a screening tool to identify if adults are malnourished or at risk or malnutrition. Where a risk was identified a risk assessment and management plan was implemented to support staff to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. People identified at risk also had food and fluid charts in place to monitor their intake. However these charts were not consistently completed with minimal action or guidance recorded by the nurse in charge. Whilst recording practices for food and fluid charts were poor, in practice, risks to people were known and discussed during the daily and weekly clinical risk meetings. Appropriate action was then taken to support people to have their nutrition and hydration needs met, for example, referrals to healthcare professionals such as speech and language therapists or dietician. Care plans were also updated to provide guidance for staff on how to support people to meet their nutritional needs safely and effectively.

We recommend that the provider review their current systems and processes for recording food and fluid to ensure more robust oversight of people identified at risk of malnutrition or dehydration.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the service was working in accordance with MCA legislation and appropriate authorisations for DoLS had been submitted. The registered manager kept a DoLS tracker which gave them effective oversight of applications which ensured that people's rights and freedom was upheld. Staff had received training in the MCA and understood the importance of gaining consent. People's care plans included detailed information in relation to people's capacity and consent to care forms had been signed by people or their representatives. Staff were aware of the importance of supporting people to give consent and make choices. One staff member told us, "Everybody here has a choice, a choice of food, drink and how they like things done."

Care records detailed people's health needs and how they should be met. Peoples health needs were discussed in the daily and weekly clinical meetings to ensure all staff had the most up to date information including details of health appointments and the outcomes. A regular weekly GP service had been arranged which was used to review people's health needs. The GP regularly reviewed people's medication and arranged referrals to other healthcare professional as required. We saw that people had been supported to access a range of healthcare professionals, including optician, speech and language therapists, dieticians, and chiropodist. A person told us, "There is a doctor here if you need one, and a chiropodist and hairdresser; you can get anything you want really." Guidance from healthcare professionals was recorded in people's care records and followed through with monthly evaluations in their care plan.

The environment had been designed to meet the needs of the people who lived there and the building was in a good state of decor and repair. There were lots of areas for people to sit and relax in including a large garden. People's bedroom doors were individualised to help them identify their own room. Bedrooms had enough space for people to move around and appropriate furniture in place. A relative told us, "I didn't ask for it, but the manager has put this extra matching armchair in Mum's room, which was thoughtful of her." Bathrooms were suitably equipped to meet people's needs. Most people had en-suite showers and those

that didn't had access to adapted bathrooms.

Good

Is the service caring?

Our findings

At this inspection we found the service continued to be caring and the rating remained Good.

Throughout our inspection we observed positive and caring interactions between people and staff. A person told us, "The staff are all nice and give me lovely smiles." Staff described how they ensured a caring approach. One staff member told us, "I try to treat people how I would like to be treated, and I will take longer rather than rush." Staff were attentive to people's needs to ensure their emotional wellbeing, for example, making sure that a person had their doll and that another person was happy with the music that was playing.

People and their families were encouraged to share information about their life history. People's care plans included a section titled 'My life story' which detailed the person's life history and family tree. This information helped staff to get to know people and form positive relationships with them.

Care records provided staff with guidance on people's sensory and communication needs. For example, in one person's care plan it had been recorded that the person was unable to use their buzzer so hourly visits were required to check their welfare. Another person's care plan detailed that they used pointing, gestures and their artwork to communicate. This meant that staff could communicate with people on an individual basis.

People told us they felt listened to and were involved in decisions about their care and support. People and their representatives were invited to monthly care reviews, and encouraged to express their views and wishes and suggest any changes. Resident meetings were also organised which were used to discuss aspects such as people's preferences for menu choices, housekeeping and activities.

At the time of inspection there were no people living at the service who required an advocate. However, the registered manager was aware of their responsibilities and told us that where required the service was able to facilitate access to independent advocacy services to support people to be fully involved in decisions around their care and support.

Staff demonstrated that they understood the importance of respecting people's privacy and dignity, for example, by knocking on people's bedroom doors before entering. Staff described how they protected people's dignity when providing care and support. A staff member told us, "We tell people exactly what we are doing and make sure curtains are drawn, doors are closed and they are covered with a towel."

People's strengths and abilities were identified in their care records which helped staff to promote people's independence. A person told us, "It's really first class here. I like to be as independent as possible. I know the staff, and they are all very friendly and often come in for a chat; I don't need very much help, as I can do most things for myself but all the staff are lovely."

We looked at how the service recognised equality and diversity and protected people's human rights. Care

records captured key information about people including any personal, cultural and religious beliefs. The service organised a monthly church service which was well attended by people and any relatives who wanted to join them. Weekly visits from a lay preacher were also arranged to visit people who were known to them from the community as well as meeting new people who expressed an interest.

During our inspection we observed that visitors came and went throughout the day and were made to feel welcome by staff. A visiting relative told us, "It's very friendly here and they [staff] always make me feel welcome."

The service understood the need to keep people's information confidential. We saw that personal information held about people was kept securely locked away which meant that confidentiality was respected and maintained.

Good

Is the service responsive?

Our findings

At this inspection we found the service continued to be responsive to people's needs and the rating remains good.

The service involved people in planning their care and support. When new people joined the service their strengths and abilities were assessed and a care plan was designed to reflect their needs. Using a 'Resident of the Day' scheme, the service ensured people's care and support was regularly reviewed. Invites were sent to people and their representatives three months in advance to encourage participation in the reviews.

People's care records included information about their needs and wishes, likes and dislikes, routines, hobbies and interests. This information supported staff to provide care and support which was person-centred. Person-centred care means care tailored to meet the needs and wishes of each individual. Staff described how they provided a person-centred approach. One staff member told us, "We care for the individual; for example, some people like personal care early and others prefer to wait until later." A person told us, "I get up when I want and go to bed when I want. I don't really like my own company so I get as involved with the activities as possible, but I'm always back in my room by 6pm; it's my choice."

We saw several examples where people's routines and preferences had been documented and respected. For example, one person's care plan stated, "I like classical music and talking French to staff". When we visited the person's room classical music was playing. In another person's care plan it had been recorded that they loved to paint. When we visited their room they were painting and their art work was evident in their room. However, We found that people's preference for gender of care staff was not always recorded or fully understood by staff.

We discussed our concerns with the registered manager who gave us assurances that the issue would be addressed and people's care records reviewed to ensure that this information was included and shared with staff.

People were supported to follow their interests and take part in activities of their choosing. The provider employed a member of staff who was responsible for activities within the service. They told us they provided a wide range of activities both within the service and out in the community in response to people's expressed interests, for example, bowls, outside entertainers and trips to the garden centre and coffee shops. On the day of inspection we observed a quiz taking place which was well attended by fifteen people plus some relatives.

Consideration was given to people who remained in their rooms. The activities staff told us that they did one to one sessions and arranged specialist activities, for example, for two people the service had organised for a company to bring owls in. The service had also formed links with the local community. A toddler group visited every couple of months and at least 15 people attended the session. The toddler group played their own games and sang songs and people joined in.

Systems and processes were in place to respond to complaints. We looked at past complaints and found they had been dealt with appropriately. We saw that lessons had been learned from complaints. For example, where a complaint had been made regarding arranging timely medical support for a person, a new risk assessment tool had been introduced to support nursing staff to make the correct decision and be better able to communicate the rationale to people and their relatives.

If people chose, the service supported them to explore and document their preferences and choices for their end of life care. For people not wanting to be resuscitated, Do Not Attempt Resuscitation (DNAR) forms were in place within their records informing the staff team of their wishes. All of the nursing staff received specialist training in end of life and the service had close links with the local hospice. The registered manager told us this benefitted people's care as the service was able to contact the hospice for advice, particularly in relation to pain and symptom management and support for relatives such as counselling. A visiting lay preacher was also available to give communion and spend time with people who were unwell or at end of life.

Good

Is the service well-led?

Our findings

At our previous inspection we found the service was well-led. The service continues to be well-led and the rating remains 'good'.

There was a registered manager in post. 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 registered manager understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe. They were supported by a deputy manager and together were responsible for the day to day running of the service.

The registered manager and deputy were hands-on and visible within the service and were able to demonstrate that they were knowledgeable about the service and the people who lived there. People and staff said they found the registered manager accessible and approachable. A person told us, "There are really friendly staff here and the manager has been really helpful. "

The service worked in partnership with other organisations and the local community, for example, the local churches, local schools and children's groups and the hospice. These links supported people to have their cultural and spiritual needs met and promoted social inclusion. In addition, a resident and relative Committee had been formed which included relatives who no longer had relatives living at Hutton Village but who wanted to maintain links with the service. The committee member's role included supporting with activities and chatting with new people to help them settle in and feel welcome.

The culture within the service was positive. Staff contribution was recognised through an awards scheme. The registered manager told us, "Treat staff well, value them and this will be passed on to people who will receive good care." Feedback we received confirmed that people and staff felt valued and staff were committed to providing good quality care. Because staff were valued and felt well supported this encouraged staff retention and the long term sustainability of the service.

The service was open and transparent with people. Feedback from people about the service and the actions taken in response was displayed publicly on notice boards around the building in the form of 'You said; We did' posters.

There were robust quality assurance systems in place to monitor the safety and effectiveness of the service. We saw that a range of audits were completed by the management team including health and safety, infection control, catering and medicines. Where issues were identified, actions were taken to ensure improvement. For example, a medication audit highlighted errors in stock control. In response the service introduced additional stock checks of all boxed medication at each medication round and a review of the stock levels for each person. The lessons learnt lead to a sustained improvement in medicines management.

The service demonstrated a commitment to improving the quality of the service people received. For example, there had been recognition of the importance of fresh air and sunshine to promote people's wellbeing. Therefore, the provider had installed a new pond and sensory garden. In addition a marquee was erected to provide an adaptable outdoor seating area to encourage people to spend time outdoors with adequate shelter.

Staff, management and the provider were clear about their roles and responsibilities. Performance discussions had been held with staff to set goals in response to areas identified as requiring improvement. For example, two recent goals set for staff included responding in a timely manner to call bells and ensuring that recording charts were consistently filled in. The registered manager told us they felt well supported by the provider and were responsible for sending weekly reports to head office to ensure robust oversight at provider level. The regional manager visited the service on a bi-monthly basis to carry out their own checks and audits to assure themselves of the quality and safety of the service. Any actions identified were shared with the registered manager and completed within an agreed timescale.

People and relatives were included in the running of the service. Residents' meetings were held on a quarterly basis and the service listened and responded to what people said. For example, following a recent residents meeting the service had increased outings to the community from once weekly to twice weekly as people had requested this. One person told us, "We've been out to Shenfield and Billericay recently, and when it's warmer we plan to go to Southend ; it's the residents choice where we go." In addition, satisfaction surveys were sent to people annually requesting feedback on the service and this was used constructively to drive improvements. For example, where people had stated that improvements were required in the tidiness of bedrooms and communal areas, the service recruited an additional housekeeper.