Bondcare (London) Limited

Beech Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 29 and 30 August 2018 and was unannounced on the first day and announced on the second. The service had not previously been inspected whilst being managed by the current provider.

Beech Court Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beech Court Care Centre accommodates 50 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia, one specialised in providing care for younger people with learning disabilities and the other unit worked with older people. 49 people were using the service at the time of our inspection.

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

We found that medicines were not managed safely and had not been recorded correctly. We have recommended the nurses complete refresher training in medicines administration and work to best practice standards.

There were appropriate safeguarding procedures at the service. There were enough staff working at the service to meet people's needs. Appropriate recruitment procedures were in place. Risk assessments were completed to support people in a safe manner. There were infection control procedures utilised. Steps had been taken to help ensure the premises were safe.

People's needs were assessed before they started using the service. Staff were happy with the training they received. New staff received an induction. People told us they enjoyed the food and were supported to eat where necessary. They were supported to access relevant health care professionals. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us and we observed that staff were caring. Staff understood the need to respect people's privacy and dignity and people confirmed they did this in practice. People's independence was promoted.

Care plans were detailed and ensured staff knew what people's needs and preferences were and how best to meet them. Care plans were regularly reviewed. There was an activities coordinator and people were supported and encouraged to engage in various activities. The service had a complaints procedure in place and people knew how to make a complaint.

People and staff knew who the registered manager was and spoke positively about them. There were robust quality assurance systems in place. The provider sought feedback from people who used the service to drive improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not recorded properly.

People were safeguarded from abuse.

Appropriate risk assessments were completed and regularly updated.

Sufficient staff were employed by the service and all were checked for suitability to their role.

Staff understood how to prevent the spread of infection.

The service acted appropriately when things went wrong, informing the right people and attempting to learn from mistakes.

Is the service effective?

Good

The service was Effective.

The service was effective.

People's needs were assessed to provide them with appropriate care.

Staff were trained to do their jobs.

Staff were supported in their roles through supervision and appraisal.

People were supported to eat and drink healthily.

Staff communicated effectively to support people using the service.

People were supported by the service to meet their healthcare needs.

Staff at the service understood the Mental Capacity Act and the

registered manager complied with Deprivation of Liberties Safeguards guidance.

Is the service caring?

Good

The service was Caring.

Staff were kind and caring.

People were involved with decisions about their care.

People were able to express their views.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was Responsive.

People received personalised care and their needs were documented and updated appropriately.

The service provided activities for people to attend.

People's concerns and complaints were listened to and acted upon appropriately.

People were supported appropriately at the end of their lives to have dignified deaths.

Is the service well-led?

Good

The service was well-led.

People and relatives found the registered manager approachable.

The staff team thought highly of the service and took pride in their jobs.

People, their relatives, and staff were all engaged with the service and were able to provide input into how the service worked.

The provider assured quality of service through the use of audits and analysis of incidents, compliments, complaints and suggestions.

The service worked with others to provide better care to people using the service.

Beech Court Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 28 and 29 August 2018 and was unannounced on the first day and announced on the second day. It was carried out by one inspector.

Before the inspection we reviewed the information, we held about the service. This included details of registration and notifications we had received from the service. We used information the provider sent us in the Provider Information Return. This 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 contacted the local authority with responsibility for commissioning care from the service for their feedback about the service.

We spoke with four people and four relatives. We looked at five people's care plans, reviewed ten medicine administration records, six staff files and maintenance records. We also reviewed complaints records, incident records, training records, minutes of meetings and audits. We spoke with the registered manager, the deputy manager, the training coordinator, one nurse, one senior carer and two carers. We used the Short Observational Framework for Inspection (SOFI) during one lunch time. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. We found recording issues of medicines being prescribed to people. We counted the controlled medicines and whilst the majority were correct we found one recording issue. The NHS defines controlled medicines as "classified (by law) based on their benefit when used in medical treatment and their harm if misused." We found two more controlled medicines tablets for one person than had been recorded. This meant that staff had miscounted medicines.

We brought this to the attention of the registered manager who immediately checked on the wellbeing of the person who had been prescribed the medicine, completed a medicines error form and informed the pharmacy. The registered manager informed us the recording issue had occurred that day citing the person's capacity to receive the medicines, their understanding and desire for pain medicines and their ability to communicate if they were not to receive their medicines.
Controlled medicines counts occurred daily and require two nurses to sign off and handover to each other and record in two separate books, one being the controlled medicines register and the other being total count score book of controlled medicines. Medicines were stored appropriately in locked rooms that were temperature checked regularly. They were systems to return medicines that had not been used and the pharmacy that provided medicines did so regularly, with capacity to do so at short notice and completed an annual audit at the service location.

We also found a medicine in a medicine trolley that was not recorded on a medical administration record (MAR) sheet. The registered manager informed us this likely due to the medicine being cancelled for use by the GP and that the medicine should have been removed from the trolley and destroyed.

We recommend that the nurses follow best practice guidance on medicines management and complete refresher medicines management training to ensure they are working to best practice standards.

We observed a nurse administering medicines and saw that they were caring and considerate and that a drink was offered to the person receiving medicines, who was also aware of what they were being offered.

We looked at MAR sheets for ten further people and found them to be correct. People told us that staff let them know what meds they are taking. One person said, "I can ask her [nurse]." Another person said, "Yes I get medication and offered water. " MAR records contained photos of people being prescribed so that staff knew who should receive which medicines. There was sufficient information about people within MAR record folders including their allergies, specific information about certain drugs and risks and signs of side effects. MAR Record folders also held information on who was able to administer medicines as well as the provider's policies around medicines.

People felt safe at the service. All the people we spoke with told us they felt safe living at the service. One person told us, "I wouldn't want to go anywhere else." We looked at the safeguarding records the service maintained. This included the alerts raised with the local authority, the investigations into safeguarding concerns and the notifications sent to CQC. Staff understood what abuse was and what to do if they thought

someone had been abused. One staff member we spoke to said, "Report to the manager any abuse – make sure the resident is safe first." Whilst another staff member said safeguarding was, "to protect residents from harm and abuse."

We were informed by the Registered Manager that training on Safeguarding was mandatory. We were provided a training matrix that indicated four carers and two senior carers had not completed their Safeguarding Adults at risk training. We spoke to the registered manager about this and they assured us that all staff would complete the mandatory training within the following month and provided us evidence of this whilst this report was being drafted.

Risk to people were monitored and managed. A relative told us, "They know definitely" when we asked whether staff about risks to people whilst another said of the same question, "Yes, definitely." The service maintained an accident and incident log that fed into audits the service completed.. Incidents and accidents were recorded appropriately and shared to relevant people. Ad Hoc meetings were held as well as regular meetings to discuss when things went wrong so that learning could be sought from them. The service acted appropriated when things went wrong.

The registered manager reviewed and analysed the audits and shared them with the provider and learning was shared with the staff team. Care plans held relevant risk assessments on people's physical and mental health needs. These included moving and handling, falls, nutrition and skin integrity. Risk assessments were reviewed and updated regularly. Staff used these risk assessments regularly to manage the care needs of people. One staff member said when asked if they used risk assessments, "Yes – and review them monthly or when needed. [about] Falls, using wheelchair, hoist, sling, nutrition, dehydration." These risk assessments and monitoring of incidents and accidents meant that the service knew the risks to people and managed them appropriately.

The property where the service was located was assessed for environmental risks regularly. These risk assessments and maintenance checks ensured risks to equipment and premises were minimised. These assessments included Fire system checks, gas safety checks, call bells checks, electrical appliance testing and moving and handling equipment checks.

The service ensured people lived in a safe environment as far as possible. Fire risks assessments and evacuation plans were maintained and reviewed regularly. Fire drills were completed and there were Personal Emergency Evacuation Plans (PEEP) for each person living at the service. There was a contingency management plan kept by the main entrance in case of emergency.

People told us there was enough staff. One person said, "Yes. they are good to us." They also went on to say, "They are not rushed." Relatives and staff said there was enough staff. One relative told us, " Yes there are definitely - they are forever walking up and down and they keep an eye on [person]."
The service used a dependency assessment tool to assess the staffing needs of people and created a rota accordingly. The provider used a bank system to cover shortfalls on the rota and did not use agency staff. This meant people were supported by staff who knew the service and had worked there previously.

Recruitment files demonstrated that all the staff working for the service had been verified as being who they said they were. They had relevant work experience and qualifications, were permitted to work in the UK, were of good health and received adequate Disclosure and Barring Service (DBS) checks. DBS checks assist employers employ suitable candidates by checking their criminal records and ensuring they do not feature on lists of people who pose a threat to vulnerable adults. Nurses had up to date pin numbers which meant they were qualified to practice as nurses in the UK. This meant Staff at the service were appropriately

recruited and the provider checked their suitability for roles.

People told us their service was clean. One person told us that the best thing about the service was "The cleanliness". We saw there was rota of domestic staff that cleaned the service regularly. Staff were trained in infection control and were able to talk us through how they prevented the spread of infection. One staff member told us they prevented infection through, "Hand washing. If we go to person we use PPE [Personal Protective Equipment] method. Gloves and aprons. Throw away things appropriately in the sluice room. The linen in personal care go to the red bags. ". The service had also recently received the top rating of five in food hygiene from the Food Standards Agency.

Good

Is the service effective?

Our findings

People's needs were assessed appropriately to provide them with good care. We looked at five care plans and saw that people's needs were assessed before being admitted to the service. Once admitted the service completed further assessment to detail each person's needs. Assessments were personalised and contained relevant information to provide necessary care. This meant the service knew whether they could provide the right care necessary to people before they were admitted to service.

Where relevant, assessments were signed which indicated that the person receiving the care, or a relative acting with their best interests, were involved with the assessments. One person told us, "[I came] straight from hospital and my sister dealt with [registered manager] and [deputy manager] when they first came." We saw assessments regarding dependency, nutrition, mobility, physical and social needs, mental state, capacity, risks, breathing and falls. All assessments we saw had been reviewed monthly.

Staff were trained adequately to fulfil their roles. One person said when asked whether the staff were skilled and knowledgeable, "Yes - because the nurse here saved my life." A relative said of the same question, "They are yes. I'm referring to nurses but the carers are excellent too. " All staff files we looked at showed that staff had completed induction with the provider. We also saw that the provider maintained a training matrix which gave them oversight as to what training each staff member had completed. Staff members told us they received the training they needed to perform their roles. One staff member said "There is level two and three training. Dementia and challenging behaviour training [too]." We noted that some staff members were completing National Vocational Qualifications (NVQs) with the support of the provider.

We saw that all staff had been trained in Equality, Diversity and Inclusion, Fire Evacuation and Safety, Moving and Handling, Food Safety Awareness and Infection control. Nurses had received training specific to their roles including medicine, bladder and bowel continence, pressure care and prevention and management of pain. This meant people were being cared for by staff who had the knowledge to deliver effective support.

Staff received supervision and had appraisals. Staff told us they received enough support to do their jobs. One member of staff said, "Yes. From nurses and manager. I get supervision from [nurse]. And I do appraisal annually too." We saw supervisions occurred regularly and that all staff received annual appraisals. The registered manager was able to track supervisions occurred and appraisals through spreadsheets and on line trackers within the training system. basis. The registered manager also completed observations to monitor the care being provided by nurses and to revalidate their registration as nurses. This meant staff were supported in their roles.

People were provided with sufficient nourishment and refreshment. One person told us, "There's a menu with two main courses and a pasta or salad or you can say what you want, something different like today, I had a cheese salad. They try to sort us out if we say we like stuff. The food is good." Another person told us, "the food is good." Care plans contained nutrition assessments and as well as tools to monitor food and fluid intake and people's weight. A GP visited the service weekly and had input on people's diets. We saw people also had input from Dieticians and Speech and Language Therapists around their diet and this was

recorded appropriately in their care plans. This meant people were supported to eat and drink healthily.

The service provided daily meals to people using the service. People could choose to dine in the dining room or have their meals in their rooms. We completed a SOFI during lunch time and noted that where necessary people were supported by staff to eat and drink. Staff attending to people sought their permission, asked their choices and provided care in a dignified and respectful manner. Where suitable they also prompted people to be independent and encouraged to feed themselves where they could.

People had the opportunity to feedback on the menu through surveys, in resident meetings and directly to the chef who we observed visited the different dining rooms on the premises.

There were systems for staff to communicate effectively with each other to support people. One staff member told us, "When we come to work we are informed by the nurse – if there is something everyone has to know then they will hold a unit meeting. We are also in the handovers." Staff held daily handover meetings where people's needs were discussed. There were also meetings held when information needed to be shared. There were up to date daily notes in each of the care plans we saw that recorded how people were. This meant knowledge of people's changing needs were easily shared among the staff.

People told us they had access to healthcare support. One person told us, "Yes if you want one [doctor or health professional] you just tell the nurse." Each floor had a nurse during the day whilst one nurse covered all three floors during the night. The nurses had responsibility for the care of people on the units they worked in. Nurses liaised with other healthcare professionals to support the needs of people. A GP visited the service weekly and there were also visits from chiropodists, pharmacists, speech and language therapists and opticians. All healthcare professional visits were recorded in people's care plans. This meant anyone providing care could see what the people's most recent healthcare needs were and how they were being treated by professionals. This meant that people's healthcare needs were supported by the service.

People's individual needs were met by design and adaptation of the premises. The service provided a lift so that people could move between floors. Corridors were sufficiently wide for movement of wheelchairs and Zimmer frames. There were hoists that were routinely checked to ensure their functionality and safety.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We observed people's consent being sought. One person told us, "Yes always [staff seek permission before providing support]." Staff working in the dementia unit provided choice to people and sought their consent when assisting them with their lunch. This demonstrated that even though people lacked capacity in some aspects of their lives, staff still wanted to ensure that people were provided to with a choice and asked to make their own decisions where possible.

People's care plans contained capacity assessments. A staff member told us, "the residents are assessed to see if they can make decisions." They continued, "Some of them cannot weigh up the info you give them. [So we] Involve the family and do best interest assessments." Where people lacked capacity, there was paperwork demonstrating best interests decisions were being made on their behalf by relatives, social services and health care professionals. Where people lacked capacity, and had their liberties restricted either through locked doors or bedrails, there were copies of their DoLS applications and or authorisations to the local authority.

We saw the provider had applied for DoLS for 13 people. The provider was waiting on one to be authorised but had completed all the necessary paperwork and was waiting on the local authority's approval. The service kept a folder for people's DoLS applications and authorisation, which duplicated paperwork in their care plans. This meant the registered manager had ready access to information about people whose liberties were being restricted. We also saw that the registered manager had notified CQC about DoLS authorisations.

Staff understood MCA and DoLS. They had received training on MCA and DoLS. Staff we spoke with were able to tell us about consent, choice and the principles of the MCA. One staff member said, "That resident who have mental capacity they can make their own choice and wishes." Another staff member said this about consent, "We need to assess and then the manager does the DOLS assessments to see if they[people] can understand or retain information."

Good

Is the service caring?

Our findings

People told us that staff treated them kindly and were caring. One person told us, "They[staff] treat us very well." We observed staff interacting with people whilst completing their jobs. We saw people were treated with the dignity and respect. Staff were pleasant and smiled when providing care to people and acted courteously and professionally. Staff asked permission before doing anything with people and sought their choice where possible. This meant people were treated compassionately with kindness and respect.

We spoke to relatives who continued to visit the service after the death of their loved ones, as they had formed an attachment with the other people and staff. This indicated that staff were compassionate in their work and understood the needs of people and the relationships they have. When we asked whether staff were kind or caring, one relative told us, "Very…if they hadn't caught [person] with the fit they would have died." Another relative told us, "When [person] had pneumonia – [staff member] stayed late with them and [staff member] was in and out putting cloths on his head."

We saw numerous compliments made to the service about the care they provide. Many stated staff were, "caring" and "thoughtful." The registered managers placed complimentary cards up on a notice board in reception where they had received thanks from relatives about the care that had provided. In some instances, these cards were received after the person using the service had died and the relative wanted pass on their gratitude for caring for their loved one in their final days.

Care plans were signed and contained notes indicating people's involvement in them. One person told us, "My two daughters were involved – they do the paperwork I leave it to them." Where people could not be directly involved in their care planning due to a lack capacity, their relatives, the service and the local authority supported them in making best interest decisions. People and their relatives told us they were involved in the care planning. This meant people were involved in decisions about their care and treatment.

People and relatives expressed their views at meetings. One relative told us, "I don't normally go to the relative meeting, If I had a suggestion I think they'd listen" The service held quarterly resident meetings. These meetings were publicised on notice boards and minutes indicated when the next meeting would be. People told us they were able to attend meetings should they wish. Similarly, there were quarterly meetings held for relatives. Topics discussed at both meetings covered food, activities, maintenance, housekeeping, care planning and fees.

The registered manager also held a weekly surgery. Whilst the surgery wasn't minuted in the same manner as a meeting, we saw that the registered manager had recorded the input from people attending and drawn out actions in response. During the inspection we also saw that if any person was inclined, they could visit the registered manager in their office as the door was usually open and the registered manager welcoming in their manner to visitors.

Staff told us they respected people's privacy and dignity and people and their relatives confirmed this. One staff member told us, "This is my responsibility. If the personal care [in their room] I make sure the windows

and doors are closed and ask them whether they are ok and I will take them to the toilet and whether it's ok to change their clothes and I assure the resident and complete my task. If they are afraid or not feeling safe I make sure they are feeling safe and talk to them and listen to them." A relative said, "God yes. Definitely. They put a screen around to make sure its kept [their dignity]." This meat that people's privacy and dignity was respected.

People's confidential information was kept secure. Peoples' care plans were kept in a locked cabinet in a locked office. This meant that only staff could access confidential information.

We observed people coming and going from the service. This indicated they could do as they wish and remain independent. All the people we spoke with told us staff support them to remain independent. One person said, "Yes if you want to do things you can." Staff confirmed what people told us and explained they encourage people to do what they can. They mentioned, "If they are capable to do it, give them a fork and everything – if they can't hold a fork then help but it's all in the care plan." This meant people's independence was promoted.

Good

Is the service responsive?

Our findings

A staff member told us about people's care plans, "They are helpful and they show us what to do and care for the residents." Another added, "we can read it and understand the past of the resident. What care has to be given. It's very helpful." We looked at people's care plans and saw they documented people's needs and preferences. All care plans had photos and personal details and advanced care plans at the beginning of the file. This meant that staff could access important information immediately in emergency situations.

Care plans detailed people's physical and mental health needs and focused on their social profile and preferences. Social profiles were presented in diagram form. This meant the service had taken steps to provide information in a non-verbal way, which would benefit people who had communication difficulties. This meant people received personalised care suited to their needs.

Care plans also contained snap shot care plans. These were two-page documents that briefly indicated the needs and preferences of people in summarised fashion. They covered medical histories, emotional and psychological needs, maintenance of a safe environment, food and drink, as well other headings that would assist staff with accessing important information in an immediate way. This meant that new staff members could easily find out about a person's needs without having to read the entire care plan.

The service provided activities for people to attend. One person told us, "We have things that go on, and on Fridays an entertainer comes and you can go to them through the week. "A relative told us, "[activities coordinator] comes and talks to [person]. They lift people's spirits." We met the activities coordinator and saw a regular program of events. Care plans held records of activities people had been involved with each month. This extended to one to one activities for those who were unable to leave their bed or chose not to participate in group activities. Activities included hair dressing, massage, bingo, reading the paper and visiting entertainers. This meant that people had things to do and their daily lives were enriched by activities the service provided.

The service was visited by different religious denominations who would support residents to either attend an external service or receive prayers at the service. The staff also supported people by escorting them to places of worship. This meant people were supported to maintain religious faith should they choose to.

People knew who the registered manager was and their deputy and told us they would complain to them should they need to. They also told us they felt their concerns would be listened to. One person when asked who they would complain to said, "I suppose [registered manager] – the head lady or [deputy manager] – oh yes I think so [I would be listened to]." We looked at the complaints received and saw that they had been responded to appropriately. We saw that the registered manager had written to the complainants and provided an apology where suitable and demonstrated the concern raised had been dealt with. This meant peoples' concerns and complaints were recorded and responded to appropriately.

People were supported appropriately at the end of their lives. We asked people whether the service had supported them with their end of life decisions, one person said, "Oh yes I've done all that." The service

completed end of life and advanced care plans for people. These documents sought to gather people's wishes and preferences in regards to their deaths. One staff member we spoke to attended End of life training during the inspection. They told us "I am going for End of Life training tomorrow – about red bags. We don't have them yet. But we will soon." The red bags they referred to were also known as just in case bags and would keep important information about a person's health in one place that was easily accessible to ambulance and hospital staff.

Good

Is the service well-led?

Our findings

People told us the service was well managed. One relative said, "[Registered manager], they're quite good. they listen to what you say. They look at you when you're talking."

The service had a registered manager. One person told us the registered manager was, "Very approachable." The registered manager was supported by a deputy manager. Both registered manager and deputy manager were registered nurses. This meant they were able to clinically supervise the nurses providing the clinical care at the service, understood the pressures in the nurse role and were able to cover if necessary. Both registered manager and deputy manager were thought of positively by people, relatives and staff.

The nurses at the services supervised the carers in each unit. All the staff we spoke to thought highly of the service and two of them stated that teamwork was what the service did really well whilst others spoke of a sense of family in the work place. One staff member said, "We work as family and if there is a problem we talk." We observed staff readily supporting each other and responding to requests for support in a friendly manner. This demonstrated a positive culture where staff were willing to work together to achieve better care for people using the service.

Staff communicated the changing needs of people through handover meetings, daily notes and other meetings. Staff also told us they would contact their colleagues over the phone to ensure they had the right information to fulfil their roles. We also observed staff communicating changing needs with family members in person and over the phone.

Staff were supported to do their roles. Staff told us they received enough support to do their jobs. One member of staff said, "Yes. From nurses and manager. I get supervision from [nurse]. And I do appraisal annually too." We saw supervisions occurred regularly and that all staff received annual appraisals. The registered manager was able to track supervisions occurred and appraisals through spreadsheets and on line trackers within the training system.

Staff, people and relatives were engaged with the service. Staff residents and relatives could all engage with and provide input into service direction through participation with meetings. We saw minutes from all these meetings. The entire staff team met every six months whilst nurses, housekeepers and night staff held meetings at more regular intervals. These meetings provided forum for staff to receive updates from the provider and to give input into the operation of the service. Staff told us they felt they had a voice in the service. One staff member said, "Yes – I've got a big mouth, if I don't like it I can open it and say something. Yes [I] make a difference because my interest is to give the residents a higher standard of care."

People and relatives completed surveys to provide feedback to the provider on the standard of care being provided. One person said, "Yes, I've filled out a form and had my say," A relative told us, "Yes, I've done one [survey]," We saw that there was general approval of the quality of staff, food and services being offered.

The provider maintained quality assurance through audit and analysis of accidents, incidents and

complaints. When we asked whether they were involved in any audits, a staff member told us, "Yes – some infection control audit and peer auditing with the care plans." The registered manager, and staff they delegated, completed numerous audits to check on the service being provided. We saw monthly medicines audits that were detailed and covered a variety of topics including administration of medicines, ordering and receiving, recording methods, storage and disposal of medicines.

The registered manager audited care files checking that all sections were complete ensuring that people's needs and preferences were recorded. There were further audits on catering, infection control, personnel files and controlled drugs and homely remedies. Most audits we saw were scored and all provided scope for actions to be completed. Most audits were completed quarterly other than those completed monthly. The registered manager maintained a schedule for audits on the wall of their office. Nurses told us they also peer reviewed each other's care files.

The provider's quality team and the local authority also attended the service to completed quality audits. The provider's quality audit occurred every six months, would check the audits the registered manager had completed and provided detailed actions which the registered manager would draw into an action plan and then complete. We saw that the registered manager had completed the majority of actions drawn from the most recent quality team audit and the outstanding actions were delayed to waiting on external contractors to provide documentation. All these quality assurance processes and audits meant that the service sought to continually improve, making the service better for people who used it.

The service worked in partnership with other agencies. The service had good links with local health care services and was visited weekly by a GP. The registered manager was involved with the Havering care association and kept up to date on best practice through subscription to magazines regarded highly in adult social care. The registered manager was also able to talk to us about attending a recent local conference on end of life care. This meant the service sought to provide better care to people using the service whilst keeping up to date with innovation and best practice.