

Mr C and Mrs LA Gopaul

Kenilworth Nursing Home

Inspection report

26-28 Kenilworth Road
Ealing
London
W5 3UH

Tel: 02085671414

Date of inspection visit:
03 May 2017
04 May 2017

Date of publication:
24 July 2017

Ratings

Overall rating for this service

Requires Improvement 

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?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 3 and 4 May 2017 and was unannounced.

The last inspection took place on 11,12 and 13 April 2016, when we identified breaches regulations relating to safeguarding service users from abuse and improper treatment, safe care and treatment and the need for consent. Additionally we recommended that the provider continue to make improvements to the environment in line with the National Institute of Care Excellence (NICE) guidance about environments for people with dementia.

The provider sent us an action plan dated 24 June 2016 indicating how they would address the issues raised at the inspection. Improvements had been made, but some areas required further improvement.

Kenilworth Nursing Home is a nursing home registered to provide accommodation, personal and nursing care for up to 40 people, some of whom are living with the experience of dementia, mental health conditions and people that are being cared for under the Mental Health Act 1983. At the time of our inspection there were 33 people living at the service.

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.

We found that the service did not always administer medicines as prescribed. The provider told us they assessed the competency of staff who administered medicines but this had not been recorded at the time of the observation.

The service had safe recruitment procedures in place and there were a sufficient number of staff to meet people's needs.

People using the service were protected from harm and abuse. Staff had safeguarding adults training and they knew how to report any safeguarding concerns they might have. Safeguarding information was displayed throughout the service.

The service had risk assessments and management plans in place with guidance on how to minimise risk and promote people's wellbeing.

Staff were supported through supervisions and appraisals to have the skills they required to provide care and support to people using the service. However, observational spot checks were not formally recorded.

We saw evidence that consent to care and treatment was sought in line with the Mental Capacity Act (2005)

guidelines.

People's nutritional needs were assessed and met.

People's files contained evidence of timely referrals and access to relevant healthcare professionals.

We observed staff were kind and caring. They treated people with dignity and respect and gave people the opportunity to make choices and have control of decision-making. Staff were aware of people's individual needs and preferences.

The service had an accessible complaints procedure and people we spoke with knew how to make a complaint.

The service had systems in place to monitor how effectively the service was run to ensure people's needs were being met.

Relatives and staff said they could speak to the registered manager about concerns.

CQC is currently considering the appropriate regulatory response to the repeated breach of Regulation 12 and we will report on this once this work has been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Medicines were not always administered safely. Medicines competency testing was recorded as a discussion instead of an observation.

Safe recruitment procedures were in place and the service had sufficient staff to meet people's needs.

Staff could identify different types of abuse and knew how to respond appropriately to keep people safe from harm.

People had risk assessments and risk management plans in place to minimise the risk to people using the service.

Requires Improvement 

Is the service effective?

Managers and staff indicated practical observations were being undertaken but these were not being formally recorded.

Staff received supervisions, appraisals and up to date training to develop their skills.

The service was working within the principles of the Mental Capacity Act (2005).

Dietary and nutritional needs were met.

There was good access to and communication with healthcare professionals.

Good 

Is the service caring?

Staff treated people respectfully and kindly.

People were supported to have choice and make decisions.

Staff respected people's dignity and privacy.

Good 

Is the service responsive?

People were involved in developing their care plans and these recorded people's preferences.

Good 

There were few complaints but these had been responded to appropriately.

Is the service well-led?

There was no overall audit for either people using the service or staff files, but there were a number of other audits and data management systems in place.

The service had good community links.

Managers were knowledgeable about people's needs and preferences.

People using the service and staff said they could approach the management team.

Requires Improvement 

Kenilworth Nursing 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.

The inspection took place on 3 and 4 May 2017 and was unannounced.

The full inspection team for two days included an inspector, a pharmacist and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of supporting someone who was living with dementia and experience of using mental health services. On 3 May 2017 the inspection team consisted of an inspector and an expert-by-experience and on 4 May 2017 an inspector and a pharmacist undertook the inspection.

Prior to the inspection we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We viewed the Provider Information Return (PIR) which the provider completes and sends to us to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority's Safeguarding Team and Clinical Commissioning Group to gather information on their experience of the service.

During the inspection we spoke with nine people who used the service, three relatives and one visiting professional. We observed staff interaction with the people who used the service. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We spoke with the registered manager and deputy manager and interviewed eight staff including the nurses, care staff and catering staff.

We looked at the care plans for eight people using the service. We viewed eight files for staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. We also looked at records including maintenance and servicing checks and audits.

Is the service safe?

Our findings

At the inspection on 11,12 and 13 April 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because we found that some of the medicines practices the staff followed meant that there was a risk of errors and therefore a risk to people's safety and wellbeing. These practices included that the staff did not always follow the provider's procedures for recording medicines, specifically regarding handwritten information on the medicines administration record (MAR), PRN (as required) medicines were being administered as a daily dose and medicines were being transferred from their original container into a dossett box (secondary dispensing). Additionally, the provider did not have evidence that they had assessed the competency of the staff administering medicines.

At the inspection on 3 and 4 May 2017 we saw as per the provider's action plan, they had employed a new pharmacy. All the MAR charts were now typed and if there were changes, the pharmacy provided a new MAR chart and there was no longer a need for handwritten information on the old MAR charts.

We saw evidence, and this was confirmed by the GP, that the service completed a list of points for the GP to address on their weekly visit and this included reviewing the medicines of people who received PRN medicines regularly and a new, more robust PRN form was implemented.

The risk of secondary dispensing for social leave was resolved through the pharmacy providing a separate blister pack with medicines for the exact amount of time the person was away from the service.

The provider's action plan dated 24 June 2016 stated that nurses who administered medicines would complete medicines competency assessments. However, we found during the 3 and 4 May 2017 inspection, competency assessments were being done as a discussion exercise during a one to one meeting with the manager rather than as an observational exercise that was recorded at the time of the observation. The registered manager explained that there had been observations prior to the one to one meetings and this was what was discussed at the meeting. Nonetheless, the records we viewed showed that not all staff responsible for administering medicines had completed their medicines competency assessment training and this had potential to undermine the safe management of people's medicines.

At the inspection on 3 and 4 May 2017, we looked at MAR charts, care plans, audits and training records in relation to medicines management. We also spoke to nursing staff and the home management team regarding medicines management and administration.

We observed the majority of tablets in the blister packs contained dispersible aspirin which should be dissolved in water before swallowing. We asked two staff nurses how these were administered and were told that all medicines were given to people using the service to be swallowed with a glass of water. When we discussed this with the registered manager, they consulted their pharmacist and GP, and responded that the dispersible aspirin could be taken whole with food or water, although ideally it should be dissolved or mixed with water, that it can be swallowed and that only soluble aspirin should always be dissolved. We agreed that for the three people receiving covert medicines this was not an issue as they were receiving the

dispersible aspirin in food and we saw evidence of this in the paperwork. However, for those not receiving medicines covertly there was no evidence to suggest they were receiving the dispersible aspirin with food. Furthermore, on the blister pack and MAR chart it was clearly labelled, "dissolve in water before swallowing", and the instructions were not followed. Additionally the nurses administering the medicines appeared not to be aware that the medicine had changed from enteric coated aspirin to dispersible aspirin. Lastly, incorrectly administering medicines in this way was not picked up by the competency testing, indicating the current practice of observing without writing the observation down at the time of the observation was not effective. This meant the service was not consistently safe and put people at risk of harm.

We saw evidence that a topical cream was not administered to a person using the service as prescribed. It was not signed for by nurses on the MAR chart as given and nor was a code used to describe why it had not been given as per the service's medicines guidance. When we discussed it with the deputy manager they advised the cream was not signed for as refused because it was PRN and that the person was on the list for the GP to review their medicines that week. However, there was nothing on the MAR to indicate it had been cancelled.

The above paragraphs show a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw records of fridge and room temperature monitoring although it was unclear how accurate the recorded fridge temperature was. Consequently, before we completed the inspection, the provider purchased a new fridge to store medicines in.

Medicines received from the pharmacy were recorded on the MAR charts and the quantity could be reconciled with the administration records which were clear and accurately documented. We checked the medicines disposal records and found that only two items were documented as returned or destroyed in the last twelve months. Medicines were stored safely and securely.

We saw evidence that people who had their medicines administered covertly had the appropriate documentation. Covert administration is when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. An appropriate assessment must be performed by a medical practitioner to establish whether the person lacks mental capacity. If it is determined that the person does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the service user's best interest. Paperwork was in place to document the process by which the covert medicines decision had been made with review dates.

The GP visited weekly, people's medicines were reviewed regularly by their GP or other healthcare professionals and we saw some evidence of medicines reviews carried out by people's GPs. Additionally the local Clinical Commissioning Group (CCG) pharmacist had completed an audit in February 2017 and made two minor recommendations that had been actioned.

We looked at the recruitment files for eight staff members. The provider had safe recruitment procedures in place. However, we saw one file where the reference from a previous employer was not listed on the application form and two files had references that did not have the previous employer's stamp to indicate the references were authentic. We discussed this with the registered manager and they agreed to follow up references and record any discrepancies in the future.

The service had a suitable amount of staff to meet the needs of people using the service and the staff team

was stable. The service did not use agency staff but had their own bank staff that were familiar with the needs of people using the service. When we asked relatives if they felt staff were available and communicated with them, they told us staff were available and communicated appropriately. Comments included, "I think they are all lovely, very kind, friendly", "Yeah there is a lot of staff", "Truthfully, I am a retired (healthcare professional) and they are excellent, very, very good!", and "Yes, they never leave the lounge unattended, always staff there". Most people using the service told us they felt safe.

Staff we spoke with had received relevant safeguarding adults training, were aware of different types of abuse and what action to take if they suspected abuse. Comments included, "I would talk to the staff nurse and then the manager and to CQC (the Care Quality Commission) and the council" and "If I saw bruising I would report it to the staff nurse and management. I can call the council and we have a number here for the safeguarding team." The service had safeguarding and whistleblowing procedures that had been updated in the last year to keep people safe and provide guidance to staff.

People had risk assessments to identify risk and risk management plans in place to minimise the risk to people using the service. Assessments included moving and handling, pressure ulcers, nutrition, risk assessments for falls and fire risk assessments (specifically with regard to smoking). There was clear guidance for staff on how to manage the risk. We saw where people did not have capacity to make decisions, risk management plans had been discussed with family members.

The service recorded and acted on incidents and accidents appropriately. Notifications were made as required to the local safeguarding team and CQC. Care workers told us they had an accident book for both staff and people using the service and the "staff nurse would be the first point of contact unless you need to call the ambulance service." Incident forms included the action taken and follow up action. We saw the service was undertaking a yearly falls audit as part of their incidents and accidents analysis and management.

People lived in an environment which was safely maintained. The London Fire Brigade had inspected the home in June 2016 and found them to be compliant. Fire equipment was regularly serviced and fire training was conducted yearly. Fire drills took place monthly and the nominal role for people using the service stated what support people required to evacuate the home. Additionally, people's bedroom doors were colour coded to indicate if they required assistance to evacuate the building.

The service had a no smoking policy in the home and had a large, accessible garden with a designated smoking area which was constantly in use. We received feedback concerning smoke from outside blowing into bedrooms near the smoking area. When we discussed this with the deputy manager they said they were already aware of the concerns and were in the process of making changes to address the issue. The home environment risk assessment had been reviewed in August 2016 and updated to include areas such as second hand smoking. The service had a number of service contracts that checked the electrics, water and equipment such as hoists.

Is the service effective?

Our findings

At the inspection on 11,12 and 13 April 2016 not all the people sharing bedrooms had evidence in their files of consenting to share a room. At the inspection on 3 and 4 May 2017, people's files contained signed shared bedroom consent forms. Where the person was not able to consent, there was evidence of capacity assessments and best interest decisions being made that involved the family, social care professionals and advocates.

The service was actively trying to reduce double bedrooms. The home was in the process of being refurbished and several double bedrooms had been converted to single rooms with en-suites. When bedrooms had become available, people sharing rooms had been offered single rooms but most of them declined.

At the inspection on 11,12 and 13 April 2016, protocols for some people who received medicines administered covertly (without the person's knowledge) had not been agreed by the prescribing doctor, person's next of kin or dispensing pharmacist and there was no recorded review date for these decisions. At the inspection on 3 and 4 May 2017, we saw that the service was working within the principles of the Mental Capacity Act 2005 (MCA) as each person being administered covert medicines had a record of the best interest decision, signed by the relevant people and reviewed every six months by the GP.

At the last inspection we recommended that the provider continue to make improvements to the environment in line with the National Institute of Care Excellence (NICE) guidance about environments for people with dementia. During the inspection on 3 and 4 May 2017, there was evidence the provider had made improvements to the environment by painting doors differently, having distinctively different coloured furniture and flooring and providing people with more sensory stimulation such as sensory lights and cushions.

During the inspection on 3 and 4 May 2017 we observed that staff had a good knowledge of how to support the people they cared for. Healthcare professionals told us, "The core clinical team is stable and consistent over time, this has the significant benefit of ensuring that the people providing care know their residents well and are able to provide consistent care and respond to any changes in presentation as needed" and " (The service) can have challenging people and they handle it well."

Staff were supported to develop their skills through inductions, supervisions and appraisals. We looked at 19 supervisions completed in February 2017 and saw areas discussed included performance and procedures. For example, we saw one supervision discussion on infection control and another recorded the person had been tested (verbally) on their safeguarding knowledge. About supervision, care workers told us, "At least you know if you are falling back on something and it can be pointed out before it goes any further. It's good to get a review" and "We get to discuss what we need to improve and we get to discuss a bit more about the work." Additionally we viewed 16 appraisals for 2016/17 and the appraisal matrix indicated all staff who had been with the service for longer than a year had an appraisal.

Care workers were assisted to develop the skills required to support the people they provided care to. The service promoted training and once new staff had completed their six month probation, they could apply to undertake a health and social care diploma.

Training the provider considered mandatory and that staff had completed in the past year included safeguarding adults, Mental Capacity Act (2005) training, moving and handling, medicines, mental health awareness, therapeutic activities and dementia awareness. Some staff members had completed advanced courses including medicines training and challenging behaviour. The service's internal training officer provided training on the weekends and we saw areas covered included privacy and dignity and fluids and nutrition. Managers and staff told us the training officer carried out observations of care worker's practice and provided feedback. However, the observations were not formally recorded as stand-alone documents. We spoke to the deputy manager about this and they agreed to record practice observations.

The service communicated effectively and professionals and family members said they were kept informed. Staff had handovers between shifts and there was always a senior staff member available to provide support. Staff we spoke with said they could seek guidance from either a staff nurse or one of the management team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Care workers had completed Mental Capacity Act training and understood the principles of the MCA. Comments included, "If people are able to make decisions, they can consent to care and make their own decisions which we have to respect. If they can't we would apply for DoLS", "If a person is able to consent for themselves (then) I can advise residents, if they say "No", I can't take it upon myself to say what's best. If somebody is wearing clothes not appropriate, I will gently tell them or maybe remind them, they don't eat pork" and "We make sure they make their own decisions. Everybody is different. People decide when they go out, how they dress and what they want to eat."

When we asked people using the service if they could go out when they wanted to, they said, ""No not at all", "Yes", "Mostly, yes", "I am free to go but have nowhere to go", "Yes I do sometimes. I have an escort" and "I haven't asked yet, but if I need to go anywhere I get escorted". Some people had DoLS authorisations and their liberty was therefore legally restricted.

The service applied for DoLS authorisations appropriately and kept a record of applications, authorisations and expiry dates. Where a DoLS authorisation had been granted this was recorded clearly with any conditions attached and what action staff needed to take to meet the conditions. This was signed by staff and a family member and reviewed monthly.

Not all files had a signed care plan agreement which listed a number of items the person consented to such as their care plan, administering their own medicines, the use of their photo, sharing a room and holding

money. People who were newer to the service had these generic consent forms and the deputy manager advised they were currently auditing everyone's files and the consent forms were included in the audit.

People's nutritional needs were assessed and recorded and we saw evidence of involvement with the speech and language team and the dietitian. Where required, people's weight was monitored. We asked people if they enjoyed the food and if they could eat when they wanted to. Comments included, "No do not like it here at all, do not like any meals", "Lunch is very good", "No complaints about the food, quite well fed really" and "Yeah during the course of the day, (we have) sandwiches and biscuits, other than main meal." We observed people being offered drinks throughout the day and when anyone asked for a snack, staff brought them one.

There was a choice of meals prepared freshly each day and the daily meal request form recorded specific needs and preferences, for example if the person was diabetic, required soft foods, favoured a certain cultural dish or required one to one support. Minutes from residents' meetings indicated food and menus were discussed. We also saw evidence that managers carried out a mealtime assessment which made recommendations that were shared with the staff to action.

People using the service engaged with a number of other professionals and this was confirmed by the people we spoke with. Comments included, "Yes, optician and dentist", "I try to. I see the dentist and go to the hospital" "No, but I have a caring social worker I do not see often" and "I do get to see a dentist". People's files had multi-disciplinary contact records of various professionals who had seen them. These included occupational therapists, speech and language professionals, dieticians, advocates, GPs, chiropodist and a diabetic nurse. Healthcare professionals said, "I find the service communicates well highlighting issues and concerns that the Clinical Commissioning Group (CCG) requires assurance about appropriately" and "If anything crops up, they will call. It's a good working relationship."

Is the service caring?

Our findings

When we asked people using the service if staff listened to them they told us, "Depends on the person. Some (are) good, some not so good", "Well some do, some don't", "They are here they listen", "They do their best I suppose" and "Yes they are pleasant." Relatives said, "They are very, very good. When he first arrived he showed challenging behaviour, but they dealt with that. He is still a bit unpredictable but they manage", "I can see the way they are with others. I have never seen staff treat residents other than very well" and "Yes they do (treat people with respect). Everyone is very caring." A healthcare professional told us, "I think it is a very caring atmosphere and I pick that up from speaking to relatives."

The deputy manager told us, "In the care plan there is a section of personal choices and preferences. You tell us what your routine is and that's what we'll do." We saw evidence that one person who was interested in music was supported to attend a recording studio monthly and another person attended a day service. The service had contact information displayed for a number of local places of worship. People told us community members from differing religions visited the service and some people preferred to visit their place of worship in the community.

We observed people calling some staff by name, and care workers responding in a cheerful manner. When someone asked a care worker for "anything" to eat, the care worker sat down by them and offered them several options. Care workers knew the needs of the people they were supporting and we saw them talking to people about their specific interests, for example sport or music. We saw that there were a number of staff, and not all care workers, who spoke to people in their first language. We also saw more than one care worker manage inappropriate behaviour discreetly.

People were treated with dignity and respect. We asked care workers what was important when they were supporting people with personal care. They told us, "The main thing is, knock on the door, say "Hi" and ask do they want a bath or shower. You have to always give them the option even if they can't respond (verbally)", "You have to engage. You have to tell them what you are doing throughout the process and keep communicating with them" and "We know who likes to wear shirts and we wouldn't put them in T-shirts. Other people always like to have a handkerchief in their pocket. We help to dye their hair and do their nails and make-up." One person confirmed, "Sometimes they paint your nails and sometimes they help with my bath and putting on clothes."

Meetings for people who used the service were held monthly. Areas of discussion included menus, safeguarding and complaints. The service had information for advocacy service displayed and people with Deprivation of Liberty Safeguards (DoLS) in place had advocates.

We saw evidence in individual files of end of life discussions with people and their families.

During our inspection we observed family visiting people at the service and the files we viewed recorded family involvement where appropriate.

Is the service responsive?

Our findings

We viewed the care plans of eight people using the service. We saw that people and their families were involved in contributing to planning their care. People said, "I do have a care plan" and "Yes I have had several". Relatives told us, "When (person) first arrived I went through the care plan with the care manager, it all seemed appropriate" and we completed a "care plan when he came and updated it." People had an initial assessment and there was information provided from other services such as the local authority. We saw people's individual needs and preferences were recorded and they were encouraged to have choice and control where possible. This included areas such as if they preferred a male or female carer, their likes and dislikes and their morning and evening routines. For example, one person's file indicated they liked to receive communion every Friday and the type of music they liked. There was also a personal profile that included information regarding people's families and interests. We saw all care plans had been completed within the last year, were signed and that everybody had a review of their needs completed within the last two months. A healthcare professional told us, "Services they provide are in line with identified need as documented in individual residents' records. I am not aware of deviation from care plans in the provision of care."

Some people using the service had Antecedent-Behaviour-Consequence (ABC) charts and we saw care plans contained information on how to support people displaying certain behaviours. Files provided staff with guidelines on both how to prevent and manage specific behaviours. For example, one care plan said, 'Call him Mr (name). Explain the procedure, maintain his wishes, choice and dignity and avoid confrontation.'

Each person had a daily log which was mostly task orientated and recorded any activities people had attended that day. We saw hourly monitoring charts for all people completed during the day and night time monitoring was dependant on people's needs.

Care plans recorded the kinds of social and recreational activities people enjoyed. The deputy manager told us they were trying to do some more meaningful activities that increased people's confidence and helped them particularly if they were being assessed to move to more independent living. These activities included baking once a week which was popular as people were able to eat their finished products, hair and make-up skills and domestic skills in people's bedrooms. The service had an activity co-ordinator who told us they were trying to incorporate a better understanding of dementia and Alzheimer's into their activities and were now using sensory lamps, sensory matts and had reminiscence cards to prompt conversations with people.

There was an activity schedule which had excursions twice a month and a programme of daily activities in the lounge. On alternative weeks the service had either a harpist or a person who played more lively music to entertain people using the service. We saw evidence that people celebrated cultural festivals. For example, they had recently celebrated Easter.

During the inspection, we saw people going out with support and a number of ongoing activities in the larger lounge. This included ball games, board games, knitting and individuals reading. We saw some people throwing a ball between themselves and laughing. Other people required one to one support and we

saw staff singing songs with one person and polishing another person's nails.

People told us that they knew how to make a complaint. The complaints policy was reviewed in December 2016 and each person's room had a complaints form with contact details for the local authority and the Care Quality Commission. One person told us if they had a complaint they would write a letter. The registered manager told us they encouraged people and their relatives to talk to him if they had any concerns. The complaints we saw had been responded to appropriately and included a 'lessons learned' section.

Is the service well-led?

Our findings

We found that the provider had responded to and acted on concerns from our previous inspection on 11,12 and 13 April 2016 and we saw evidence of improvements to the service. However, some of these improvements were not enough to keep people safe and mitigate risks. For example, we found a repeated breach relating to the safe management of medicines. The provider's audits had not identified this risk or gaps in the records about the staff regarding recruitment and practice observations were not recorded. However, the deputy manager said that they had begun an audit of the files and said they would complete this for everyone's files.

People told us they could speak with either the registered manager or the deputy manager. Comments included, "Yes she is alright, I get on with her well", "He is a wonderful manager" and "Yes I am able to talk to the manager". Relatives said, "I think it is managed on a best interest of the patients basis", "Manager is so approachable and deputy very approachable", "Yes they are (visible on the floor) and I have just seen the manager" and "He is always approachable, if not here always on the end of a phone. The deputy manager is very, very approachable too. Very helpful".

The service was a family run business and the staff team was stable. Staff we spoke with said they felt supported by the management team and that they were always accessible. Comments included, "The managers are here more or less every day and we've been given their phone number. They're very hands on. They're easy to approach" and "The manager is really nice. They're here most of the time. They're here on the weekends."

We saw minutes from monthly team meetings which indicated areas covered included safeguarding adults, activities, health and safety, complaints, activities and menus. Care workers said, "At team meetings we are all talking about what we think is good for the client. Everyone has their own idea and management will decide" and "Team meetings are really helpful. We discuss about the patients. A lot of us get to discuss what's happening on the floor. It's really good. We all listen to each other."

The service had a number of weekly and monthly checks and audits to monitor the quality of the service delivered to ensure the needs of the people using the service were being met. These included a weekly wound check for high risk people, a referrals audit of people they had referred to other professionals, monthly infection control audits, a monthly checklist for food safety and hygiene regulations, a weekly kitchen cleaning schedule, a weekly call bell maintenance check for people who damaged call bells and monthly call bell audits for all people who used the service, monthly maintenance schedules and a monthly fire audit. A Disclosure and Barring Service (DBS) audit was completed in December 2016 and we saw in line with the service's policy, staff DBSs were being renewed every six years. However, there were no overall audits for people using the service or staff files to ensure that all the required documentation in individual files was up to date.

The service had completed an audit of key challenges for the coming year and an action plan. Additionally we saw annual maintenance and decoration plan for the process of refurbishing the whole home.

The management team kept up to date with good practice through attending the local authority's provider forums and registered manager forums. They also had links with the local authority and local CCG. The service had recently registered with the Social Care Commitment scheme, which is the adult social care sector's promise to provide people who need care and support with high quality services.

The registered manager had notified the Care Quality Commission and the local authority of significant events as required.

The service had undertaken satisfaction surveys with both people using the service and staff. Overall, the feedback was positive and the service had analysed and completed an action plan as a result of the surveys.