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Ella McCambridge Care Home

Inspection report

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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 21 and 22 August 2018 and was unannounced. This meant the provider and staff did not know we would be coming.

We previously inspected Ella McCambridge Care Home in August 2017, at which time the service was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the previous inspection we rated the service as requires improvement. At this inspection, whilst there had been improvements in some areas, the service remained rated requires improvement.

Ella McCambridge 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.

Ella McCambridge accommodates a maximum of 67 older people across two floors. Nursing care is not provided. The first floor supported people with higher levels of dependency. The service supported people, on both floors, living with dementia or a dementia related condition. There were 55 people using the service at the time of our inspection.

A registered manager was in place, with suitable skills and experience. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 manager had applied to be registered with CQC and was registered as the manager prior to the completion of this report.

Medicines administration practices required improvement, particularly with regard to topical medicines (creams), patches, and protocols for when people required medicines 'when required'. The registered manager and deputy managers began improving these processes during the inspection, as well as reviewing how medicines were audited. This was another area identified as requiring improvement.

At the previous inspection we recommended that the provider review guidance regarding dementia friendly environments and make improvements. We found they had done this and the surroundings were in line with dementia-friendly good practice. The premises were suitable for the needs of people who used the service, with ample bathing, communal and outdoor facilities.

Risk assessments were in place, specific to people's needs and regularly reviewed.

There were sufficient staff in place to keep people safe and meet their needs. Staffing was well planned.

The service was clean throughout with sufficient domestic staff and resources.

All staff were aware of their safeguarding responsibilities.

A range of mandatory and additional training had been delivered to staff or was planned. Staff were knowledgeable in the areas they had been trained in and external professionals confirmed they engaged well and took an interest in new practices.

People received a range of meal options and we observed pleasant mealtime experiences. The use of showing people different plates of food to help them choose was used intermittently and needed to become part of the culture. Feedback about food was consistently positive.

People were supported to have maximum choice and control of their lives in the least restrictive way possible. Staff had received training in the Mental Capacity Act (2005) and were able to answer a range of questions. Consent was sought with regard to day to day interactions throughout the inspection. Some care files needed reviewing to ensure consent was appropriately documented.

Care plans were being reviewed at the time of inspection but contained sufficient person-centred information for staff to understand and act on people's needs. Staff knowledge of people's needs was good. Interactions with and advice from external healthcare professionals was well documented.

People who used the service, relatives and external professionals gave consistently positive feedback about the caring, compassionate and patient approach adopted by staff.

The atmosphere was welcoming and communal. People received good continuity of care due to a very low turnover of staff, who knew them extremely well.

Activities were planned by an activities co-ordinator and provided a variety of in-house entertainment. The advertising of these activities would benefit from review in line with the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.

There had been no recent complaints. All people and their relatives we spoke with knew how to raise any concerns.

Auditing arrangements required review as there was some duplication of work by senior managerial staff, whilst some audits were not effective.

The culture was one focussed on caring for people in a homely environment, with support from a stable and committed staff team. The registered manager and other staff demonstrated a desire to quickly make improvements in the areas we identified.

We have identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

Medicines storage and administration was not always safe and in line with good practice.

There were sufficient staff on duty to ensure people were safe and their needs met.

Premises were clean and well maintained.

Is the service effective?

Good

The service was effective.

Staff had received a range of core training and training specific to individual's needs.

Staff supervisions and staff meetings were in place and all staff confirmed they were well supported.

Staff ensured people had access to primary and secondary external healthcare.

People enjoyed a range of meal options and were well supported by staff to maintain a healthy diet.

Is the service caring?

Good

The service was caring.

People who used the service, relatives and external professionals all spoke positively about how well staff cared for people.

We observed numerous patient and calming interactions between staff and people who used the service. People were treated with dignity and respect.

People were involved in decisions about their care and confirmed they felt part of the homely, welcoming community atmosphere.

Is the service responsive?

Good

The service was responsive.

Care records were sufficiently detailed to enable staff to understand and act on people's needs.

End of life care planning was in place and relatives told us how patient and compassionate staff had been at this difficult time.

Activities were varied and planned by an activities co-ordinator, although the means by which upcoming activities were shared with people could be improved.

External professionals provided positive feedback about how staff worked with them and implemented advice.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Auditing processes were not always effective and sometimes led to a duplication of work. Medicines audits in particular required improvement.

Staff, people who used the service and external professionals gave extremely positive feedback about the approachability and commitment of the registered manager and deputy managers.

The culture was one geared towards ensuring people felt at home and were cared for by a stable staff team who knew and respected them.

Ella McCambridge 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.

We visited the service on 21 and 22 August 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of one adult social care inspector, one specialist advisor with a background in nursing, and one 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 service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection.

During the inspection we spent time speaking with eight people who used the service, 12 relatives and two visiting healthcare professionals. We observed interactions between staff and people who used the service throughout the inspection, including at lunchtime. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could

not talk with us.

We spoke with 13 members of staff: the registered manager, two deputy managers, the area manager, five care staff, two kitchen staff and two laundry staff. We looked at six people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. Following the inspection we spoke with another healthcare professional.

Requires Improvement

Is the service safe?

Our findings

The storage and administration of medicines was not always in line with good practice issued by the National Institute for Health and Care Excellence (NICE). For instance, there were no specific protocols in place for when people required medicines 'when required'. These are known as PRN protocols and should give staff clear instructions regarding when and why the medicines may be needed. Protocols help to ensure staff use such medicines appropriately and do not, for example, give people psychotropic medicines such as Lorazepam when it may not always be required. We reviewed the use of this and other 'when required' medicines and found no use of over medication.

For a medicine that staff administered as a patch, a system was not in place for recording the site of application and the days when the patches were renewed or replaced. This is necessary because the application site needs to be rotated to prevent skin damage.

The administration of topical medicines (creams) was similarly not documented appropriately. There were no body maps in place to clearly indicate to staff whereabouts on a person's body a cream needed to be administered. When we reviewed the prescribing information, this was similarly not always specific enough to direct staff whereabouts on a person to administer the cream. This meant the service was reliant on the ongoing knowledge of longstanding staff to appropriately apply creams, rather than accurate documentary information. This presented a risk should staff unfamiliar to people's needs be required to support them.

We reviewed individual medicines administration records (MARs) and found, where people had no allergies, this was not clearly documented on the MARs. Again, this is good practice and the deputy manager addressed this during the inspection.

Whilst medicines were suitably locked in an appropriate room, the medicines fridge appeared to be de-frosting as there was a pool of water underneath it where paper towels had been placed to absorb the water. The deputy manager told us they would address this immediately.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection and immediately subsequent to it, the registered manager, area manager and deputy managers made improvements to the administration and storage of medicines. For instance, on day two of the inspection a new fridge was installed, topical medicines body maps were implemented, transdermal patch administration charts were in place and people's MARs were updated to clearly state where they had no allergies. The area manager demonstrated that a PRN policy was in place and the deputy manager had begun implementing these protocols. This meant, where we had found a range of areas of where practice required improvement, the registered manager responded promptly and appropriately.

They also demonstrated that they had recently moved from one pharmacy provider to another, and had a meeting planned with the incumbent pharmacist, who was also due to undertake external audits of

medicines practices. In light of our findings during the inspection this meeting was brought forward and the registered manager was able to demonstrate further improvements since the inspection.

Risks were assessed to ensure people were safe and actions were identified for staff to take to mitigate these risks occurring. Risk assessments in place included moving and handling, mobility, falls, risk of falling out of bed/chair, nutrition and hydration, continence, skin integrity and personal hygiene. Where people were subject to risks specific to a health condition, such as relating to diabetes or a catheter, these specific risks had been documents and information was available to staff to enable them to keep people safe.

We noted that, whilst staff did know what warning signs to be aware of regarding people at risk of developing pressure sores, and could demonstrate this was reviewed regularly, no recognised tool was used for the assessment of the risk of pressure sores. During the inspection, the deputy manager showed us they had implemented the Waterlow scoring tool to help staff consistently review the risks people faced. The Waterlow tool is a commonly used scoring method for assessing the potential risk of pressure sores for a given person.

People who used the service told us they felt safe and relatives all praised the efforts of staff in ensuring people were protected from harm. One person said, "Staff look after me very well." Relatives told us, "I come in here all the time unannounced but I know I don't need to – I've got total confidence in them," and, "I have never had any concerns whatsoever – they look after people brilliantly."

We observed staff interacting with people. This was always calm and at the person's pace and people were evidently comfortable in the company of all staff. We observed appropriate moving and handling techniques being utilised by staff throughout the inspection. Where someone did begin to show signs of anxiety, staff used their knowledge to calmly distract the person and put them at ease.

There were sufficient staff on duty to ensure people were safe and their needs could be met. We saw staffing was planned via a dependency tool. Rotas demonstrated, and conversations with staff, people who used the service and relatives confirmed, staffing levels were always appropriate. We observed call bells being responded to promptly.

The service was clean throughout and there were no concerns with regard to infection control. The laundry had a 'clean in/dirty out' policy, with two doors, although at the time of inspection there was a backlog of drying as one machine was awaiting repair. The registered manager assured us this would be repaired as a priority. Staff had received infection control training and the kitchen was clean throughout, having achieved a '5' score (this is classed as 'very good') by the Food Standards Agency.

Pre-employment checks remained in place for new members of staff, including Disclosure and Barring Service (DBS) checks and references. The DBS maintain a list of people who are not permitted to work with adults who may have vulnerabilities, helping employers to make safe recruiting decisions. The safeguarding and whistleblowing policies had been signed as read by staff and all staff demonstrated an awareness of their safeguarding responsibilities. Whistleblowing means raising concerns about a service externally.

Servicing and maintenance of utilities and safety equipment was in place, for example gas safety testing, portable appliance testing (PAT), fire safety equipment servicing and lifting equipment.

Personalised Emergency Evacuation Plans (PEEPs) were in place to help in the event of an emergency. These were kept in people's care files. During the inspection the registered manager ensured copies were kept accessibly in a 'grab bag' so that, should there be an emergency situation, external professionals could

have ready access to this evacuation information.

Accidents and any safeguarding incidents were documented and a log kept so they could be analysed in case any trends or patterns developed.

Good

Is the service effective?

Our findings

People received care and support from a staff team who were well trained and supported, and committed to ensuring people received good levels of care.

Training covered a range of areas the provider considered mandatory and equipped staff with the necessary knowledge and skills. Training topics included first aid, moving and handling, nutrition, dignity and respect, health and safety, diabetes, medicines administration, infection control and dementia awareness. These were delivered via a combination of workbooks and face to face training. Staff told us, "The training is great, we're always getting new things," and, "We get lots of training and I feel well supported."

We also saw training had been put in place for staff supporting people who required percutaneous endoscopic gastrostomy (PEG) feeding. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. We spoke with the external professional who trained staff in this area and they told us, "They didn't rush it, they came to us and made sure they were comfortable as it's a totally new thing for a lot of them. We pop in to support from time to time but they have gained a level of confidence. I was surprised by how many attended the training – they should be commended for that."

This was a consistent theme in feedback. Another healthcare professional, who had delivered bespoke training in using the least restrictive option to support a person during personal care and, in some circumstances, using restraint, was also positive about staff know-how and desire to learn new skills. They said, "We often get four or five staff coming forward for training. Here, we had 15." They said, "Staff follow everything we put in place to the 'T' and it means [person] can remain in the place they feel at home because staff have the additional skills to support them in that one area."

Staff supervisions were held regularly. A supervision is a meeting between an employee and their manager to discuss areas of training they may need, areas for improvement, and reflecting on positives. Staff meetings were also in place and we found the minutes of these demonstrated that the team regularly spoke about current areas of good practice and how to improve the service. Staff supervisions, training and a range of other information was in the process of being uploaded onto a central database, which the provider hoped would in time streamline the need to track all these requirements. One member of staff told us, "I have had training to enable me to move up a grade. This was all management led and with management support."

People were supported to access external professionals to maintain and promote their health. Care plans contained information on the involvement of professionals such as General Practitioners (GPs), district nurses, SALT, dietitians, community psychiatric nurses, consultant psychiatrists, PEG nurse specialists and chiropodists. Care plans reflected people's needs and clearly showed where referrals to healthcare professionals had been made.

Relatives told us, "Our [person] gets the best help. Every three months they go to the hospital to have their

eyes done and staff are always letting us know if there are any changes." Another said, "I have such confidence in them."

Staff had been trained appropriately in the Mental Capacity Act 2005 (MCA). Staff we spoke with were able to answer questions about, for example, the principles of the MCA and what that meant for people who used the service on a day to day basis.

The 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS applications had been made.

We observed staff ensuring people consented to day to day choices such as moving around the home, changing their mind about meals and taking part in activities. One external professional told us, "They have a good understanding of trying to find the best, least restrictive solution and working in a person's best interests." We found this to be the case, however there were isolated instances of care records containing contradictory information about people's ability to consent to care and treatment. The registered manager and deputy manager reviewed this paperwork during the inspection and agreed to do more to ensure practices of documenting people's capacity to consent was always consistent.

At the last inspection we recommended the provider improve the environment, particularly on the first floor, to ensure it was more dementia friendly. We found significant improvements had been made, for instance vibrant three-dimensional wall decorations depicting shop fronts, post boxes, phone boxes and various tactile distractions for people to engage with. One person walked with us along the corridors and pointed out the decorations they liked. The premises were well adapted to people's needs and provided ample communal areas including a well maintained garden at the rear, which we saw in regular use during the inspection. Music was playing in various areas of the home, which helped create a more relaxed and homely environment. All bedrooms were en suite and there were ample bathing facilities throughout.

People had a choice of meals. They and relatives gave positive feedback about the standard of food. One person said, "The food is very satisfying here," and another said, "Oh yes, I always have a big breakfast. I eat well here." We observed mealtimes and found them to be pleasant experiences for people, with sufficient staff to support them who knew their preferences and anticipated their needs. Some staff were more effective than others at ensuring they showed people who used the service alternative plates of food in order that they could better choose what they preferred. We fed this back to the registered manager, who agreed they needed to ensure the practice was embedded within the culture, as a lot of people who used the service could not easily decide between meal options if they were just given the options verbally.

Kitchen and care staff communicated well to meet people's varied nutritional needs, whether these were through preference or clinical need.

Staff used the Malnutrition Universal Scoring Tool (MUST). MUST is a tool which helps identify where people are at risk of malnutrition and puts in place measures to help prevent this. The deputy manager liaised with the local GP on a monthly basis and highlighted where people may be at risk of malnutrition.

Good

Is the service caring?

Our findings

People who used the service and their relatives all spoke positively about care staff. They told us, "I am very happy here. I have my friends here and my days are full," and, "The manager and staff are very easy to talk to." Relatives said, "I can't fault the staff one bit. They are lovely – she knows them well and gets on well with all of them," "They always take an interest - not just in the people they're looking after but in us, the relatives. They don't rush people and they focus on people, not just the tasks" and, "The staff are all wonderful – they genuinely really care for people as if they were family." External professionals told us, "They have a great manner with people," and, "I've always found them to be completely committed to people feeling at home."

The registered manager, deputy managers and the majority of care staff had been at the service for a number of years. Relatives and external professionals confirmed they felt this continuity had a beneficial impact on people who used the service. One professional said, "There is a consistency that comes with staff being there for so long – it's good for people so they're not getting different carers all the time." One relative said, "The continuity is one of the most important things – it meant [person] was that bit more relaxed as they needed more and more help with personal care." We observed people interacting with staff they knew well in a trusting, relaxed fashion.

The atmosphere at the home was extremely relaxed and, particularly in the entrance foyer, communal and vibrant. People interacted with each other and visitors and evidently enjoyed being part of a community. One person who used the service had a dog they were no longer able to look after. This was now looked after by staff and spent much of the day in the entrance area. People enjoyed interacting with the dog and relatives confirmed they felt it made the service feel more homely. Staff ensured the dog regularly spent time with its owner and took it for walks to ensure it was settled and relaxed when in the home.

Staff had a good knowledge of the things that made people diverse individuals. For instance, where a person had a particular faith but had become unable to attend church briefly, staff read the bible with them to keep them actively involved in their religion. They were now able to visit church again. Another person followed a particularly rare religion and staff had taken the time and effort to research this to ensure they knew what was important to the person and to ensure they did not unknowingly offend them.

Staff communicated well with people, some of whom were particularly anxious and were put at ease by the calm demeanour of staff.

We saw a range of recent thank-you cards which further demonstrated how highly relatives regarded the care at the home. They read, for example, "Thanks to all the staff for their efficiency, understanding and kindness," and, "Thank you all for the wonderful care and support."

People were treated with dignity and respect and staff had received relevant training on equality, diversity and dignity. Relatives told us, "They treat her with the utmost respect and individuality." All people we spoke with were well dressed and had been to the hairdresser when they had chosen to. It was evident people were helped to make the day to day decisions that gave them more of a sense of inclusion and involvement.

For example, people and their relatives confirmed they were encouraged by staff to personalise their rooms with their own belongings.

Good

Is the service responsive?

Our findings

We saw in the care records that end of life care plans were in place for people, with terminal and life limiting illnesses which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Relatives gave consistently exceptional feedback about the support they had received and the care they had observed when staff had been supporting a loved one during end of life care. One relative told us, "They held my hand through every stage and they respected [person] completely. Everything stopped and there was no pressure – everything was geared up to make sure [person] was content and we were as a family, too." They confirmed the registered manager and other staff had been able to talk openly to them about what the person's final wishes would be, and that this openness and the calmness of staff put them more at ease.

Activities were planned and delivered, in the most part, by an activities co-ordinator. We noted that there were no photographs displayed of any outings or activities. The registered manager told us this was due to the restrictions of the new General Data Protection Regulation (GDPR). The GDPR is a law regarding data protection and people's private information. It does not restrict the displaying of such information, provided appropriate consent is in place, and the registered manager agreed to reinstate the displays of recent activities, provided people consented to this. They agreed to do this as part of a review of the documentation of people's consent in their care files, as discussed in the Effective key question.

Activities included a party to celebrate the recent royal wedding, art and crafts, exercises, knitting, bingo, puzzles and fish n chip afternoons. People told us, "I do plenty," and, "I really like the singing," whilst relatives felt there was a good array of in-house and external activities. There was a monthly newsletter in place. This listed the events that had previously taken place, rather than showcasing what was planned. Likewise, there was little information displayed to tell people what activities were upcoming. The provider could do more to ensure upcoming activities were better advertised and in line with the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Whilst there had been improvements to the dementia friendly environment, the use of pictures or videos, for example when displaying menus and potential activities, needed to be explored further.

Records were person-centred to a degree. Person-centred means that care is planned and delivered in a way that sees the people as equal partners in planning and puts their needs and individualities first. The area manager was in the process of introducing a streamlined approach to care plans. We found care records contained information specific to people's health and social care needs and that staff had a strong understanding of the things most important to people. There was some duplication in care files. For instance, people had a number of records pertaining to their social and personal history, including a 'This is Me' document, a family tree, a 'Service User Social Assessment' and a 'Social History/Lifestyle' document. 'This is Me' is a document produced by the Alzheimer's Society, designed to give care staff and families someone's life history and to aid person-centred care. The registered manager and area manager agreed there was a duplication of information and a risk that important information could be lost. The area

manager showed us a document they were working on which included a 'pen portrait' of the things most important to people. This demonstrated the provider was aware that documentation needed to accurately reflect people's preferences, and they were taking steps to ensure this happened in the most efficient and accessible way.

People's changing needs were well identified and acted on by staff. We saw evidence in care files and other documentation of staff liaising with external professionals when people's needs changed. Staff knew people's needs extremely well and were well placed to identify subtle changes and to seek advice accordingly. One staff member said, "We are allocated residents to work with so we have the chance to get to know their history." Relatives told us, "If there's any change whatsoever they check it out and they keep me informed." Relatives we spoke with confirmed, as did the registered manager, that formal relative and residents meetings no longer happened. The registered manager told us this was due to there being a lack of interest and the formality of the meeting. They agreed to restart these meetings, initially by way of introducing topics of discussion into an informal gathering of visitors that generally happened on a Wednesday. This would enable them to give relatives and residents another forum in which to raise any queries or contribute ideas.

All relatives we spoke with also confirmed they were involved in the planning and review of people's care. We saw regular reviews of people's care files had taken place.

There was a complaints policy in place and all people we spoke with and their relatives felt able to raise concerns if they had any. No one we spoke with had raised a complaint. Others said, "If I have to raise anything the door is always open and they always try to resolve things quickly. They are very receptive."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place who had the relevant skills and experience to run the service. They had worked at the service for twenty years. They were well supported by two deputies who had also been at the service for a number of years and understood people's needs extremely well. The registered manager was not present for the first morning of the inspection and a deputy gave us a tour of the building and was able to describe all systems and processes we asked about.

The management team all took part in aspects of auditing and we found the service would benefit from a wholesale review of who audited what areas of the service, when and how. At the time of inspection there was some duplication of efforts and, in some cases, auditing was not effective.

For instance, there had been a medicines audit completed on a monthly basis but this had not identified any of the core areas of poor practice we saw during the inspection. This was because the current medicines audit was essentially a stock check rather than a qualitative analysis of medicines storage and administration practice. The registered manager confirmed they would implement a new medicines audit which would ensure compliance against the regulations and areas of good practice. The registered manager sent us the minutes of a meeting they held with the incoming pharmacist provider and all auditing staff the week following the inspection. They also confirmed they intended to have in place a medicines champion, who would have supernumerary time each week (and more in the first place to ensure all paperwork was up to date) to review medicines practices.

Other areas of auditing would benefit from review, both in terms of ensuring the service was able to continually identify areas of poor practice and implement good practice, but also to ensure managerial staff were not overburdened by work duplicated elsewhere. For instance, the deputy managers conducted a comprehensive monthly check of, including other things, medicines and health and safety checks such as fire doors. These checks were also done on a regular basis by other members of staff. The impact was that, rather than use audits to focus on areas of practice and drive improvements, they were duplicating work for senior staff and were less focussed due to the amount of work involved. The registered manager and area manager agreed to review auditing across the service.

The registered manager, senior team, and all staff we spoke with were passionate about achieving the best outcomes for people and ensuring they were well cared for in a homely environment. Where we identified areas for improvement, staff responded promptly and effectively. Subsequent to the inspection the registered manager and other colleagues shared updates with us and documents they were working on to address the areas of improvement, particularly medicines, that we had identified. The area manager confirmed there would be support available from the provider's other locations in terms of sharing good practice and auditing examples to ensure Ella McCambridge Care Home could attain compliance effectively.

All people we spoke with and their relatives praised the leadership of the service and the culture at the home. People said, "The staff are all lovely, top to bottom," whilst relatives said, "You couldn't get a better team – they go all out to make things nice for people living here," and, "Give the manager credit – there's a

reason staff stay here and that's it's so nice."

Turnover of staff was low and staff morale was high, with all staff we spoke with confirming they felt part of a team and were well supported. Staff confirmed the registered manager and deputy managers were approachable and took a hands-on approach to leadership. One said, "They're always there if you need them and they always get involved – they don't hide away in offices." Another said, "If you need anything, they're right there. They understand the job."

The provider had recently implemented a new staffing model with four care co-ordinators supporting the deputy managers in some of their work and providing a link between deputy managerial staff and care staff. At the time of inspection care co-ordinators told us they were looking forward to the additional responsibilities. We fed back to the registered manager and areas manager that this was an area to include in the review of auditing, as there was scope to delegate some responsibilities.

The provider was also trialling a new database system which, when fully rolled out, would contain information regarding training, supervisions, annual leave, sick leave and Disclosure and Barring (DBS) checks, automatically updating management and staff when action was required. Care staff we spoke with had not yet accessed the system and the area manager acknowledged there would need to be ample familiarisation and training time. The administration officer demonstrated a good understanding of the system and was key to supporting the registered manager and deputy managers in ensuring important documentation and systems were kept up to date.

Relatives and people we spoke with felt part of the community at the home. We observed many relaxed and positive interactions not just between staff and individual people, but between staff, people who used the service and a range of visitors. This meant people were not isolated and felt part of a community. One person's relative told us, "At the last place they were away in their room but here everyone is involved. It feels like a proper community."

The registered manager used surveys of people who used the service, relatives, staff and visiting professionals to help gather feedback and understand how well people felt the service was performing. These were all returned with positive results.

The registered manager also encouraged people to complete reviews for an independent reviews website and we saw these were consistently extremely positive (an average score of 9.8 out of 10).

The registered manager demonstrated a good understanding of when and why to notify CQC of specific incidents and had done so, promptly and with an appropriate level of information. Registered providers and managers must ensure they notify CQC of major events, such as serious injuries or stoppages in the service, so that CQC can monitor the service. The registered manager also liaised well with other agencies and professionals to ensure people's needs were met and people were kept safe.

We found the culture was one clearly focussed on ensuring people felt at home and were cared for by staff who knew them extremely well. All staff we spoke with, at all levels, shared this ethos and were committed to the people who lived at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were stored and administered in a safe manner, in line with good practice.