Berrystead Nursing and Residential Home Limited

# Berrystead Nursing and Residential Home Limited

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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|---|---|
| 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

We carried out an unannounced inspection visit on 20 September 2016.

Berrystead Nursing and Residential Home provides accommodation, personal care and nursing care for up to 46 older people. Forty three bedrooms have an ensuite bath or shower and all have a wash basin. At the time of the inspection there was one bathroom and two shower rooms in use. The home has a communal dining room, a lounge, an activities room and large conservatory. There is a small courtyard garden and a large landscaped garden. Accommodation is on two floors, the first floor is accessed by a lift or stairs. The home is located in grounds that are set off from the main Leicester to Syston road.

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

At our last inspection on 30 October 2014, we found that bathrooms had not been adapted to meet the needs of people who required support with their mobility or who had a physical disability. We also found that some maintenance of the premises was required to make the environment safer for people using the service, staff and visitors. We asked the provider to make improvements. We received an action plan from the provider. At this inspection we found that a refurbishment programme was in progress and that the home environment was safer. No work had been carried out to adapt bathrooms but the provider was in discussion with structural engineers about how such work could be carried out within the physical constraints of the existing structure of the building.

Staff knew how to identify and report concerns about people's safety. Risks associated with people's care and support were identified and managed to protect people from avoidable injury or harm. The provider's recruitment procedures ensured as far as possible that only staff suited to work at the service were employed. Staff were suitably deployed to be able to meet the needs of people using the service. They attended to people's needs promptly.

People usually received their medicines at the right times, though medicines administration records were not always signed. There was no system to provide documented assurance that medicines were administered as prescribed. Medicines were stored securely but arrangements for ensuring medicines were stored within recommended temperature ranges were not consistently followed. An out of date medicine had not been disposed of.

People were supported by staff with the right skills and experience. Staff were supported through training and supervision.

Staff at all levels understood the relevance of and acted in accordance with the Mental Capacity Act 2005

and Deprivation of Liberty Safeguards when they supported people.

People were supported with their nutrition. People with special dietary requirements were supported with their specific needs. People were supported to access health services when they needed to.

We observed that staff demonstrated care and compassion when they supported people. Staff engaged in meaningful conversation with people and showed an understanding of their needs. The registered manager promoted `dignity in care' and was one of ten dignity champions at the service.

People using the service and their relatives were involved in making decisions about their care and support. People and relatives we spoke with told us they received information they needed about the service before and after they began to use it.

Staff respected people's privacy and dignity. They were discrete when they provided care and support. People were able to spend time where they wanted, including when they had visitors.

Although there were five bathrooms, only three were in use. Two were being used as storage areas. Only one of the three bathrooms in use was big enough to accommodate the use of a hoist. The other two were `shower / wet rooms'. This meant that bathing facilities were limited for people with limited mobility. Those people had `bed washes'. The provider was looking into modernising and adapting the bathroom facilities.

People's care plans were focused on their individual needs. People were supported to maintain their independence and were supported to follow their hobbies and interests. An activities coordinator excelled at providing a range of stimulating activities for people using the service. People's relatives were able to participate in activities.

People using the service and their relatives knew how to raise concerns and their views were acted upon.

People using the service, their relatives and staff were involved in developing the service. The provider acted upon their feedback. The registered manager had procedures for monitoring the quality of the service which included seeking people's views about their experience of the service. However, the monitoring had not identified shortfalls in medicines management that we identified. The registered manager took action to make improvements in areas identified as requiring improvement at our previous inspection and they had the provider's support in implementing improvements.

## 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 consistently safe.

People mainly received their medicines at the right time, but administration records were not always completed. Medicines were securely stored, though temperature checks of storage areas were not always carried out.

Staff understood how to recognise and report concerns about people's safety.

Staff were effectively deployed. The provider had recruitment procedures to ensure as far as possible that only staff suited to work at the service were employed.

### Is the service effective?

**Good**

The service was effective.

Staff were supported through supervision, coaching and relevant training.

People who did not have mental capacity to make decisions about their care and support had their rights protected because staff understood their responsibilities under the Mental Capacity Act 2005.

Staff supported people with their nutritional needs and with access to health services when they needed them.

### Is the service caring?

**Good**

The service was caring.

Staff at all levels supported people with care and compassion.

People using the service or their relatives felt involved in decisions about their care and support.

Staff respected people's privacy and dignity.

## Is the service responsive?

Good

The service was responsive.

People received care that was centred on their individual needs.

People had access to a range of stimulating and meaningful activities that supported them to maintain their interests and hobbies.

People and relatives knew how to raise concerns about the service.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's arrangements for monitoring the quality of the service had not identified shortfalls in medicines management. Other monitoring activity was effective.

Monitoring included seeking and acting upon people's views of their experience of the service.

People using the service, their relatives and staff were involved in developing the service.

# Berrystead Nursing and Residential Home Limited

**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 site visit took place on 20 September 2016 and was unannounced. The inspection team was made up of an inspector, a specialist advisor who was a qualified nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for a person who uses this type of care service. Our expert had experience of caring for older people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 10 of the 38 people using the service at the time of our inspection and two relatives of another person who was using the service. We looked at seven other people's care plans and associated records, including medications administration records. We spoke with the registered manager, deputy manager, a nurse, a senior care worker, the service's activities coordinator, five care workers and a kitchen assistant.

We looked at one staff recruitment file along with training plans and records associated with the provider's quality assurance system for monitoring and assessing the service. We observed how staff supported and interacted with people using the service.

We spoke with the local authority that funded some of the care of people using the service. We contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care

services to see if they had feedback about the service.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection on 30 October 2014, we found that the service was not consistently safe because bathrooms had not been adapted to meet the needs of people who required support with their mobility or who had a physical disability. We also found that some maintenance of the premises was required to make the environment safer for people using the service, staff and visitors. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Premises and equipment. We asked the provider to make improvements. We received an action plan from the provider in which they explained how they would make improvements.

At this inspection we found that a refurbishment programme was in progress. Communal areas had new carpets and maintenance work had been carried out where required to make the environment safer for people using the service, visitors and staff. No structural work had been carried out to adapt bathrooms because the rooms were too small to accommodate hoists. However, the provider was in discussion with structural engineers about how such work could be carried out to one of the bathrooms within the physical constraints of the existing structure of the building. The provider had taken action to mitigate the impact of bathrooms not being suitable for people with limited mobility or physical disability.

Storage arrangements for medicines were not consistently safe. People's medicines that were in current use were stored in three locked trolleys which were located in the dining area. Stocks of medicines were kept in cupboards in a `nurses station'. Medicines that required storage at low temperatures were kept in a medicines refrigerator. However, we found that temperatures inside the trolleys, cupboards in the nurses station and refrigerator were not consistently checked and recorded. An independent medicines audit carried out on 17 June 2016 by the pharmacist who supplied medicines to the service identified similar concerns. Failure to consistently check storage temperatures meant that the effectiveness of medicines could be compromised.

The medicines refrigerator contained a person's anti-biotic medicine. The medicine was opened on the 7 September 2016. An instruction to discard the medicines after five days was clear, but they had not been disposed of at the time of our visit. The medicine had not been given to the person, but there was a risk that had we not brought this to the attention of the registered manager it might have been because staff had access to the medicine.

Records of administration of people's medicines were made on medicines administration records (MARs). We found two people's MAR charts that were not consistently completed. The pharmacist's audit carried out in June 2016 raised concerns about MARs not being completed. They identified 39 gaps in MARs in May 2016. Our findings were that these omissions were still occurring and that we could not be assured that people had been given their medicines as prescribed by their doctor.

We also identified that a person's medicine was given a day late (20 September instead of 19 September). This had not caused the person harm, but it was another example of the services's medicines management being inconsistent. Another person's medicine was recorded as being out of stock on eight occasions

between the 9 and 19 September 2016. We brought this to the deputy manager's attention and they told us that the medicines had been ordered. However, the delay meant that for an 11 day period medicines which may have been required were not in stock. The person did not come to harm but it meant the therapeutic value of the medicines was delayed.

Four people were prescribed pain relief in the form of seven day trans- dermal patches. When staff applied the patches they made no record about the area they applied them. They did not use recommended no charts to indicate the site of application and safe removal of the previous patch which is necessary to avoid placing a patch in the same area as that can have side effects.

Some people using the service were prescribed a medicine that should be given in the morning 30 to 60 minutes before eating food or taking other medication to ensure its effectiveness. The person administering medicines on the day of our inspection told us they supported people at the beginning of a medicines round and returned to them later. However, we found there was no system in place to provide assurance that that particular medicine was administered as prescribed. There are known side effects of the medicine not being taken at least 30 minutes before other medicines, but we did not witness these.

People using the service told us they felt safe. Most said they felt safe because of the quality of care and support they received. A person told us, "I feel very safe here I've no worries at all I feel well protected in every way". Another person said, "I feel very safe. I'm very poor on my legs but the staff are very good at helping me and keeping me safe". Another person with limited mobility said, "They [staff] are very good. I've no worries about being safe here at all". Another reason people told us they felt safe was staff did not "rush" when they provided care and support. A person said, "My care is never rushed and I feel very safe with the staff, no worries about that at all". People also told us that when they summoned assistance by using call bells, staff always responded quickly. Comments included, "I have the call bell in my room and the staff come when I call" and " I've got a call bell in my room and when I need the staff to come I never have to wait for very long they are very good".

Staff we spoke with had a good understanding of the different types of abuse and were aware of how to report any safeguarding concerns. They knew how they were able to escalate their concerns if they felt that they were not being listened to, for example contacting the Care Quality Commission (CQC) or a local authority adult safeguarding team. All staff had received training about safeguarding people from abuse and avoidable harm. They were aware that there was a whistleblowing policy in place. The registered manager told us that staff had used the policy to report concerns and they had reported concerns to the local authority adult safeguarding team and the CQC. The nature of concerns raised demonstrated that staff had a good practical understanding of how to identify and report abuse. People using the service could be confident that staff working at the service protected them from abuse.

We observed staff using equipment safely when they supported people with their mobility. For example, we saw two staff use a hoist safely and in a way that helped the person being supported feel comfortable and safe. Staff spoke with the people whilst supporting them to offer reassurance. A person using the service told us, "When staff take me to the toilet I feel very safe in the hoist. I'm used to it now". When staff moved people around in wheelchairs they adjusted the footplates and used the brakes to keep people safe.

People's care plans included risk assessments associated with people's care routines. The risk assessments included information for staff about how to support people safely and how to protect them from harm or injury, for example from falls. This meant staff had access to information about how to support people safely. Some people had been assessed as being at risk of falls. Since our last inspection there had been no reported incidents of people experiencing serious injuries at Berrystead from falls or other reasons. This

showed that people had been protected from avoidable harm.

The registered manager decided what staffing levels were required using a calculation that was based on the assessed dependency needs of people using the service. This ensured that enough staff were deployed during the day and night. People using the service did not tell us directly that they felt enough staff were on duty. However, they did say that staff were always available. A person told us, "I've got a call bell in my room and when I need the staff to come I never have to wait for very long they are very good". Two relatives told us they visited the home often and always found that staff were available. One told us, "There are always staff on hand". All staff we spoke with told us they felt enough staff were on duty and that they had time to provide what they believed was quality care and support. Our observations were that staff responded promptly when people used call bells. Staff were always available and in close proximity to people using the service. We also saw that staff engaged in conversations with people when they were not carrying out personal care routines. A person told us, "In the afternoon staff sit and talk with us" which showed that staff had time to do that because there were enough staff. A nurse told us, "Staffing levels were good. There are always qualified staff on duty". Our observation and what people and staff told us showed that people using the service could be confident that the provider had effective processes for ensuring that enough staff were deployed.

The provider had recruitment procedures that ensured as far as possible that only staff suited to work at the service were employed. The recruitment procedure included assessment interviews for people who were selected for interview after submitting an application to work at the service. All the necessary pre-employment checks were carried out before a person joined the service. These included Disclosure and Barring Service (DBS) checks. These checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce. People using the service could be confident that the provider had effective staff recruitment procedures.

Good

# Is the service effective?

## Our findings

People using the service told us they felt well looked after by staff who they felt were well trained and knowledgeable about their needs. A person using the service told us, "I feel that staff know and understand what I need". Another said, "The staff are very good at providing care for me".

Care workers we spoke with told us that their training had prepared them to understand their role and the needs of the people they supported. A care worker told us, "The training has been very good". Care workers told us they found the training they had on using hoists to be particularly helpful. They described how they experienced being hoisted themselves and how that helped them to understand more about how people using the service felt when they were supported with transfers by hoist. We saw care workers use a hoist when they transferred a person from a wheelchair to an armchair. They did so safely and in line with the training they had. This showed that staff put their training into practice.

Care workers recruited after April 2015 were supported to achieve the Care Certificate which is a national benchmark for staff induction that covers 15 standards of care. Three new recently recruited care workers were working through the 15 modules that made up the course work. They were being supported by the registered manager. It was expected that all would successfully complete the training by the end of September 2016. This showed that the provider was supporting new recruits with their induction.

Staff were supported through supervision meetings with their line-manager. For care workers that would be a senior care worker, for senior care workers it would be the registered manager. Nurses had supervision meetings with the senior nurse. Supervision meetings provided staff to receive feedback from their supervisor about their performance and discussion about training needs. The provider's expectation was that all staff had six supervision meetings a year (April to March). A schedule of supervision meetings we looked at showed that all staff had at least two supervision meetings since April 2016. Care workers we spoke with told us they found their supervision meetings to be helpful. One told us, "My supervisions have been really helpful. I get feedback about my performance and I'm told about developments at the service, for example about the refurbishment at Berrystead". We saw a sample of supervision meeting notes which showed that supervisions were used to provide feedback to staff about their performance and, where necessary, how they could improve their performance. People using the service could be confident that the staff who supported them were themselves supported through training and supervision that helped them develop the skills they needed.

We saw and heard care workers display effective communications skills when they supported people. When they spoke with people who were seated they knelt so that they spoke to people at their eye level. They spoke clearly and slowly so that people could understand them. We did not hear people ask care workers to repeat what they'd said but we heard them reply to things care workers said. We saw several instances of staff engaging in conversation with people. This showed that staff put the training they had about communicating with people into practice to positive effect. Staff shared information about people's needs with other staff. They did this at `handover meetings' when they shared and passed on information verbally and through written handover notes which contained information about people's latest needs. Care workers

we spoke with told us they found the handover meetings and notes to be very helpful because it meant that knew about people's needs when they began their shift.

The registered manager and care staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation that protects people who lack mental capacity to make decisions about their care and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority. The registered manager understood this and had made two applications for DoLS authorisations for people using the service who lacked mental capacity to make decisions about their care and support. All nurses and care staff had received training about the MCA and DoLS. Staff we spoke with understood the key principles of the MCA, for example that people using the service had to be presumed to have mental capacity unless there was evidence to the contrary. They also understood that when people with mental capacity made decisions that appeared to be unusual they had to support people with those decisions, for example if a person wanted ice cream for breakfast or wanted to go outside when it rained to experience the sensation of rain.

People using the service told us that staff sought their consent before providing care and support. A person told us, "They [staff] always ask permission before doing anything". Another said, "Staff do what I want and if I say `no I prefer not to' to something then that's always okay with them". We saw and heard staff ask people for consent before they carried out a care routine. People either verbally agreed or gestured that they wanted support. Staff then explained how they were going to support the person and continued to talk with them throughout the routine.

People using the service told us they enjoyed the meals at Berrystead. Comments from people included, "The food is very good there's always enough of it" and "I enjoy the food. I've put some weight on". People had a choice of a variety of food and drinks. A person told us, "I have a good choice of meals. Staff ask me what I want." We saw and heard care workers asking people what they'd like for lunch. On the day of our inspection people had a choice of home-made meat balls, shepherd's pie or a vegetarian bake and a variety of fresh vegetables and deserts. This was representative of the range of choice people had.

People's care plans included information about their dietary needs and preferences. This information was known to staff in the kitchen where food was prepared. People with special requirements, for example food in pureed form or fortified drinks received the support they required. People were supported with their personal preferences with regards to meals. For example, a person liked to have ice cream for breakfast. Another had a cooked breakfast then a light lunch on a Tuesday. This showed that staff supported people in line with their food preferences. Where people needed support they were given adapted cutlery and plate guards and staff asked if they needed help to cut the food up. Where people needed help to eat, staff sat beside them explaining what was on the plate, asking if the food was at the correct temperature for them and helping the person slowly and at their pace.

The provider had procedures in place for staff to monitor people's nutritional health. This included regularly weighing people and acting on any unplanned weight loss, for example by arranging for peoples doctors and dieticians to be involved in their care. We saw evidence that this had happened. Staff kept records of the amounts of food and fluid that people consumed for people who were assessed as at risk of malnutrition or who wished to lose weight. The records were monitored by nurses who were therefore able to monitor people's food and fluid intake and to take action if the recommended amounts were not consumed.

Relatives we spoke with told us that they felt their loved one's health needs were met. A relative told us, "I can't fault the care [person] receives." Care records we looked at contained evidence that the home was

responsive to fluctuations in residents health needs. For example, nurses reported concerns to the deputy manager (a nurse) or registered manager who contacted a GP or, if a person had already been referred, a dietician. We also saw evidence in care plans that people were supported to access health services, for example to attend appointments at dentists and health centres.

Good

# Is the service caring?

## Our findings

People using the service told us that staff were kind and caring. A person told us, "The staff are very kind". Another person told us, "The staff are very kind at night because I don't sleep well and they will come in and hold my hand and talk to me".

The provider promoted `dignity in care'. They had a dignity charter and nine staff were `dignity in care champions' which is recognition given to staff who have demonstrated that they have put into practice their training about dignity in care and who support other staff to do likewise. The service had applied to be assessed by a local authority for a dignity in care award.

We saw examples of staff being kind and compassionate. For example, a person using the service asked a care worker about what had happened to their glasses. The care worker replied that he would find out and when he returned explained that the person's glasses had been sent away for repair. He reassured the person then engaged in conversation with them for several minutes about things the person asked about. A person we spoke with told us they were worried they hadn't brought their call alarm with them after leaving their bedroom. A care worker overheard that and explained they would fetch the call alarm immediately. We saw staff act to relieve a person's discomfort. This happened when a person became distressed and was complaining of pain. A care worker promptly went and found a nurse who came and spoke with the person. They asked the person how they were feeling before giving the person some medication to ease their pain. People told us that staff ensured they were comfortable. A person told us, "The staff have been really good to me. I feel the cold and they've done their best to make me feel warm". A care worker we spoke with told us they had found an extra thick duvet for the person to help them feel warm. These examples showed that staff cared about people using the service and understood their needs. Staff did not presume things about people's comfort. For example, it was a very warm day but staff did not presume that every person was warm. We saw staff offer people blankets and jumpers to people who were susceptible to feeling cold.

People using the service had opportunities to be involved in decisions about their care and support. Those opportunities occurred when their care plans were reviewed, for example when their circumstances changed. People told us about everyday decisions they made, for example when they got up in the mornings, when they went to bed and where they had their meals. A person told us, 'I can get up at seven and then I usually go to bed at half past six I have a TV in my room so I like to watch TV at night I can really do what I like to do". None told us about being involved in planning their care, but relatives told us they (relatives) were involved. A relative told us, "I'm been very much involved. What's more important to me is that I'm kept informed about how well [person using service] is. I'm kept very well informed".

Staff treated people with respect. They referred to people by their preferred name. They were alert to people's needs and provided discrete support when it was needed. Staff also respected people's privacy. Some people preferred to stay in their rooms. A person told us, "I have a lovely en-suite room I like to sleep in the afternoon because I don't sleep very well at night. The staff are very good because they know I like to do that". Other people were seated in `quiet' areas where they were not disturbed.

People told us they were supported to be independent. A person told us, "The staff are very good. They know I try to be as self-sufficient as I can and do most things for myself and they let me do that". Another person said, "I like to be self-sufficient and do as much as I can for myself. I like it that way and I'm very happy". Another person told us that staff had given them confidence to move around the home in their wheelchair. They told us, 'I'm in the wheelchair but I can move myself around which is good".

People's friends and relatives were able to visit them without undue restriction. A person told us, "My family visit regularly, most days usually". We saw on the day of our inspection and from entries in the visitor's signing-in book that friends and relatives visited from morning to evening. This was important to people using the service. One told us, "It's lovely because my daughter can visit daily".

Good

# Is the service responsive?

## Our findings

We saw in care plans we looked at that people using the service who were able to, contributed to the assessment of their needs and planning of care. Care plans included information about people's needs and guidance for care workers and nurses about how they wanted to be cared for and supported. A person using the service told us, "The staff are very good at providing care for me. They do just what I want". Another person said, "The staff are very good at providing care for me. They do all that I ask with no problem".

Staff supported people to contribute to the planning and delivery of their care. People's choices were respected. People told us they got up in the mornings and went to bed when they wanted to. They told us they were satisfied with the quality of the care and support they received. A person told us, "I get very good care I'm quite happy living here" and another said "I'm very well treated here". People's comments reflected the findings of a satisfaction survey carried out in January 2016. In that survey all twenty people who responded said that they were treated as individuals.

People's care plans included information about the specific needs and preferences and what nurses and care workers had to do to support people with their needs. The care plans included detailed information about people's preferences. For example, detail such as [Person's name] likes two pillows'; `prefers to wear slippers' and `prefers strip washes and doesn't like showers or baths'. Daily care records we looked at showed that people using the service had the support they wanted or required with their personal care. Records also showed that people who were at risk of developing pressure ulcers or who had one received the care and support they required. A person who acquired a pressure ulcer before they came to live at Berrystead received care and support that prevented the ulcer from getting worse and had begun to improve.

The service excelled at providing people with stimulating activities. These were varied and provided people with opportunities to participate in both social and individual activities. A person told us, "I'm going to play bingo today. I enjoy playing bowls as well we do some good things, a good variety". Another told us, "I enjoy the activities. I like to do puzzles and I enjoy the bingo sessions". We watched a game of bingo. It was adapted by the activities coordinator who made it an enjoyable occasion for every person who participated. When we spoke with the activities coordinator they displayed great knowledge of people's interests and hobbies. They showed us photographs of activities people had participated in at Berrystead and places in Leicestershire. These included an `awards night' were people were presented with trophies for having won games and competitions, `themed nights' and themed suppers. Innovative activities included `virtual cruises' were for three or four successive days activities represented what people would do on a cruise to France, Italy or Greece, places where people had taken holidays in the past. The activities coordinator had made personal invitations and itineraries for every person. People were supported to maintain their hobbies like knitting, baking or gardening. Memorabilia from activities was displayed in a lounge and in an area of the home that was furnished with `old style' furniture. This showed that the service paid attention to research about creating dementia friendly environments in care homes.

People using the service had access to a sensory garden. The activities coordinator told us that people told

her they liked to listen to the sounds of nature so she designed the garden to be a place they could do that. A person told us, "I like to sit in the sensory garden and catch the sun. Staff take me out there and I really enjoy that and all the activities". Another person told us, "I love to go out in the grounds for a walk. The activity co-ordinator usually takes me out in the gardens. Also, I like having my hair and my nails done".

Large screens with images were used to remind people what season it was. At the time of our inspection images of early autumn were displayed to help orientate people to the time of the year.

Other activities included visits by entertainers, day trips to places of interest and activities such as barge trips and meals out. People with faith needs were supported with their needs. A person told us, "A priest comes every week for me to take communion, which is so good for me". The activities coordinator arranged for monthly faith services at Berrystead.

We asked the activities coordinator where they got their ideas for activities from. They told us they spoke with people using the service and their relatives to find out what they were interested in and what they had enjoyed in their lives. We heard staff engage in conversation with people, talking about their families, hobbies and interests. Activities were then planned to incorporate their interests. They told us, "I've worked here for many years now. I just love my job". We found that they put their enthusiasm for providing people with stimulating activities into very good effect for people using the service. A relative who participated in an activity to celebrate the Queen's birthday expressed their views in a compliments book. They wrote, `It was lovely. [The activities coordinator] and staff go out of their way to entertain and bring a smile to people'.

People using the service and relatives we spoke with told us they knew how to raise concerns and were comfortable about doing so. However, they added they had not experienced an occasion when they needed to do so. A person told us, "I've never had to make a complaint about anything. I'd speak to the carers first if I was worried about anything and ask them to speak to the manager for me". Every one of the twenty people who participated in the provider's most recent satisfaction survey said they knew how to make a complaint and were aware of the provider's complaints procedure. Relatives had complimented the service for the quality of care it provided. We saw nine `thank you' cards that included positive comments about the quality of care and kindness of staff.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager arranged for the pharmacist who supplied the service with medicines to carry out audits on the management of medicines at the service. An audit carried out on 17 June 2016 had identified that improvements were required with regards to temperature controls in medicines storage areas. Interim arrangements, an electric fan, were in place for temperature control. An air conditioning unit was ordered after our inspection visit. Whilst action had been taken to implement recommendations from the pharmacist's audit, these had taken three months to implement. During that time, which included the warmest weather of the year, there were no room temperature controls other than an electric fan. The provider's medicines management audits had not identified the shortfalls we identified in aspects of safe medicines management, for example inconsistent record keeping, temperature checks, storage and disposal of unused medicines. Monitoring of other aspects of the service was effective.

People using the service did not tell us directly that they felt involved in developing the service. However, they felt involved in day to day decisions about the delivery of care; for example when they were supported to get in the mornings, where they ate their meals, how they spent their time, activities they participated in and when they went to bed.

People using the service knew who the registered manager and deputy manager were. A person told us, "I like [deputy manager] she is always around and talking with us". Throughout the day of our inspection we saw the registered manager and deputy manager walking around the home and talking with people using the service, relatives and with staff. People were able to distinguish what roles staff had because of the uniforms they wore.

Staff were supported to raise concerns they had about the quality of care people using the service received. They were aware of the provider's safeguarding, whistle blowing and incident reporting procedures. They told us they were confident about raising concerns with the registered manager and deputy manager; and they knew they could report concerns externally to the local authority safeguarding team and the Care Quality Commission.

Staff we spoke with told us they felt supported by the management team and that they were kept informed about developments at the service. For example, they knew about the work to achieve a `dignity in care' award from the local authority. They also knew about how the refurbishment of Berrystead was progressing. They told us the refurbishment had been the biggest improvement they'd experienced at the service in recent months because it had improved the experience of people using the service and staff. This showed that the registered manager had continued to follow through their action plan following our last inspection when we were critical of parts of the home's environment.

The registered manager was aware of their responsibilities to inform the Care Quality Commission (CQC) and the local authority that paid for the care of some of the people using the service of events at the service. These included expected and unexpected deaths, serious injuries and incidents between people using the service. The quality of reports to the CQC was good and meant we were kept informed about events at the

service.

The management team had a shared understanding of the challenges facing the service. Staff were involved in planning how to meet those challenges through supervision and staff meeting. We saw from supervision records we looked at that staff received constructive feedback about their performance and, when required, were supported to improve their performance. Staff we spoke with told us they felt motivated for a variety of reasons. They told us that management listened to their opinions and suggestions, for example how the staff team was organised and about the activities provided for people. Staff told us that Berrystead was a nice service to work at because the people and staff got on well and created a "nice atmosphere".

The registered manager had introduced a new improved procedure for monitoring the quality of the service which took account of our guidance to providers. Quality assurance activities included audits of people's care plans and records, observations of staff practice, checks of equipment and premises to ensure people's safety. The audit findings were reviewed and analysed. Aspects of the service requiring improvement were identified. Notable improvements had been made to the quality of the premises through a programme of refurbishment. The registered manager had continued to make suggestions to the provider about further improvements, for example improvements to bathing facilities and air conditioning in a nurses work station.

The quality assurance procedures included asking people for their views of their experience of the service. This was done through a comprehensive annual survey which included questions about a wide range of aspects about the service. The most recent survey results were that all people who participated were satisfied with all aspects of the service. For example, they said they were well cared for and supported, felt safe and found it easy to raise concerns if they had any. People's feedback about the service was consistently good. A person told us, "It's just brilliant here".