Essex County Care Limited

Beechlands

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 4 July 2017 and was unannounced. The service was previously inspected on 2 September 2016 at which time it was rated as good.

Beechlands is registered to provide accommodation with personal care for up to 27 older people, some of whom may be living with dementia. There were 22 people living at the service on the day of our inspection.

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

The provider had recently changed to an electronic system for managing medicines which was not robust which meant we could not be sure that people were receiving their medicines as prescribed. The stock counts for people's boxed medicines did not match with what was recorded on the electronic system. Weekly medicine audits were completed to monitor the safety and effectiveness of medicine management but these audits had not been effective in picking up on the shortfalls that we found.

Risks to people were assessed and management plans put in place. Staff were aware of the risks to people and knew how to minimise them to keep people safe.

There were sufficient numbers of staff deployed who had been recruited safely.

Staff were supported with training and supervision to ensure they had the necessary skills and knowledge to care for people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken. This ensured that any decisions taken on behalf of people were in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated codes of practice. People were supported to exercise choice and control in their daily lives and were involved in making decisions about the care and support they received. Where people experienced difficulties with decision-making, they were supported appropriately in accordance with current legislation.

A choice of food and drink was available that reflected peoples nutritional needs, and took into account their preferences and any health requirements. People were supported to maintain their health as had regular access to wide range of healthcare professionals.

Staff had developed positive relationships with people and were attentive to people's needs. People's privacy and dignity was respected and their independence was promoted.

People were treated with kindness and courtesy by staff who knew them well and who listened to and respected their views and preferences.

People were supported to keep in contact with their family and friends who were made welcome at the service.

Staff enjoyed working at the service. Staff and people were included in the running of the home and the registered manager responded appropriately to any complaints or feedback.

The registered manager had systems in place to monitor the quality and safety of the service and to drive improvements. However, these systems had not always been effective at identifying the concerns we found.

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.

Improvements were required to ensure the safe management of medicines.

Staff understood their safeguarding responsibilities and knew how to recognise, respond and report abuse or any concerns they had about safe care practices.

Risks to people were assessed and staff knew how to manage risks to people to minimise the risk of harm.

There were sufficient staff employed who had been recruited safely.

Is the service effective?

Good

The service was effective.

Staff received effective support and training to provide them with the skills and knowledge required to carry out their roles and responsibilities.

The principles of the Mental Capacity Act were adhered to and Deprivation of Liberty Safeguards applications were appropriate to protect people's best interests.

People had enough to eat and drink which met their nutritional needs and reflected their preferences.

People had access to healthcare professionals when they required them.

Is the service caring?

Good

The service was caring.

Staff were kind and courteous and had formed positive relationships with people.

People were listened to and involved in decision-making around

their care and support.

People were treated with respect and their privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred which enabled staff to provide care and support which reflected people's preferences, wishes and choices.

People were supported to enjoy activities both at the service and in the community.

There were systems in place to manage complaints which were dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led

Aspects of the quality assurance systems and processes required strengthening.

There was a positive, open culture where the needs of the people were at the centre of how the service was run.

The registered manager was approachable and supportive of staff.

Beechlands

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 4 July 2017 and was unannounced and carried out by two inspectors.

As part of the inspection we reviewed information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

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.

On the day of inspection we spoke with the registered manager and five members of staff. We spoke with 10 people who used the service and two visiting relatives. We reviewed five care records, five staff files as well as looking at other relevant documentation such as training records, quality audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

The service had recently introduced an electronic medication system for administering medicines to people. Staff used a hand held device that scanned each individual medicine box, the scanner then identified the persons individual medicine administration record (MAR). The MAR included all relevant information staff required to administer the medicine as prescribed. The system had in-built safety mechanisms which prevented medicines from being administered too early; however, we found that the new system was not robust and the provider's arrangements for the management of medicines required improvement. We audited people's medicines and found discrepancies relating to stock management. We counted 25 boxes of tablets, out of these, ten items of medicine did not tally with the MAR. Therefore we could not be sure that people had received their medicines as prescribed. We saw that the registered manager was completing an audit of medicines weekly but this had not picked up on the discrepancies we found.

Where people had been prescribed 'as needed' medication (PRN) such as pain relief or medicines to aid their sleep, guidance was not available to staff to determine when to use these medicines. For example, where people were unable to communicate verbally that they were in pain, or anxious, there was no personalised guidance provided to guide staff when to use these medications. Medicines were stored safely; the temperatures of the room and the medicines fridge were correct and were checked daily.

We discussed our findings with the registered manager who was pro-active in addressing our concerns and immediately provided us with an action plan to address the concerns which included re-training of staff, the introduction of a paper based tracker to keep a manual tally of the stock and an overhaul of their auditing process.

People told us they felt safe living at Beechlands. One person said, "If I need help, I know where to go; I feel very safe here and leave my door open." Another said, "I do feel very safe here, I have made my room my own, and when I go to bed at night I feel like I am in my own bungalow."

Staff understood how to protect people from harm and were aware of the tell-tale signs that could alert them that someone was being abused. Staff knew how to report concerns including whistle-blowing and were confident that if they raised an alert the registered manager would deal with any safeguarding concerns quickly in order to keep people safe. One staff member told us, "I would look for signs such as bruising or marks on skin, scratching, or a change in mood or personality." And, "I have used the whistle-blowing policy, it was dealt with appropriately, I have a duty of care." We saw that the registered manager recorded and dealt with safeguarding issues, including notifying us of concerns in a timely fashion.

There were systems in place to assess and manage risks to people and these were reviewed monthly or sooner if something changed for people. Risk Assessments were personalised to each individual, for example, one person had a risk assessment in place for smoking. This provided guidance for staff on how to support them safely as well as identifying the person's favoured place for smoking. The risk assessment stated, "The smoking area for [person] is at the back of the garden, this is her favourite."
SPACING

We saw that risk assessments were linked to people's care and support plans and were live documents which evolved as people's needs changed. For example, where a person's communication risk assessment identified that their ability to talk had deteriorated, the person was given a note pad to help them communicate and this was updated on their risk management plan.

The registered manager had signed up to various projects to improve people's safety including Prosper, a local authority initiative that aims to reduce the incidents of falls, pressure ulcers and urinary infections.

Staff told us they had a handover at each change of shift where they shared information with each other about any risks to people. The information was also written in a communication book kept in the main office. A staff member told us, "We all talk to each other; the communication is really good here."

Staff demonstrated a good awareness of risks to people and knew how to support them to manage them. For example, one member of staff told us, "[person] walks with a stick, we always need to remind them to use it, they have fallen in the past; They have glaucoma, we watch their pressure, if they say their eyes are hurting this is a sign and we need to get them checked out."

We looked at how staff worked with people throughout the day and saw that they supported people to stay safe. We observed staff reminding person to use frame correctly and put their glasses on so that they could see where they were going and walk safely. We saw one person who had one to one supervision throughout the day when they walked about as it had been identified that their risk of falling had increased due to poor health.

People and staff told us that there was sufficient staff available to meet people's needs. We saw that staff were not rushed and assisted people in a timely and unhurried way. The registered manager told us, "We don't use agency staff, we cover amongst ourselves so we have consistency; it's important for the residents and it means we know them really well." A member of staff told us, "There are enough staff, if a person calls in sick we have enough staff to cover for each other, plus the registered manager is hands on and will roll up her sleeves and help."

A dependency tool was used to assess people's current level of need and this was reviewed on a monthly basis to ensure there were enough staff to continue to meet people's needs safely. The registered manager told us that this might mean that staff numbers were increased but that they were never decreased.

Staff were recruited safely. Checks on the recruitment files for four members of staff evidenced they had completed an application form, provided proof of identity and satisfactory references were obtained. The provider had also undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Accidents and incidents were logged and the information was analysed and action plans were generated in response to promote people's safety. An individual log of accidents was kept for each person which included details of the accident, actions taken and the outcome. For example, where a person had been recorded as having a skin tear, they were referred to the district nurse. Another person had fallen so was referred to the falls clinic.

People were safe in the service as there were arrangements in place to manage and maintain the premises and the equipment both internally and externally. We saw that health and safety, maintenance, fire drills, accidents and incidents were all recorded and the necessary action taken.

Fire safety including people's emergency evacuation plans were currently being reviewed as the service was working through an action plan they had developed in consultation with the fire service.

Good

Is the service effective?

Our findings

People told us they thought the service was good and they would recommend it to others. The feedback we received from people and relatives was universally positive. One person told us, "You would not find anything as good as this." Another said, "If I have got to live anywhere other than my own home, then I could not live anywhere better." A visiting relative told us, "I think it's a very nice place here and they keep it lovely."

Staff told us when they joined the company they received an induction which included classroom based training and the opportunity to shadow experienced staff and have their practice observed. They were also given time to read people's care records and talk to people and staff so that they could get to know people and their needs.

We spoke to two new members of staff who confirmed they had received an induction and training to support them in their new role. One staff member described their experience of starting work at the service. They told us, "I'm new to care; I had an induction and face to face training in mental health, safeguarding adults, basic life support infection control and manual handling. After that I did shadowing until they could see that I knew what I was doing and felt confident to do it." And, "Everybody is so supportive here; we work together as a team. If you are not sure of something you can always ask someone. I learnt all about people by reading their care plans, talking to them and at staff handover where we share information."

We spoke with the registered manager regarding their induction process. They advised us that they did not support staff to complete the Care Certificate which is considered best practice for inducting staff into the caring profession. Instead, all new staff were automatically signed up to complete a level 2 qualification in health and social care which covers similar subject areas, but in greater depth. Staff confirmed that they were supported to complete Level 2 and 3 qualifications so that they could develop professionally.

Staff were supported by the provider to have access to ongoing and refresher training to keep their knowledge and skills up to date. The registered manager kept a training matrix to identify when refresher training was required. We looked at this document and saw that staff training was current.

Staff told us and records confirmed that they received regular supervision and an annual appraisal and that they felt supported in their role. They told us supervision was a positive experience which provided an opportunity to talk about any concerns and identify any training needs. One staff member told us, "I have supervision with [named team leader] every few months; it's nice to get feedback on how you are doing." And, "They are always putting me forward for training, asking me if I want to do it."

In addition to mandatory training, the provider had organised for specialist training relevant to the people the service supported. For example, staff had received training in dementia awareness and had been provided with the opportunity to wear a GERT suit. This is a specialist piece of equipment that staff put on to give them an appreciation and greater understanding of what it feels like to have age related impairments such as reduced grip and poor vision.

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's care records evidenced that their mental capacity had been considered by the service and there was recognition that people's capacity can fluctuate so staff were advised to assess people on a day to day basis to support them to make their own decisions. People told us they were supported to do what they wanted to do and make their own choices. One person told us, "I have decorated my room how I want it, my Granddaughter helped and they let me do what I wanted." Another said, "I am asked daily what I want for breakfast; I had two eggs this morning."

Staff told us they had received training in the MCA and demonstrated a good understanding of the principles of the act and were able to provide us with examples of how they supported people with decision-making. One staff member told us, "I will show people items, I don't give too many choices and don't rush and give them time to make their own decision if they can." People said that staff always gave them choices and asked permission before providing any care or support and we observed this in practice.

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 Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, nobody living at the service had a DoLS authorisation in place. An application had been made for one person and an independent mental capacity advocate had been arranged but the authorisation had been declined as it was established the person had capacity.

We saw that people were free to walk around the building without restriction, there were no security keypads or locked doors and people were free to come and go as they pleased and could leave the building unaccompanied. We saw that one person was getting ready to go out to bingo so staff helped them get ready and painted their nails. Another person was going to meet a friend for lunch and was helped to get themselves ready. Where it was identified that a person had deteriorated and required constant supervision which meant they may require a DoLS the registered manager confirmed that an application had been submitted.

Staff were aware of what constituted restraint and how to ensure people were not unlawfully restricted. One staff member told us, ""We can't physically restrain people; we just try to talk to them and explain the risks."

People were supported to have enough to eat and drink which met their preferences and any health needs. People told us they liked the food and there was plenty of choice. Comments from people included; "We have three choices and the menu is on the wall, we also get three choices of dessert and all the food is cooked fresh." And, "The food is excellent here." And, "I am not a big eater but there is usually a choice I like, as meals go I usually enjoy them." And, "If you don't like what you picked, they will get you something else."

We saw that people had hot and cold drinks provided to them and left within reach throughout the day. In addition, the tea trolley came round at 3pm with tea, biscuits and sandwiches. All of the meals were prepared by the cook and served by staff who all demonstrated an awareness of people's likes and dislikes. People could choose where they had their meals. Although some people took their meals in the dining room, some people chose to have their breakfast or lunch in their bedroom or remain seated in the lounge and staff respected these choices.

During the lunchtime meal, we observed that the atmosphere in dining area was chatty and relaxed with lots of laughing and joking between people and staff. The dining tables were nicely presented with condiments on the table, tablecloths and napkins. People were reminded of the meal choices available at the time of the meal. We saw that people were all able to eat independently but staff were on hand to support people if required. Although people chose what they were going to have to eat the day before, they could change their mind on the day and had lots of choice available to them, for example, burger and chips, ham egg and chips or jacket potatoes. We saw that people were regularly offered drinks and extras such as whether they wanted onions or cheese on their burgers.

People had daily record books which staff completed which included food and fluid charts. We found that some people's food and fluid intake was being monitored and supplementary records were completed. Staff recorded everyone's fluid but not all entries contained the amount of fluid the person had drank or set optimum fluid level targets to be reached. It was not always clear why some people's food and fluid was being monitored.

We spoke to the registered manager about the inconsistencies regarding food and flood recording. They advised us that recording the actual amount of fluid and setting targets would only be completed if a person was considered at risk. We saw one person who was considered at risk and their fluid intake had been recorded with more detail including the amount drank. We also saw that one person had been identified at low weight and had been referred to the GP and was receiving food supplements. This evidenced that people at risk had been identified and appropriate intervention had been provided.

We recommend that the provider review their current system for recording food and fluid and provide clear guidance for staff.

People were supported to maintain their health and wellbeing. We saw records which showed that medical assistance had been sought appropriately and in a timely fashion if people became unwell or required referrals to health or social care professionals. For example, where a person had fallen they had been referred to the falls clinic. Consent for treatment had been sought from people, for example, where people had agreed to have the flu vaccine we saw signed consent forms in place.

People were seen regularly by a range of health professionals including dentist, GP, district nurse, physiotherapist, chiropodist and optician. Visits by health professionals were logged including the reason for the visit and the outcome for people. We were advised that the service had organised for the local GP to conduct a weekly surgery at the service. A separate room was put aside to normalise the experience for people so they had somewhere to go and have a doctors appointment in private.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. Comments from people included, "It is lovely here, and the staff are very nice." And, "We are a big happy family here." And, "They [staff] are all lovely, very caring." And, "We are very well looked after, all the girls are very kind, it's wonderful here." A visiting relative told us, "[named] always looks very nice and well looked after, it's reassuring; I think this is a very nice place; the staff are always happy and very caring and nothing is too much trouble."

We saw that staff knew the people they cared for well. A person told us, "Staff know me; they know how many sugars I take in my tea without having to ask." We observed this in practice when staff made hot drinks for people they put right amount of sugar in although they did check with each person to make sure it was still ok.

Staff demonstrated a good awareness of people's interests. This meant that staff could have conversations with people about things that were important and of interest to them. We observed a member of staff come into the lounge with jellied eels for two people. They said, "After us talking about jellied eels last week I thought I would get you both some, I will put them in the fridge for your tea." A relative of one of the people was in the lounge and offered to pay for them but the staff member said, "No it's my treat."

People told us they felt listened to which meant they received care and support how they liked it. One person said, "Staff are very good, they do what I want, and if I tell them how I like things to be done they do it." Another said, "Staff are very helpful and they always try to do what we want." People were involved in their care and support planning. One person told us, "I have just signed my care plan."

Care was seen being delivered in a relaxed pace and was not rushed and staff had time to spend with people. A staff member told us, "I like to spend time talking to residents, it's a big part of caring for people, building up a bond; I like to reminisce with people; it makes me feel proud knowing that people feel comfortable talking to me, it makes my job worthwhile."

Staff were very attentive to people's needs and alert to signs of distress. We saw a person who was living with dementia becoming upset and tearful. Staff noticed and went and sat with them to comfort them. They took a magazine and looked through it with the person, talking about the contents and engaging with the person to distract them. The person calmed down and began to chat happily about shoes and bags.

Staff spoke to people with kindness and courtesy. We saw that staff knocked on people's doors before entering and called them by their preferred names. A person told us, "They [staff] are all very pleasant, I haven't met a rude one yet." Observations of staff interacting with people showed that people were treated with dignity and respect. People were assisted to their bedroom, bathroom, or toilet whenever they needed personal care that was inappropriate in a communal area. A person told us, "They always knock if they want to come in." Another said, "They help me with a shower, it is always a woman and the door is kept shut." Another person told us, "I like my door left open but they still knock."

People had designated keyworkers which helped people and staff build a rapport. One member of staff told us, "I'm keyworker for [person] so I do their showers; I go shopping for them, I get them birthday cards. Quite often we just sit and have a chat; they confide in me; we have a lovely bond." People knew who their keyworker was and spoke positively about the relationship. One person told us, "I have a keyworker; her name is [named carer]. I can talk to her about anything."

We observed that staff encouraged people to be as independent as possible and were patient to enable people time to complete care tasks themselves. One staff member told us, "[person] likes to feel useful so I go to the kitchen with her encourage her to make tea with me and if I'm washing up she will help me; it's about getting people involved, getting them to join in." People we spoke with told us their independence was promoted. Comments from people included; "I am very independent, I go out when I want, I am waiting to be picked up soon by my friend." And, "I put the kettle on for the staff this morning, I like to be useful." And, "The carer comes and asks me if I want a cup of tea first, then they help with my back and feet, then I do all the rest myself."

People were supported to maintain relationships that were important to them as visitors were made welcome at the service. A visiting relative told us, "Staff are fantastic, very helpful and welcome us with open arms." Another said, ""It's such a nice atmosphere all the time, the staff are very friendly, I love the set up. I always feel welcome; I can come at any time. They have said if I want to come and have lunch with [person] then I can."

Feedback from relatives regarding the level of care and support people received at the end of their life was positive. One relative said, ""The end of life care was sympathetic and loving as if [person] was their own family member."

Good

Is the service responsive?

Our findings

Care plans were personalised to each individual and included information about people's likes and dislikes, preferred routines, hobbies and interests. Information was also recorded about people's life history including photographs, details of their family history and jobs people had done in the past. Care plans also included a summary of people's first day at the service which was used to get to know the person, understand their needs and become familiar with their routines. This information helped staff to get to know people well and understand how best to support people in the way they wanted and provide person-centred care. Person-centred care means care that is tailored to meet people's individual needs rather than the needs of the service.

We asked staff how they provided person-centred care. One staff member told us, "Every person has different needs; it's about getting to know them, listening to them and doing things how they want." Another said, "[Person] likes a shower every morning before breakfast. Another lady likes her breakfast in bed; we do what people want, respect their personal preference; some people like to get up early and some late; people can have a bath or shower whenever they want one."

People confirmed that their likes, dislikes and preferred routines were known and respected. They told us that they could get up and go to bed, go out and about and bathe whenever they wanted. One person said, "I have a shower whenever I like." Another said, "Staff are very good, they do what I want, and if I tell them how I like things to be done they do it."

Care plans were reviewed monthly by senior members of staff who sat with people to complete the review. We saw that care records had been signed to indicate the person or their family member, if appropriate, was included in review. However we found that the monthly reviews had not always accurately recorded changes to people's health or care and support needs. For example, in one person's reviewed care plan it was recorded that they had a sacral sore. However when we spoke with staff we were told the sore had healed but this information and not been updated in the latest review. Whilst recording practices were not always consistent, risks to people were mitigated as people were supported by a stable and consistent workforce who knew people well and were aware of peoples current care and support needs.

We recommend that the service review its systems and processes for reviewing and auditing people's care plans to ensure staff always have access to the most up to date information and guidance.

The service employed an activity staff member who worked part-time during the week but also worked at the weekends. We saw there was a programme of activities available such as arts and crafts, quizzes, bingo and board games. The activities staff told us, "The men downstairs like dominoes, scrabble and cards; I usually set them up as they can play together." We observed a group of men playing together on the day of inspection. One told us, "We play dominoes, cards and scrabble as we prefer that."

We were advised that outside entertainment was also organised which people enjoyed. The service also had access to transport which was used to take people on outings such as visits to garden centres. We saw that

one person had a piano as they liked to play and another had a budgie which they kept in their room.

People told us there were structured activities available if they wanted to join in but that this was not forced upon them. Feedback from people included; ""We did bingo this morning, there is a fete on Saturday and we make cards, It seems enough to me." Another said, "We have gone out once in a while, I think they are organising another, I am quite happy with what I do." One person told us, "I go to a club, but there are things to do here, they do all they can. We make cards and all my family are coming to the fete." Another person said, "There are things to do but I am a loner, it's here if you want it, but I like the fact they don't force it." Some people told us they were aware of activities but chose not to join in. One person said, "I prefer to sit and do my crosswords." Another said, ""I like my own company, and watch TV."

On the day of inspection we saw staff interacting with people, supporting them with range of everyday activities that people chose and enjoyed. For example, we saw ladies getting their nails painted and being supported by staff to get ready to go out and meet friends for lunch.

To meet peoples spiritual needs a church service was organised on a Wednesday which was non-denominational and provided people with an opportunity to sing hymns which people told us they enjoyed.

The service kept a log of the activities people engaged in. However, we found this information had been recorded in two different places which made it difficult to accurately monitor what people had been doing. We recommended that the service review its recording practices for logging activities to ensure information is accurate and accessible.

There was a system in place for managing complaints and we saw that any complaints were dealt with appropriately. For example, where a person's tap was leaking this had been logged and actioned by the maintenance man. In another example, where a person had complained about the state of their carpet, the carpet had been changed.

When people joined the service they received a service user guide which included a copy of the complaints policy. All of the people we spoke with said they knew how to make a complaint but had never had to. One person said, "I've never had to make a complaint but would go to [registered manager] or [Staff name]." Another person said, "If I was worried about something would talk to [named staff]." Another person said, "Overall I am very comfortable, no complaints." People told us that when they had provided feedback to the service on ways it could be improved this had been received positively. One person said, "I have no complaints but I have made comments which they [management] responded to very well."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe. The manager belonged to various groups that promoted best practice in the care sector including 'My Home Life'. My home life is an initiative that promotes quality of life and aims to deliver positive change in residential care homes for older people. They also attended monthly neighbourhood meetings with health care professionals such as GP's and district nurses along with other home managers to talk about how to support people to stay healthy and avoid hospital admissions.

At our previous inspection we found a lack of provider oversight of the service as there had been no external monitoring of the service by the provider since 2014. At this inspection we were advised that the provider had recently introduced a monthly external health and safety audit. We looked at a copy of the audit for June 2017 and found that where issues had been identified and action plan had been generated. This outlined what actions were required and who was responsible, however there were no target dates set for the actions to be completed.

The registered manager completed a range of audits to monitor the safety and quality of the service people received but these had not picked up on some of the issues we found. For example, the weekly medicines audit had failed to identify the mistakes with regard to the stock count of people's medicines. We saw that some audits had been more effective. For example, the monthly audit of people's care plans had identified that a person's risk assessment had not been updated so the registered manager had added the correct information onto it. The manager also audited people's daily records. We saw that they had identified that fluid charts were not always fully completed appropriately and had brought this up at staff meetings to remind staff on the correct procedures.

We spoke to the Registered Manager about our concerns regarding aspects of their auditing processes. They were pro-active in providing us with an action plan which set out how they would make the necessary improvements to ensure their system for auditing medicines was sufficiently robust.

The manager was visible within the service and staff told us they were supportive, approachable and listened to them. Comments from staff included; "[registered manager] is really easy to talk to." And, "I like [registered manager] they are very strict about safety and cleanliness for people." And, "The registered manager is great, they encourage me a lot, always manage to calm me down, support me, you can go to them anytime, if they are busy they will always come back to you; they make an effort." Staff told us the registered manager was hands-on and would always muck in and help out and we observed this in practice.

We found the culture within the home was warm and friendly where people were listened to and supported to live their lives the way that they chose. The registered manager told us, ""Going home and coming to work is the same for me." This sentiment was echoed by people and staff who felt part of a big family. There was a strong emphasis on putting people first. This was illustrated by the fact that when an inspector accidentally

used a person's mug a member of staff came and found it and took it back so the person could have their tea in their own mug.

People were included in the running of the service and their opinions were sought through a range of mechanisms such as quality surveys, residents and relatives meetings and the use of a 'residents listening form' which staff filled in regularly with people to obtain their feedback. We looked at minutes of the meetings and saw that people were actively encouraged to have input into the how the service was run and staff always asked people if they had any complaints they would like to raise. The registered manager told us that they also did a walk around the service every morning to speak to everyone and make sure they were happy. Staff were also included in how the service was run. Staff meetings were held every month and the registered manager also organised a weekly catch up with senior members of staff to share information and discuss staff development.