Health & Care Services (NW) Limited

Potton House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 22 June 2016. At our previous inspection in June 2015 we found that there was insufficient staff to provide one to one support for people who required it at all times, or to provide people with the support that they wanted in a timely manner. During this inspection we found that there were sufficient staff to provide the support that people needed and people's needs were responded to without delay.

Potton House provides nursing care and support for up to 24 older people with dementia and needs relating to their mental health. At the time of our inspection there were 20 people who lived at the home.

The home had a registered manager, as required by the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

People's needs had been assessed before they moved into the home and they had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met. People or relatives acting on their behalf had been involved in determining their care needs and the way in which their care was to be delivered. Relatives were involved in the regular review of people's care needs and were kept informed of any changes to a person's health or well-being. However, people were not well supported to maintain their hobbies and interests and had not been encouraged to use the activity and stimulation equipment that had been introduced by the registered manager.

People had choice of good nutritious food and their weight was monitored with appropriate referrals made to other healthcare professionals when concerns were identified.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the entrance of the home. There were a number of other information leaflets on the notice boards

around the home which included information about the service and organisations that could be contacted for support or to report concerns.

There was a very friendly, family atmosphere about the home. People, relatives and staff were able to make suggestions as to how the service was provided and developed. An effective quality assurance system was in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

People's medicines were managed and administered appropriately.

Is the service effective?

Good

The service was effective.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a good choice of nutritious food and drink.

People were supported to access other healthcare professionals to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

People were provided with information about the service and friends and relatives were able to visit whenever they wanted to

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to maintain their hobbies and

interests and records showed that there was very little in the way of activities to maintain their interest. People had not been encouraged to use the activity and stimulation equipment that had been purchased and much of it was not readily accessible to people.

People and relatives had been involved in the development of their care plans and involved in the regular review of these.

People were aware of the complaints system but had not found it necessary to make a complaint.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post who was known to people, relatives and staff who found them to be approachable and supportive.

Staff and relatives were encouraged to make suggestions on the development of the service.

There was an effective quality assurance system in place.

Potton House

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.

This inspection took place on 22 June 2016 and was unannounced. The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 also reviewed the information available to us about the home, such as notifications and information that had been provided by staff and members of the public. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with five people and three relatives of people who lived at the home, four care workers, a laundry worker, the deputy manager and the registered manager. We also spoke with three health care professionals who visited the home during our inspection. We carried out observations of the interactions between staff and the people who lived at the home.

We reviewed the care records and risk assessments for three people, checked medicines administration and reviewed how complaints were managed. We also looked at two staff recruitment records and reviewed information on staff training. We looked at how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

When we inspected the home in June 2015 we found that there were not enough staff to ensure that people who required one to one support at all times received it. During this inspection we found that there was only one person who required one to one support and this was provided at all times. There were enough staff to provide safe care and support for all the people who lived at the home. One person told us, "I don't usually have to wait for people to help me if I need it." A relative said, "There always seem to be enough staff here, not just for [name] but for others too." Another relative commented, "They've got the right number of staff here I think at all times of day people seem to be fine."

Staff told us that there were always enough staff on duty to care for people safely and effectively. One staff member told us that the ratio of staff members to people had been increased to one care worker to three people. An incentive scheme had been introduced to encourage permanent members of staff to cover any vacant shifts and on the day of our inspection a nurse was covering a shift for a care worker which had been unfilled. This reduced the need to employ agency staff and meant that people were supported by staff who knew them. We saw that the rota was completed in advance and additional cover had been provided when people had needed to be accompanied by staff to appointments. This allowed members of staff to plan their off-duty time and volunteer for any unfilled shifts that they wished to cover.

We looked at the recruitment files for two staff that had recently started work at the home. We found that there were robust recruitment procedures in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work. The registered manager told us that the recruitment process had been changed so that potential new employees spent time with people prior to them being offered posts within the home. This enabled the registered manager to evaluate their suitability to work with people and also enabled the potential employee to understand better the people that they would be working with and the challenges that this presented.

People and the relatives of people we spoke with told us that they felt they or their relative was safe and secure living at the home. One person told us, "They know me and they care about me." A relative said, "I've been here at night, it is very safe and very calm." Another relative told us, "[Name] is safe here; they always tell me if there is anything wrong – even very small things." We saw that the exits to the building were protected by way of a numbered key code so that people were unable to leave the building unless they knew the key code or were accompanied by a member of staff.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. One member of staff said, "If anything were to happen that would put a resident at risk, staff will step up. I have done and knew I would be supported for doing the right thing." Information about safeguarding was displayed on a noticeboard in the entrance hall together with details of the telephone numbers to contact should people wish to. The staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might

suffer.

There were personalised risk assessments in place for each person who lived at the home. The actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. These included the identification of triggers for behaviour that had a negative impact on others or put others at risk and steps that staff should take to defuse the situation and keep people safe. One relative told us, "I've never heard and raised voices. [Name] is safe here and I know it." We noted that the atmosphere at the home was calm all day. A member of staff told us, "We don't do speeding up here, the job gets done. We focus on calm all the time here."

Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. We noted that where people had been assessed as at risk of sustaining falls a risk assessment was in place and a record kept of every fall that the person experienced to enable potential causes to be identified and the risk of reoccurrence to be reduced. One person had fallen three times during May 2016 and they had been referred to the local authority falls team to identify any steps that could be taken to reduce the risk of further falls occurring. Staff told us that they were made aware of the identified risks for each person and how these should be managed by looking at people's risk assessments, their daily records and by talking at shift handovers. Staff therefore had up to date information and were able to reduce the risk of harm.

Accident and incident forms were completed appropriately and were analysed by the registered manager on a monthly basis to identify any trends or changes that could be made to reduce the risk of harm to people who lived at the home. An analysis of the 17 incidents that had occurred in May 2016 showed that nine incidents had involved one person, seven of which had been assaults on members of staff. The registered manager had arranged for the person to be reviewed by the GP and their medicines had been changed.

The manager had carried out assessments to identify and address any risks posed to people by the environment, including fire and portable electrical equipment. There was an emergency plan in place, which included information of the arrangements that had been made for major incidents such as the loss of all power or water supply. Each person had a personal emergency evacuation plan (PEEP) in place, which had been reviewed an updated as people's needs had changed. For example one person's PEEP instructed staff that they should be evacuated using a wheelchair as their mobility had decreased and they would be too slow to exit the building if they were assisted to do so whilst walking.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Only qualified nurses administered medicines and they confirmed they had received regular training updates. Each medicines administration record (MAR chart) included information about any 'as required' (PRN) medicine or homely remedies a person took, including information about the medicine and any possible contra-indication with their regular medicines. There was also some additional documentation for those people who had medicine delivered by way of patches applied to their skin. We looked at the MAR charts for all of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held for two people which were in accordance with those recorded and the controlled drugs documentation which had been completed in accordance with current recommendations. Stocks of controlled drugs were checked and found to be correct. There were robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

Relatives we spoke with were confident in the ability of the staff to provide effective care for the people who lived at the home. One relative told us, "The carers are marvellous here. Even when the residents are abusive they are still so good."

Staff told us they received training to help them undertake their roles. One member of staff said "My induction was very informative. I spent three days shadowing (watching an experienced member of staff) with [the deputy manager]. I went through the induction booklet and only when I was happy and confident that I knew what I was doing was I put on a shift working alone. There was no pressure. They were happy to accommodate me until I was confident that I knew what to do." Another staff member told us that training was mostly delivered by way of e-learning although some was delivered face to face. They told us that the registered manager monitored that they were up to date with their training and reminded them when training was due. They went on to describe the benefits of the 'Creative Minds' training that all staff within the home were to complete. They told us, "It gives you fundamentals that you would not think of. It makes you think. For example [name] would see only half their plate when they were eating and therefore thought they had finished their meal when they had only eaten half of it. When I turned their plate round they ate the rest. [Name] worked on a farm and all their conversations had farm connotations. We now understand the meaning of some of the sentences that they use to tell us what they want."

Staff told us that they were supported by way of regular supervisions during which they could discuss any aspects of their work and identify ways in which the service could be improved. They were also able to identify any additional training that they wanted. The registered manager showed us the schedule of supervision meetings that showed that these were held for each member of staff every two months. All the members of staff at the home had appraisal meetings with the registered manager in February or March 2016 at which their performance had been reviewed, areas for improvement had been identified and future goals had been agreed. This demonstrated that staff were supported to improve and develop their skills to care for and support the people who lived at the home.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that best interest decisions had been made on behalf of people following meetings with relatives and healthcare professionals and were documented within their care plans. In one record best interests decisions had been made in respect of the delivery of

personal care and treatment to a person who had been assessed as not having the mental capacity to understand the decision. Following a meeting with the person, their family, GP and the staff it was agreed that it was in the person's best interests for them to receive care and treatment at the home.

Applications for the deprivation of liberty had been made for all the people who lived in the home as they could not leave unaccompanied and were under continuous supervision. This made sure that these decisions, which impacted on their rights to liberty, were made within the legal framework to protect people's rights. We saw that, where assessments had been made and authorisations to deprive people of their liberty had been approved, appropriate people had been appointed to represent the individuals.

People told us that they were always asked for consent before care or support was given. We overheard members of staff asking, "Would you like me to help you .....?" before they provided support to people. Staff told us of ways in which they gained consent from people who could not communicate verbally with them before providing care. They explained that they used non-verbal methods of communication by using gestures, pictures and showing people items to gain consent and give them choices. Our observations confirmed that these methods were used effectively to gain consent and understand people's needs. People's care records contained consent forms signed by people's authorised representatives for aspects of the care and treatment given, such as the use of photographs and receipt of vaccinations for pneumonia and influenza. However, we noted that some of these had not been properly completed so it was not clear whether consent had been given.

We looked at the records of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) in respect of three people who lived at the home and found that these had been completed correctly with the involvement of people, their relatives and other healthcare professionals where this was appropriate.

People and their relatives gave different opinions on the food and drink that was available to them. People said that it was 'alright'. One person told us, "The food is ok, not great." When a relative said, "I've eaten here and the food was good." their relative added, "Well it was a special occasion and they knew there would be visitors so you'd expect it to be good then!" Another relative told us, "The food is alright. It is edible food to keep them going. It's difficult to feed lots of different people with different needs. The meat is always tender."

We observed good interactions between staff and people using the service at lunchtime in order to make it a social occasion. Family members who liked to help their relative eat at mealtimes were encouraged to do so and joined in the general chatter with people and members of staff during the meal time. Staff encouraged people to sit at the dining table and offered support appropriately. Some people chose to sit on settees or soft chairs and were supported to eat with small tables put in front of them to hold their plate and cup. We saw that people who required assistance to eat their meals were given this is a caring, supportive way. Members of staff gently encouraged them to eat their meals at their own pace. Other people were encouraged to eat and where they appeared not to like the food they had were offered an alternative choice of food. We saw that the registered manager had noticed that one person had been sitting with their meal untouched in front of them and stopped on their way through the dining area to encourage them to eat it. A list of people needing food supplements was provided by care staff and retained in the kitchen.

We saw that jugs of drinks were available in all communal areas and that staff encouraged and supported people to take fluids outside of mealtimes. All the care records included nutrition assessments and associated eating and drinking care plans. People's weight was monitored and food and fluid charts were completed, for people where there was an identified risk in relation to their intake, which provided detailed information on what they had consumed.

The care records showed that people were assisted to access other healthcare professionals to maintain their health and well-being. One person told us, "I don't go on my own, a carer comes with me." Another person said, "A GP comes and sees me here when I need someone." When healthcare professionals visited people at the home the reason for the visit and the outcomes had been recorded. There was evidence that staff had appropriately responded to people's needs as they arose, such as making referrals to their GP, a podiatrist or mental health services. Healthcare professionals that we spoke with during our inspection told us that staff always contacted them when it was necessary to do so and followed any guidance that they gave them. One healthcare professional described the staff interaction with people as, "…faultless." They went on to say, "They [staff] are very attentive. They are always there to help me get the treatment done with the least amount of distress."

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and considerate. One person said, "The carers here are happy, jovial and there [is] nothing they won't do for you." A relative told us, "There's a family atmosphere here."

Staff were observant of people's needs. For example, one member of staff was helping with something unrelated and had noticed that one person appeared to be unwell. On checking with the person the member of staff found that the person's hand was swollen and uncomfortable. The member of staff checked that this had been dealt with, the person had been prescribed antibiotics, before moving on with their task.

Positive, caring relationships had developed between people who used the service and the staff. Staff were able to demonstrate that they knew the people they cared for well, were aware of their life histories and were knowledgeable about their likes and dislikes. We listened as one care worker spoke to a person to calm a situation. The member of staff knew all about the person's background and their childhood in Ireland and "riding a cow to school." The member of staff knew how to make the person laugh by using these memories. They understood the person, knew the triggers for their behaviour and how to make life easier for them and for the other residents.

We observed the staff interacting appropriately and continually with people throughout the day. A healthcare professional told us that staff interacted with people 'very well.' Staff told us that they also used body language and other non-verbal forms of communication, such as facial expressions and picture cards, to understand people's needs. Staff described how they offered people choices about what they wore by holding up two garments if they were not able to respond orally and what they ate by showing them the meals that were available.

We saw that people were able to make decisions about their care. Care records for one person showed that on occasion they would refuse to go to bed at night and preferred to 'cat nap' in a chair. The care plan was to respect this choice, offer them a hot drink and encourage them to return to their bed but if they decline then staff should ensure that they were warm and comfortable. Thus, their choice was supported, whilst seeking to ensure their comfort and safety. People were able to make choice of whether they received care and support from male or female members of staff. One person told us, "They always ask me first and I don't usually mind. Sometimes they say, 'if you want a wash now then you will need to have (male),' and so if I don't want to wait then I have him. "

People were encouraged to be as independent as they wanted to be. However relatives told us that people had not been encouraged to maintain their skills. One relative told us, "They don't seem to encourage [relative] to be independent, they do a lot for [them]." Another relative said, "[relative] could walk when [they] came in but I noticed today [they are] being hoisted. If they [people] don't want to do something they [staff] don't seem to push it. [Their] skills have gone down now. I could get [them] into the car but if [they] need hoisting I won't be able to. If there was anything I could change it would be to get them to make

[relative] walk more."

People and their relatives told us that the staff protected people's dignity and treated them with respect. They told us that doors were closed during personal care and that they were respected by the staff. We commented to one person on how smartly they were dressed and they told us, "That's because the carers here care about what they do." We saw that when people were receiving treatment from a visiting healthcare professional screens were placed around the area in which they were providing treatment to provide privacy and protect people's dignity. We observed that staff knocked on people's bedroom doors and waited for their permission before entering.

People, relatives and staff told us that friends and relatives were free to visit at any time during the day and evening. One person told us, "Oh yes my family can come whenever they want to." Another person said, "My family visit often, they are very good. They come when they can but otherwise it is very boring." A relative told us, "They give us the combination (key pad) and we can come and go as we please. We have to sign something saying we won't give it out." Another relative said, "It's open house here."

Information about the service, safeguarding, the complaints policy and fire evacuation instructions was clearly displayed on notice boards around the home. The noticeboard just inside the entrance clearly displayed the ratings given following the last Care Quality Commission (CQC) inspection.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the home in June 2015 we found that people's needs were not always responded to in a timely manner. During this inspection we noted that there were sufficient staff to respond to people when they required assistance without undue delay. When people used their call bells these were responded to immediately. When people requested assistance, such as to go to the toilet or to have a drink, this was provided in a timely fashion.

Records showed that people and their relatives had been involved in deciding what care they needed and how this was to be given. A relative of someone recently admitted to the home told us, "We are here on one to one care and I have been told everything will be reviewed in a month." They had been visited by one of the managers whilst in hospital who had assessed whether they could provide the care the person needed before they moved into the home. The manager undertook a thorough pre-admission assessment that fed into the assessment of needs that determined the care plans that were necessary.

The care plans followed a standard template which included information on people's personal history, their individual preferences and their interests. They were individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. However, we found that some information, such as a distressed reaction chart included in the records, had not been supported by a care plan in relation to the need.

Each person had been allocated a named nurse who was responsible for updating the care plan. One relative told us, "… in practice we all know the carers and the residents do too and so it doesn't really matter." Relatives told us that they were involved in reviews of people's care plans. One relative said, "They do talk to me about his care." Another relative told us, "Yes there is a care plan and they guide me and they update me every few weeks or if there are any changes."

Although there was some evidence that people were supported to maintain their interests, such as one person being supported to write letters, people told us that there was very little for them to do. One person said, "Some days I have things to do but other days there is nothing here. Usually there isn't much." Another person said, "I'd really like to go out and get my [relative] a card, I want to get it myself not someone else to get it for me but I can't. I really hate that!" Although a care worker said that they would assist the person to make a personalised card for their relative this did not address the real need of the person who wanted to go out. We observed people as they sat in the main lounge for hours with little to stimulate them. A care worker had proudly shown us sensory items that had been recently purchased that could be used provide stimulus and prompt interaction between people. However, these were not always readily accessible to people. For example the dominos that had been purchased had been put away in a drawer and the large 'Connect Four' puzzle had been stored behind a chair. We discussed this with the registered manager who told us that a considerable sum of money had been used to purchase equipment to provide for activities for people. They immediately arranged for the equipment to be made more readily available for people and for care workers to encourage them to use it. A short while later we noted that a group of people were enjoying a game of dominos at a table in the dining area and the 'Connect Four' was readily accessible for people to

use.

We spoke with the activities co-ordinator who had been in post for a number of years. They told us that each person had their own record of the activities that they had undertaken and showed us some drawings and paintings that one person had completed with their assistance. We looked at the activities records of three people who lived at the home and reviewed the activities recorded over the previous four months. These showed that people had done very little over this period. One record showed the person had been assisted with only one 'activity' a month. In February the activities co-ordinator had spent a short while holding the person's hand. In March .they had assisted the person to eat their breakfast. In April the activities co-ordinator had accompanied the person on a walk in the garden. In May they had again accompanied the person on a walk in the garden but the record showed that their attention had been diverted by talking with a care worker and the person had lost interest in the walk. A second record showed that the activities recorded in April 2016 had been two visits from a person's relative. In May 2016 the only activity recorded had been a walk to the conservatory and in June 2016 it had been tea and a chat with another person who lived at the home.

We spoke with the registered manager who told us that the home shared a minibus with another of the provider's homes. However, the activities co-ordinator in the other home was more pro-active and used the mini-bus to take residents from their home out fairly regularly. Priority for use of the minibus was also given to people who needed to attend healthcare appointments. It was not often available for outings for people who lived at the home, although some were planned during the summer months. The registered manager told us that one of the care workers played a musical instrument and regularly entertained people. In addition they had arranged for an entertainer who impersonated Elvis Presley to visit the home on a regular basis. A local singing group had also attended the home to provide entertainment for people and would be returning after the summer.

We noted that no person who lived at the home had been supported to register to vote in local elections or the forthcoming referendum on membership of the European Union even though some had the capacity to understand the issues and may have wished to be able to exercise their right to take part in the ballots.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the home. However people told us that they had not had reason to make complaint. One person said, "If I have any problems I just talk to anyone – they all help and there hasn't been anything big." A relative told us, "I've had little niggles but I'm completely happy and they are all sorted." We noted that there had been no complaints received in the 12 months prior to our inspection although the registered manager had maintained a record of 'niggles' that had arisen and how these had been resolved. We saw that a relative had been concerned about the number of medicines one person had been prescribed. The registered manager had arranged for the GP to carry out a review of the person's medicines with their relative present which had resolved the matter to their satisfaction.

Good

Is the service well-led?

Our findings

Since our last inspection in June 2015 the registered manager at that time had left and a new manager had been appointed by the provider. Their registration with the Care Quality Commission had been confirmed in May 2016.

People, relatives and staff told us that they knew the registered manager and that they were approachable and supportive. One relative said, "The manager is hands on and will help the staff if there is a problem. People can always talk to him." A member of staff said, "[Registered manager] is brilliant. If there is anything I'm not sure of I can always ask. I ask questions and no question is too silly. [Deputy manager] is good too." Another member of staff said, "[Registered manager] and deputy manager] are both hands on when needed." We observed the registered manager as they passed through the lounge. They stopped to talk with four of the residents as they passed through. The people clearly knew and liked the registered manager. They made each person smile with little comments which were personal to them.

A member of staff described the culture of the home to be, "relaxed and organised." Another member of staff said, "I like it here. It is like a family. You have your ups and downs but everyone works together." Comments made in a recent survey of relatives described the home as being, "a relaxed, homely, caring and secure environment," for the respondents relative.

People and relatives were involved in the development of the service. On the day of our inspection a meeting of relatives and the registered manager had been arranged. The registered manager sent us the minutes of this meeting that showed that the topics discussed had included the use of the donations fund, staffing, volunteers and changes to the garden. In May 2016 the relatives had discussed a report from Bedfordshire Clinical Commissioning Group, reviews of care plans and the revised recruitment strategy. As part of the annual survey of relatives they had been asked to make suggestions for improvements that could be made at the home. One suggestion had been for an activity box to be in the main lounge. We noted that an assortment of activity items had been purchased and, following our conversation with the registered manager, were available in boxes in each of the lounges.

Staff told us that were able to make suggestions for improvements to the service during their supervision meetings and at staff meetings. We saw that at the meeting held in May 2016 staff had discussed topics such as the rota, the use of social media, carpets and information to be shared during handovers.

The manager had carried out a number of audits of the quality of the service. These had included infection control, the environment, care plans and the kitchen. We noted that action plans were devised following these audits where improvements had been identified. In addition the provider's Operations Director carried out monthly quality audits of the service during which they spoke with people, their relatives and staff. They also reviewed management records, care documentation, medicines management, maintenance and internal and external compliance. Following the Operations Director's audit in April 2016 we saw that an action plan had been devised to address the areas for improvement identified. These had included the replacement of the carpet in the lounge, the introduction of an agency staff induction form, face to face

moving and handling training for staff and the acquisition of activity and stimulation equipment. We noted that an action plan had been devised following this audit and many of the actions had been signed off as they had been completed.

People's records were stored in a locked cupboard within an office used by staff that was accessible only by using a key pad. This meant that people's records could only be accessed by persons authorised to do so.