Berry Pomeroy Home For Elderly People

Berry Pomeroy

Inspection report

26-28 Compton Street
Eastbourne
East Sussex
BN21 4EN

Tel: 01323720721
Website: www.berrypomeroy.org.uk

Date of inspection visit:
07 June 2018

Date of publication:
05 July 2018

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was carried out on 07 June 2018, and was unannounced.

Berry Pomeroy is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Berry Pomeroy is two large town houses which have been joined together. People's bedrooms were provided over four floors, with a passenger lift in-between. There were a range of sitting rooms and a dining room, with an enclosed garden to the rear. Berry Pomeroy is situated in a residential road in Eastbourne. Both men and women lived in the home. Some people were not able to communicate their feedback and experiences verbally of living in the home.

This was the first comprehensive inspection following a change of legal entity and registration on 08 June 2017. At the time of our inspection, 17 people lived in the home.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home. 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 home is run.

People were safe at Berry Pomeroy. Staff knew what their responsibilities were in relation to keeping people safe from the risk of abuse. Staff recognised the signs of abuse and what to look out for. There were systems in place to support staff and people to stay safe.

There was a pro-active approach to promoting people's safety and independence which was reflected in people's risk assessments and care plans. People were supported by staff that had been recruited safely and had checks undertaken to ensure they were suitable for their role.

Medicines were managed safely and people received them as prescribed.

Staff encouraged people to actively participate in activities, pursue their interests and to maintain relationships with people who mattered to them.

People received the support they needed to stay healthy and to access healthcare services.

There were enough staff to keep people safe. The registered manager had appropriate arrangements in place to ensure there were always enough staff on shift.

Each person had an up to date, person centred care plan, which set out how their care and support needs

should be met by staff.

Staff received regular training and supervision to help them meet people's needs effectively.

People were supported to eat and drink enough to meet their needs. They also received the support they needed to stay healthy and to access healthcare services.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005.

Staff showed they were caring and they treated people with dignity and respect and ensured people's privacy was maintained, particularly when being supported with their personal care needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the home supported this practice.

The registered manager ensured the complaints procedure was made available in an accessible format if people wished to make a complaint. Regular checks and reviews of the home made to ensure people experienced good quality safe care and support.

People and staff were encouraged to provide feedback about how the home could be improved. This was used to make changes and improvements that people wanted.

The registered manager provided good leadership. They checked staff were focussed on people experiencing good quality care and support.

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.

Risks to people's safety and welfare were managed to make sure they were protected from harm.

Staff knew how to recognise any potential abuse and so help keep people safe.

The registered manager followed safe recruitment practices.

Medicines were managed and recorded in a safe way.

There were enough staff available to meet people's needs.

Is the service effective?

Good

The service was effective.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

Staff received on-going training in areas identified by the provider as key areas. Supervisions and appraisals were carried out by the registered manager.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

Staff were knowledgeable about people's health needs, and contacted other health and social care professionals if they had concerns about people's health.

People's human and legal rights were respected by staff. Staff had the knowledge of Deprivation of Liberty Safeguards and Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them

well.

Staff protected people's privacy and dignity, and encouraged them to retain their independence where possible.

Staff were aware of people's preferences, likes and dislikes.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

Is the service responsive?

Good

The service was responsive.

There were activities located around the home for people to engage in.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well-led.

There was a quality assurance system and this was effective in rectifying shortfalls identified.

There was an open and positive culture which focused on people.

The provider and registered manager sought people and staff's feedback and welcomed their suggestions for improvement.

Berry Pomeroy

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 checked 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 was a comprehensive inspection, which took place on 07 June 2018 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

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 looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We observed staff interactions with people and observed care and support in communal areas. We spoke with ten people who used the service. We also spoke with two visiting relatives.

We spoke with four care staff, one activities coordinator, two senior care staff and the registered manager.

We looked at the provider's records. These included four people's care records, which included care plans, health records, risk assessments and daily care records. We looked at four staff files, a sample of audits, satisfaction surveys, and policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including training records and deprivation of liberty safeguards (DoLS) information.

The information we requested was sent to us in a timely manner.

Good

Is the service safe?

Our findings

People told us they felt very safe and secure living in the home. One person said, "I am very safe here. They look in on you every two hours during the night". Another person said, "I was very poorly before I came to live here but they have helped me regain my health and I feel safe and well and this is my home now". A third person said, "I feel very safe. No worries about anything. It is a wonderful place to be".

A healthcare professional said, "My client at Berry Pomeroy has felt very safe and content during his time there and has always wished to remain there".

The risk of abuse was minimised because staff were aware of safeguarding policies and procedures. All staff were aware of the company's policies and procedures and felt that they would be supported to follow them. Staff also had access to the updated East Sussex local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the East Sussex area. It provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff spoken with told us that they would refer to this guidance whenever required. All staff said they would report any suspicion of abuse immediately. A member of staff said, "Safeguarding is about the protection of people from all harm such as abuse. If I suspect anything, I will report to my line manager. If the manager failed to look into it, I will go to the trustees, CQC or the local authority safeguarding team". Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. A member of staff said, "I have recently completed this training. If I suspect bad practice, I will report it to my manager". The registered manager also had information about whistleblowing on a notice board for people who lived in the home and staff.

People were supported in accordance with their risk management plans. We observed support being delivered as planned in people's care plans. Risk assessments were specific to each person and had been reviewed in various months in 2018. The risk assessments promoted and protected people's safety in a positive way. These included moving and handling, medicines, care plans and daily routines. We saw they had been reviewed when circumstances had changed. Staff told us these were to support people with identified needs that could put them at risk, such as when their needs changed. For example, one person who recently had a fall from bed had their risk assessments reviewed in line with advice from healthcare professionals and this was discussed with staff on how to best meet their needs going forward. Guidance was provided to staff on how to manage identified risks, and this ensured staff had all the information they needed to help people to remain safe. For example, we saw diabetes guidance, which was detailed for staff to follow in the day to day management of one person's diabetes.

There were enough staff to support people. Staff rotas showed the registered manager took account of the level of care and support people required each day, in the home and community, to plan the numbers of staff needed to support them safely. The registered manager told us there were four care staff in the morning, two in the afternoon and two at night. In addition, there was a senior care staff who led both morning and evening shifts, an activities coordinator, three housekeepers, two cooks, four kitchen assistants, a maintenance staff, two deputy managers and the registered manager. Records confirmed this level of staffing. We observed that staff were visibly present and providing appropriate support and

assistance when this was needed. We noted an air of calm in the home and staff were not rushed.

We checked recruitment records to ensure the registered manager was following safe practice. The registered manager had carried out sufficient checks to explore the staff members' employment history to ensure they were suitable to work with people who needed safeguarding from harm. We reviewed four staff files and saw that recruitment processes were always fully carried out in line with Schedule 3 of the Health and Social Care Act. Gaps between staff education and employment histories were fully explored. Two references had been received before staff started work. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Suitably trained staff followed the arrangements in place to ensure people received their prescribed medicines. These were stored safely in medicine cabinets in the care office. People's records contained up to date information about their medical history and how, when and why they needed the medicines prescribed to them. We looked at medicines administration records (MARs) which should be completed by staff each time medicines were given. There were no gaps or omissions which indicated people received their medicines as prescribed. Staff explained how they give medicine to people and observed them while taking their medicines. One person said, "I always get my pills on time and they record it and watch me swallow them".

Some people required topical creams for their skin, which care staff administered. We noted the topical creams on MARs and there were no gaps in staff signatures. When PRN (as required) medicines were administered, the reason for administering them was recorded within the MAR chart. This indicated that the registered manager had an effective system in place for the administration of medicines safely.

We found the management of controlled drugs, which are medicines requiring additional measures to ensure they are managed securely, was safe. Records showed two staff always signed when a person was administered a controlled medicine as required, including if these were administered during the night shift and these records were audited daily. Staff told us and records confirmed that only the senior care staff administered medicines and they had undertaken the provider's medicines training and had their medicines competency assessed annually to ensure their practice was safe.

We found that each care plan folder contained a Personal Emergency Evacuation Plan (PEEP), which was reviewed in 2018. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was in place. Fire equipment was checked weekly and emergency lighting monthly. The home had plans in place for a foreseeable emergency. This provided staff with details of the action to take if the delivery of care was affected or people were put at risk for example, in the event of a fire. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies. A visiting relative said, "They often have fire drills when all the doors close. If it was a real fire they would come up to the room to help you".

The provider reviewed all accidents and incidents to ensure that relevant action had taken place. Records evidenced that the provider had referred people on to the community physiotherapist if they had frequently fallen and this had been done through the GP. Copies of people's accidents and incidents were kept in their care file which helped staff understand why care plans or risk assessments had been amended.

A business continuity plan was in place. A business continuity plan is an essential part of any organisation's

response planning. It sets out how the business will operate following an incident and how it expects to return to 'business as usual' in the quickest possible time afterwards with the least amount of disruption to people living in the home.

The environment and equipment used by people was safely maintained. There were regular checks on health and safety, cleanliness and whether equipment was in good working order. We saw that these had been recorded and action had been taken when concerns were identified. There were regular checks on fire safety equipment, gas and electrical safety, water supplies and window restricting devices. The home was well lit, with plenty of room to move around and seemed quite homely. There were lots of books, retro radio, soft toys, and magazines in the lounge and dining areas. Soft toys were used as a form of therapy for the elderly, particularly those who have a form of dementia. There were rails along the corridor walls as adaptations for people, which enabled safe movement.

There were systems designed to prevent and control the spread of infection. The domestic staff were aware of their protocols for work, responsibilities and schedules of cleaning. The equipment they used for cleaning were colour coded. We observed that the environment was clean and odour free during our inspection. There were sufficient domestic staff and they were busy throughout the day. The registered manager carried out infection control audits where any concerns were identified. These had been acted on. All staff wore personal protective equipment, such as gloves and aprons. These were disposed of after use. There was a schedule for checking and cleaning equipment, such as mattresses, hoists, slings and commodes; and the registered manager checked that staff were following these.

Good

Is the service effective?

Our findings

Our observation showed that people were happy with the staff who provided their care and support. There were positive interactions between people and staff. One person said, "I have watched them [Staff] have many training sessions in the dining room". Another said, "The staff are a happy crowd you never hear them being impatient or complaining. I think they enjoy their work".

People's initial assessment led to the development of their care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff told us they had all the information they needed within the care plan to support people well. Care plans covered all aspects of people's daily living and care and support needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, emotional feelings, cultural needs, dignity and independence. The cultural area of the care plan identified the support required by each person for example, if they needed support to attend the church. For example, in one person's plan it stated that they like to attend church on Sundays. We found that this person was supported by staff to attend the church whenever they wish to. Information such as whether people were able to communicate if they were experiencing pain was detailed. Sometimes people were reluctant to wash or shower and this was addressed in the care plan for personal care, giving guidance to staff. Most people changed their minds if staff returned a short time later and asked again, or if a different member of staff asked. If people still chose not to wash then this was respected as their decision at that time. Care plans were regularly reviewed. All the care plans we looked at had been reviewed in February 2018. Care plan reviews were thorough, capturing any changes since the last review or if there had been interventions such as with health care professionals.

Staff undertook mandatory training and refresher trainings in topics and subjects relevant to their roles. New staff had undertaken the provider's induction which included the incorporation of the Care Certificate and relevant topics considered mandatory. The in-house induction included shadowing of experienced staff. The induction included assessments of course work and observations to ensure staff meet the necessary standards to work safely unsupervised. The provider's mandatory training included first aid, infection control, medicines administration, food hygiene, health and safety, fire awareness, moving and handling, equality and diversity and end of life care. Staff were supported and encouraged to complete work based qualifications.

Staff were regularly supervised and had an annual appraisal with a member of the management team. Staff had their competency to provide care and support assessed by a member of the management team in a range of topics, to ensure the care and support people received was of a good quality and reflective of staff training and the policies and procedures of the provider.

The dining room had a menu board, which detailed the menu options for the day. The dining room was decorated with pictures of different foods and drinks to help people show staff what their choice of meal was. Tables were set at mealtimes with condiments and cutlery. We met one person who told us that they liked setting the table and the registered manager and staff enabled them to be inclusive. The person said, "I love setting the table for lunch. It helps me focus".

People ate their lunchtime meal in the main dining room, whilst a small number of people remained in the lounge. People who remained in the lounge required assistance with eating, which was provided in a sensitive and caring manner. The menu was chicken pie, mashed potatoes and broccoli or beef stroganoff and rice. The vegetarian option was mushroom stroganoff. Desserts were sticky toffee pudding or trifle or yoghurts and fresh fruit. Ice cream was also available. Carers went around with fruit juices and gravy. Everyone had a named place at their table and there was a very happy buzz of conversation, making it a happy social occasion.

The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP and the local authority falls prevention team demonstrating that the provider promoted people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as visits, phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months, which meant that each person had a professional's input into their care on a regular basis.

We observed that people were supported to have as much choice and control over their lives as they wished. People's decisions and choices were respected by staff. For example, we observed one person who decided that a particular member of staff should support them with their lunch. The member of staff respected the person's choice and supported them.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were in place.

People's consent and ability to make specific decisions had been assessed and recorded in their records. Where people lacked capacity, their relatives or representatives and relevant healthcare professionals were involved to make sure decisions were made in their best interests. Staff had received training in MCA and DoLS and understood their responsibilities under the act. Only one application was made to deprive one person of their liberty, this had been properly made and pending authorisation by the appropriate body. We were shown the response from the local authority which confirmed that they had received the request and the case was on their waiting list pending allocation to a best interest assessor. Records showed the provider was complying with the conditions applied to the authorisation. We saw evidence of this in the care plan.

Good

Is the service caring?

Our findings

We observed that people were supported by caring staff who were sensitive in manner and approach to their needs. People looked relaxed, comfortable and at ease in the company of staff.

One Person said, "The staff are marvellous. We are so well cared for". Another person said, "Rooms have fans to cool us down if we get too hot, they are very thoughtful". Other comments included, "My privacy is always protected, everyone knocks on the door and asks for permission to attend to tasks, you can put a 'do not disturb' note on the door and no one will enter".

Visiting relatives said, "This care home is perfect. Staff will listen to your concerns and act upon them." And "I think all the staff are kind, understanding and supportive and they all have a sense of humour".

A healthcare professional said, "I always observe a warm rapport between staff and client. I have visited a client many times at Berry Pomeroy and when discussing with staff they clearly know and understand the client well and this mirrors my own experience with him. Overall, his feeling of safety and security there speaks volumes to me and I have no concerns about the home".

The registered manager ensured people's individual records provided up to date information for staff on how to meet people's needs. This helped staff understand what people wanted or needed in terms of their care and support.

People's bedrooms and the corridors were filled with their items, which included pictures, furniture and ornaments. This combined with information in their care plans, provided staff with a wealth of information about people, for staff to use to engage them in conversation. Staff therefore had a good understanding of people's personal history and what was important to them.

We observed numerous pleasant interactions between people and staff during our visit. In the morning, we observed staff sitting with one person in the lounge. Staff were holding hands with the person and singing as the person smiled and nodded along to the tune. Later, staff noticed a person walking without their shoes on. The staff member gently encouraged the person to put some slippers on and when they refused, the staff member respected their decision and checked their socks were a good fit to avoid a slip or fall. The staff member then accompanied the person safely to their room. Staff were committed to their roles and this was reflected in their feedback to us.

Staff knew the people that they were supporting. They [Staff] knew people's names and they spoke to them in a caring and affectionate way. People's care records contained information about people's background and preferences, and staff were knowledgeable about these. Staff were able to give us details on people throughout the day, without needing to refer to care plans. They [Staff] understood the importance of respecting people's individual rights and choices.

People were involved in their care. Throughout our visit, staff were observed offering choices to people.

People were offered choices of hot and cold drinks throughout the day. At lunch time, people were shown the food on offer and encouraged to make a choice. In the afternoon, we heard staff informing people of activities taking place in another part of the home and offering people the chance to attend. People's preferences were recorded and staff were knowledgeable about these when we spoke with them. For example, one person liked to stay in their room and have their lunch. We found that staff knew about this and respected their wish.

People's independence was encouraged by staff. One person told us, "I like to wash myself and staff let me do this. I get up at 6am every day and shave and wash myself. When I shower, I wash my private parts and they do the rest. This is how dignity and privacy is maintained". People's care plans recorded their strengths and what they were able to do so that staff could support them in a way that encouraged them to retain independence. One person was able to wash their face and attend to their oral care independently and this was recorded in their care plan. Another person liked to do their own make up each day after being supported with personal care and this was recorded in their care plan.

People's right to privacy and to be treated with dignity was respected. People's individuality and diversity were celebrated, respected and recognised by staff who made every effort to provide people with opportunities to celebrate and take part in a lifestyle of their choosing. People's individual needs were understood relating to their cultural diversity and met by staff. People's care plans reflected the importance of their privacy and dignity and how this was to be supported by staff.

Staff respected confidentiality. When talking about people, they made sure no one could over hear the conversations. All confidential information was kept secure in the office. People had their own bedrooms where they could have privacy and each bedroom door had a lock and key which people used. Staff also helped people to stay in touch with their family and friends. For example, we observed people using telephones in their bedrooms to phone relatives. This further promoted their privacy. People's relatives told us that they were able to visit their family member at any reasonable time and they were always made to feel welcome. Records were kept securely so that personal information about people was protected.

The care people received was person centred and met their most up to date needs. People's life histories and likes and dislikes had been recorded in their care plans. Staff encouraged people to advocate for themselves when possible.

People accessed their bedrooms when they wanted time alone, this was respected by staff. Staff always knocked on people's door and sought consent before entering their room.

Good

Is the service responsive?

Our findings

One person said, "If something arose, I would go to the office and they [Staff] would sort it. We have resident's meetings and we can discuss anything. We had one yesterday. If I do not want to go they [Staff] send you the minutes". Another said, "They [Staff] go the extra mile for me, they help me tidy my room".

The registered manager undertook an initial holistic assessment with people before they moved into the home. The assessment checked the care and support needs of each person so that the registered manager could make sure they had the skills and levels of staffing within the staff team to care for the person appropriately. People and their family members were fully involved in the assessment process to make sure the registered manager had all the information they needed.

People had care plans in place, which reflected their current needs. Detailed daily records were kept by staff. Records included personal care given, well-being, activities joined in, concerns to note and food and fluids taken. Many recordings were made throughout the day and night; ensuring communication between staff was good which benefitted the care of each person.

End of life care was provided sensitively and in line with people's needs and preferences. People's care plans contained plans for the end of their lives and these took into account people's wishes named 'last days of life'. One person at the home was receiving end of life care and we saw evidence of regular involvement of the GP, hospices and relatives. People and relatives were provided with information packs and the home had links with therapists and religious ministers to provide appropriate support at these times. Where people had specific end of life needs relating to their religion, these were documented and met by staff. Staff were being trained on end of life care.

The registered manager employed an activities coordinator who planned and facilitated a number of group and individual social activities. There was a plan of special events and activities and these were advertised on the home's notice board. We saw the activities coordinator encouraging people to take part. People were offered individual support according to their needs and choices. There were activities such as cards, dominos, board games, mindful colouring and knitting in the home. Activities were person centred. For example, one person who was able to use the computer was provided with an iPad, which enabled them to access the internet. The person said, "They gave me an iPad and I use it to look up information". Another person said "I have a laptop. My nephew does my finances and I can see them. I can skype and send emails".

The provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display on the notice board in the home. The policy included information about other organisations that could be approached if someone wished to raise a concern outside of the home such as the local government ombudsman. There had been one complaint received in the last twelve months and this was resolved satisfactorily. A guide to resolving complaints was given out to relatives and people who lived in the home. Compliments log we looked at showed that the home had received several thank you cards/letters from relatives in the last 12 months.

Good

Is the service well-led?

Our findings

We observed people engaging with the staff in a relaxed and comfortable manner. One person said, "The manager is always about and very approachable. She has a good team which she supports". Other people said, "This is a good place to be, you get a sense of freedom, no one dictates to you and it is like a family hotel" and "I would recommend this place as excellent to anyone".

A healthcare professional said, "The manager has always responded promptly to any actions that my client has needed such as escorting him out to compete tasks. Communication has always been good and feedback provided. A good working relationship has developed".

There was a management team at Berry Pomeroy. This included the two deputy managers, the registered manager and the board of trustees. The registered manager was an experienced manager who had been working in the home for several years and had a very proactive and enthusiastic approach to service development and improvement. Support was provided to the registered manager by the board of trustees. There was a strong emphasis on continually striving to improve.

Staff told us that the management team encouraged a culture of openness and transparency. Staff told us that the registered manager had an 'open door' policy which meant that staff could speak to them if they wished to do so and worked as part of the team. A member of staff said, "My manager is fantastic, good, kind, able to talk to her at any time. There is no fear to approach like in other places. They are very good". Another staff said, "The manager is approachable with doors always open. They are always in the mix, involved with everything". We observed this practice during our inspection.

The open approach by the registered manager ensured staff were kept informed about any changes to practices to enable staff to work collaboratively. Regular staff meetings took place and the minutes of these showed a range of topics were discussed to ensure the people received good quality care. Minutes of meetings had recorded where people's needs had changed. They showed staff reflected upon any changes in the level of support a person required along with the involvement of health care professionals where concerns had been identified. Meetings were also used as an opportunity to comment and influence the day to day running of the home. For example, priorities set by the registered manager. Changes to policies and procedures were discussed to ensure staff had up to date information. Staff were provided with feedback from visits by external stakeholders who monitor the home, this information was used to share improvements required and to celebrate good practice.

We found that the registered manager had a comprehensive quality assurance system and used these principles to critically review the home. Regular checks were carried out on the quality of the care delivered at the home. Records showed that the registered manager carried out a range of audits in areas such as medicines, risk assessments, incidents and accidents, health and safety. The registered manager carried out a monthly holistic audit in which they looked at a range of areas such as documentation and staff practice. The registered manager also carried out a series of audits either monthly, quarterly or as and when required to ensure that the home ran smoothly, such as infection control and call bells. They used these audits to

review the home. We found the audits routinely identified areas they could improve upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken. For example, we saw where irregular water temperatures had been identified as an area that needed action. This had been rectified by the maintenance man immediately.

The registered manager had a good understanding of the requirements of their registration with the Care Quality Commission. All necessary notifications had been made to the CQC and we saw that the duty of candour had been adhered to following any incidents. Where necessary, the registered manager had undertaken investigations into incidents, accidents and complaints.

Where accidents or incidents occurred, staff responded appropriately. Staff took actions to ensure that people were safe following incidents such as falls or illness. Staff understood how to respond if they suspected abuse had occurred and we saw evidence of them doing so. The registered manager analysed accidents and incidents as well as clinical needs and risks as part of the registered manager's audit. Where patterns or trends were identified, appropriate actions to reduce risks were identified and implemented by staff. The registered manager kept a record of any accidents or incidents that occurred and documented the actions taken in response to them. The records showed that staff acted appropriately to minimise the risk of the same incident occurring again. The registered manager analysed accidents and incidents each month and produced a report that identified any trends such as if people were falling regularly in a particular part of the home or at a certain time of day. An analysis was also carried out on people's weights, skin integrity and infections each month. This helped to reduce a repeat of these falls. The registered manager noted that one person had fallen at least three times in one month and their risk assessment was reviewed after each fall. The registered manager met with staff and a plan was developed. Staff noted changes to the person's behaviour that increased the risk of them falling, so the person's falls practitioner for targeted care home support was contacted. Staff increased their supervision of this person to reduce the risk of further falls and recording any changes in behaviour on a behaviour chart. This showed that the registered manager had systems in place to learn lessons from, and respond to, repeated risks.

The registered manager had systems in place to receive people's feedback about the home. The registered manager had recently asked people using the service and other stakeholders to complete surveys about their experiences. The response from these showed that people were happy with the service. People said they felt safe, were happy and well cared for. Some of the comments people made in the surveys and in cards to the registered manager included, 'Thank you for caring for [X]' and 'We will always be grateful for the help and support you gave us'.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the home where a rating has been given. This is so that people, visitors and those seeking information about the home can be informed of our judgments. As this was Berry Pomeroy's first rated inspection following a change of legal entity, this was not applicable.