City of York Council

Windsor 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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Windsor House is a care home that accommodates up to 31 older people, some of whom may be living with dementia. On the day of the inspection there were 26 people living at the home. The home is situated in Acomb, on the outskirts of the city of York. Bedrooms are located on the ground and first floors and there is a passenger lift to reach the first floor.

At the last inspection in July 2016 we were concerned that risks had not been managed safely, including the risks associated with medicines and the frequency of fire alarm tests and fire drills. We issued a requirement in respect of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that medicines were managed safely. Risks had been assessed and fire alarm tests and fire drills were taking place. The provider was no longer in breach of this regulation.

At the last inspection in July 2016 we were concerned that staffing levels did not allow staff time to engage people in meaningful activities and that staff could not always respond to people's needs promptly. We issued a requirement in respect of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that staffing levels were sufficient to meet people's individual needs and that people received prompt attention from staff. The provider was no longer in breach of this regulation.

At the last inspection in July 2016 we were concerned that there was a lack of consistent evidence that people's capacity to make informed choices had been considered when seeking consent. We issued a requirement in respect of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that records evidenced people's capacity to consent had been assessed and people were supported with decision making. The provider was no longer in breach of this regulation.

At the last inspection we recommended that the registered provider continued to review staff training needs and that staff training was kept up to date. At this inspection we saw that staff had completed appropriate training. People told us they felt staff had the skills to carry out their roles effectively.

At the last inspection we recommended that the registered provider continued to develop support for people to engage in meaningful activities. At this inspection we saw that the availability and variety of activities had improved.

At the last inspection we recommended that the quality assurance systems needed to improve to ensure concerns were identified and action was taken to address these concerns. At this inspection we saw that the manager carried out numerous audits each month. Any shortfalls had been identified and there was evidence these had been considered and improvements made.

At this inspection we found there was a manager in post who was registered with the Care Quality

Commission (CQC) and that they were being supported by an acting manager who ran the service on a day to day basis. People who lived at the home, relatives and staff reported that the service was well managed.

Staff had been recruited following the organisation's policies and procedures and people told us they felt safe living at the home.

People told us they were happy with the choice of meals provided at the home. Nutritional needs had been assessed, people's special diets were catered for and food and fluid intake was being monitored when this was an area of concern.

Staff were kind, caring and patient. They encouraged people to be as independent as possible and respected their privacy and dignity. It was clear that staff knew people well and this helped them to provide person-centred care.

Staff received training on safeguarding adults from abuse. They were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm.

Accidents and incidents were recorded appropriately and had been analysed to identify any patterns or trends, and any areas that required improvement.

People understood how to express any concerns or complaints and were encouraged to feedback their views of the service provided. We received positive feedback from everyone who we spoke with.

Staff told us they were well supported through supervision and staff meetings.

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 recruited safely and were aware of their responsibilities to protect people from the risk of harm. There were sufficient numbers of staff employed to ensure people received the care and support they needed.

Medicines were managed safely.

The premises had been maintained in a clean and hygienic condition.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and people were supported with decision making.

People told us they enjoyed the meals at the home and we found their individual nutritional needs were assessed and met.

People had access to health care professionals when needed.

The premises were suitable for the people who lived at the home; there was some signage and the décor promoted a homely feel.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and there were positive relationships between people who lived at the home and staff.

People's privacy and dignity was respected by staff and their independence was promoted.

Information about advocacy services was available within the home.

Is the service responsive?

Good

The service was responsive to people's needs.

People had care plans in place that described their individual support needs.

Activities were provided to ensure people had social stimulation.

There was a complaints policy and procedure in place. People and their relatives had the opportunity to share feedback about the service provided.

Is the service well-led?

Good

The service was well-led.

There was a manager who was registered with CQC as well as a manager with day to day responsibility for running the service.

Staff told us the day to day manager was approachable and that the home was well managed.

Regular audits to monitor the quality of the service had been carried out and any areas that required improvement had been addressed.

Windsor 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 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 that took place on 27 September 2017; the inspection was unannounced. The inspection was carried out an adult social care 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 this inspection we reviewed the information we held about the home, such as notifications we had received from the provider. Notifications are documents that the provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider was asked to submit a provider information return (PIR) before this inspection. The PIR 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. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with seven people who lived at the home, seven relatives, four members of staff, the manager and the nominated individual. We also 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.

Following the day of the inspection we received feedback from four social care professionals.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the personnel records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

At the last inspection we were concerned about the management of medicines as medicines were not always kept securely or stored at the correct temperature, and the provider had not effectively risk assessed the safe storage of medicines. We were also concerned that weekly fire alarm tests had not been completed consistently and that more frequent fire drills were needed. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection we found there were thorough policies and procedures on the management of medicines, including homely remedies and the reporting of missed medicines. In addition to this, the home had obtained guidance from the Royal Pharmaceutical Society and the NHS. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. The two medicines trolleys were fastened to the wall when they were not in use. The temperature of the medicines room and fridge were taken regularly and staff were aware of the action to take if either were not within the recommended parameters.

The person administering medicines made sure people had taken their medicines before they signed the medication administration record. Boxes and bottles were dated when they were opened to ensure they were not used for longer than recommended. There were specific instructions in place for 'as and when required' (PRN) medicines. We discussed with the manager that it would be good practice to request a copy of the prescription for any medicines prescribed 'mid cycle' so that staff could check that the medicine prescribed by the GP was the same as the medicine delivered by the pharmacy.

We found that fire alarm tests were taking place; when any faults had been identified action was taken promptly to contact the relevant contractors to request repairs. There was a fire risk assessment in place, a fire drill had taken place on 17 July 2017 and there was an emergency 'grab bag' available to be used in the event of an emergency.

This meant the provider was no longer in breach of Regulation 12.

At the last inspection in July 2016 we were concerned that there were insufficient numbers of staff to ensure people were able to take part in meaningful activities, and that people were having to wait for attention. We issued a requirement in respect of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that there were sufficient numbers of staff to ensure people received person-centred care and support. People were assisted in a timely manner and staff allowed people to take things at their own pace. We also observed that staff had time to spend chatting with people.

On the day of the inspection we saw there was the manager, a care leader, four care assistants (including an agency worker who was familiar with the home), two general assistants, a cook and an administrator on

duty. Two care assistants worked on the ground floor and two worked on the first floor. The general assistants were responsible for domestic and kitchen duties, which meant care staff were able to concentrate on supporting people who lived at the home. A dependency tool was used to determine people's dependency levels and indicate the number of staff required to support people.

People told us they felt there were enough staff working at the home and that staff had the skills they needed to meet their needs. Comments included, "The staff are very good – they support me when I need help" and "The staff look after me well. They come quickly when I need them." Comments from relatives included, "There always seems to be enough staff" and "The staff may sometimes be a bit stretched but they are all fantastic. I have no issues."

This meant the provider was no longer in breach of Regulation 18.

Service certificates evidenced that equipment and systems had been appropriately maintained. This included the fire alarm, emergency lighting, fire extinguishers, the electrical installation, portable appliances, gas appliances and systems, the passenger lift and mobility / bath hoists.

We walked around the premises and looked at communal areas of the home, bedrooms, bathrooms and toilets. We observed that these were being maintained in a clean and hygienic condition. Laundry facilities were satisfactory; dirty laundry was washed in one room and clean laundry was stored and ironed in another room. This meant the risk of infection was reduced. There were ample supplies of personal protective equipment (PPE) such as gloves and aprons and we observed staff using these appropriately on the day of the inspection.

The home had received a food hygiene score of five, which is the highest score available. The inspection had been carried out by the health and safety team of the local authority, and checked hygiene standards and food safety in the home's kitchen.

People told us they felt safe living at the home and this was supported by people's relatives. One relative said, "[Name of relative] used to fall at home and that doesn't happen now" and another told us, "My relative's care needs are looked after 24 hours a day – that is a great relief to me." Staff described how they promoted safety in the home. Comments included, "Our training on safeguarding, moving and handling and MCA / DoLS gives us the information we need to keep people safe." One social care professional told us that any risks identified in respect of people they had placed at the home had been well managed. Another social care professional told us, "I feel staff are vigilant in regards to safety and monitoring of residents. The doors and the lift are key coded and staff take care when residents are near the door or lift."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. The manager told us about the 'Be Independent' scheme, which was used to access 'telecare' and assistive equipment for people. When it had been identified that people were at risk of falling or they were unsettled during the night, bed and / or door sensors had been provided to alert staff the person was out of bed. Chair sensors could also be provided if they were considered to be helpful. We saw staff assisting people to mobilise around the home and noted that any transfers were carried out safely. Care plans also recorded the specialised equipment people had been provided with to prevent the risk of pressure sores developing.

Staff received training on safeguarding adults from abuse. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would pass on any concerns to the manager and were certain their concerns would be dealt

with immediately. We checked the folder where safeguarding information was stored. This contained comprehensive safeguarding policies and procedures to advise staff on how to recognise signs of abuse and how to report any concerns to the relevant authorities.

Some staff had been redeployed to the home from other local authority services, but no new staff had been employed since the last inspection. The recruitment records we saw were satisfactory. References and a Disclosure and Barring Service (DBS) check had been obtained prior to people commencing work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

A 'significant events' form in each person's care plan recorded any accidents or falls and the action taken by staff. Accidents and incidents were recorded and analysed each month to identify any patterns that might be emerging. Body maps were used to record any injuries, sore areas or bruises. This helped staff to monitor the person's recovery from any injuries and on-going skin integrity.

There was a business continuity plan in that provided advice for staff on how to deal with unexpected emergencies, such as unavailability of key staff or disruption to utilities. In addition to this, people had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises in an emergency.

Good

Is the service effective?

Our findings

At the last inspection we were concerned that there was a lack of consistent evidence that people's capacity to make informed choices had been considered when seeking consent. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we saw that care plans recorded a person's capacity to understand and retain information, and to make decisions, such as, '[Name] can weigh up information and retain information therefore is considered to have capacity.' When people had capacity to consent to their care, they had signed the relevant documents themselves; these related to having photographs taken for their care records. We discussed with the manager that relatives should only be asked to consent on behalf of their family member if they had lasting power of attorney (LPOA) for health and welfare. This is when a person has been legally authorised to make decisions on another person's behalf.

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 Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that care plans recorded any DoLS applications that had been submitted and / or authorised, and when they were due for renewal.

Staff had undertaken training on the MCA and DoLS and our discussions with staff indicated they were aware of how this legislation influenced their day to day work. One member of staff demonstrated this by describing the five principles of the Act to us. Staff described to us how they helped people to make day to day decisions. One member of staff said, "We get to know them. We give them time. We consult with families." We also noted that advocates had been asked to support people when they had difficulty making important decisions for themselves.

This meant the provider was no longer in breach of Regulation 11.

People could choose where to spend their day, and told us they could decide whether to have their door open or closed when they were in their bedroom. They also said they could choose whether to eat in the dining area or another area of their home.

At the last inspection we recommended that the registered provider continued to review staff training needs and that staff training was kept up to date. At this inspection staff told us they completed thorough training during their induction period that helped them to get to know people who lived at the home and the home's policies and procedures. During their one month induction period new staff were 'buddied up' with an experienced member of staff and their capabilities were monitored. Staff who were new to the caring profession were also required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards. People and their relatives told us that staff had the skills they needed to carry out their roles. A relative told us, "[Staff] are skilled in dementia care."

Training records showed staff had completed training on the topics considered essential by the home,

including first aid, infection control, safeguarding adults from abuse, moving and positioning people, fire safety, person-centred dementia awareness and food hygiene. Senior staff had also completed training on care planning and managing medicines.

Agency staff were expected to read information before they worked at the home and sign to agree they had been shown the fire panel, the reference sheet for the day's duties and information about answering emergency call bells and people's dietary needs. They also signed to confirm they had received training on moving and handling, food hygiene and infection control and completed the fire induction checklist. This was good practice.

Staff told us they were well supported by the manager and senior staff. They said they had one to one supervision meetings with a manager and also had competency checks, such as being observed carrying out care tasks.

Relatives were positive about the communication they had with the home. Comments included, "They are really good at keeping in touch" and "I know if my phone hasn't rung then there isn't a problem. That gives me peace of mind." This was supported by social care professionals. One professional told us, "Staff at the home maintain very good communication and are always able to provide updates and feedback as requested, and have a very good knowledge and understanding of the care needs of the person being discussed."

We received positive feedback about the meals and mealtimes. There were various areas of the home where people could eat their meals, and people could also use the café if they had visitors over mealtimes. Comments included, "The food is very good. The puddings are nice" and "The food here is good. You get a choice so you can pick what you like." A relative told us, "[Name of relative] eats breakfast now. They never did when they were at home." We saw there was a menu on display that included words and pictures. Staff also showed some people the different meals to try to help them make a decision. The meals looked appetising and people were offered a choice of both food and drink. Staff were aware of who needed help or encouragement to eat, and people were assisted appropriately by staff. Hot and cold drinks and snacks were also available throughout the day. One person told us, "I've never seen so many cups of tea made."

We observed the lunchtime experience. Tables were laid with table cloths, paper napkins and condiments. The atmosphere of the dining room was pleasant and homely, and when staff had finished serving lunch they sat with people to eat their own lunch.

People's special dietary requirements and their likes and dislikes were recorded in their care plan, and people had appropriate nutritional assessments and risk assessments in place. When concerns had been identified about the risk of malnutrition or the risk of choking, advice had been taken from a speech and language therapist or dietician, and this had been recorded in people's care plans. People's weight loss or gain was monitored as part of nutritional screening. The cook described people's different diets, such as diabetic, gluten free and coeliac, as well as people's likes, dislikes and allergies. They told us they made sure people received food with high nutritional value by making homemade vegetable soups; this was always offered as a starter at tea-time. The cook was responsible for completing people's food and fluid charts; they either observed what people had eaten and drank themselves, or care staff gave them this information. This system had proved to be successful as the records were made at mealtimes so were more accurate.

We observed that people who could mobilise independently walked around the home without restriction. The corridors were wide and mainly straight, which gave good lines of sight for staff so they could identify if people required any assistance. There was signage to assist people in finding toilets and bathrooms,

although there was only limited directional signage to help people move around more independently. However, people who we spoke with were not concerned about this and told us they could find their way around.

We saw that some communal areas of the home were decorated to look like a person's own home. There were china cabinets, net curtains at the windows, traditional living room furniture and items to aid reminiscence, such as an old typewriter. There was also a cinema room. Bedroom doors displayed the person's name, room number and other information to help the person locate their own room.

People told us they were supported by their own GP and other health care professionals, and that staff at the home would arrange appointments for them. A relative told us, "If I cannot take [Name of relative] to a hospital appointment, a member of staff will go with them." The contact with health care professionals was recorded and any advice given had been incorporated into care plans.

Good

Is the service caring?

Our findings

There was a significant level of social interaction between some of the people who lived at the home and staff, particularly over lunch, and this was encouraged by staff. People were relaxed and comfortable in the company of staff. Comments included, "It keeps me going living here", "The staff are kind", "They look after me really well" and "The staff seem very caring." Staff told us they felt the staff team genuinely cared about people who lived at the home. One member of staff said, "We are like a little family." A social care professional told us, "I have always found the staff to be very helpful, friendly, positive and caring."

One relatives told us, "They care for [Name of relative] as an individual. That's what I like about it here". Other relatives commented, "It's a warm and joyful place, very caring", "Every one of the staff is brilliant" and "We wanted to take [Name of relative] to a family wedding. When I arrived I expected to have to get them ready, but they were all dressed and had had their hair done. The staff made a real fuss of them and they loved the attention."

We observed that staff were kind, caring and patient and this was also demonstrated during our SOFI observation. We saw positive interactions between people who lived at the home and it was clear that staff were skilled at engaging people in both conversation and activities.

One person told us that staff treated them with dignity and respect. They said, "Staff always explain what they are going to do before they do it." We saw people who lived at the home looked well cared for, were clean shaven (when this was their choice) and wore clothing that was in keeping with their own preference. Staff described how they promoted privacy and dignity. Comments included, "We make sure doors are closed and we are respectful." We saw that staff were polite and sensitive to people's needs, although we noted staff did not always knock on people's doors before entering. One social care professional told us that they had been impressed with privacy and dignity at the home, and another told us, "I have observed staff closing doors when taking residents into their rooms or the toilet for personal care, ensuring their dignity is maintained." Another social care professional told us they were directed to a private room when they needed to have a conversation with someone who lived at the home.

People were encouraged to personalise their rooms to make them feel more familiar and homely. This included bringing in their own furniture and belongings. A relative told us, "The home is small which makes it more homely and intimate."

People told us that staff encouraged them to be as independent as possible. We saw that staff encouraged people to eat independently and only assisted them if they were struggling. Some people were provided with plate guards so they could eat their meal without assistance.

Information about advocacy was available in the home and an advocate had supported one person who required additional support with decision making. Advocacy services help vulnerable people access information and services, be involved in decisions about their lives and explore choices.

We saw that written and electronic information about people who lived at the home and staff was stored securely. This protected people's confidentiality.

Good

Is the service responsive?

Our findings

At the last inspection we recommended that the manager provided meaningful activities for people who lived at the home. At this inspection we saw staff undertaking activities with people, including a quiz. Staff told us, "Some people have poor attention spans. We spend a lot of time sitting with people to chat and interact" and "It's good when we spend one to one time with someone and make them smile." People who we spoke with were aware of the activities on offer, but not all of them wished to join in; some people told us they preferred to stay in their room. Another person told us, "I like the sing alongs." A relative told us, "[Name of relative] can choose how to spend the day. He loves to chat with other people and is always doing something, like the music club." A social care professional told us they felt people would like more outings and more varied activities.

The manager told us about a scheme provided by an Accessible Arts team. This project provided space where people could relax, forget about the outside world and feel free from anxiety via the use of massage, music making and visual projections. The manager told us about two people who had really benefited from taking part in this scheme. A group called 'Musical Connections' also visited the home each Thursday; this team provided group musical activities.

People told us that their friends and relatives were able to visit at any time, and were made welcome. We saw that trays of tea and biscuits were made for relatives when they visited, and were taken to the service user's room. There was also a kitchen and a café where visitors could make themselves a drink. A social care professional told us, "Myself and family members are always greeted warmly and during review meetings coffee and tea is offered."

An initial assessment of people's needs was undertaken before they moved into the home, and a care plan was developed from this assessment. This care plan included the use of recognised assessment tools for tissue viability and nutrition. Care plans contained information for staff about how to meet people's needs in a variety of areas, including communication, washing / dressing, social participation, mobility and sensory needs. A 'circle of contact' form recorded their family relationships, their medical history, their likes and dislikes and their daily routines, such as, 'I like to have a lie-in in the mornings.' People had signed their agreement to the content of their care plan when they were able to do so.

It was clear that staff understood people's individual needs. One person who lived at the home said, "Staff know my likes and dislikes." Relatives told us, "[Name of relative] gets on great with staff. They are kind and caring and have a laugh with him. They understand his nature" and "[Staff] care for my relative as an individual." Social care professionals told us they could approach staff or the manager and they would be able to answer any queries about the person concerned. One professional told us, "The manager and care leaders have quickly got to know the individual needs of the residents and the individuals appear to have settled easily into the home. I am confident that when I ring Windsor House to follow up how people are settling, they will be able to discuss the individual needs of the residents with knowledge and understanding." Another social care professional said, "I believe the staff treat people as individuals. If they don't want to get up early its fine – they assist them later in the morning. I have seen staff accompany a

resident who smokes to the outside smoking area and stay with them until they have finished."

Care plans were reviewed regularly to ensure they contained up to date information; some people told us they had been involved in reviewing their care plan. Staff told us, "If we observe something new about a person, we record it. This helps keep care plans up to date" and "The new care plan format is more person-centred." Twice daily handover meetings took place when any concerns about people who lived at the home were discussed. This provided staff with up to date information. A social care professional told us the home had requested an early review for one person, as they wanted to be certain they were doing all they could to support them. They said the review meeting confirmed staff were doing all they could and were able to meet the person's needs.

No formal complaints had been made to the home during the previous 12 months. The complaints procedure was displayed in the home so was available to people who lived there, relatives and other visitors. None of the people we spoke with had made a complaint but they told us they would not hesitate to speak to a member of staff or the manager. A relative told us, "I have no concerns at all. Anything that is mentioned is dealt with quickly."

Care plans included a 'customer feedback survey'. These had been completed on a regular basis by staff asking people if they were happy with the care and support they received. One survey recorded, '[Name] and his grandson stated they are very happy with the care received at Windsor House.' In addition to this, people received more formal satisfaction surveys when they were asked for feedback about their bedrooms, meals, laundry, activities, outings with staff, privacy and dignity, visitors and flexibility.

Meetings were held for people who lived at the home and their relatives. Minutes of meetings showed that improvements made to activities, fire safety, infection control, oral healthcare, hospital appointments and the security of the home were discussed. Relatives also received satisfaction surveys. The most recent survey was on-going so had not yet been analysed, but we saw two returned surveys that both contained positive comments, such as, 'The care at Windsor House is excellent and I am very happy with my mum's care.'

Good

Is the service well-led?

Our findings

At the last inspection of the service we recommended that improvements were made to the quality assurance systems so that issues and concerns were identified and action taken to address them. At this inspection we saw the manager completed audits each month on areas such as infection control, care plans, medicines, staff and service user meetings, staff supervision and dependency scores. These audits were dated and there was a record of any areas of improvement that needed to be made as well as the action taken. For example, the most recent medicines audit identified that some boxed medicines had not been dated when staff had started to use them and that corrective action had been taken. At the inspection we saw that all boxed medicines had been dated when opened.

A member of staff described how investigation of medicines errors had led them to believe that 'as and when required' medicines were being over prescribed. They had sent a letter to all GPs to ask them to review this type of medicine. This showed that there had been some learning from audits that had been carried out.

There was a manager in post who was registered with the Care Quality Commission. 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. There was another manager in post who was responsible for the day to day running of the home.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept and easily accessible.

The manager had submitted notifications to CQC as required by regulation. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

People told us that the home was well managed. They said they knew who the manager was and they could approach them with any problems they had. Staff told us the manager was approachable and would sort out any issues that arose. The manager had completed training on supporting people who were living with dementia via Bradford University and had cascaded this to other staff. They had received an award for 'inspirational leadership'. A social care professional told us, "I feel [Name of manager] has good leadership skills and cares about the residents and the staff. With this comes increased staff morale which is good for everyone." A member of staff told us, "[Name of nominated individual] is also very involved."

The manager told us the culture of the home was one of openness and providing person-centred care by understanding people's personalities, beliefs, hobbies and interests. They said, "I am passionate about what I do." Staff told us the culture of the home was positive. Their comments included, "We are a close knit team. We are dedicated – service users get 100%" and "We are happy and friendly, and very person-centred. We

know people's individual needs. "A relative said, "The staff are always very positive." A social care professional told us, "Windsor House is a home I enjoy liaising with. I feel confident that the home is able to provide care and support to a very good standard."

We viewed the report completed by Healthwatch following their visit to the home on 29 August 2017. Healthwatch is the consumer champion for health and social care. They received very positive comments from people who lived at the home.

Staff meetings were held for care staff and ancillary staff. Minutes of these meetings showed that topics discussed included staff rotas, staff supervision, health and safety, staff responsibilities, key working and activities. Satisfaction surveys were also distributed to staff; they were currently being asked to comment on team work and the management arrangements at the home. A member of staff told us, "We are consulted and we speak up."