Care Quality Commission

St George's (Wigan) Limited

St George's (Wigan) Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 on 18 November 2014 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.

St George's (Wigan) Limited provides nursing and residential care and support for up to 62 people in a variety of single and shared rooms. At the time of the inspection there were 35 people using the service.

There was not a registered manager at the home, but the acting manager of the home was in the process of registering 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.

Summary of findings

The previous inspection was carried out on 18 June 2014 when there was found to be a breach of regulation 9 relating to care and welfare. As a result of this a warning notice was issued by CQC.

We observed that the home was clean, but a little cluttered in places. It was not always safe as, for example, one of the supplies cupboards in the upper floor office was unlocked and left unattended. The medicines fridge was not maintained at the correct temperature to ensure safe storage of medical supplies such as eye drops.

The home had up to date safeguarding vulnerable adults policies and staff were aware of the reporting procedures. Safeguarding referrals were made appropriately.

We saw there were sufficient numbers of staff to attend to the needs of the people who used the service on the day of the inspection. Staff were observed to be polite and respectful and administered care in a kind and caring manner. We spoke with people who used the service and some visitors, who felt the care offered was good.

Care plans included relevant health and personal care documents and were, for the most part, accurate and up to date. However, there were some instances when information had not been cross referenced with other documents, which could have impacted on the accuracy of care records.

Risk assessments were in place within care records and up to date. Staff were working within the requirements of the Mental Capacity Act (2005). Appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made and documentation was in place.

Medication was administered by qualified staff and systems were in place to help ensure the safe ordering and disposing of medication.

There was no signage to assist with orientation around the home for people living with dementia and some of the areas designed to stimulate people living with dementia were not appropriately situated. There were no activities taking place on the day of the inspection and we saw little recorded in care plans about people's participation in activities at the home.

People had choices regarding meals and when and where they had their meals. We observed staff assisting people with their meals and ensuring people's dietary needs and preferences were adhered to.

Staff training was comprehensive, up to date and on-going and staff we spoke with displayed good knowledge of their roles and responsibilities. Some staff support was in place but staff meetings were poorly attended. Staff reported morale was improving amongst them, which was further evidenced via a recent staff survey.

There was an up to date complaints policy displayed on the notice board at the home and complaints were followed up appropriately.

We saw that the home worked well in partnership with other agencies and professionals.

Some notifications had not been submitted to CQC in a timely way, but this had recently improved.

We saw from minutes that staff meetings were poorly attended, which could possibly result in staff not receiving information and support needed to carry out their jobs well. The manager agreed to address this.

Staff reported morale had been low during the period without a manager, but was improving amongst them since the new manager had taken over. They also said improvements were being made to the systems in the home.

We saw evidence of audits and that analysis of the results had taken place and actions taken.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe as some areas required improvement.

Some areas were in need of attention, such as keeping the medical supplies cupboard in the upper floor office locked and ensuring medicines requiring cool storage were stored within the correct manufacturers temperature range.

Safeguarding vulnerable adults policies were in place and up to date. Staff demonstrated good knowledge of safeguarding policies and procedures.

Rotas and observations indicated there were sufficient staff to meet the needs of the people who used the service. Checks were in place to ensure maintenance of equipment was up to date.

Risk assessments were in place within care records and up to date. Medication was administered by qualified staff and systems were in place to help ensure the safe ordering and disposing of medication.

Is the service effective?

Requires Improvement

The service was not always effective.

Care files were generally up to date and complete but there were some records that needed updating and where information was not accurate. The documentation around best interests decisions was not always complete.

There was no signage to assist with orientation around the home and some of the areas designed to stimulate people living with dementia were not appropriately situated, that is, they were in bedroom corridors, rather than in rooms in use during the day.

People had choices regarding meals and when and where they had their meals.

Staff training was comprehensive, up to date and on-going. Staff displayed good knowledge of their roles and responsibilities.

Appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made and documentation was in place.

Is the service caring?

Good

The service was caring.

We saw many instances of staff offering care in a kind and considerate manner. Interaction between staff and people who used the service was good.

We spoke with people who used the service and relatives and all were positive about the care offered.

Summary of findings

Staff we spoke with were able to give examples of how people's privacy and dignity were preserved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were person centred and reflected people's personal preferences. However, there was no evidence of formal methods of obtaining people's views and suggestions.

We saw no activities taking place on the day of the inspection and we found no meaningful recording of people's participation in activities at the home.

There was an up to date complaints policy displayed on the notice board at the home and complaints were followed up appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some notifications had not been submitted to CQC in a timely way, but this had recently improved. Staff meetings were poorly attended, possibly resulting in staff not receiving information and support needed to carry out their jobs well.

Staff reported morale had been low during the period without a manager, but was improving amongst them since the new manager had taken over. They also said improvements were being made to the systems in the home.

There was evidence within the care plans that staff worked well with other agencies. The manager was in the process of registering with Care Quality Commission.

Regular audits were carried out. Issues identified were addressed appropriately.

St George's (Wigan) Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 18 November 2014 and was unannounced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission, a Specialist Advisor, who had specialist knowledge in dementia, 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.

We did not ask the service to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, prior to the inspection. We reviewed information we held about the home in the form of notifications received from the service.

We spoke with Wigan Local Authority Quality Assurance Team, who had been monitoring the home, prior to the inspection to ascertain their experience of the service.

We spoke with three people who used the service, five relatives and seven members of staff including the manager. We also looked at records held by the service, including four care plans and two staff files, the home's training records, supervision records, policies and procedures and minutes of staff meetings. We undertook some pathway tracking via the home's documentation and we observed care within the home throughout the day.

Requires Improvement

Is the service safe?

Our findings

We spoke with five relatives and three people who used the service and all said they, or their family member, felt safe at the home. One relative said, "I feel that [the person] is very safe here, the room is kept clean. I did complain about the number of agency staff and they have taken on more carers so it seems OK now."

On our arrival at the building the front door into the foyer was locked and the door released from inside by staff. External doors were on an electronic door release to prevent people accessing the building. This was also to help ensure people who used the service, who were subject to Deprivation of Liberty Safeguards (DoLS), did not leave the building without the knowledge of the staff, as they had been assessed as being unsafe to do so alone.

On the upper floor we noticed that the nurses' office was open and unoccupied as the nurse in charge was busy administering medication in the dining room. There was a supplies cupboard which was unlocked and open and contained a number of bandages and dressings. There was also a container for the disposal of needles etc. in the cupboard, containing a number of used razors. This had a large opening at the top and was accessible to any person who used the service or visitor who may walk into the room, putting them at risk of harm. We spoke with the nurse in charge and the manager about this and the cupboard was immediately closed and locked.

In the same office there was a fridge containing eye drops and the temperature was registering at 16.8 degrees C, though the manufacturer's recommended temperature range for storing such items should be between 2 and 8 degrees C. The eye drops were unopened and there were no other medical supplies in this fridge. We spoke with the manager about the risks associated with using medical supplies which had not been stored at the correct temperature and she agreed to dispose of the eye drops immediately.

We saw that the fridge was in need of defrosting and cleaning. We spoke with the nurse in charge who said they thought the temperature gauge was faulty. We noted that temperatures had not been recorded since 2013 and these recordings were on a tattered piece of paper which was smudged and in a file. We spoke with the manager who was unaware of this. She agreed to address this immediately.

We continued to look around the building and saw that most areas were clean and odour free. However, there were two bathrooms where there was some clutter as they were being used to store wheelchairs and some communal toiletries and cloth towels. These towels were not in communal use, but were being stored in the bathrooms. According to National Institute of Care Excellence (NICE) guidelines cloth towels in communal bathrooms and toilets should not used due to the risk of cross infection. Light fittings in these bathrooms were in need of cleaning and the toilets were not flushed. We saw that paper towels and liquid soap were available and in use via dispensers.

We saw that bathrooms had suitable aids and adaptations such as bath hoists, rise and fall bath seats, grab rails and raised toilet seats. The bathrooms were usable but the décor and tidiness required some attention as the surroundings were not very pleasant for people who used them. We spoke with the manager who told us this was in hand and they had a list of refurbishment requirements and timescales for completion. We did not see this list at the time of the visit.

Staffing levels were good on the day of our visit. At that time there were 18 people who used the service on the upper floor and 17 on the lower floor. We saw sufficient numbers of staff attending to people's needs and some providing one to one attention to people who used the service who required that level of care.

We looked at staff rotas and saw that they confirmed there were sufficient numbers of staff on each shift. We were told by the manager that staffing levels were adjusted according to need and we saw evidence of this via the staff rotas.

We looked at two staff files which demonstrated a robust recruitment procedure had been followed, including the production of identification, taking up of references and obtaining Disclosure and Barring Service (DBS) checks. These helped ensure people's suitability to work with vulnerable people. The files also confirmed the completion of a robust induction procedure.

We spoke with a carer who was sitting with a person who used the service and who was asleep in their room. They explained that this person had been risk assessed as

Requires Improvement

Is the service safe?

requiring one to one support from 8 am to 8 pm. They told us another person had been assessed as requiring one to one support and they were currently in hospital, so the carer was with them there to ensure they received continuity of care. The staff member told us "Agency staff are used only when we're really stuck."

We looked at medication procedures within the home. People's medicines were only administered by registered nurses and there were photographs of each person who used the service on the medication administration records (MAR). We observed the administration of the lunch time medication on the ground floor, which was undertaken safely. The fridge storage temperature used in this area for the storage of medicines was correct and recorded correctly.

Safe systems were in place for the ordering and disposing of medication and we saw the returns being recorded and sent back to the pharmacy on the day of the inspection. We saw that the MAR sheets were signed when the medication had been administered. Some medication was given only once a week as prescribed and this was given each Sunday morning.

We saw the home used a small amount of controlled drugs. These were locked in a controlled drugs cupboard and there was a controlled drugs register. All people's medicines were accounted for, signed and countersigned as required.

The home had up to date safeguarding vulnerable adults policies and procedures in place. We asked staff for examples of how they would deal with safeguarding issues and they were generally knowledgeable about the subject, aware of the reporting procedures and confident to follow them. The home were reporting safeguarding incidents to the local authority and CQC appropriately at the time of the inspection.

One nurse we spoke with demonstrated little understanding of the term Continuous Professional Development (CPD), which requires nurses to continue to access training and development to comply with their professional registration. Her professional registration was up to date at the time of the inspection. We pursued this with the manager who said the nurse misunderstood the term, rather than the requirement, and agreed to address the issue with the nurse concerned via a supervision session.

Requires Improvement

Is the service effective?

Our findings

We spoke with visitors about the mealtime experience at the home. One family member told us, "[The person] needs a wheel chair and help with feeding and you can't tell what [the person] is saying. The staff spend as much time as needed with [the person]". Another said, "For breakfast [the person] has porridge and a full fry up - the food is very good."

We observed the lunchtime meal, which consisted of soup, corned beef and chicken sandwiches, sausage rolls and dessert. People enjoyed the food and were given a choice of alternatives if required. Special diets, such as diabetic diet and pureed food were catered for. We saw that the evening meal, which was the main meal of the day, was a choice of liver and onions or quiche and a dessert.

There were nine people who used the service in the dining area, four of whom were asleep or dozing. Only two people sat together at a dining table, others were in easy chairs. One visitor was assisting their relative with their meal.

Carers woke those people who were asleep and assisted those who required support with their meal. When carers were assisting people who used the service they were taking time with them and being gentle and careful. We noticed a carer carefully wipe a person's face with a damp towel. We saw that there were some individually plated meals, which were pureed. Each item on the plate was pureed separately, offering people who used the service a variety of colours and textures within their meal.

We saw a member of staff completing a food and fluid intake chart immediately after the person had finished their meal and drink. This ensured records were a true and accurate reflection of what had been eaten.

We spoke with the chef in the kitchen, and we were asked to wear a white coat prior to entering the kitchen, to help ensure hygiene standards.The chef was busy preparing the evening meal. They showed us the whiteboard and spreadsheet on which each individual was named along with any special dietary needs or allergies, preferences and meal choices. There were eight people requiring pureed food and one person needing a diabetic diet. We saw that a four week rolling menu was used.

We spoke with a member of the Wigan local authority quality assurance team prior to the inspection. They had been monitoring the home for some time and felt the home had responded to all requirements made of them and had made a number of improvements recently.

We looked at four care plans which contained a range of documents. There were care plans, risk assessments relating to areas such as moving and handling and falls, monitoring charts detailing temperature, pulse, blood pressure. There were also nutritional assessments and monitoring, documentation around wound care and correspondence relating to appointments and visits from professionals such as GPs.

Care plans included consent forms, most of which were signed by the person's next of kin as the result of a best interests decision where people did not have the capacity to make the decision themselves. We saw that some people who used the service their medicines administered covertly, that is given in food or drink. The correct paperwork was in place from GPs as this being the best method for certain people to have their medication and best interests decisions had been made about this in line with MCA requirements.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw documentation relating to Deprivation of Liberty Safeguards (DoLS) was included within care files and was complete and up to date. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

When asked about the Mental Capacity Act, which sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times, staff demonstrated a good understanding of this.

In one of the care records, within the section around capacity there was reference to best interests. The DoLS authorisation imposed certain conditions, including giving

Requires Improvement

Is the service effective?

medication to alleviate symptoms of anxiety and distress. We saw that a best interests meeting had taken place and the person's family had been part of this, indicating good practice in this area.

One care file included documentation of a difference of opinion between the home and the person's relative regarding their capacity to make decisions. Comments from the relative were included in the file, indicating transparency by the home. The staff at the home were acting in the person's best interests, but there was no clear recording of actions taken to evidence this. Clear records would have helped ensure an audit trail around the decision making process.

We looked at the daily records kept in journals in the person's room, these included turning and fluid charts. The daily journals were quite a new innovation and had been implemented as a way of facilitating communication between staff and relatives. There were sections such as "What's important to me" within these journals. There was no detailed personal information within the files, as they were in people's rooms and accessible to visitors. However, it would be useful to record whether people had consented, or were able to consent, to having this information available in their rooms.

We noted there was a lack of signage to assist people with orientation around the home on both floors, although a high number of people who used the service were living with dementia conditions. The home had several corridors which may lead to people become disoriented if they were looking for the lounge areas or their bedroom.

There were two areas within the home, designed to be stimulating for people living with dementia. One area was decorated as a seaside and one as a pub. We discussed with the manager whether these were appropriately placed as they were away from the main hub of the home and served no purpose to aid with reminiscence as they were just a facade. Current good practice guidance, such as that produced by Social Care Institute for Excellence (SCIE), promotes the use of reminiscence for people living with dementia. The manager had considered moving the reminiscence areas to somewhere they could be more interactive, for example, the lower ground floor.

There was a memory lane reminiscence room decorated with items to help stimulate people's memories and facilitate conversation. A few handbags and scarves were displayed on corridors for people to rummage with. These were not well used on the day of our inspection. Staff were not seen to engage with people in the using this as a form of activity.

We recommend that the service consult current best practice guidance on dementia care.

The home had a dementia café, providing a safe environment for people who used the service to socialise with each other and members of the local community. This was situated on the lower ground floor, which was open to the community one day per month. Although funding for this had been withdrawn the home management had decided to continue to offer this service as people had begun to rely on it.

We spoke with six members of staff and they were able to give us information about their induction in some detail, including orientation, shadowing a more experienced staff member and induction training modules.

We looked at the training matrix and saw that a significant number of staff had recently completed training in dementia. We saw most staff had completed training in safeguarding, challenging behaviour, equality and diversity, DoLS, fire, health and safety, food hygiene, moving and handling and infection control. The nurses had also undertaken training in medication administration. We asked staff about training and they all felt training was comprehensive and regular. One person said, "There's always training going on. It's scheduled and mandatory".

Good

Is the service caring?

Our findings

We spoke with three people who used the service and three relatives. One person told us, “The staff knock on the door before they come in. I choose to make my own bed and keep my room tidy”. Another person who used the service said, “They really look after me, I couldn’t manage on my own”.

A family member commented, “There is an air of friendliness about the place. All the carers and cleaners treat [the person] with dignity and respect. The care is excellent, they spend as much time as needed to feed [the person]. [The person] needs a hoist to get out of bed to take him for a shower, every other day.” Another visitor told us, “I’ve got nothing but praise for the staff”. A third relative said, “[The person] is being very well cared for, the carers are very good”.

We spoke with six members of staff, who were generally positive about their roles. One staff member told us, “Relatives need to know their loved one is seeing a nice smiling face all day”. We heard staff giving explanations about what they were doing throughout the day, to people who used the service. Staff tried to involve people in all aspects of their care.

The home was warm and there were no malodours. There were a number of shared rooms occupied on both floors. We noted that fixed privacy screening was in place between the beds. One of the staff we spoke with explained how they preserved people’s privacy and dignity when assisting them with personal care, filling a bowl with warm water and washing people in their beds, behind the screening. The rooms were clean and the majority had been personalised with peoples own belongings.

The atmosphere in the lounge/dining area was one of calm and the staff in general were observed to be kind, friendly and respectful. We observed a carer giving a resident a manicure and polishing her nails, whilst chatting amiably with her.

We observed that a person who used the service was becoming agitated when a carer started to take another person back to their room, as they also wanted to go back. The carer spoke to them gently and calmed them down, reassuring the person that they would be back in a couple of minutes. The carer did return after about 5-10 minutes to attend to this person.

One carer had noticed that a resident’s top had ridden up, exposing her stomach, and pulled it back down, saying loudly to her (so that others could hear), “You’re showing your belly!” Whilst it was good that she covered the person up, it could have been done a little more discreetly.

We were outside the room of a person who used the service whilst they were being assisted to eat their breakfast by a member of care staff. We overheard the carer offering pleasant reassurance throughout and, although the person did not answer, the carer spoke often, using their name in a gentle and caring way. The carer was not aware of being observed at the time.

Throughout our examination of records, the office door was left open and we heard staff interacting well with each other and with people who used the service. There was constant chatting and laughter.

Requires Improvement

Is the service responsive?

Our findings

We spoke with three people who used the service and three family members. We asked about whether people who used the service had choices related to their care delivery. One person who used the service told us, "I have my meals in my room as I prefer to keep myself to myself. I can look after myself really, and can come and go as I please". We saw people making choices about where they ate their meals and whether they stayed in the rooms or in the lounges throughout the day. This demonstrated a commitment by the home to ensure people were treated as individuals and allowed to make their own choices.

We saw that people's choices and preferences were recorded in their care files. One person who used the service said, "When I first came there were two beds in the room and I said that I didn't want to share and was told that wasn't necessary. Sometime later, they came and removed the extra bed."

A family member told us, "If there is something to complain about I go to one of the four (nursing) sisters. If I ask for something, it happens, they'll do it. They got a special bed for [the person] to ease the pressure sores. I complained about the bedding (duvet and cover) and they changed that. I did want the room redecorated as it was becoming tatty, but they moved [the person] downstairs instead and I'm happy with that."

We observed people getting up as and when they wished to and having breakfast at their leisure. One person who used the service was taken to the dining area, sat down and given cornflakes for breakfast at 11:30. We later asked a carer if this was a little late and were told that "It's her choice. She watches late night TV and gets up late."

We saw that a number of people were being nursed in bed in the afternoon. We asked staff about this and they were able to explain that some residents had returned to their room following lunch, for bed rest. Others were poorly on the day of the visit and two people stayed in bed on alternate days as per their care plans, due to their health conditions as per advice from the health professionals involved in their care.

We saw within the care records that the manager had amended the pre-admission assessment document, which was now much more comprehensive and individualised. This included people's choices, preferences, likes and dislikes. There was an area relating to consent to share a room, though this was more about relatives' consent. We discussed this with the manager who assured us that every effort was made to ascertain the person's wishes and needs with regard to sharing a room prior to admission.

We asked staff about their roles and responsibilities. We found that registered nurses always administered people's medicines and some assisted with hands on care, whilst others did not. It was the nurses who were responsible for writing in the care plans and keeping these up to date. We asked one nurse how they recorded information given to them by a carer when, for example, the person had not eaten their food. We were told they would commit this to memory and enter it on the computer when they got the chance, which did not seem an efficient system and could result in mistakes being made or incidents being missed.

Most records were generally in good order, but there was some inconsistency in whether information contained in the journals had been transferred to care support plans. This could be improved to ensure all staff were aware of all relevant information.

It was evident from observations, records and discussion with the manager that the home was caring for a number of people with complex care needs, who had been admitted under the previous manager. A number of admissions had been taken from Sefton Unit. Sefton Unit cares for people with behaviours that challenge and people who had possibly been sectioned under the Mental Health Act. The manager told us that the assessments carried out in the future would be mindful of not taking too many people with complex needs to help ensure all people admitted could be cared for appropriately.

The manager told us two younger people were inappropriately placed at the home. Although the home was caring for them they felt they could not necessary meet their social needs. The manager was in the process of looking into more appropriate placements for these people, in conjunction with their families, to try to ensure all their needs were met properly.

An activities plan in small print was displayed on both floors and in care files we looked at, but nothing to say if people had participated or what they had gained from the activity. There was no evidence of organised activities seen during the day of visit, but the activities organiser was on holiday.

Requires Improvement

Is the service responsive?

In the basement of the home there was a dementia café. This was used by people who used the service and was open to the community on a monthly basis at the time of the inspection.

A relatives' survey had been undertaken to ascertain the views of people's families. A newsletter had been produced in November 2014 for people who used the service and their relatives. It offered information about menus and explained refurbishment plans for communal areas and bedrooms.

The complaints procedure was displayed on the home's notice board. We looked at the home's complaints file. There was one complaint logged, which had been dealt with by the previous manager. This was backed up by the records.

We looked at recent compliments received by the home via cards and letters. One included the comment, "Thank you for looking my X so well and thank you for care and kindness".

Requires Improvement

Is the service well-led?

Our findings

There was a manager at the home who was currently going through the process of becoming registered. 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.

We had reviewed notifications prior to our visit. Some of these had been delayed being submitted to CQC due to the change of manager. However these were now being submitted as required.

We spoke with six members of staff and most felt the new manager had made positive changes to the service. They told us training was moving forward, supervision for staff was on-going and staff morale had improved.

One staff member told us the paperwork was more up to date, monitoring charts were being filled in more appropriately and turning charts were now complete and up to date. They told us they found the manager approachable and felt she had facilitated changes, such as carers now having more input and involvement in care plans.

Other staff described the manager's manner as occasionally abrupt, but still found her approachable. One staff member told us they felt a firm manner was necessary to ensure changes were implemented. They commented, "It is harder work (since the new manager took over) but I love my job and like what I do".

We looked at the results of a staff survey carried out recently. The response was generally positive, 75% of staff feeling they were involved in the running of the home, 75% saying they were able to approach the management about any concerns and 100% saying they felt valued as an employee and that staff morale was getting better.

We saw regular audits relating to infection control, general environment, bedrooms, bathrooms, store cupboards and laundry. We saw notes of actions taken around issues identified. We saw that care plan audits were up to date, comprehensive and complete, weight audits were complete and highlighted rapid weight loss or gain.

There were audits relating to falls and accidents and incidents. The falls audits contained only numbers of falls and more detail would have been useful in identifying causes, patterns and trends in order to address these. However, accident and incident audits were more detailed and identified issues and recorded actions to be implemented. For example, equipment such as hip protectors and new pressure pads had been purchased to help some people who were having a number of falls.

We saw fire safety audits and kitchen audits where issues had been identified and addressed via actions. Monthly bed rail checks were undertaken and these records were up to date and complete.

A relatives' survey had recently been undertaken. The results of this were that all who took part felt happy with the care of their relative and the care plan. A large percentage said their relative enjoyed the food, had participated in a review of their relative's care and were happy with the bedroom décor.

We saw that staff meetings took place and looked at some minutes. We noted that attendance was low and spoke with the manager about this. The manager confirmed that all staff were updated with minutes of the meetings which were in with their wage slips. Better staff attendance at these meetings would ensure all staff were getting the chance to air their views and receiving relevant information.