

# Barchester Healthcare Homes Limited

## Windmill Manor

### Inspection report

2 Fairviews, Holland Road  
Hurst Green, Oxted RH8 9BD  
Tel: 01883 718120  
Website: [www.barchester.com](http://www.barchester.com)

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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?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



### Overall summary

Windmill Manor is a purpose built care home that provides nursing and personal care for up to 60 people. Many of the people living at Windmill Manor are living with dementia. The home is set across two floors; with the ground floor mainly for people who require nursing care and the first floor for those who are living with dementia.

At the time of our inspection 55 people were living at Windmill Manor.

This inspection took place on 20 May 2015 and was unannounced.

The home is run by a registered manager, who was present on the day of the inspection. 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 and associated Regulations about how the service is run.

We found the home did not have a sufficient number of trained staff to meet the nursing needs of the people who lived there.

Where restrictions on people were in place to deprive them of their liberty, staff had not always followed legal

# Summary of findings

requirements to make sure this was done in the person's best interest. The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications to comply with their responsibilities; however these had not been made appropriately.

Complaint procedures were available for people. The registered manager had received two complaints and were responding to them. However, we heard from people they felt their complaints had not been taken seriously.

People were involved in their care and support however we did not see staff encourage them to do things for themselves. We found staff did not always make people feel as though they mattered or treat them with consideration.

Staff told us and we saw, ways in which staff supported and enabled people to maintain their independence and take part in various activities. However we saw people sitting for long periods of time without social interaction from staff. Appropriate activities for people living with dementia were not always provided.

Care was provided to people by staff who were competent to carry out their role. Staff told us they received supervision, but did not have appraisals.

Staff felt supported by management however we found improvement was needed to ensure senior staff were aware of the needs of all people living in the home.

Checks had been carried out to make sure people were safe living in the home and any risks they may take were minimised.

Medicines were managed appropriately and people received their medicines in a safe way.

The provider had ensured they followed appropriate recruitment processes to help them employ suitable staff to work in the home.

Staff understood their responsibilities in relation to safeguarding. We were assured they knew how to report any concerns they may have.

A choice of meals was provided to people and people were involved in making decisions about what they ate.

Staff referred people to external healthcare professionals when appropriate and the local GP was actively involved in the home.

Care plans contained information to guide staff on how someone wished to be cared for. When people's needs changed, staff responded to these appropriately and provided effective, responsive care.

People and relatives were involved in making decisions about the home and they were asked for their feedback.

Quality assurance checks were carried out by staff and the provider to help ensure the environment was a safe place for people to live.

During the inspection we found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# 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?

The service was not always safe.

There was an insufficient number of qualified nursing staff to meet the needs of all people who required nursing care.

Staff followed good medicines management procedures.

There were enough care staff on duty to meet the needs of the people and appropriate checks were undertaken to help ensure suitable staff worked at the service.

Staff were aware of their responsibilities in relation to safeguarding and people's risks had been assessed and were managed effectively.

**Requires Improvement**



### Is the service effective?

The service was not always effective.

Staff did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act. Best interest meetings and mental capacity assessments had not been carried out and inappropriate DoLS applications had been submitted.

Staff were trained and supported to deliver care effectively.

People were provided with enough food and drink throughout the day.

Staff ensured people had access to external healthcare professionals when they needed it. People's changing health needs were monitored by staff.

**Requires Improvement**



### Is the service caring?

The service was not always caring.

We observed occasions when people were not treated with the attention they should expect from staff. We saw people sitting for long periods of time with little social interaction from staff.

Staff support people make their own decisions about their care. Staff knew people well and welcomed visits from friends and family.

**Requires Improvement**



### Is the service responsive?

The service was not always responsive.

People were supported to participate in a range of activities; however there was a lack of individualised stimulation for people living with dementia.

People were able to express their views and were given information how to raise their concerns or make a complaint. However, complaints were not always responded to in a timely way.

**Requires Improvement**



# Summary of findings

People and their relatives were involved in developing care plans and changes to people's needs were reflected and acted on by staff.

## Is the service well-led?

The service was not always well-led.

Records were not always kept up to date or contain relevant information for staff.

People and relatives told us the registered manager was very supportive and visible in the home. However the registered manager and deputy manager did not always know the individual needs of people.

Quality assurance checks were untaken to help ensure a the service was safe for people.

Staff were able to give feedback to the management of the service.

**Requires Improvement**



# Windmill Manor

## 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 inspection took place on 20 May 2015 and was unannounced. The inspection team consisted of three inspectors.

Although the provider had completed a Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service we have not referred to this in our report. This was because we carried out this inspection as we were responding to some concerns we had received.

As part of our inspection we spoke with seven people, seven staff, three relatives, the registered manager and deputy manager and two healthcare professionals. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included five people's care plans, five staff files, and some policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We last carried out an inspection to Windmill Manor in April 2013 when we had no concerns.

# Is the service safe?

## Our findings

Staffing levels were not regularly assessed or monitored to make sure they met people's needs. The registered manager was unable to provide us with an accurate and up to date dependency tool to show how she determined how many staff should be on duty each day. The registered manager provided us with a folder with individual dependency assessments for people. This was undertaken in March 2015 by the provider. However, we found that despite many people living with dementia, assessments indicated no one required best interest meetings for decisions due to their lack of capacity. We also found that information contained in at least two of the assessments was incorrect. For example, one person had been noted as only having a short period to live, however this was not the case. The registered manager told us the dependency tools determined they needed an additional eight hours of care staff, which she was recruiting to. Staff said, "We've been short staffed in the past, but it's getting better now."

There were insufficient numbers of staff with appropriate qualifications for people who required nursing care. We were told that the nurse on duty provided nursing care to people on the ground floor only. People who lived on the first floor had district nurses coming in to provide nursing care. This meant people who were being funded for nursing care and lived on the top floor were not receiving nursing care they required from in-house staff. The registered manager told us they needed to, "Move people around" to try to ensure all those who required nursing were on the ground floor. However this was not possible as there were no available rooms. We looked at the website of the home following our inspection and noted it advertises as a, 'residential and nursing home', but with the present level of qualified staff providing nursing care only the people living on the ground floor receive this routinely from the provider's own staff.

The lack of appropriately qualified staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a sufficient number of care staff on duty on the day of our inspection. Staff told us there were enough staff to meet people's needs. One staff member told us, "I feel staff are deployed well, each day is different." The deputy manager told us they felt there were enough staff.

Safe recruitment practices were in place. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw staff had Disclosure and Barring System checks to identify if they had a criminal record. The provider had also obtained references and checked staff employment history.

Staff were aware of their responsibilities in relation to safeguarding and could recognise signs of potential abuse. Staff were able to give us examples of the types of abuse that may take place and how they would act if they had any concerns. One member of staff said, "There would be no hesitation, I would report any concerns. If it was my grandma, I would want something done." A relative told us when they walked out of the home they knew his wife was in safe hands and he didn't have to worry. Guidance was available for staff to follow if they wished to report anything. The registered manager demonstrated they responded to safeguarding concerns. For example, in relation to a recent concern which had been raised by a relative.

People were enabled to take risks in a protective environment. We saw people walking around independently throughout the day and staff allowed their freedom. People's care plans included information around risks for individuals, such as their mobility or risk of malnutrition or dehydration. For example, we read one person who was at risk of falls had a bed rail fitted. Another person who was unable to use the call bell was encouraged by staff to sit in communal areas throughout the day. We saw this happening during the inspection. People living with dementia on both floors were able to access communal areas unaided. Staff were aware of the risks for people and we saw them support people when appropriate to walk between different areas of the home.

In the event of an emergency people would be kept safe. On the day of our inspection the home had a fire alarm, which was not a test. We observed some staff remained in the building at

pre-determined points to ensure the safety of people who had not left the building. People had their own individual evacuation plan and we saw fire evacuation equipment available should the building need to be vacated.

People received their medicines as prescribed and staff followed current guidance in relation to the management

## Is the service safe?

of medicines. We saw staff give people their medicines after checking the information contained in their medicines administration record (MAR). MAR records included a photograph of the person, any allergies they may have and information related to what medicines they were on and when they should be taken. Individualised medication care plans were in place for people. We read people who required PRN (as required) medicines had protocols which described to staff how, why and when a PRN medicine should be given. Some people required PRN medicines on a daily basis which meant they had become a regular prescription. We read staff had requested the status of the medicine to be changed. A homely remedies (medicines that can be bought over the counter) policy which had been agreed by the GP was available for staff.

People received their medicines when they required it. We watched staff give those people who required medicines after lunch at the appropriate time. People were given time to finish their lunch before staff administered the medicines and they watched to ensure people swallowed their medicines before updating the MAR record.

Medicines were stored securely and reviewed when appropriate. We saw staff recorded fridge temperatures on a daily basis and all boxed medicines had an audit chart for staff to count stock levels following the dispensing of tablets. The GP visited the home during our inspection and we heard as a result two people's medicines were changed. We read staff updated the care plans appropriately.

# Is the service effective?

## Our findings

Where people may not be able to make or understand certain decisions for themselves, the registered manager and staff had not followed the requirements of the Mental Capacity Act (MCA) 2005. We found mental capacity assessments had not been carried out for people in relation to individual decisions and there was little evidence that best interest meetings were held to discuss a decision and how it could be made with the least restriction for the person. For example, in the case of people who required covert medicines (administration of medicines in a disguised form). Best interest meetings had not been recorded as being held in this respect. We read protocols were in place for these people but they had not been reviewed for some period of time to check whether or not the person still required the medicines in this way. Staff told us however, "Where people lack capacity we involve family as much as we are able." Staff gave us examples of how they gain consent from people before they provided care. We saw this happen throughout the day.

The registered manager had submitted Deprivation of Liberty Safeguard (DoLS) applications for most of the people living in the home. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We found people were restricted to areas of the home. For example, all major external doors and most internal doors were locked and had key coded access. However, we found applications may not always have been made appropriately to the local authority. For example, applications had been made for all people with a diagnosis of dementia without considering if the person lacked the capacity to make decisions about their care arrangements. Others had been made for people who had capacity to make a decision for themselves. Applications which had been submitted contained the same generic statement which showed us individualised capacity assessments and decisions had not been understood or considered by staff.

The lack of understanding and failure to follow legal requirements is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have enough to eat and drink. The chef told us they worked hard to ensure people were provided with a nutritious meal and healthy balanced diet. People who required foods given to them in a specific way (for example, pureed) were given the same meals as everyone else but we saw, served appropriately. We saw staff support people who were unable to eat for themselves. However we saw one person who, according to their care plan required, 'constant prompting to eat' not being supported during their meal. We saw this person only ate a small proportion their meal and their plate was taken away. Staff were unaware of this and when we spoke with one staff member at the end of the day they told us this person had eaten all of their lunch.

**We recommend the provider reminds staff of the importance of following the individual care plans for people.**

People had a choice of meal. We saw staff offer plates with different meals to people to allow them to see what was on offer before making a choice. When one person did not wish either, we heard staff suggest alternative options. One person asked for an omelette and another person requested ice-cream. These were provided. We heard one person say, "Mmm, the minced beef looks nice, I will have that." Another person told us the food was good and they were always given a choice.

People were involved in decisions about what they ate. We heard staff give people a choice of the meal and drink they had as well as where they wished to sit. One person chose to have a beer with their lunch. Some people had clothes protectors on, but we heard staff ask people first. Finger foods were provided in the communal corridor areas for people who wished to snack mid-morning or mid-afternoon. The chef had held a meeting with people to discuss any concerns, suggestions or feedback they had in relation to food. A relative who visited the home regularly told us they had always seen a good balanced diet being served to people.

Risks to people with complex needs were identified. Staff ensured they told the chef of people who required a soft diet, for example, or those who could not eat certain foods. The information was contained on a board in the kitchen and updated regularly by staff.

People who required it had access to dietary and nutritional specialists who provided guidance for staff to



## Is the service effective?

follow. For example, we saw one person had been referred to the dietician. Staff told us of the importance of recording what people ate and drank and why it was necessary to weigh people regularly.

People were cared for by staff who were trained in their role. Staff told us the training they received was good and it was sufficient and appropriate to enable them to carry out their duties. New members of staff shadowed more experienced staff until they felt confident they could work unsupported. One (staff) told us, "Training has been quite good." Another member of staff said, "The training is amazing." We saw staff working in an independent way, and staff who were new to the home, sought guidance from the deputy manager. Staff received supervision, however the registered manager said staff appraisals had not been done and this was something they needed to organise. The training manager told us, "What we do is important, we promote the values and build on this (during training)."

Staff received training specific to their role. On the day of the inspection a training session was being held called 'So

Kind'. This provider organised training included sessions on dementia awareness and challenging behaviour. However, we did not find staff always put their training to use effectively. For example, there was inadequate provision for people living with dementia in terms of interaction or activities.

### **We recommend the provider considers specific and appropriate activities for people living in the home.**

Staff ensured people's daily health needs were met. The GP came to the home once a week to review people who were not well, or whose health needs had changed. We were told staff referred people appropriately and in a timely manner to the GP surgery.

People had access to external health care professionals. We read in people's care plan they had involvement from the GP, district nurse, chiropodist, speech and language therapy team. One person had lost weight and we read staff had referred them to the dietician.

# Is the service caring?

## Our findings

One person said they were happy in the home and felt nothing could improve. Another person told us they were very happy and things, "Couldn't be better." They told us they were well looked after by staff. A relative said, "I feel that people and my wife are well cared for here."

However, people were not made to feel as though they mattered. We saw staff standing around or sitting with people in lounges without talking to them. Most people were seen to be dozing or sleeping during the morning due to lack of interaction from staff. We heard one person ask a member of staff if they would accompany them outside in the garden, but this was refused as the staff member was too busy. On another occasion a member of staff asked someone if they would like the television turned off and music put on, with no consideration for others in lounge. We saw a member of staff supporting one person to eat their lunch. However the member of staff hardly interacted with the person at all during this time. We saw them looking around the room after each mouthful was given. We saw the person was not given sufficient time to finish what was in their mouth before the member of staff put another spoonful in front of them.

People were not always treated with consideration. We heard one person say, "I don't like all the noise, I prefer to be quiet." However we saw staff try and encourage this person to be part of group activities. Another person who liked to read the newspaper, was unable to read the small print. Although he had glasses, staff did not offer to go and fetch them for him.

Staff did not respond to people quickly enough and there were times when we were aware there were no staff about to see to the needs of people. Despite at least two staff being available, we saw one person waiting to be assisted for over five minutes. We heard their call bell ringing but staff seemed totally unaware of it. Eventually this person called out, "Hello, hello" to try and attract staff. On another occasion we heard one person calling out on and off for a period of 20 minutes when no staff were in the room.

Staff did not take the time to socially engage with people. We saw one member of staff standing, leaning up against the wall outside the communal lounge area. Six people were sitting in the lounge with the television on, although most people were not watching it. The member of staff

came into the lounge and sat next to one person for over 15 minutes but did not speak to them. They later went out a stood against the wall again. During a period of one hour we observed people received no interaction from staff. Staff told us this was because people appeared to be asleep, however people were dozing through lack of stimulation.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could make their own decisions about the care they received. We heard from people how they could get up or go to bed when they wished and those who preferred to eat lunch in their own room where provided with this. One person was asked if they would like to get dressed. They declined and staff respected this. Other people were asked if a member of staff could take their blood pressure. One person refused and this was accepted. However, we did see one person being cajoled into having their nails painted by staff, despite them telling staff they had already been done.

People were able to have privacy should they wish it. People told us they could return to their rooms and have time on their own if they wished it. One person told us they liked to spend time in their room. We saw people meeting with their relatives and moving to other areas of the home in order to have time alone.

People were shown dignity. For example, we saw one person who required a hoist to be moved and we saw staff cover their legs appropriately. Another member of staff went and found a person's hearing aid. And another person's trousers were falling down and staff responded to this straight away.

People were encouraged to be independent. We saw people sitting in the lobby area of the home, reading the newspaper. Other people sat in seating areas in communal corridors drinking tea and eating nibbles which staff had provided.

Visitors were made to feel welcome. It was evident relatives were welcomed into the home and could call unannounced. We heard relatives talk to people and staff in a relaxed and friendly manner. Relatives were able to use the communal coffee area to make drinks and eat snacks should they wish.

We saw some positive examples of real care from staff. We saw one member of staff hug one person and spend time

## Is the service caring?

with them chatting and taking an interest in what they were saying. Another member of staff was seen sitting with someone chatting for a few minutes. A member of staff chatted with someone whilst they were painting their nails and when tea was offered to people, the member of staff moved side tables to ensure people could reach their drink. One person liked to change their clothes several times during the day and we saw staff support them to do this. Staff told us, "I think the care is good, staff work from their hearts", "I think there is good care from everyone" and, "I love the residents, we all have such a good laugh, I enjoy making someone feel better."

People's individuality was known by care staff. Although one person's background had not been completed in their care plan, staff were able to tell us what their hobbies were and what they had done as a job.

People were treated with compassion. Staff spoke with people in a kind way and listened to people when they wanted to talk or if they were anxious. We overheard one lady getting anxious in her room but staff remained supportive and relaxed and were able to provide the care to her she required. When people became agitated by other people, staff re-assured them and calmed them down.

# Is the service responsive?

## Our findings

One person told us they joined in on some of the activities, but they said there were not always enough staff around to do extra activities, such as trips out.

Activities were available to people. We saw people join in on a karaoke singing session in the afternoon. It was lively and it was evident people were enjoying it. The home had a resident cat and a dog was in most days. We saw a relative bring their dog into the home and watched how one person responded to this, stroking the dog and telling the relative about the pet they used to have.

Although activities were available there was a general lack of stimulation for people. We did not observe any specific activities suitable for people living with dementia and staff were not able to give us examples of appropriate activities. We noted the home had 'sensory' corners. These included animals, a beach scene and reminiscence items. However, despite the home being advertised as providing, 'personalised residential dementia care' we were told these sensory areas had only been created that week as part of dementia awareness week. The sensory areas contained memorabilia for people living with dementia, however they were located at the end of corridors which people would not walk past and we did not see any one use these areas or staff guide people towards them. Staff told us they felt activities could improve. They said, "Activities could improve a lot, there should be more one to one's with people", "Not all people get as much one to ones as they should, we are introducing baskets into people's rooms with personalised items that people enjoy" and, "Activities aren't too great."

People were socially isolated. During the morning we found people sitting in lounge areas with the television on, but no other stimulation. For those who could join or wished to, there was a 'bunting' making activity on the first floor, but nothing was in place of it for those who chose not to or were unable to participate. Lack of stimulation was identified during a recent provider support visit. The report stated, 'quality of interactions - little seen for an hour or so'.

The environment was not always suitable for people living with dementia. We saw, on the whole, the interior of the home was decorated in plain colours and pictures were

used for specific rooms, for example the toilet. However we found not everyone had a memory box outside of their room, or some form of identification specific to them. As a result we saw one person walk into someone else's room.

The lack of involving people is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could make complaints if they wished. We read the registered manager was currently dealing with two complaints from relatives and we read some actions which had been taken. However, records relating to all of the actions undertaken had not been updated which meant another member of staff may not have been aware of how a complaint had been responded to.

People did not feel their complaints were responded to in a timely way. A relative told us they had complained for some time about an issue and they felt it had not been taken seriously by the registered manager. Another relative told us they had made a complaint recently but were still waiting for an outcome.

**We recommend the provider ensures all records in relation to complaints are recorded appropriately and complaints are responded to in a timely manner.**

People's support needs and information about their lives were recorded in care plans. This included personal details such as the person's likes and dislikes. People were portrayed as individuals as care plans included information about their lives before moving into the home. Relatives said they were involved in the development of care plans as well as their reviews. Staff told us any changes to a person's needs were discussed during their handover meeting and also written in a communications book which all staff signed to say they had read. However, we read daily notes were not always written in a comprehensive way and did not always record up to date information.

People received responsive care. One health care professional said staff were good at following their guidance to ensure someone regained their health. We read in one person's care plan they were at risk of falling and staff had installed an alarm in their room to alert them if the person got out of bed. This person had been admitted to the home with a pressure sore, but due to responsive care from staff this had now healed. Another

## Is the service responsive?

person had notes which showed they were provided with antibiotics due to a chest infection. We read how their care plan was updated and changed when the person recovered.

People were supported to follow their interests. We saw several people go out in the morning to a church service. One person told us they enjoyed doing this.

People and relatives were involved in the running of the home. Residents meetings were held to which relatives were invited. We read the notes from the last meeting which had involved discussion about staffing and learning session about dementia. One relative we spoke with told us it was a very useful meeting. The registered manager said they planning to hold joint meetings once a quarter.

# Is the service well-led?

## Our findings

The home did not demonstrate good management and leadership. Senior staff did not always know the people they cared for and the registered manager had not ensured staff were working in a cohesive way. People and relatives were generally happy with the service provided and the care they received. However, one relative told us they hardly ever saw the (registered) manager out on the floor and felt they didn't know people well. This was borne out by our discussions with the registered manager. We raised an issue in relation to a person living on the top floor. The registered manager was unable to identify who this person was. We did not see the registered manager particularly visible in the home. On the occasions we did see her on the individual floors we were not aware of her spending any time talking to people, or addressing them by name. When we spoke with the deputy manager about people who required nursing care on the top floor, they told us, "I don't think there is anyone up there, district nurses do come in but they see to people upstairs. All CHCs (people funded for nursing care) are downstairs. I don't know the residents as well upstairs." However, we had identified people living on the top floor who were being funded for nursing care. The deputy manager was also one of the nursing staff which meant they were clearly not involved in the care of all people living in the home. Staff told us, "It would be great if we could work toward a whole home."

The lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records held in the home for people were not robust. We read in one person's care plan they should be checked every hour throughout the day. We checked the daily records but could not find where this had been recorded. Further in this person's care plan it stated they should be checked every two hours. We read during the night there was a period of five hours where this person appeared not to have been checked by staff. Daily notes were written at the end of the day shift and at the end of the night shift which meant information recorded may not be fresh in a staff member's mind. For example, in relation to the person who did not eat their lunch. Staff told us they were going to record they had eaten it all. Accidents and incidents were

recorded and learning from these was shared at handover meetings and during team meetings. However, we read in some of the completed accident forms, no actions had been included.

**We recommend the provider ensure all records are up to date and recording of daily notes takes place in a timely manner.**

Staff felt supported. Staff told us they felt supported by the registered and regional managers. They said they were encouraged to progress and recent changes following the recruitment of the registered manager were for the better. Comments we received included, "I feel really supported and I like the (registered) manager", "The (registered) manager is fantastic and very supportive" and, "they (staff) are a nice bunch here, all staff made me feel so welcome." However, staff were not provided with the opportunity to meet on a one to one basis with their line manager to discuss their progress.

**We recommend the provider ensures the completion of staff appraisals as soon as possible.**

Staff said that as part of their induction they learnt all about Barchester Care Homes and their ethos and aims. They told us senior staff checked they followed best practice. One member of staff told us they were happy working in the home and were provided with everything they needed. They said the registered manager came around each day to check staff were okay, however they were not sure they knew people particularly well.

Staff were involved in the running of the home. We read staff meetings were held regularly. This included a full staff meeting, or individual meetings relating to the different elements for the home, for example, a kitchen meeting.

The provider carried out monthly quality assurance visits to the home. This was to ensure the home maintained a good standard of safety for the people who lived there. We saw actions which had been identified as a result of the last visit. For example, issues with some prescriptions and the nurses' station was left unlocked. We saw most actions had been completed. The GP told us they had worked together with the nurse and staff to resolve the issues with the prescriptions and things were now working well.

The registered manager carried out a number of checks to make sure people received a safe service and any issues

## Is the service well-led?

identified were resolved. For example, we saw she produced a monthly nutrition report which identified people who may require supplements or a referral to the dietician.

People, relatives and staff were asked for their feedback on the service. People and their relatives were happy with the quality of the service provided. We read the results of the

last survey which showed people were happy with the staff and care, choice, home comforts and their quality of life. We read the satisfaction of people had increased from the previous year. The registered manager provided us with compliments which had been left by relatives. We read how one relative said their family member had become, "Mum again" since living at Windmill Manor.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care  
**People were not provided with person-centred care.**

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect  
**People were not encouraged to be involved.**

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent  
**The provider had failed to follow legal requirements in relation to consent.**

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance  
**The provider had not ensured good governance in the home.**

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
**The provider had not ensured sufficient numbers of appropriately qualified staff.**