

Barchester Healthcare Homes Limited

Gorseway Care Community

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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

This inspection took place on 7 and 8 March 2017 and was announced.

Gorseway Care Community is a registered care home and provides accommodation, support and care, including nursing care, for up to 88 people, some of whom live with dementia. This is provided across two houses, one of which can accommodate up to 28 people and the second can accommodate up to 60 people. At the time of this inspection the provider was not using the house which could accommodate up to 28 people and the registered manager told us they would only provide support to up to 50 people in the other building.

During our inspection there were 22 people living on what was known as the elderly frail floor. This provides support to older people who require more physical care and nursing support. There were 14 people living on the floor known as 'Memory Lane'. Memory Lane provides support and nursing care to people living with dementia.

A registered manager was in post. 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. The registered manager was also a director of the company and the nominated individual.

There has been a history of breach of regulation in this service since July 2013. Multiple action has been taken by CQC to encourage the provider to make the improvements needed. This has included requirement actions and enforcement action. The provider did make improvements to the service and the last comprehensive inspection in January 2016. However they did remain in breach of Regulation 17, Good governance because systems used to assess quality were not always effective in identify the need to ensure records for people were clear and accurate. The seriousness of this breach was assessed as low because the impact on people was minor. We issued a requirement notice and asked the provider to send us an action plan detailing what they would do to rectify this concern.

At this inspection we found further improvements had been made in the service. Records had improved and contained all relevant information, however some wording needed review and one person records regarding their mobility were slightly conflicting. The registered manager was open about the need to ensure these improvements were further developed, fully embedded and sustained. As such they had implemented additional measures of checking records. Systems and processes to monitor the service continued although a change to the provider's regional structure had supported some of the systems to be more responsive. Although there was no longer a breach of regulations, there were still areas for improvement in records. We made a recommendation about this.

People were supported by staff who knew them well and demonstrated kind, compassionate care. At times

staff were not always able to respond promptly to verbal calls for support because they were supporting other people. People, their relatives and staff consistently raised concerns that the staffing levels were not sufficient. We found staff were responsive to people's needs and provided the physical care they required but there was general feedback that staff had little opportunity to spend time 'with' people other than when delivering care. The regional manager and registered manager told us they would explore the reasons why people felt there were not enough staff with people, relatives and staff.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. Medicines were managed safely and risks associated with people's needs had been assessed with plans developed to mitigate such risks. People could be confident they were being cared for by staff appropriate to do so because the provider operated safe recruitment processes.

Staff felt well supported and received the training they required to effectively support people. Supervision meetings for staff had improved and regular meetings were held which they could attend to make any suggestions or raise concerns. People had access to a range of health and social care professionals and staff acted on specialist advice given when planning and delivering care and support.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had applied that knowledge appropriately. They understood the importance of obtaining people's consent when supporting them with their daily living needs. People were involved in decisions about their care and support. Care records reflected people's needs.

A complaints policy was in place and people knew how to use this if they needed to. The provider responded appropriately to complaints.

The registered manager was visible in the service and consistently described in a positive manner. They were open and transparent and supported staff to work proactively.

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 always safe.

Consistent concerns about staffing levels were raised by people. People received physical support when needed but may benefit from more staff having more time to provide emotional/social support. The regional manager and registered manager said they would review this.

Staff and the management team understood their responsibilities in safeguarding people from harm. People were kept safe through risks being identified and well managed. Medicines were well managed and staff were recruited safely.

Is the service effective?

Good 

The service was effective.

Staff received support and training they needed to work effectively with people.

Staff understood the need to ensure people were supported to make their own informed decisions.

Where people needed support with specialist diets this was provided and staff accessed other professionals to ensure support provided was appropriate for people's needs.

Is the service caring?

Good 

The service was caring.

People were supported by staff who were kind and caring.

People, or their representatives, were involved in decisions about their care and support.

Staff demonstrated an understanding of respect, privacy and dignity.

Is the service responsive?

Good 

The service was responsive.

People received care and support that took account of their needs and wishes.

There was a clear complaints policy and people knew how to use this.

Is the service well-led?

Good 

The service was well led.

People benefitted from a registered manager and senior staff team who were open and approachable. A change to the regional structure enabled the provider support to be more responsive to the service.

People's quality of care was monitored by the systems in place and action was taken to make improvements when necessary. Records had improved although further improvements could be made and the registered manager felt these needed further embedding into the service. We made a recommendation about records.

Gorseway Care Community

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.

The inspection took place on 7 and 8 March 2017 and was unannounced. The inspection team consisted of one inspector, a specialist nurse advisor and an expert by experience who had experience of caring for older persons. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports and looked at our own records such as any notifications of incidents which occurred (a notification is information about important events which the service is required to tell us about by law). Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 14 people who used the service and eight relatives. We spoke to the registered manager, regional manager, deputy manager and clinical development nurse. We spoke to 10 other staff including registered nurses, care staff, activity staff and ancillary staff. We observed the care and support people received in the shared areas of the home. We also received feedback from two external health and social care professionals.

We looked at the care plans and associated records of eight people and sampled a further three peoples. We looked at medicines administration records for everyone living in the home, six staff's recruitment, and supervision and induction records. We looked at staff training records, records of complaints, accidents and incidents, policies and procedures, safeguarding and quality assurance records.

Is the service safe?

Our findings

People told us they felt safe living at Gorseway and their relatives confirmed they felt their loved ones were safe because staff understood their needs. However, we consistently received feedback from people, their relatives and staff that staffing levels were not appropriate to meet the needs of everyone living at the home. Some relatives expressed concerns that their loved ones would feel lonely and isolated because staff did not always have the time to provide emotional and social support to them.

Concerns about staffing levels had been raised with us at the inspection in January 2016 and at that time we made a recommendation that the provider review this. At this inspection the provider continued to use an assessment tool to determine the number of staff required to meet people's needs. This was reviewed by the registered manager every week based on a dependency assessment of people's needs. The regional manager told us how due to the history of concerns within the service the provider had ensured more staff were available for a significant amount of time. However due to improvements within the service and a stabilised management team, it had been with the registered manager to return to using this assessment tool more effectively and as a result staffing levels had reduced about three months before our inspection.

Duty rotas for staff who provided direct care, for the three weeks before and the week of the inspection reflected that more staff were provided than the assessment tool identified was needed. However, we noted that for one week the number of staff provided for two days were lower than the assessment tool recommended. In addition to the staff on the duty rota, activity, housekeeping, administration, maintenance and kitchen staff were available. People received personal care at varying times of the days which staff told us was due to the staffing levels. However discussions with people and a review of care records reflected that the time for delivering personal care had been agreed with people. Our observations showed that call alarms were responded to promptly and when people requested support they received this. However we found one record which reflected a person did not receive the support they needed for almost one hour and staff had documented the reason for this was that they were unable to provide this support alone. The registered manager told us they would report this incident to the local authority safeguarding team and investigate this.

Staff took opportunities when they were able to engage with people and support their mental/social wellbeing. However there was general feedback from people and relatives that staff had little opportunity to spend 'with' people other than when delivering care. We observed long periods of time when there was a lack of occupation for people.

The regional manager told us how Gorseway Care Community was due to commence an accredited programme looking at support provided to those living with dementia. They said part of this programme involved a review of the staffing levels. A dementia care specialist was due to visit the service on 16 March 2016 to commence this programme. The registered manager and regional manager told us they would explore the reasons why people felt there were not enough staff with people, relatives and staff.

Staff had been provided with training on how to recognise abuse and how to report allegations and

incidents of abuse. Policies and procedures were available to everyone who used the service. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. The registered manager reported safeguarding concerns to the appropriate external agencies including CQC and we saw evidence that any concerns were investigated and learning taken from these.

One member of staff told us how a review and update of moving and handling practices had taken place following concerns about unexplained skin tears.

Staff knowledge of the people they supported was good, they understood their needs and any risks associated with their support. Assessment tools continued to be used to identify risks to people including falls assessments, skin integrity assessments, moving and handling assessments and nutritional assessments. Where a risk was identified this was then incorporated into the care records for that person. For example, where people had been assessed as at risk of falls during an assessment and following a review of any accidents and near misses, care plans were in place. Action was taken by staff to minimise risk of falls and injuries as a result of falls where the risk could not be reduced. For example, evidence of discussion with health professionals about support measures was apparent. Sensor mats were used to alert staff to a person's movement, although the sound of these did not differ to the usual call alarm. In discussion with the regional team and registered manager, they identified that Gorseway would benefit from trialling different equipment for sensor mats and advised they would propose this to the provider.

People's medicines were safely managed. There were policies and procedures in the safe handling and administration of medicines. Medicines were stored safely within locked trolleys and locked rooms. Storage room and fridge temperatures were taken daily to ensure medicines were stored within safe temperature ranges.

Records were available to guide staff to the medicines a person was prescribed. Medicines were counted and signed in when received at the home. Medication administration Record (MAR) sheets were accurate and contained no gaps. Medicines that were prescribed on an as required basis (PRN) had protocols in place for their use. These included details including when and how a nurse should offer a particular medicine to a person, the dosage (including minimum time between dosages and maximum dosage in twenty-four hours) and in what circumstances the doctor should be informed.

Where people were taking a medicine which required specific monitoring, their records showed this was done safely. These records contained test results, subsequent scheduled tests and the exact dose to administer. Risks associated with these types of medicines had been incorporated into care plans. Where people were able and chose to, they managed their own medicines. Assessments of their ability to self-administer their medicines had been completed and formed part of their care plans.

Staff confirmed they received training and completed competency assessments before being able to give medication.

Appropriate recruitment and selection checks had been carried out before staff began work. Applicants completed an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place. We reviewed six staff files. Enhanced Disclosure and Barring Service (DBS) checks had been carried out and numbers issued. References were present, including the previous employer reference (unless the person had not previously been employed, in which case an educational reference was sought, along with a character reference). These help employers make safer recruitment decisions and help prevent unsuitable staff from working with people who use care

and support services.

Is the service effective?

Our findings

Relatives felt staff were knowledgeable and well trained. Staff said they received training that supported them in their role. People confirmed they were always asked for their permission before staff provided care and observations reflected this.

The registered manager told us how the provider induction was due to change and that this would be a more comprehensive plan for new staff. Induction for new staff included training completed away from the service and time spent shadowing staff, completing assessment workbooks and being assessed as competent. Staff completed a probationary period where the registered manager checked if they were performing to a suitable standard. Staff were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The registered manager told us how they were encouraged to undertake additional health and social care vocational qualifications.

Staff completed mandatory training and updates including safeguarding, moving and handling, fire safety and infection control. Some training such as moving and handling was delivered practically. Additional training included subjects such as leadership, people management, falls management, code of conduct as well as other subjects. Staff told us the training was helpful in their roles and enabled them to keep up to date. They felt able to request any training and were confident this would be explored for them.

Staff told us they received supervisions which they found helpful and supportive. They told us these meetings were a two way discussion where they could share concerns or make suggestions. Records showed the meetings took place and the frequency of these had improved since previous inspections.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff showed a good understanding of consent and observations reflected they sought this before providing care. People and their relatives confirmed staff always asked permission before providing care and respected people's decisions. Staff understood the principles of the Mental Capacity Act and ensuring that the people they supported were given choices and supported to make informed decisions of their own.

People told us how staff respected their decisions and relatives confirmed how they and their loved one were involved in making decisions where this was needed. When more complex decisions needed to be made including whether the person was able to consent to living at Gorseway Care Community, mental capacity assessments had been undertaken and best interests decision making was recorded. Best interests decision involved people's loved ones and staff familiar to the person. Where required Deprivation of Liberty Safeguards applications had been made. Only one had been authorised at the time of the inspection and no conditions were attached to this authorisation. All records regarding people's capacity to make decisions and applications under the Deprivation of Liberty Safeguards were contained within their care plan folders, however we noted that the reasons for the applications had not been incorporated into care plans. Staff were aware of the reasons why applications had been made for people.

Most people spoke positively about the food and said they were given plenty of choice. They told us and we observed that if they didn't want what was on the menu they could have something different.

All food was freshly prepared and staff had guidance about how to ensure the consistency of food and drinks were correct to meet people's needs. Kitchen staff were provided with information regarding people's nutrition needs by the care or nursing staff. Kitchen staff had a good knowledge of people's needs and held information about their preferences and needs. They were able to explain how they catered for specific diets and how they ensured food was fortified. The chef was involved in serving meals which enabled people to express any preferences on the day to kitchen staff. Show plates were used to support people to make choices about what meal they wanted at the time of serving.

Monthly assessments of people's nutritional status were undertaken using the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. People had care plans in place regarding their nutritional needs and where weight loss was a concern we saw other professionals' involvement and specific dietary care plans were in place.

Health and social care professionals visited the service as and when required. Care records held feedback from GPs, speech and language therapists, social workers, dieticians and occupational therapists. Staff identified changes in people's needs and involved health and social care professionals appropriately. An external health professional told us about their involvement in the service. They said that staff knowledge of people was good and that trained nurses were keen to learn and develop their skills to meet people's needs.

Is the service caring?

Our findings

People and their relatives spoke highly of the staff. They told us they were kind, caring and compassionate. One person told us "I have been here a long time I have made many friends. The staff are all very kind. The chef always talks to us, and the girls from the reception." Another person said "It's very nice here. The staff are brilliant, they can't do enough for you." A relative told us "I find the informality is delightful. It has allayed my worries."

Observations reflected people were comfortable and relaxed in staff's company. They engaged positively throughout our visit, laughing and joking with staff. We found the atmosphere in the service was warm and friendly.

Staff were knowledgeable of people's life histories, preferences and needs. When able, staff spent time talking with people however; this was limited to times when they were providing direct care. Observations reflected that staff explained what they were doing when they supported people and gave them time to make choices and decisions. Staff spoke clearly and repeated things so people understood what was being said to them. One relative expressed concerns about the ability of some staff to understand and communicate with their loved one as English was not all staff's first language. However, the deputy manager told us how some staff had enrolled on English courses to support them to develop this skill.

People were offered choices and these were respected. Staff showed they had a caring attitude towards people and their relatives. We saw one member of staff offering kind and discreet support and reassurance to a person new to the home and their family. However at times interactions and responses to people were limited and delayed due to the workload. For example, during lunch time of the first day of our inspection we heard a person repeatedly call out for a nurse. It was six minutes before a staff member responded as they were providing support to other people at this time.

Staff demonstrated a good understanding of the need to respect people's dignity and privacy. Staff gave examples of how they ensured people's dignity and privacy. Staff knew people's preferences about who they were supported by. Staff knocked on people's doors and waited for a response before entering. Staff used people's preferred form of address, showing them kindness, patience and respect. When speaking to people staff got down to the same level as people and maintained eye contact. Staff understood confidentiality and the need to maintain this. They told us that details about people should not be discussed outside the home. We observed that all personal and confidential information was appropriately stored and only those people who were permitted to access it could.

Everyone spoken to said staff asked them how they wanted to be supported and ensured they had choice over this and were able to make decisions. The registered manager encouraged people and their relatives to share their views and feedback and to be kept up to date through regular resident and relative meetings. A schedule of meeting dates was in place although we saw no relatives attended the meeting planned for February 2017. Resident meetings involved heads of departments as well so that they could take responsibility and action for any issues that people may raise in relation to their area of support. Minutes

reflected that people were provided with updates around the kitchen, care staff, activities, maintenance and housekeeping. Their feedback about these areas was requested and opportunities to raise any others issues were available.

Is the service responsive?

Our findings

An external professional told us they felt the service had improved since the last inspection and was more responsive. They said specific training was arranged when they highlighted this as an area of concern and interim plans put in place until the training could be arranged. They also described how the manager worked with a person's family to ensure a specific piece of equipment was in place for the person. Although they did express concern that without their intervention this may not have happened for the person. One relative told us "my [relative] is happy here, [they] is well looked after, they are all very good."

At the inspection in January 2016 we found improvements had been made to care records but these improvements needed to be further embedded into the service to ensure consistency across all records. At this inspection care records were further improved and staff responded to people's changing needs. However there was scope for further improvement of the records and the registered manager was aware of this.

Each person had their needs assessed before they moved into Gorseway Care Community. The pre admission assessment looked to make sure the service was appropriate to meet the person's needs and expectations. Following the assessment comprehensive care plans were developed and agreed with people and/or their representatives. The registered manager told us if training needs were identified at the time of assessment, the date the person would move in would be delayed until such time as staff were trained. Staff knowledge of people's needs, their likes and dislikes was good. Relatives told us they felt staff understood their loved ones needs and provided support in a way which they not only needed, but also wanted.

Care plans were more personalised than previously seen. They included not only the person's abilities and needs but also their likes, preferences and dislikes. For example, one person's care plan described them as being "fiercely independent" and often declines and dislikes offers of help. It informed staff how offers of support could lead to the person becoming "very cross" and guided staff about how to offer support to the person.

Care records and assessments were reviewed on a monthly basis or more frequently if a person's needs changed. For example, we saw that one person had fallen on numerous occasions. Staff at Gorseway had involved other professionals including the GP and occupational therapist and had kept the care plan up to date. We noted that recently this person's mobility had further deteriorated. Their moving and handling risk assessment had been updated to reflect the support they now required however the associated care plan needed this information incorporating into it. All staff were aware of the change in need for this person and the most appropriate way to support them.

The registered manager told us how they had been working with staff to develop their understanding of the need to ensure daily monitoring charts were in place and completed effectively. This had improved since our last inspection although further work on embedding this and ensuring consistency was required. Most relatives were confident that should staff need to respond to a changing health need that they would do this. However, two relatives were concerned that communication with their loved ones was not as good

as it could be due to concerns with their hearing aids. One relative told us their loved one's hearing aid had not been working for three months. Staff had requested an appointment for this to be repaired and the deputy manager told us they had been chasing this appointment. A second relative told us their loved one was not consistently supported to ensure their hearing aid was in place. The registered manager told us how this concern had been raised with all staff but that they would discuss this with staff again. They also told us how they had allocated one staff member to be responsible for ensuring the batteries were changed weekly and the aid was cleaned. This had been signed as being done the week of our inspection.

There was a complaints procedure in place. People and their relatives knew how to raise a complaint. Records showed when concerns had been raised the registered manager had taken appropriate action to investigate the concerns and learn from these.

Is the service well-led?

Our findings

The management of this service had not been stable over a number of years. In four years there had been seven different managers. A registered manager had been appointed and had been in place for about 10 months at the time of our inspection. The deputy manager had been in post for just over a year at the time of this inspection.

The regional manager told us how the provider had recognised a need to review the regional structure to ensure services received the support they needed at the time they needed them. As such a change to the region had been made. Gorseway was now supported by a regional team consisting of a regional manager, quality role, clinical development nurse and regional trainer. The regional manager told us this change had enabled them to provide focused support where this was needed. The clinical development nurse told us how they had spent at least one day a week in Gorseway providing support to the team when the restructure took place but promptly realised that weekly support visits were no longer required because staff were working proactively and consistently.

There was a staffing structure in the home that had become embedded into practice with registered nurses being supported to take more of a leadership role. The registered manager, deputy manager and nursing staff had completed a leadership programme run by the provider. Team leaders led the care staff and allocation of the shift. Staff understood their roles and responsibilities and the provider supported staff to develop their knowledge and skills for the benefit of people who used the service.

At our last inspection we found a repeated breach of Regulation 17 of the Health and Social Care Act 2008 because people's records were not always clear, accurate and contemporaneous. In addition the quality systems were not always effective in identifying concerns and driving improvement. Due to the knowledge of staff the risk this posed was assessed as low however this needed to be improved to meet the regulation. We issued a requirement notice and asked the provider to send us an action plan telling us how they would rectify this, which we received.

At this inspection we found improvements to the records had been made and this was no longer a breach. Care records contained all necessary information needed to support people, however, one person's moving and handling assessment and mobility care plan conflicted slightly and the language used in two risk assessments for a further person required review. The daily records had improved but would benefit from more detail. For example, charts used to monitor behaviours often did not detail the actual intervention and support that was provided or any information that might help staff to understand why the behaviour was occurring. The registered manager told us how they continued to work with staff to ensure these records were of a good standard. They described this as needing to be embedded. We recommend the registered person review the use of records to ensure they can be used in the effective evaluation of care delivery and are not conflicting.

The provider undertook a variety of audits of the service to check and ensure the quality provided. These included health and safety audits, and the provider's regulation team audits. The last regulation audit was

carried out in January 2017 and the report made recommendations and actions. Some of these had been completed at the time of our inspection while others were still being worked on by the management team. For example, reinforcing the importance of accurate and completed daily recording of care.

All incidents and accident records were analysed and inputted into the provider system for collating clinical governance information. The registered manager reviewed each record and where required documented any further action that was required. The information was reviewed by the region's clinical development nurse. They also analysed the information and where necessary produced a report with actions for the registered manager and staff to take forward. The clinical development manager told us the registered manager and deputy had usually undertaken all necessary actions before they had the opportunity to suggest them.

In addition to the provider quality audits the registered manager had a system in place to audit all care records and medicines management on a monthly basis. Following these audits action plans were produced, the actions were allocated to the appropriate member of staff for completion and these were then marked as completed. Random unannounced visits to the home by the management team took place at a variety of times, including at night and early hours of the morning. We saw the last visit involved discussion with staff about concerns that had been raised.

The registered manager was consistently described in a positive manner by staff, people and relatives. They were described as open, transparent and easy to approach. Everyone said they wouldn't hesitate to talk to the registered manager about any concerns they may have. They were confident if they raised concerns or made suggestions these would be acted upon, although one relative told us they found it frustrating that they felt they needed to raise issues of concerns regularly because improvements by staff were not always sustained. Staff said the registered manager listened to them and to people using the service. One member of staff said "I feel like we are now appreciated". A healthcare professional told us the registered manager was always friendly and welcoming. Their door was always open and they appeared to have a good understanding of any current issues in the home. One person's relatives told us there had been improvements since the registered manager and deputy manager had started. They said they were "100%" confident in their ability to take action if things needed to improve and to communication in an open and transparent manner.

Staff felt able to make suggestions and ideas for improvement. The registered manager told us how a new member of staff and a team leader had made suggestions about how they felt the shift could be run better. They had plans to meet with these staff to discuss their ideas further. We noted from the minutes of staff meetings that these were used as opportunities to promote good care. The registered manager facilitated daily meetings with all heads of departments followed by clinical meetings with the registered nurses on duty. These enabled all senior staff to understand the needs of the day, summarise any issues from the previous day and take any further action as required to ensure people's needs were met.