Windsor Care Limited

The Manor Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 11 and 12 March 2015 and was unannounced.

The service provides personal and nursing care to up to 60 older people who live with dementia, mental frailty and or physical disability. Accommodation is provided over three floors each with its own lounge and dining rooms.

The service was required to have a registered manager and one was in place. 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.

People, relatives and external health care professionals told us the service provided good care to the people it supported. They said the manager and staff were approachable and listened to their views. Relatives felt

Summary of findings

they were kept appropriately informed of changes in people's wellbeing. People and relatives told us that various aspects of care, the meals and staffing had improved more recently.

Staff received appropriate induction and training and were supported through supervision meetings and appraisals. Staffing levels were sufficient to meet people's needs and the registered manager could and had varied these where the need arose.

People's changing needs were responded to promptly by staff and the advice of external health care professionals was sought when required. Staff requested people's consent before providing care. The service provided a range of activities and outings to meet people's social and emotional needs and any spiritual or cultural needs were provided for.

People were mostly treated with respect and dignity but we saw a small number of examples of inappropriate language being used by staff verbally and in care notes.

People were given their medicines safely by trained staff. Some improvements were needed to the documentation where people received their medicines covertly to ensure that the agreement of the prescribing GP was clearly recorded. The details of the involvement of others in the decision also needed to be more clearly recorded in some cases.

We have made a recommendation about the recording of consent and 'best interests' discussions regarding covert administration of medicines.

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?

Good

The service was safe. Staff understood how to keep people safe and how to report any concerns.

People's needs for assistance with their mobility had been assessed and staff were trained and knew how to support this.

Staffing levels were sufficient and the registered manager could change the numbers of staff when necessary if there were changes in people's needs.

People's medicines were administered safely by trained staff.

Is the service effective?

Requires Improvement

The service was effective although some of the recording around consent for covert administration of medicines required improvement.

Staff received appropriate induction and training to enable them to meet people's needs. Staff received support through supervisions, appraisals and team meetings.

People's rights and wishes about their care were respected and their consent sought before care was provided.

People's dietary and health needs were met. The environment had been adapted to support them.

Is the service caring?

Good

The service was caring and people and their relatives felt appropriately involved in decision-making.

Most of the interactions between staff and people were respectful and supported their dignity although a small number of instances and written records did not reflect this.

People's cultural and spiritual needs were provided for.

Is the service responsive?

Good

The service was responsive. People felt able to raise any concerns they had with the management team. Changes had been made in response to people's suggestions.

The service sought appropriate information about people's background and interests as well as their physical and health needs. Staff identified changes in people's needs in a timely way and sought appropriate support from external health care providers.

A range of suitable activities and outings were provided to meet people's social and emotional needs.

Summary of findings

Is the service well-led?

Good

The service was well led and people were happy with the actions taken when they had raised an issue. Staff also felt the service was well led by the management team who they found approachable.

The registered manager and the registered provider monitored the operation of the service and actions were planned to make ongoing improvements.

The advice of external specialists was sought to enhance the quality of service provided.

The Manor Care Home

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 11 and 12 March 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

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. We looked at the information provided in the PIR and used this to help us plan the inspection. We contacted two health professionals and two local authority care commissioners to seek their views about the service.

During the inspection we spoke with six people using the service, four relatives, eight staff, the registered manager and deputy manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care plans and associated records for six people, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and were treated well by staff. Two relatives said they were: "Very pleased overall" but added that sometimes the staff could be under pressure. Relatives said that there had been some staff shortages but this had improved recently and they had: "Built up the numbers". One relative told us there had been more staff: "Since Christmas, especially on the first floor". People and relatives felt staffing was now more regular with less use of agency staff. One person said they felt safe in the service because there was always a member of staff in the lounge.

The manager maintained a computerised record of any safeguarding or whistle-blowing issues. This included details of the action taken and outcome. As part of safeguarding people the manager had taken appropriate disciplinary action, following spot check visits, to address issues of staff performance.

Staff knew about different types of abuse and were aware of how to report any concerns. They had received training on safeguarding and whistle-blowing and were aware of the action they should take if they thought anyone was at risk of harm. Staff had also received training on moving and handling. We saw they applied safe practices when assisting people to transfer either manually or using hoist equipment. One person who required assistance with a hoist when moving from their bed to a chair, said: "Oh yes, their safety procedures are bang on".

Risk assessments were carried out where a potential risk was identified, such as a risk of falls. The staffing levels required to safely support or transfer people were also identified. Raised bed sides, low-level beds and 'crash mats' were sometimes used to reduce the risk of people falling from bed or the risk of injury from doing so. We noted that risk assessments had been completed where they were used. The service recorded and monitored accidents and incidents and notified these to us and the local authority where they were required to do so.

The registered manager had the authority to decide the necessary staffing levels and deployment based on dependency assessments. Where necessary she was able to address identified needs quickly. Vacancy levels were low at the time of this inspection and had been reduced significantly over the previous three months, following a previous period of high staff turnover. The registered manager said she was increasing the day staffing on the ground floor with an additional care staff from 8am until 2pm in response to changes in dependency levels.

There were 20 people on the ground floor supported by one nurse and four care staff throughout the day. Staff told us there was usually an additional care staff member on duty, but one had called in sick that day and another staff member had been contacted and was coming in to cover the remainder of the shift. Staff felt there were usually enough staff on duty. One commented: "Sometimes an extra one, if we are facing challenges, would help". Another staff member described staffing levels as: "Very good" and added: "They [management] will bring in extra if needed".

Some agency staff were used to cover vacancies and sickness but this was reducing. In the week prior to the inspection nineteen shifts were covered by either agency nurses or care staff. The registered manager explained that wherever possible she used known agency staff who had previously worked in the service to minimise disruption and maintain continuity. Staff, people and relatives also told us this was the case.

Some employment records did not follow the requirements of regulations or best practice. We saw that five people's application forms contained gaps in their employment history without an adequate explanation recorded. At the time of our inspection visit the manager had commenced action to ensure all staff files contained the required information.

Nursing staff were trained to administer medicines and had their competency assessed. People received their medicines on time and medicines were reviewed with the GP to ensure they remained appropriate. Medicines were stored safely in locked medicines trolleys on each floor.

The MAR sheets noted where anyone had refused medicines and the action taken. One person's records showed they had been refusing their medicines. Discussions had taken place with the person's relatives, their Community Psychiatric Nurse (CPN), their GP and the hospital consultant to agree the appropriate action in their best interests. The pharmacist had provided written guidance regarding the appropriate and safe methods of concealment for each person's medicines where covert administration had been agreed.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the service met people's needs effectively. Two relatives told us the staff managed a person's medical condition well and encouraged them to take part in activities in the service. One said that staff were: "very good and knew how to communicate with her, and she responds to them". One person told us the staff sought their consent before supporting them with personal care and said: "I think that has improved". Another person told us the staff listened to them if they didn't want to do something and respected their decision.

Relatives felt staff were good at meeting people's food, drinks and activities needs. One relative said: "Fluids are offered regularly and they encourage [the person] too, and she eats well". Another relative told us support with meals was better now that more permanent staff were in post. One person told us: "staff look after me well, they are kind always and the food is excellent". Another person said; "The food is good, I think it has improved", a sentiment with which others agreed. One person told us: "I am becoming less able so I need more support for meals, which I'm getting".

People were offered a choice of meals by staff in advance. This was done verbally or using photos of meals. The registered manager said and staff confirmed, that additional meals were always cooked to allow for any changes of mind to be accommodated. The registered manager told us new menu boards were on order from a specialist company including magnetic pictures of meals. The menu for the week was posted on the notice board and included the daily options. However the print size would have made it hard for some people to read it.

People were risk-assessed for dehydration or malnutrition on admission and this was periodically reviewed. People's care plans included details of any individual requirements with regard to diet, such as thickened fluids and soft or liquidised meals. Staff offered, encouraged and supported people to take fluids regularly. Hot and cold drinks were available throughout the day. Staff were aware when people were nutritionally at risk and required supplements or thickeners in drinks. They kept records of food and fluids where people's intake was being monitored**.** These were overseen by the nurses to ensure that action was taken if they indicated concerns.

New staff received at least a two week induction which included core training and shadowing more experienced staff. The period of shadowing was extended where necessary. An induction booklet was signed off by a member of the management team as each part was completed. Training was provided by external specialists and certificates were on file. Competency was assessed in key areas such as medicines management and moving and handling. Staff confirmed they had received a thorough induction and had not been asked to do anything they didn't feel confident to do. One staff member said they had: "Really good support" and commented on there being good teamwork. Another said: "The senior carers are very very good".

Staff confirmed they had attended training which provided them with the knowledge and skills to meet people's needs. They told us training had included practical elements like using hoists. However, not all staff were fully conversant with the home's computerised care planning and records system and additional training was due to be provided. Health practitioners told us nursing staff had been trained on end-of-life care. One described staff as: "Keen and engaged to take this training and clinical skill on board and to be able to deliver the best possible care for their resident". Another had seen: "An improvement in the levels of staff training and understanding of resident's needs". The registered manager was described as: "Positively keen to engage her staff in training and best possible patient care".

Staff were supported through quarterly individual supervision meetings, annual appraisals and quarterly team meetings. However we found this had fallen behind due to a senior staff shortfall that was resolved in December 2014 when a deputy manager was employed. The management team were working to bring supervisions and appraisals for all staff up to date and senior staff had received supervision training.

Handover meetings took place between shifts involving nurses and care staff. However, written records of those meetings were not being made which could mean that key information was not passed on between shifts. During our inspection the registered manager reinstated a previous written handover record and stated the format would be monitored to see whether it needed further development.

Where there was doubt about people's capacity to make decisions about or consent to their care, a capacity

Is the service effective?

assessment had been carried out under the Mental Capacity Act 2015 (MCA). This Act protects the rights of people unable to make decisions about their welfare and defines how their capacity must be assessed. Where people had capacity in some areas or variable capacity this was also noted to ensure they were as involved as possible in decisions about their care. Where people had 'Advance Decisions' defining their wishes or had others with 'power of attorney' (POA) for decision-making on their behalf, this was noted on their files and respected. Advance decisions are a legally binding record of people's wishes about their care, made by them when they had the capacity to state their wishes.

Most people had "Do Not Attempt Cardio-Pulmonary Resuscitation" (DNACPR) forms in place confirming they were not to be resuscitated in the event of heart failure. In most but not all cases, these forms included details of consultation having taken place with the person or their representative. DNACPR forms are signed by the lead clinician responsible for a person's care which in care homes is normally the GP. Some people's forms had been signed by the registered manager or other senior nursing staff in the service and were then countersigned by the GP. During the inspection process the registered manager sought appropriate guidance on this and told us she has referred all DNACPR forms to the GP to be the lead signatory.

Where people would be unable to leave the home safely without supervision a service must apply to the local authority for a 'Deprivation of Liberty Safeguards' (DoLS) authorisation. DoLS authorisations are provided under the MCA to safeguard people from being illegally restrained or prevented from going out. The registered manager confirmed that this applied to all of the people currently in the service. DoLS applications had already been made for the majority of people. We discussed the needs of the remaining people and the registered manager planned to make the remaining referrals to ensure that anyone whose liberty was restricted or potentially restricted in terms of going out unaided, had DoLS approval in place.

We saw and people told us they were asked for their consent when personal care or support was provided. The care files contained 'Consent to care and treatment' forms signed by the person or their representative together with a confidentiality statement identifying with whom the service could discuss the person's needs. Staff described how they sought people's consent and responded when people were initially reluctant. One staff member explained: "I always ask first. I tell them what is being done. If they say no I encourage them or try again later. If they still say no then I document it" Another staff member described a similar process and added that they reported care refusals to senior staff.

People told us they were able to see the doctor and other health professionals when they needed to. People had also been supported to attend hospital appointments. The service sought the advice and support of external health specialists appropriately where necessary, including tissue viability nurses, CPN's and the 'Speech and Language Therapy (SALT) team'. Guidelines from the SALT team were incorporated in the care plans where relevant. One person who had begun to refuse food and drink, had been referred to the GP and the SALT team for investigation of any medical causes, then for CPN support.

The registered manager said that covert administration of medicines, (the concealment of medicines in food or drinks), had been agreed for eight people although it was not always necessary to do this in each case. Covert administration may be appropriate where a person lacks capacity and refuses to take medicines considered to be in their best interests. In order to ensure covert administration is only carried out with proper authorisation it is necessary to clearly record the decision of the prescribing GP or CPN. It is also necessary to demonstrate that appropriate discussion has taken place with the person's representative(s) to agree that it was in the person's 'best interests'. The registered manager said this was only done subject to a 'best interests' discussion with the person's representative and consent from the GP or CPN.

The care records contained various references to 'best interests' discussion regarding covert administration. Some people's records noted that the GP/CPN had agreed this approach. However, others noted only that this had been discussed with them. Care plans noted that discussions had taken place with people's representatives but did not state clearly in all cases, whether they had agreed covert administration was in the person's best interests.

We recommend that the service consider current guidance on covert medicines administration to people and take action to update their recording practice accordingly.

Good

Is the service caring?

Our findings

People and relatives told us staff were caring and respected their privacy. One person said: "They knock on the door, they respect my privacy", but added that: "Manners aren't spread equally amongst staff". A relative said: "She is happy here, the staff are always good with her" and added: "Staff look after her dignity". One relative told us they had noticed an improvement in the general standard of care over the recent months and said there was a: "Noticeable difference now".

Staff were described as: "Marvellous, kind and caring" and one person said: "Oh yes, the staff are very nice". Another person said they were: "treated very well" and added: "They [the staff] have all been very kind, they are OK with everybody, they have been wonderful". When providing support with personal care, staff were described by one person as: "Gentle".

One relative of a person living with dementia told us they were involved, where appropriate, in decisions about the person's wellbeing. One person told us about the social activities available in the service. They said: "I get told about them but I don't have to go".

Staff had developed positive and caring relationships with people and involved them in decisions about their care. Staff were seen supporting a person living with dementia to find the toilet. The care assistant was gentle, encouraging and supportive. Another care assistant reassured a person who was anxious and looking for a relative.

Staff told us people were asked about what time they wished to get up and whether they wanted to be woken. One of the staff said: "There is no set schedule of getting people up". We saw that some people got up at various times through the morning. Another staff member said: "This is their home, they have the capacity to let us know what they want". One external health provider told us: "The staff are always polite and I have no concerns about the interactions that I see between them and the residents". They added that they would be happy for a relative of theirs to be cared for in the service.

The approach of staff towards people's dignity was varied. During our observations we saw one care assistant was quick to notice and adjust the skirt of a person who was asleep to maintain her dignity. Others spoke as quietly as possible to people when checking whether they wished to use the toilet. We saw that people were dressed appropriately and wore jewellery and make up if this was their wish. People's hair and nails were well cared for. People were encouraged to have their hair done and praised for how they looked.

However, we saw some examples where people's dignity was not respected. Staff went to put a clothing protector on one person without consulting them. After they had declined this, another staff member tried to do the same, causing them to become agitated. Another staff member was heard using inappropriate language in discussion with a colleague outside the dining room within earshot of people.

Within care records we also found some examples of inappropriate terminology used to describe people's behaviour, although most records were professional in tone. Records were kept securely within a combination of paper and computer-based files. Staff communicated about changes in people's needs or wellbeing and important information was passed on to other team members.

We saw examples of positive interaction by staff who chatted to and reassured people while supporting them with transferring from chair to wheelchair. We saw staff having little conversations with people in passing, to make sure they felt involved and cared for. Staff also used humour appropriately at times when engaging with people to encourage their involvement. People were encouraged to do what they were able to for themselves to maintain their abilities and enhance their dignity.

The service has a small number of double bedrooms but these were only used where two people specifically wished to share. All of the other bedrooms were single rooms and were provided with en-suite facilities to address people's dignity.

The service also provided for people's cultural or medical needs with regard to diet. In one example an alternative type of sausages had been sourced to address one person's cultural needs. Culturally diverse foods had also been provided on request. One person was provided with a gluten-free diet in response to their health needs.

Good

Is the service responsive?

Our findings

People told us they felt able to approach the management team with any concerns or complaints they may have. One person aid: "If I wanted to bring something up I was unhappy with, I wouldn't hesitate to do so". Another said: "I have nothing to complain about". When we asked how staff met their needs one person told us: "They are very good, some better than others, but we are generally on the same page". People told us about the activities available in the service. One person said: "The activities person is very good. She knows what she is doing and encourages everybody". Relatives were positive about how the staff responded to changing health needs.

People's needs were assessed prior to admission and detailed individual care plans were available within the paper and computer based records. Assessments included judgements about dependency levels and the level of care support required. Background information was sought from family where the person was unable to provide it. We saw care plans were regularly reviewed by the nurses who periodically consulted the person or their representatives. People and relatives confirmed these took place and that they had been involved.

People's skin integrity was assessed and equipment to reduce the risk or treat pressure sores was used based on an action plan. The service managed and treated pressure sores effectively. However, the treatment records were split between paper and computerised records and were not always easy to follow. The manager told us this would be reviewed to enable treatment progress to be followed more easily. A relative told us the home had successfully managed a person's pressure area by regularly turning them so this was no longer an issue. Support from external health professionals was sought in a timely way in response to changes in health needs.

Where necessary people were provided with one-to-one support during the day by staff. This was the case for two people at the time of this inspection. Staff recorded any identified triggers which had led to people needing support with behaviour issues, to enable staff to be alert to these. Where people had mental health needs the service liaised with the CPN or psychiatrist and acted in accordance with any guidance they provided to support people with their behaviour.

The staff were aware of people's needs and provided appropriate support. During lunch one staff member showed good awareness by withdrawing when their presence appeared to be increasing the agitation of a person living with dementia. A relative told us one person living with dementia had been moved to another floor where the environment was quieter, to better meet their needs. The relative had been consulted and agreed the move. Relatives told us they were kept appropriately informed of changes in people's wellbeing. During the daytime one person preferred to remain in their room by choice and was reluctant to allow staff into the room to clean. Instead, the night cleaner had been asked to clean the bedroom during the night when the person tended to spend time with staff outside the room.

Staff responded to people's needs in a timely way. The call-bells were heard to be answered quickly during the inspection and people told us this was usually the case. During our observations we saw that staff helped to ensure that people were comfortable and offered fluids regularly. One person said they were cold and one of the care staff immediately provided a blanket and checked she was ok. One person had not taken a drink from their tea and a staff member saw this and offered to help them, which was accepted. One visiting health professional told us: "The nursing staff know the residents well and promptly identify when something is wrong". Another health professional described the service as: "Responsive and flexible".

A wide range of social activities were provided, led by the activities coordinator. The scheduled activities for the month were shown on a calendar prominently displayed on a notice board. In addition to in-house activities, a series of twice-weekly outings were also planned to places of interest, local garden centres and local pubs for lunch. The service had its own wheelchair accessible minibus to provide transport for these outings. Seasonal and cultural festivals and events were also marked with focused activities. A monthly church service was provided and two people attended external places of worship. A Church of England representative also visited the home weekly. Flower arranging and a quiz took place on the first day of the inspection. People from all floors were encouraged to attend.

Activities took place on each floor. People living with dementia were encouraged to take part if they wished to or were supported to spend time as they preferred. People

Good

Is the service responsive?

living with dementia were able to access other parts of the home and a relative told us: “We go to the ground floor for a change of scenery and for a walk outside”. People and relatives confirmed they could access the garden when the weather was suitable.

We observed the lunchtime service in two of the dining rooms. There were sufficient numbers of staff available yet people on the second floor waited longer than they should have to be served. The reason for the delay was unclear and staff did not explain this or apologise. People were given the meal they had chosen and were offered additional vegetables. Where people required support this was provided by staff who sat with the person they were assisting to concentrate on their needs. Once or twice staff did get up and briefly assist or encourage others with their meal, then return to assist the person they had been sat with. Staff did not hurry people and engaged them in conversation to make the experience a social one.

The provider had a complaints procedure, details of which were included in the service user handbook. However the procedure was not displayed in the service and complaints forms were not readily available without request. The registered manager agreed to arrange for the procedure to be displayed and a frame for this purpose was ordered during the inspection. The registered manager responded appropriately to a concern we passed on from a relative during the inspection. The registered manager had met with families in the past to resolve concerns and explained how they had responded to concerns where family dynamics had been a factor. The service had responded appropriately to these and other issues raised with them. The complaints log showed how issues and complaints had been responded to.

Relatives confirmed they had completed surveys and that residents/relatives meetings had taken place. Relatives/residents meetings took place most recently in August 2014 and January 2015. They were attended by the registered manager and registered provider(s) as well as people, their relatives and other key staff. The minutes showed a diverse range of subjects had been covered including changes in relevant legislation. People had raised concerns which had been answered and were invited to meet with the registered manager if they wished to take any issue further.

The latest survey of people and relatives views had been issued a month before this inspection. Some responses had been received but the manager was waiting for a larger sample before reporting back on them. Analysis of the early responses suggested there remained room for improvement in various areas, including the laundry service, activities, meeting individual needs and staff attentiveness. The service had made improvements in response to feedback received previously. A template for obtaining preadmission information had been developed for relatives to provide useful background information to help the staff to get to know people.

Good

Is the service well-led?

Our findings

People and relatives felt the service was well run. Relatives gave examples of how people's changing care or health needs had been well managed, as evidence of this. People said the manager was approachable if they had anything they wished to discuss. People and relatives had previously been concerned about staffing levels and the level of agency staff used. They were pleased with the action taken to address these issues which were now less of a concern. One relative said of the improvements over the last six months, there was a: "Noticeable difference now".

Staff were complimentary about the management team. Staff meetings were held and staff felt they were able to contribute. One staff member described the management team as: "Very supportive". Another told us: "Yes, we are able to bring things up, always". Staff said the managers were always checking with them asking if they had any problems.

The most recent full staff meeting had been held over two sessions in June 2014. The minutes stated that the target was that such meetings would be six monthly. A new care staff meeting took place in February chaired by the new deputy manager/clinical lead. These were scheduled as a monthly meeting going forward. The minutes showed that a varied agenda had been discussed and actions agreed.

The manager had a particular interest in promoting good quality end of life care and in ensuring that people's rights were protected whether or not they retained decision-making capacity. The service liaised with the Thames Hospice regarding end-of-life care issues and had received some training and guidance from them and the Macmillan Cancer Support service. They consulted regularly with GP's and other health practitioners where required and followed the guidance provided, for example, dietary advice provided by the SALT team.

The registered manager and senior staff had also attended forums provided by the local authority on wound/skin care, falls and end-of-life care in order to maintain current knowledge of best practice. The local patient transport service had also been used to increase transport availability to people in the home to access the community. Local authority training courses have been attended by staff, for example on safeguarding vulnerable adults and DoLS.

The registered manager explained that reflective practice discussions had taken place in the team around such issues as managing challenging behaviour. Nurses were supported to maintain their continuous professional development.

The registered manager made sure that where events required notification to either the Care Quality Commission or the local authority, this took place. Additional information or updates were provided when necessary.

The registered manager explained that she monitored care practice regularly by means of direct observations and out of hours visits, although the findings of these were not generally recorded. She also sometimes supported care directly and observed some mealtimes. The providers attended residents/relatives meetings and meetings of heads of department to maintain awareness of the day-to-day operation of the service. We saw minutes of 'heads of department' meetings in October 2014 and January 2015 which the registered provider had also attended. The agenda included managerial issues and plans for the future development of the home.

The registered manager effectively monitored various aspects of the service's operation such as falls, accidents and incidents and completed audits of care records. The registered manager had in the past maintained a collective record of reviews and other key documents and told us she would reinstate this as it provided an effective overview to monitor that people's reviews were completed when necessary.

The registered manager had identified a significant number of medicines errors in the previous 12 months. Her audit showed these related mostly to failures to initial the 'Medicines Administration Record' (MAR) sheet to confirm administration, rather than failures to administer. In most cases the nurse had marked the MAR sheet with a dot to indicate the medicine had been taken to the person but had not followed this up with initials to confirm administration.

Following her medicines audit the registered manager took action to remedy the issue. Refresher medicines training and re-assessment of competency for some nurses was carried out. The registered manager also wrote to nurses reminding them of the need to maintain the proper

Good

Is the service well-led?

records. MAR sheets were now checked every evening by the nurses and any issues addressed. Monthly MAR sheet audits were being completed which showed a reduction in errors.

A new service audit process had been developed and the first audit was carried out in October 2014. The report identified where action needed to be taken to address shortfalls, for example on staff supervision. Action had been taken to address this. The audit was due to be carried out again after six months. The registered manager said that her main priorities had been to focus on reaching full legal compliance and stabilising the staff team through ongoing recruitment to minimise the use of agency staff to improve continuity of care.