Care Quality Commission

Bupa Care Homes (ANS) Limited

Maypole Nursing Centre

Inspection report

Lower Northam Road, Hedge End, Southampton
Hampshire SO30 4FS
Tel: 01489782698
Website: www.bupa.co.uk/care-services/care-homes/maypole-nursing-centre-southampton

Date of inspection visit: 18,19 and 24 February 2015
Date of publication: 07/04/2015

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 18, 19 and 24 February 2015 and was unannounced.

The last inspection of this service was in June 2014 when we judged the service to be in breach with five regulations. The provider sent us their action plan showing how they would meet the regulations. Our visit in February 2015 showed they had implemented improvements in all the areas concerned and there were no breaches of regulations.

The service provides accommodation with personal or nursing care for up to 68 people. People living at this service included younger adults, older people and people with physical disabilities. When we visited there were 49 people living at the home. The new manager had been appointed in November 2014 and they were applying to be the registered manager of the service. 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.

The home is located near the village of Hedge End, near Southampton and is a two-storey building. Each floor has

Summary of findings

a dining room and a lounge and the ground floor lounge opens onto an enclosed, central courtyard. There is a passenger lift and stairs to the first floor. People's rooms have en-suite facilities.

Overall, we rated the home as good and a range of improvements had been implemented since our last inspection. We have made a recommendation that further staff development is required, as staff training and supervision had lapsed in some cases. This had been identified by the management team and plans were in place to renew focus on staff development.

People living at the home and their relatives said staff were attentive and caring, and if they had any concerns they were addressed promptly. People told us they felt safe, the food was good and the organisation of the home had improved under the new manager.

Appropriate risk assessments were completed and action was taken to minimise avoidable harm. This included in relation to people's individual health and wellbeing as well as with regards to the management of the home and premises. People's care was personalised to meet their specific needs, taking account of their medical history, interests and preferences. Safe systems were in place for managing medicines and staffing levels had been increased to support people's care safely and effectively. Staff recruitment was safe.

People's health needs were looked after, and medical advice and treatment was sought promptly when necessary. The home involved health and social care professionals and followed their advice and guidance. This included making decisions on behalf of people when they lacked the mental capacity to make decisions for themselves about important matters. Staff supported people to make decisions and to have as much control over their lives as possible. Staff understood the key requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Staff provided personalised care and the environment was homely and cheerful. People living at the home, their visitors and visiting health care professionals were all complimentary about the quality of care and the management of the home. Staff said the morale was good and they worked well as a team.

Governance systems were in place to identify areas for improvement. There were checks at different levels of management to monitor the quality of care to promote continuing improvement in care delivery.

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 safe.

Staff protected people from avoidable harm and understood the importance of keeping people safe. Risks were managed safely and incidents were reported and investigated.

There were sufficient staff with the right skills and experience to care for people.

People's medicines were managed safely.

Good

Is the service effective?
The service requires improvement to be effective.

Staff training and supervision had lapsed in some cases, and staff required further specialist training.

People were helped to maintain their health and wellbeing and they saw doctors and other health professionals when necessary.

People were supported to have enough to eat and drink.

Staff understood the Mental Capacity Act (2005) and the home met the requirements of the Deprivation of Liberty Safeguards.

Requires Improvement

Is the service caring?
The service was caring.

Staff related well with people and were kind, friendly and supportive.

Relatives said staff were caring and respectful. Care was delivered mindful of people's privacy and dignity.

People were involved in making decisions about their care and staff helped promote their independence.

Good

Is the service responsive?
The service was responsive.

People's individual needs and preferences were assessed and care was provided in line with their specific care plans.

Staff understood people's preferences and needs, particularly in relation to their health. Activities were arranged to reflect people's interests.

Concerns, complaints and queries were taken seriously and any issues addressed.

Good

Summary of findings

Is the service well-led?

Good

The service was well led.

Staff valued the new leadership within the home, and welcomed the changes introduced by the new manager.

Areas for improvement had been prioritised and most had been addressed. The manager understood what was required to develop the home.

Morale had improved among the staff. Staff said they felt supported, listened to and encouraged to gain additional skills.

Systems were in place to monitor the quality of the service and implement improvements.

Maypole Nursing Centre

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 18, 19 and 24 February 2015 and was unannounced.

The inspection team was made up of an inspector, a pharmacy inspector, a shadowing pharmacist, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a trained and practicing nurse.

Before the inspection we reviewed all the information we held about the service, including past inspection reports, action plans, notifications about incidents and communications with the manager and provider. We used this information to plan the inspection. During our visits to the service we talked with 11 people using their service or their visitors and relatives. We interviewed the manager and 15 members of staff, including nursing, care, domestic, catering and maintenance staff. We reviewed the care records of 11 people using the service. This included checking their care plans, medicines administration records and any other documents relating to their care. We also observed care delivery at different times of the day and carried out a Short Observational Tool for Inspectors (SOFI) during a lunch time. SOFI is a way of observing care to help us understand the experience of people who may not be able to talk with us. To inform the inspection, we also spoke with four health and social care professionals who visited the home regularly.

The last inspection of this service was in June 2014 and we judged the service was in breach of five regulations. These related to: care and welfare of people using the service, cleanliness and infection control, management of medicines, assessing and monitoring the quality of service provision and records.

Good

Is the service safe?

Our findings

There had been a focus on improving the safety of care at Maypole Nursing Centre since our last inspection.

People said they felt safe and the environment was maintained to a safe standard. One visitor said they had no concerns about the safety of the home and they were aware that risks to people's health and wellbeing were monitored and managed. One person using the service commented that they always received their medicines at the right time, even though they were quite complicated. There were mixed views on the numbers of available staff, with some people saying they waited too long when they called for assistance, but others said there were enough staff and they were "fairly prompt" at responding to call bells. Our observations of care showed staff anticipated what events could cause people anxiety or upset and took steps to remove any triggers.

The staff took action to minimise the risks of avoidable harm. Staff understood the importance of keeping people safe, including from abuse and harassment, and could describe what was meant by abuse. There were posters on display to remind staff or visitors how to report suspicions of abuse and staff told us they would be prepared to raise concerns if they had any. Staff had received induction training in recognising and reporting abuse and regular update training was arranged. Some staff were overdue refresher training on this topic but this had been recognised and was being addressed. There were local policies and protocols on reporting abuse based on the local authority's policy. Health and social care professionals confirmed that any suspicions or allegations of abuse were handled professionally, to ensure people's safety.

Risk managements procedures were in place to minimise people experiencing harm. Risks were considered effectively to balance people's freedom so they were cared for with the minimum of restrictions. Risk assessments were in place for people using the service and its facilities, and hazards associated with the premises or environment were safely assessed and managed. Staff reported accidents or incidents and reports were reviewed by the manager so that changes could be made to people's care, if appropriate, to keep them safe. The service had introduced robust systems to support people at risk of developing pressure ulcers. Similarly, if people were assessed at risk of falling or losing weight, there were clear strategies for managing these risks to minimise people experiencing harm. Trend analysis had shown these strategies were reducing the rate of incidents.

The provider had taken steps to prepare for emergencies, both those associated with the running of the home and those relating to the health and wellbeing of people. There was emergency plan, covering evacuation procedures and staff were trained in fire safety. The fire risk assessment was up to date, fire alarms were tested each week there had been fire drills. There was signage to show fire exits and an emergency bag was located near the front door. This contained up-to-date information sheets, as well as items that could be needed in an emergency such as a torch.

The home and equipment was maintained to a safe standard for people and for staff. The maintenance staff carried out day-to-day repairs and staff said these were attended to promptly. Utilities, such as water, gas and electricity, were monitored and maintained under contract and water temperatures were monitored to ensure water was stored and circulated at safe temperature levels. Equipment, such as lifts, hoists were also maintained appropriately. The kitchen had recently been inspected and given the highest food hygiene rating.

There were safe staffing levels. Staffing levels had been increased recently, as a result of an analysis of the care needs of people living at the home. Staff said this increase had been required and that there were now enough staff on duty. Arrangements were in place to ensure staffing levels were maintained for each shift, and when necessary, bank or agency staff were used to cover staff shortages. Staff said they were encouraged to work flexibly over the two floors and they reported that team working had improved with increased support and staffing levels. Visiting health and social care professionals said that people were supported by skilled, professional staff who gave a high standard of care.

Robust recruitment procedures meant applicants for jobs at the Maypole Nursing Centre were checked for their suitability, skills and experience. Suitability checks included checks for criminal histories and following up references and carrying out interviews. Applicants were required to submit an application form outlining their experience and career history. The registration of nursing staff was checked annually with the body responsible for the regulation of

Good

Is the service safe?

health care professionals, to ensure their registration was up to date. Arrangements were in place to monitor staff performance and carry out formal disciplinary procedures if required.

Medicines, including controlled drugs, were kept safely. Controlled drugs are prescribed medicines that are controlled under the Misuse of Drugs Act 1971. They require specific storage, recording and administration procedures. There were appropriate arrangements to store medicines within their recommended temperature ranges and the expiry dates of medicines were checked.

Appropriate information was available to support the administration of medicines including, allergy status, "if required" and "variable dose" protocols. Where the safe dose of a medicine was based on test results, there were records showing the test results and guidance from the prescriber or specialist to confirm the correct prescribed dose. The administration of medicines was recorded safely, including the administration of creams as part of people's personal care. Care plans showed where to apply each cream, and how frequently, and staff completed records of each application.

People were protected from the risk of infections by effective infection prevention and control measures. There had been no infectious outbreaks in the past year and arrangements were in place to minimise the spread of infections if necessary. People had their own rooms and ensuite facilities, and systems were in place for managing cleaning materials and laundry to minimise the risk of cross infections. The home was visually clean, and housekeeping and care staff had responsibilities for maintaining hygiene standards. Staff wore gloves and aprons when necessary, and these were colour coded for different purposes. There were adequate supplies available so gloves and aprons could be disposed of between specific tasks. The laundry and cleaning stores were well organised and there was a clear 'dirty to clean' flow within the laundry. Staff followed the provider's policies and procedures for infection control. Guidance was on display for staff, visitors and people using the service to follow in relation to hand hygiene and infection prevention. Alcohol gel was provided at the main entrance at other places around the home.

Requires Improvement

Is the service effective?

Our findings

People living at the home and their relatives were consistently complimentary about the quality of food. People also told us they were well cared for. One person said they had "an excellent experience" of care and that staff had ensured they received their medicines at the right time. People commented on the professionalism of the care. Visiting health professionals said they had good links with the service and were always called when necessary. They valued the professional approach for ensuring their routine visits were organised and effective. They also told us that people had good health outcomes from the care they received at Maypole.

Since starting at the home, the new management team had focused on improving medicines management, pressure area care and staffing levels. They recognised that there had been some slippage in staff training and development, and this was being addressed. Some training needs had been identified and planned for, and most staff were up to date with essential training. There were some areas where staff required training updates.

Although staff felt they could access support and guidance from colleagues and senior managers, they had not been having regular supervisions or appraisals. Meetings had been held with individual staff when it had been necessary to discuss performance issues, however, and plans were in place to train newly appointed senior staff to supervise others. Supervisions and appraisals help to ensure staff receive the guidance required to develop their skills and knowledge.

Not all nursing staff were able to describe best practice first aid procedures. In addition, it was not clear that relevant staff had received training in people's specific conditions, such as epilepsy, diabetes, multiple sclerosis and Parkinson's Disease.

Training records showed that most people had completed training considered by the provider as essential, in topics such as moving and handling, health and safety, nutrition and hydration. However, many staff had attended training in the Mental Capacity Act prior to 2014, when legal guidance changed. Their training would therefore be out of date. Training records indicated that about one third of staff required updates in fire safety training and about one third of staff had not undertaken infection control training in the past year.

Induction training was provided for new staff, to help them understand their role and responsibilities. This consisted of one week of classroom training as well as shadowing experienced staff and working shifts in a supernumerary capacity. There were plans to set up a buddy system for new staff. Induction training and 'mandatory' (or essential) training reflected the industry standard training for care staff, known as the Common Induction Standards.

People were asked their consent for care. If people refused care, this was noted in their records, so that staff could monitor if people were at risk from continued refusal. If there was any doubt about people's ability to make decisions about their life at Maypole Nursing Centre, their mental capacity was assessed in line with the principles of the Mental Capacity Act 2005 (MCA). Procedures were in place to complete mental capacity assessments, following the Hampshire County Council's guidance and involving family members, health or social care professionals and advocates as appropriate. Staff understood that people with capacity had the right to make unwise decisions, for example about their choice of clothing. Examples of mental capacity assessments were in people's care files. We identified one example of a mental capacity assessment in relation to covert medication, however, that needed review and we highlighted this to the manager.

The manager had completed Deprivation of Liberty Safeguards (DoLS) applications for two people living at the home. One had been authorised and the other was waiting for the authority's decision. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. Care practices were in place which supported people's rights to freedom. For example, the main entrance was only locked at night, for security reasons, and provision was made for people who wished to smoke.

Staff understood people's dietary preferences and people's dietary needs were assessed so people were offered a suitable diet. For example, people's likes and dislikes were requested on admission as well as any allergies or special dietary needs. This information was held in the kitchen and the kitchen staff were able to explain how they

Is the service effective?

accommodated people's specific requests or requirements. For example, some people had been assessed as requiring food of a particular consistency because they were at risk of choking, and others chose soft food as it was their preference. The speech and language therapist had been involved in reviewing some people's swallowing actions, and where necessary, people received thickened liquids to reduce the risk of choking.

When people were assessed as at risk of malnutrition, particular note was made of their dietary intake, and their food was supplemented with cream to increase its calorific content. Clear records were kept of how much people ate or drank. Some people required food supplements on prescription, and some required their food to be delivered directly to their stomach via a tube. When this was the case, instructions were in place within people's care plans and records showed these were followed. Some people ate better if they were given small plates of food, and this was known by staff who followed this guidance.

People were involved in choosing their meals and were offered a wide choice at each meal. The lunch and evening meal menus were varied and people were also offered snacks mid-morning and in the afternoon. The afternoon snacks included homemade cakes and prepared fruits. 'Night bites' were also available if people wanted additional light meals after their evening meal. People were asked for their meal preferences twice a day; in the morning for lunch and in the afternoon for the evening meal. If people did not like the meal options, either when first offered or when they were served, they were offered alternatives. This meant people were offered choices and encouraged to eat what they liked and maintain a balanced diet.

People's care plans included risk assessments and guidance to support their health. Background information summarised people's medical history and allergies to medication. If people had particular medical conditions, such as epilepsy, Parkinson's Disease or multiple sclerosis, there was clear guidance in place describing how these conditions impacted on people's health and wellbeing and what staff needed to do to support them. This included any equipment needed, guidance on nutrition, what observations were required and what to do if sometime was unwell.

The effectiveness of medicines were appropriately monitored. Documentation showed that epileptic seizures were monitored and in one case, this had led to a review of medication. Similarly, blood monitoring tests were carried out for those people with diabetes or who were prescribed warfarin.

The manager had set up robust systems specifically to protect people from pressure ulcers. Staff followed clear guidance when monitoring people's skin, and if people's skin deteriorated procedures were in place to photograph and treat the area. People were encouraged and supported to change their position regularly, to promote healing and were provided with special cushions and mattresses.

We recommend the provider delivers more about training and staff supervision, based on current best practice, in relation to the specialist needs of people living at the home.

Good

Is the service caring?

Our findings

People using the service and their visitors were positive about the caring attitude of staff. We heard comments such as, “The carers are excellent,” “It’s a nice place here, I am quite happy.” Comments about the staff specifically included, “Brilliant”, “Attentive and very caring” and “Staff are wonderful”. One relative said, “[The staff] are like family”.

Staff talked in a friendly and relaxed way with people, and there was calm environment. At lunch, people enjoyed jokes with staff and there was a lively atmosphere in the dining room. When people were eating in their rooms, the rapport between staff and those being assisted with their meals was also good. Staff demonstrated a good understanding of people’s interests, preferences and daily routines and explained how they supported people to maintain their independence. A staff member described how some people particularly enjoyed quizzes and board games, and how they had learnt to play a specific game from people using the service.

Staff listened to people and gave practical support in a kind and sensitive way. This was observed when staff offered people their medicines and when people requested assistance with personal care. When people were assisted with their meals, staff sat next to them and provided support in a respectful way, at a pace that was suitable. Domestic and kitchen staff showed they contributed to people’s day to day care and enjoyed spending time with people.

Staff understood people’s care preferences and treated people with respect. Staff explained how they respected people’s choices, for example in how they spent their time and what name they preferred to be called by. One person said they had been told about the week’s activities programme, but they chose not to participate in them, preferring to stay in their room instead. They said they still got to know what was going on and did not feel isolated. People were asked for their food likes and dislikes on admission, and also each day when the menus were discussed. Where people had difficulty communicating verbally, there was guidance in people’s care plans to ensure staff gave people time and support to help them make a decision.

Where appropriate, care records included records of discussions with family members and health and social care professionals, showing their involvement in people’s care and wellbeing. Relatives were advised if staff were concerned about people’s health and said they felt staff showed they cared.

Staff showed respect by knocking on people’s doors before entering, and they closed doors to people’s rooms when people were receiving personal care. There was also a sign on each door to remind people to knock and ask permission before entering.

Visitors were encouraged and made welcome. Both floors had satellite kitchens where visitors could make drinks and snacks and there were lounges where family groups and visitors could spend time together. People’s birthdays were celebrated and care plans showed people and their relatives were invited to participate in reviews of care. There were notice boards for people using the service and visitors, providing information about the home including activities planned for the week.

Visiting health professionals said they found the home “cheerful” and “staff very friendly”. They said staff knew their patients and developed good relationships with them.

Good

Is the service responsive?

Our findings

People using the service and their relatives said that people's care plans were up-to-date and reflected their needs and that people were encouraged to personalise their rooms with their own furniture, pictures and equipment. People were aware of the complaints process and one person said they had been listened to when they raised an issue and their concerns had been addressed promptly. Another person commented that the current management team listened to their comments and complaints and took action accordingly.

People received personalised care. Care plans reflected people's specific needs, interests and views and included details of people's life history and medical history. People's life history was noted in a 'map of life' within their care plan and staff said this helped suggest topics of conversation. For example, a staff member said they had specifically brought in books on a topic related to a person's previous hobby, and looking through this together had helped them feel at home and settled. People's requests for staff of a particular gender was respected. Where one person wanted to receive care from female staff only, this was clearly written in their care plan and on handover notes and understood by staff.

Care records were up to date and were revised following any changes in people's health, medication or wellbeing. They included records of discussions with family members and health and social care professionals. Care records showed that action was taken in a timely way if people required medical intervention or if their care needs changed. Risk assessments and care plans were personalised and included how people communicated if they were in pain and any specific support they required. For example, picture cards had been developed specifically for one person, to help them communicate their choices and views. Where people had specific medical conditions, plans were in place that explained how best to provide support, including how to identify if their condition deteriorated and what action to take.

Staff were responsive to changes in people's needs. A 'stop and watch' approach had been promoted to staff. Staff had been formally reminded to take prompt action if they had concerns about anyone using the service, and to escalate their concerns to a senior person. Systems were in place to document concerns, using the daily diary and the handover meeting between staff shifts. Concerns were also shared at the '10 at 10' meeting for heads of department to ensure issues were dealt with promptly.

A range of activities were offered which were designed to respond to people's varying interests. These included quizzes, crafts and trips to the local garden centre. If people could not access group activities or preferred 'one to one' time, activities staff spent time with them in their rooms, chatting or reading. A 'night owls' film activity had been set up, for people to watch a film together on a big screen in the lounge. In addition, the home had chickens and a cat, and in the summer, the visiting 'pet farm' was a popular event. There was a programme of visiting entertainers, and people were asked to feedback on any new acts, to ensure they provided the type of entertainment people wanted.

People were supported to maintain family relationships and friends and relatives could visit at any time. 'Welcome' files in people's rooms clearly stated this, and included an up-to-date list of the management team. There was an active Residents Support Group, formed by relatives to raise money and form a link between relatives and the management of the home. When we visited, the group was advertising to raise money to improve the chicken run, located in the central courtyard garden.

The complaints procedure was summarised in people's welcome pack and on the notice board for residents and relatives. People and visitors said they would be confident to use the complaints process if necessary but would raise issues in other ways too; directly with staff or at meetings. The complaints log showed that individual complaints were investigated, monitored and responded to appropriately.

The manager had also arranged residents and relatives meetings to gain feedback and suggestions for improvement. Feedback had resulted in, for example, replacement carpets and the development of a new noticeboard showing staff on duty. Relatives commented that the new management team was more receptive to ideas and suggestions and greater priority was given to improving the service. This view was supported by visiting health professionals, who said that communication had improved and there were better systems for monitoring people's health and wellbeing.

Good

Is the service well-led?

Our findings

Relatives and visitors generally agreed that the service was well led. One said the new manager was very good because they listened, knew what was needed and was getting a good team of staff together. A relative commented they had noticed a change, with the new manager and deputy manager making improvements, such as creating new senior care worker posts and better organisation. Health and social care professionals also commented on the improvements brought about the new management team. These included observations of improved staff morale and the development of an effective communication tool to use with the GP. They also said the home was cleaner and people were offered more choices, such as at meal times and where they wanted to eat their meals.

The new manager and deputy manager had been in post since November 2014 and had prioritised areas for improvement within the home, focusing on areas that posed the greatest risks. The management of medicines had been the key area of concern, and action had been taken to implement robust systems as well as regular oversight and audit. A pharmacy audit in February 2015, carried out the provider's commercial pharmacist, showed that almost all of the areas highlighted in their previous audit in July 2014 had been addressed as a result of the action taken. Our own inspection showed safe systems were in place. Staffing arrangements had also improved, with recruitment of additional staff and increased nursing and care staff on duty. Staff said this had meant they had more time to chat with people in the afternoons. Resources had been approved to recruit staff to work an evening shift and a senior nurse to take responsibility for medicines. In addition, the manager had introduced systems to check that people with pressure ulcers, or who were at risk of developing them, were given consistently good care. People's care plans had also been reviewed and updated and provided clear, person centred guidance for staff.

Staff said that morale had improved as a result of better guidance and leadership and they welcomed the increased staffing levels. One staff member said "There is good leadership; fair and open door, and commanding respect. Everyone likes this and staff are more motivated." They were also impressed that the new manager assisted with care and "worked on the floor". Staff generally said they were supported by the manager and they could always turn to them, senior staff or colleagues for advice. There was clearer allocation of staff responsibilities and a staff meeting structure was being established.

Staff were encouraged to extend their knowledge to support people with different conditions or specialist needs. For example, one staff member said they had received training from the occupational therapist on how best to use a new piece of equipment required by one person. Some staff had also attended training in pressure ulcer management and supporting people with percutaneous endoscopic gastronomy (PEG) feeding tubes. These are tubes that enable food to be delivered directly into people's stomach. The deputy manager was about to embark on management and leadership training, and corporately, a clinical training and supervision programme was under development for nursing staff.

The provider had established governance systems for monitoring the quality of the home and promoting good outcomes for people. Incidents such as falls and risk assessments for pressure ulcers were monitored and changes were made to people's care where appropriate. For example, equipment such as low beds, sensor mats, pendant alarms and specialist mattresses and cushions were available if required to support people's wellbeing. As a result, the rate of falls and pressure ulcer development had reduced. The manager summarised events at the home, including incidents, new admissions, unplanned hospital admissions, weight loss, deaths and staffing issues on a monthly management report. These were reviewed by the provider's quality manager and trends or anomalies were discussed. The quality report also showed when people had their medicines reviewed by the GP, any safeguarding concerns or requests to the local authority under the Mental Capacity Act and any infections or complaints. In addition, the provider carried out quarterly in depth reviews of quality to identify areas of improvement. The manager was aware of areas for development and these were captured on consolidated improvement plans. For example, audits of the call bell system had shown failings in part of the system and this issue was being raised corporately and with the supplier.

Staff understood their roles and responsibilities. There had been a lack of clarity in staff roles and accountabilities and this had been addressed. This new structure contributed to improvements in communication within the home, the

Good

Is the service well-led?

management of medicines and communications with the GP and other health professionals. There was further work required to embed these changes and staff performance was monitored and managed. Care staff were allocated roles each day to check records and to alert colleagues to any omissions or queries.

Records were managed safely. People's care plans were reviewed regularly, and updated when necessary to reflect changes in people's needs. Care plans were audited to identify areas for improvement. Old information, which could cause confusion, had been removed from the care plans for archiving and there was a system for destroying records in line with agreed timeframes. Daily records of care were generally signed and dated appropriately, and provided informative records. Care plans and daily records were normally kept in people's rooms. Medicine records were kept in locked treatment rooms and staff records were stored in locked filing cupboards.

Feedback from visiting health professionals was that the home was better organised and staff "picked up on the right things" and were proactive in seeking advice. They felt the care overall had improved and was more consistent.