Mary Feilding Guild

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Inspection report

North Hill
Highgate
London
N6 4DP

Tel: 02083403915
Website: www.maryfeildingguild.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 12 April 2016. The inspection was unannounced. Mary Feilding Guild is a care home registered for a maximum of 43 people.

At the time of our inspection there were 43 people living at the service. The service was located in a large detached building with access to a back and side garden. We previously inspected the service on 7 August 2014 and the service was found to be meeting the regulations inspected.

At the time of the inspection, the manager of the service was in the process of applying for registration as the 'registered manager' at the service. Since the inspection the person has been confirmed in this role by the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a warm and friendly atmosphere at the service. People using the service informed us that they were happy with the care and services provided. Staff talked positively about their jobs telling us they enjoyed their work and felt valued. The staff we met were caring, kind and compassionate and treated people with dignity and respect.

We saw staff were aware of people's needs and that care plans were up to date, although we found records were hard to navigate. Risk assessments had been carried out and updated regularly. We noted falls had not always been managed well in the past but there was now a new system in place to support staff to deal with these more effectively.

People were supported to maintain good health through regular access to healthcare professionals such as GPs and the local general hospital. In general people spoke well of the food, and we saw there was a plentiful and varied range of meals available. People's cultural and religious needs were facilitated by staff.

People had their medicines managed safely and received their medicines as prescribed. Medicines were stored in a locked cupboard, and the documentation was accurate and checked regularly by the registered manager.

Staff had been carefully recruited and there were enough staff to meet people's needs. Staff felt supported and there was evidence of supervision taking place across the last 12 months. Staff knew how to recognise and report any concerns or allegations of abuse and described what action they would take to protect people against harm. Staff and people using the service told us they felt confident any incidents or allegations would be fully investigated.

The Mental Capacity Act 2005 (MCA) 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. We found the service to be compliant with the legislation.

We found the premises were exceptionally clean and tidy, and measures were in place for infection control. There was a record of essential services such as gas and electricity and being checked, and equipment safely maintained. There was clear documentation relating to complaints and incidents.

People living at the service and their relatives and friends told us that the registered manager, director and other managers had a very visible presence within the home. There were a wide range of activities that took place at the service and people living there spoke highly of the person-centred care they received. There was a library and multiple laundry and kitchen facilities to encourage those who were able, to maintain their independence in these areas.

There was a lift to access upstairs and there were accessible bathing facilities for people with mobility problems. The garden was beautifully maintained.

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 effective. Medicines were safely stored and administered.

People's money was managed well and there was enough staff to support people's needs.

The building was safely maintained and checks of essential services took place.

Is the service effective?

Good

The service was effective. People living at the service and their relatives told us they had confidence in staff skills and knowledge, and we could see staff were trained in key areas.

People were supported to maintain good health and there was a wide range of food available to support good nutrition.

Staff were aware of issues of consent and Deprivation of Liberty Safeguards (DoLS) were in place where necessary.

Is the service caring?

Good

The service was caring. People living at the service told us staff were kind, caring and patient. Importance was placed on dignity and respect for people living there.

People were actively encouraged to remain independent and there were multiple kitchen and laundry facilities to enable this.

The gardens and the building were beautifully maintained which benefitted the people living there.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care records were not easy to navigate. This made it difficult to understand a person's care needs.

The service had not responded robustly to the management of falls, although there were new procedures now in place to

support staff to keep people safe.

The activities at the service were varied, creative and met the needs of the majority of the people living at the service.

Is the service well-led?

Good

The service was well led. The service had clear values of independence and dignity to guide its work.

The registered manager and director were accessible and people living at the service and their relatives praised the way the service was run.

There was evidence of quality assurance audits taking place in key areas and remedial action taken where necessary.

Mary Feilding Guild

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 12 April 2016 and was unannounced. It was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included information provided by the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with eight people individually who lived at the service and a group of five people collectively. We also spoke with five members of staff including the director and a member of the kitchen staff. The registered manager was on annual leave at the time of the inspection but we spoke with her following the inspection. We also spoke with a health and social care professional following the inspection and six relatives.

As part of the inspection we observed the interactions between people and staff and discussed people's care needs with staff. We also looked around the premises including the garden areas.

We looked at four care records related to people's individual care needs, and five staff recruitment files including supervision and staff training records. We looked at the records associated with the management of medicines, falls, complaints, incidents and safeguarding. We also reviewed documentation related to essential services such as gas, electricity and the maintenance of equipment and the management of people's money which the service looked after.

Good

Is the service safe?

Our findings

People living at the service were emphatic that they felt safe living at the service and that the environment was safe. We were told, "Almost as safe as Windsor Castle. I have stayed there in case you are wondering." Another person told us, "Totally, one of the big plusses of being here."

Staff had received training in safeguarding people. Staff were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. There were policies in place to outline what staff were expected to do if they were worried about any potential abuse. Staff were expected to sign a document to record they had read the policy. Staff also understood how to 'whistle blow,' to let the local authority or the Care Quality Commission know if they felt any issues were not being investigated by the management within the service.

Risk assessments were in place, and covered the main areas of risk. These had been updated but the system of filing care records was complicated. This made it hard to read through the files and understand the range of risks and the actions required to manage the risks. We spoke with the director regarding this and she told us the registered manager was keen to change the care records but was waiting for new management staff to take up their posts to implement the changes.

We looked at the management of medicines. Medicine trolleys were locked and kept in a locked room. Medicines requiring refrigeration were kept in a fridge in the room and the temperature was monitored and recorded. The room temperature was also recorded. Controlled drugs were safely stored and we saw from records that two signatures were required for dispensing these. The service had the majority of medicines dispensed via the multi-dosage system in blister packs. We checked the number of tablets in boxes with records for seven people and found one additional tablet that could not be accounted for. We were told by staff and the director that the registered manager was auditing medicines closely to ensure there were the minimum of errors. Only senior carers dispensed medicines. We noted a memo on the wall from the registered manager celebrating in February a fully correct audit of medicines. We were told that accurate dispensing and management of medicines was a priority for the service. There were clear instructions for staff on managing medicines for people returning from hospital, and an outline of the process and timeframe for the reordering of medicines from the pharmacist.

A number of people living at the service were able to manage their own medicines. There were no photos of people who needed support with medicines to aid safe dispensing. But a senior carer told us they were currently drawing up a sheet for each person with a list of their allergies, date of birth, room number and photograph. The photos had already been taken. We were told these would be in place by the end of April.

We looked at the management of money for people living at the service. The majority of people could manage their own money, but the service managed money for 12 people. We saw there was a well ordered system for recording incoming funds, expenditure, with accompanying receipts, and a balance for the remainder. Money was stored separately for each person in a safe. Additional services provided by the Mary Feilding Guild were billed to people directly. For example, having a person to stay over at the service or

lunch for a relative. Where family were involved in managing money we saw there was evidence a lasting power of attorney was in place.

The service had been awarded the highest rating of five stars for food hygiene in January 2016. We looked in the fridges and freezers and found them clean with food covered. We saw there was a meat pie and some meat pate in the freezer that did not have a use by date on it. The chef told us they had been opened at the weekend and the staff had forgotten to label them. He threw them away. We spoke with the director regarding this and she undertook to carry out spot checks of the fridges and freezers to ensure everything was labelled and dated to maintain good infection control.

The premises were spotlessly clean. We saw a team of housekeeping staff throughout the day cleaning both communal areas and individual rooms. The head of housekeeping could show us her system to log what needed doing and of checks once the housekeeping work was completed.

We could see that recruitment practices were safe. Mary Feilding Guild required two references for staff before employing people post 2012. We could see that from the time of this requirement there were two references in place. Staff records had in-date Disclosure and Barring Service (DBS) certificates and proof of identification. In addition, records contained evidence of the right to work in the UK where needed. Staff we spoke with told us they were not allowed to work until their DBS had come through. This meant staff were considered safe to work with people who used the service.

We looked at the rota and asked people if they thought there were enough staff on duty to meet their needs. We could see from the rota there was a senior carer and three care staff on duty from 7.45am until 9pm. and two staff awake at night, one of whom was a senior carer. Many people living at the service were largely independent and were able to manage the majority of their own personal care, laundry and shopping. Support at this level was called standard care. For both intermediate and full care, staff offered significantly more support. The majority of people told us they were happy with the level of staff support. We were told, "In the main, probably alright." and "I think so, although, I have an impression that they have pruned the staff." Another person told us they thought there was less staff available in the evening. We discussed with the director who told us the housekeeping staff had left by then so maybe it appeared there were less staff as the care staff quota remained the same. Other people told us they clearly felt there were enough staff on duty. One relative told us, "They put the most tremendous effort into helping you; this is a high calibre place."

We saw accident and incident records were kept and were reviewed three monthly to identify any patterns. Reviewing of these had prompted the senior managers to note the increased levels of falls throughout the service. This had led them to look in detail at individual's risk assessments. The director told us she intended to review these more frequently to identify trends.

All of the essential equipment, for example, gas and electrical installations and fire equipment, were serviced in the last twelve months, or within timescales recommended to ensure the building was well maintained. We saw that fire drills were taking place quarterly and issues that arose addressed. We noted that there was a period when fire alarms were not being checked weekly for a period of five weeks but these had subsequently taken place weekly. We spoke with the director regarding this who undertook to ensure that weekly fire alarm tests were carried out every week. We saw there was a Personal Evacuation Egress Plan (PEEP) on people's care records to identify if they required support in the event of a fire.

Good

Is the service effective?

Our findings

People living at the service said they thought staff were knowledgeable and understood their needs. Generally people were positive about the staff. We were told, "On the whole yes. There is an atmosphere of wanting to help. The admin staff mix amongst us." Another person told us, "The senior carers yes. [Named two carers] are very good." Only one person was slightly less complimentary about the staff. Relatives were unanimous in their praise of the staff. We were told "The staff are absolutely brilliant."

The Mental Capacity Act 2005 (MCA) 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Two DoLS applications were pending assessment by the local authority. We could see from records that people's mental capacity was noted on records in relation to specific areas of their care. We spoke with staff in relation to consent and the MCA. Staff were aware of the importance of gaining consent when working with people.

We looked at staff training records. Mandatory training included safeguarding, food hygiene and infection control, fire safety, manual handling, the MCA and DoLS, and medicines. These courses were undertaken annually and we could see the majority of staff had completed these within the last year. Falls training was not a mandatory course, although four people had undertaken the training. Plans were in place to ensure the annual mandatory training was completed by June 2016.

We could see that an induction took place for staff. This was currently based on the service's policies and procedures, and health and safety issues around the home. New staff also shadowed more experienced staff to understand how people liked care to be provided. The registered manager told us that she intended to review the induction process in the near future and base it on competencies. They were aware of the Common Induction Standards published by Skills for Care and would ensure the new induction covered all the relevant areas to be compliant.

We looked at supervision records for care staff. The policy recommended care staff are supervised every six weeks. Although supervision was not taking place as regularly as six weekly we could see that staff were receiving supervision two to three times a year. In addition they had an appraisal and there were records of spot checks of care being provided by staff taking place. We spoke with the registered manager regarding supervision who told us she will be reviewing the supervision policy and intended to introduce a more

flexible policy based on staff experience and need. New staff would therefore have more intense supervision whilst more experienced staff would likely have less. The policy would be amended accordingly. The registered manager acknowledged the value of supervision in maintaining good quality care and in retaining staff motivation as this was a time for staff to discuss their personal development.

There was a main kitchen where lunch was prepared. Everyone in the building had lunch from the main kitchen and for those who wanted it, an evening meal was prepared. All rooms for people living at the service had a kitchenette with a sink, fridge and cooker. In addition, there were numerous small kitchens on each floor with freezers and cookers so people could prepare their breakfast and evening meal should they choose to do so. For those people who were unable to do so themselves, breakfast was prepared by staff on each floor. We saw food prepared for lunch which was in plentiful supply and nicely presented. The menus were changed monthly and people were asked the day before what they wanted to eat. There were two main choices but the chef told us they could prepare omelettes or other alternatives if people were not happy with the menu options.

We asked people living at the service what they thought of the food. We were told, "It is well intentioned. We get a lot of fresh fruit. The vegetables though are over cooked." and "Yes the food here for an institution is remarkable, but I eat in my room at night." Another person told us, "For an institution it is very good and I hate institutional food!" One person added, "Breakfast & lunch is very good, but the evening meal is boring and the menu sometimes monotonous." Relatives told us, "It's better than average." and "They are doing their best." Another relative told us the food had improved over the last year and "I can't fault the home at all, but if there is room for improvement, it is in relation to the food." We discussed food with the director who explained that improvements in food were a work in progress. In relation to the evening meal they told us fewer people wanted an evening meal prepared. They had had discussions with the chef and people living at the service regarding the evening meal and welcomed people's views. They had on occasion bought in specific foods for people to cater for their individual preferences.

At the time of the inspection the system for gaining access to the GP had changed. Whilst the GP service had originally visited people at the home, people told us the practice staff were now only visiting people who could not travel to the GP surgery themselves. This was a cause of concern to some of the people living at the service as they were worried they would have to wait a long time to be seen by the GP. Following the inspection the director wrote to the GP practice to ask for a meeting to discuss how best to meet the needs of the people living at the service whilst accommodating the needs of the GP practice. All parties agreed to the meeting and to finding a practical solution.

We could see from records that people living at the service were accessing GP services as they needed. They were supported to hospital appointments if required as with dentist and optician appointments. People living at the service told us they received support as necessary. One person told us, "I had a fall and was taken there [to the hospital] and subsequently discharged back to here as they knew I would be taken care of adequately." One relative told us how their family member was provided with increased care and equipment very quickly following a fall. Another relative told us how the service took their mother back from hospital very recently following an acute episode of ill health as they knew the person was very keen to get back, and the service was willing and able to provide them with the care they needed.

The premises were fully accessible with people living on three floors. There was a lift to access upper floors and numerous communal, accessible bathrooms. There were also extensive gardens for use by people living at the service which were very well maintained with flowers and an expansive stretch of lawn.

Good

Is the service caring?

Our findings

Most people told us staff were caring. Their comments included, "Yes absolutely." and "Yes, yes a thousand times." We were told, "I would say that I am very lucky to be here. It is a very nice place indeed to be." One person told us, "I don't think about it. I talk to them naturally and they talk back to me naturally." On the day of the inspection we saw that staff were kind and caring in their interaction with people living at the service. Relatives spoke very highly of the staff, of their caring nature and kindness. One relative told us staff "go way beyond the call of duty." Another relative told us, "I was taking him home for supper one night and the care staff found out he was leaving that evening and stated that they were having smoked salmon that night and did he want some put in his room (fridge) for later. Dad said that would be great. Sure enough it was there when I brought him back later. That was considerate."

One relative told us how their family member was due to have a significant birthday and whilst her room was large it was not big enough to accommodate the number of friends and family who were due to attend. The service made available a large room and so facilitated the party.

People had an opportunity to have a week's trial staying at the service before committing to moving there permanently. One relative told us she really appreciated the support offered to her mother when she decided to move to the service permanently. Her mother initially found it difficult to adjust to her new living arrangements but with the support of staff who were caring and patient with her, she had since settled in well.

Most people told us they were very well treated. Two people told us most staff treated them with dignity and respect. We were told, "We are treated as adults." and "We like it that we are not patronised." People also told us, "We like that we are given the opportunity to determine how we are addressed." We noted from care records that people were specifically asked what they wanted to be called at the service. We saw staff knock on people's doors before entering, and we saw staff speaking with people in a calm, polite and respectful way. Staff told us how important it was to show people dignity when providing personal care and how they would do this.

One person told us, "They very much encouraged me to stay in touch with my grandsons and also insisted that I bring as much of my personal possessions here as physically possible." We saw the rooms were bright, spacious and well decorated. The director told us people were encouraged to have personal possessions in their own rooms, and we saw this at the inspection. The communal hallways had pictures and photographs. The dining room was light and airy looking out on to the private gardens which were well maintained with lawns, roses, a magnolia tree and a shrubbery. There was also a "sunroom" with well-maintained orchids as well as a "sun balcony" which had plants, tables and chairs for people living at the service and their visitors to use. The plants and gardens were very well cared for and some people living at the service helped with gardening tasks. A group of five people we spoke with together told us, "How lucky we are to all live here." We were told, "I have made some good friends since being here." People appreciated the opportunities the staff made to facilitate this. For example, there was tea and cake served every day in the well-stocked library at 4pm. People could 'drop in' at 4pm if they chose to. This made it easy to meet up with people in a relaxed

and informal way.

People's spiritual needs were met by religious personnel attending the service to see them. At the time of the inspection there was no-one who required a Halal or Kosher meal but the chef was able to cater for these needs if required.

A significant number of people living at the service were quite independent and mobile. As well as kitchenette facilities in each room there were kitchens and laundry facilities on each floor should people want to do their own cooking and laundry. There were pigeon holes for post so people could retain their privacy. People could have their newspapers delivered. We could tell from talking with people living at the service, staff and their relatives that promoting independence was a high priority at the service and this was valued by everyone.

We asked people if they were involved in their care planning. We were told, "Yes. We get regular reviews and I must sign every page." Another person told us, "Yes I have a care plan." We could see that people had signed documents on their care records or where their mental capacity was limited or they preferred their family to take on this role, their signature was obtained. The service also ensured people signed documents related to confidentiality issues so staff were clear who they could discuss people's care with.

We noted that personal information on people's files was very limited. Many people living at the service had full mental capacity so could choose what they would tell staff about their past. However, two staff were unable to tell us of any personal or historical information regarding any of the people they cared for. We discussed this with the director who undertook to include personal information in the new care records, provided they had the permission of the person living at the service.

We spoke with a health professional following the inspection who told us the service was very effective at working in partnership with health colleagues to support people at the end of their life. The service had a significant number of very elderly people and prided themselves on offering a home for life to people. There was a section in most files for advance care planning and Do Not Resuscitate discussion notes and forms.

Requires Improvement

Is the service responsive?

Our findings

There were three levels of care provided at the service: standard, intermediate and full care. Approximately 11 people were receiving intermediate or full care at the time of the inspection. This illustrated the majority of people living at the home were independent with the majority of activities of daily living such as washing and dressing. Many people did their own shopping, laundry and cooking, and so required minimal information on their care records.

We found the method of collating information for care plans very difficult to navigate. The folders did not have section dividers so it was very difficult to quickly pull out information to understand a person's needs. Although we found care records were updated, it was not easy to find the latest version of the record. Whilst it was not always easy to tell from the records, we were made aware by people living at the service and their relatives that the care was extremely person centred.

Activities at the service were varied and in many ways reflected the preferences and interests of the people living at the service. Weekly activities included an exercise class, an art class and a dance class. Other activities included indoor bowls, bingo or a sing-along. Musicians and performers, sometimes relatives or friends of the people living at the service, played, sang or performed at events. There was a film club on Saturday and Sunday. Fortnightly activities included a book group alternating with a poetry writing group, a discussion group and there was a monthly shopping trip via transport. In the summer people played crochet on the lawn and had drinks and events in the garden. One relative told us attendance at last summer's garden party had convinced her mother it was the right place for her to live.

People told us, "They have lots of activities. Shakespeare's 400th anniversary will be celebrated here. They have asked all residents to write down their favourite quote and then they will be read out at the event where drinks and nibbles will be served. Board games are freely available even in French!" The majority of people were very happy with the activities. It was noted however by one person living at the service that there is "not much in the way of physical activities for active males and other residents. I have been active all my life and would appreciate a multi gym or something like this. The activities are very female focused."

We noted that for a small group of people who were falling on a regular basis the service had not adopted a sufficiently proactive response to manage the falls or the risks associated with the falls. For example, one person had fallen on twelve occasions since the end of January 2016. The GP had been called to address the physical symptoms of the impact of the fall, and on two occasions the person had been taken to A&E at the local hospital for treatment. But a more strategic approach was not adopted until the person had experienced several more falls. By the time this person's medicines were reviewed to consider if they were having an impact on their mobility or mental state due to hallucinating, the person had fallen eight times. The person had not been referred to the falls clinic. A sensor mat, which alerts staff to a person getting out of bed so they can assist with getting up, had been ordered at the time of the inspection but not delivered for this person.

We discussed falls with the director on the day of the inspection who told us they had experienced some

difficulties engaging local health professionals to take action. Both the director and registered manager acknowledged that they had not proactively managed some falls as robustly as they would have liked in the recent past. As a result they had developed a pathway to assist staff to take action following a series of falls. They were able to show us the documentation as it had been implemented from the end of March 2016. The registered manager told us they had also been in discussion with the Community Matron at the local hospital to make direct referrals to the falls clinic and with the CCG to support them further in their management of falls. Therefore, whilst we identified that improvement was required for ongoing falls management, we could see that the service was already addressing this.

People knew how to make a complaint should they need to. Comments included, "I haven't had anything to complain about." We saw from records that complaints raised in the last 12 months had been dealt with swiftly and appropriately

Good

Is the service well-led?

Our findings

Mary Feilding Guild was established by Mary Fielding through an association called "The Distressed Gentlewomen's Association" in the 19th century. She was concerned for women who had jobs that were neither "below floor" nor "above floor", for example governesses, and what happened to them when they were no longer able to work. Mary Fielding set up "The Working Ladies Guild" and the service was established as the result. Maintaining independence and people's dignity were key values by which the service was run. Mary Feilding Guild operated as a charitable trust. Most people funded their own care but there were a limited number of bursaries available to support people to live there.

People told us they knew who the registered manager, director and other managers were and that they were accessible. Relatives were uniform in their praise of the management of the service. We were told by one relative, "It should be a model for other places." Others said, "I have a lot of faith in the management." and "We have such confidence in the staff." There were many complimentary letters and cards relating to the quality of the service over the last 12 months.

The service had ten volunteers at the time of the inspection, all of whom had been DBS checked and references taken up. They supported people in a variety of ways from running groups to taking people shopping and accompanying people to hospital appointments. People at the service appreciated the work of the volunteers. A House Committee also operated, made up of friends of the residents to oversee the activities at the service.

We could see that meetings with senior care staff took place regularly. There had been four meetings with senior staff since December 2015. There was less evidence of meetings taking place for other staff. Staff meetings are one way to provide an opportunity for the voice of staff to be heard. The registered manager told us they intended to have quarterly meeting with all care staff.

There had been two meetings for people living at the service in 2015 with an additional meeting to discuss catering arrangements. There had been one meeting in 2016. People we spoke with did not feel the meetings took place very regularly. We discussed this with the Director who undertook to review the regularity of meetings.

We could see that the director and registered manager were keen to learn from incidents and so improve the service. The director showed us documentation she had discussed with staff relating to an investigation which had taken place recently. The document highlighted learning from a health and safety issue that had arisen in the kitchen. This was helpful as it illustrated each person's responsibility to record issues in the communication book and to take personal responsibility for their role in maintaining a safe environment. The director hoped by raising awareness of the event there was less likelihood of it happening again.

We could see that medicine audits took place regularly and staff were updated on the outcome. Care plan audits had taken place with remedial action evidenced, and there were meticulous records in relation to the cleanliness of the service.

The service was recruiting to three new posts of care manager at the time of the inspection. Two posts were being funded in addition to the current staff team. It was intended that people in these posts would take on supervisory roles as well as taking on specific management tasks. Once new recruits were established in post the registered manager told us they would take the lead on falls, infection control, end of life care and dementia care. This would enable the service to further develop skills in these areas. The registered manager also intended to attend local provider forums to assist in developing best practice across the service once these people were inducted and in post.