Rushcliffe Care Limited

Castle Donington Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Overall summary

We carried out an unannounced inspection of the service on the 5 and 6 May 2015.

Castle Donington Nursing Home provides accommodation for up to 60 people who require nursing or personal care. On the day of our inspection 46 people were using the service and two people were in hospital.

Castle Donington Nursing Home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the provider told us that the registered manager was not working at the service.

Summary of findings

During our last inspection on 28 July 2014 we asked the provider to take action to make improvements to protect people living at the home. The provider was not meeting one Regulation of the Health and Social Care Act 2008. Accurate records for people were not maintained. This meant people were not protected against the risk of unsafe or inappropriate care and treatment.

Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. At this inspection we found that the actions we required had been completed and this regulation was now met.

People we spoke with and relatives were satisfied with the care and support provided. Some people raised concerns about staffing levels but all said that they felt people were safe. People also said that their individual needs and wishes were known and understood.

We found staff were caring, kind and compassionate in their approach. They understood people's individual needs and treated people with dignity and respect. People we spoke with and relatives told us that they were involved in discussions and decisions about their care and treatment. Additionally, people said they knew how to make a complaint and they would feel confident to do so if required.

Staff received appropriate training and development opportunities to review and develop their practice. Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work. Nursing staff had sufficient support for their continuing professional development. Staffing levels were based upon people's dependency needs. The provider had taken appropriate action when people's needs had changed to ensure people's needs were met. However, concerns were identified that staff did not always have sufficient time to spend with people and monitor their needs.

Staff were aware of how to protect people from avoidable harm and were aware of safeguarding procedures. This meant that any allegations of abuse were reported and referred to the appropriate authority.

People had been asked for their consent to care and treatment and their wishes and decisions respected. The provider adhered to the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008. However, the provider had identified further improvements to ensure consistency.

Medicines were safely stored and administered and people received their regular medicines as prescribed. We found one concern with a medicine that needed careful monitoring to ensure a safe dose was given. We informed the senior manager on the day of our inspection who said they would take immediate action to address this.

Improvements had been made in the planning and delivery of people's care and people had received the care and support they required. People's needs were assessed and plans were in place to meet those needs. Risks to people's health and well-being were identified and plans were in place to manage those risks. We found good practice in relation to meeting people's health conditions. Plans of care were comprehensive and information about how people took their medicines was clearly detailed and person centred.

People were supported to access additional healthcare professionals whenever they needed to and their advice and guidance had been included into people's plans of care. People's nutritional and dietary requirements had been assessed and a nutritionally balanced diet was provided.

Concerns had recently been identified by Public Health England about the systems in place in the prevention and control of infections. The provider took immediate action to improve standards. We found the required action had been completed and risks had been minimised.

There were systems in place to assess and monitor the quality of the service. This included gathering the views and opinions of people who used the service. Additionally, monitoring the quality of service provided. People's complaints and issues of concern had been responded to promptly and appropriately. However, we were concerned that the provider's internal quality assurance systems had not identified the risks associated with infection control. We were informed by the senior manager that at the time of the inspection the registered manager had left the service. Another manager had been

Summary of findings

appointed and was due to start imminently. We were concerned that the new manager would require additional time to fully embed and sustain the improvements.

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 is safe

Good

People told us they received their medicines safely. Medicines were managed correctly with the exception of one. People had risk assessments in place that made sure people received safe and appropriate care.

People said their needs were safely managed. Staff knew how to protect people from abuse and avoidable harm. Whilst issues had been identified with infection control measures, improvements had been made.

The provider assessed people's dependency needs and where people's needs had changed action had been taken to ensure sufficient staff were available.

Is the service effective?
The service is effective

Good

People were supported to access healthcare services. Plans of care to meet people's healthcare needs were comprehensive. The provider sought appropriate support and guidance from healthcare professionals when required.

People said that the food choices were good and they had sufficient to eat and drink. The menu provided a balanced diet and was based on people's needs and preferences.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards was being met but some issues were identified about consistency in adhering to the legislation. The provider had already identified this as an area to improve.

Is the service caring?
The service is caring

Good

People spoke positively about the approach of staff and described them as kind, caring and respectful.

People's privacy and dignity was respected and staff had a good understanding of people's needs.

People were involved as fully as possible in how they wished to be cared for. Confidential information and privacy was respected.

Is the service responsive?
The service is responsive

Good

Improvements had been made to ensure people's routines and preferences were known.

Summary of findings

There had recently been changes with regard to the availability of staff to provide opportunities of social activates, interest and hobbies. However, this had been addressed by the provider.

The provider had a complaints procedure that was accessible for people.

Is the service well-led?

Requires Improvement 

The service is not consistently well- led

People and relatives raised some concerns about the frequent changes in the leadership of the service.

Staff told us that recent improvements with the service had resulted in them feeling better supported. Staff felt able to raise any issues, concerns and were more involved in the development of the service.

The provider had systems in place to monitor the quality and safety of the service. However the provider's internal quality assurance process did not identify previous concerns about infection control. Further time was required for improvements to fully embed and be sustained.

Castle Donington Nursing 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.

This inspection took place on the 5 and 6 May 2015 and was unannounced.

The inspection consisted of two inspectors, a pharmacy inspector, a specialist advisor in nursing care 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.

To help us plan our inspection we reviewed the previous inspection report, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service for their views.

On the day of the inspection we spoke with 12 people who used the service and five relatives for their experience of the service. We spoke with a service manager who had overall responsibility of the service, including day to day responsibility in the absence of the registered manager. We also spoke with five care staff, two nurses, the cook, assistant cook and a senior domestic. During the inspection we spoke with two visiting healthcare professionals a GP and a district nurse.

We looked at all or parts of the care records of eight people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. 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.

After the inspection we contacted the dietetic service for their feedback about the service.

Good

Is the service safe?

Our findings

People we spoke with including relatives told us they felt safe living at the service and people were confident they were suitably cared for. One relative said, "Yes, he's [name] is safe with no falls or anything." Another relative told us that their family member had high dependency needs and staff cared for them safely.

Staff we spoke with had a good understanding of the different types of abuse and were aware of how to report any safeguarding concerns. Staff also told us about the whistleblowing policy in place and that they knew how to escalate their concerns if required. Staff training records confirmed staff had received appropriate safeguarding training. We were aware that the provider had reported safeguarding concerns to the local authority and us. The local authority has the lead role for investigating safeguarding incidents. We were aware that the provider was working with the local authority with some on-going investigations.

People we spoke with including relatives told us they felt involved in discussion and decisions about managing known risks. Risks were assessed and management plans were put in place where risks were identified. We saw that risk plans had been completed for things such as falls, moving and handling and skin care. For example, a person who had been assessed at high risk of falls had a sensor mat by their bed to alert staff when they were mobile. Additionally, their footwear had been checked to make sure it was appropriate, they had received an eye test and staff checked the person every 15 minutes. Another person was at very high risk of developing a pressure ulcer. The care that was given was appropriate in order to reduce this risk and monitoring systems were in place to regularly review the person's needs.

Staff maintained records of all accidents and incidents. We saw these were audited by the senior manager on a regular basis. We looked at the report for April 2015. This showed that all incidents had been reviewed and action had been taken to reduce further risks. This showed the provider had reviewed and analysed accidents and incidents to see if any changes or action should be taken to prevent future occurrences.

Personal fire evacuation plans had been completed and were kept in people's rooms to advice staff of how to support them in the event of an emergency. Fire safety procedures and checks were also in place. This included safety checks on equipment and the premises. We found some concerns with the safety of the outside environment. For example, a gate leading from the service was not appropriately secured. This meant people may not have been safe when in the garden. We discussed this with the service manager who took immediate and appropriate action.

Some people we spoke with told us they felt there was sufficient staff to meet their needs. However, some relatives said they had concerns about staffing levels and said there was not always staff around in the communal areas to support people. One relative said, "I feel very reassured that my father is being looked after by competent staff – mind you, at times, there aren't enough of them."

Some staff told us that they felt people's needs were met and that people were safe. However, they were aware that they were unable to monitor people at all times due to people's dependency needs and the staffing levels provided and that this was a concern to them.

There were a high number of people that required two staff to support them with their mobility or personal care needs. We found there were frequent periods when staff were not visible in the communal lounges. Some people were living with dementia and required close observation to meet their needs and manage their safety. We discussed this with the service manager who agreed to speak with nursing and senior care staff.

The service manager told us they had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels. They also said that some people's needs had changed resulting in higher support needs. They told us they had made referrals to commissioners for a review of some people's needs. During our inspection we spoke with a visiting district nurse who confirmed they had been asked to review people's dependency needs. We noted from staff meeting records in March 2015 and April 2015 that staffing levels were discussed. This included an update on the recruitment of new staff. This demonstrated the action the provider had taken to ensure sufficient staff were employed at the service to meet people's needs. The service manager also told us that they had recruited seven new staff that were due to start work the following week after our inspection.

Good

Is the service safe?

We saw examples of the action the provider had taken when concerns had been identified in relation to the practice of staff with regard to unsafe care and treatment. Appropriate action to reduce further risks including disciplinary action had been taken. Appropriate checks were undertaken before staff began working at the service. This meant people using the service could be confident that staff had been screened as to their suitability. The provider also ensured that nursing staff were appropriately qualified and had maintained their professional registration.

People told us that they received their medicines safely. We looked at the management of medicines including the medicine administration records for 46 people. We observed two nurses giving people their medicines. Both nurses were kind and patient allowing people time to take their medicines. Safe arrangements were in place to obtain, administer and record people's medicines. All medicines were stored securely including special storage arrangements for controlled drugs.

A system of daily medicine checks was in place. We found that it was possible to check that the majority of people had been given their medicines as prescribed. However, we found one person who was prescribed a medicine that needed careful monitoring to ensure a safe dose was given. We found some concerns with how this medicine was managed. We identified this to the service manager who agreed that extra checks would be put into place for this specific medicine.

We were aware that Public Health England (PHE) had recently supported the service with an outbreak of an invasive infection. We received information from PHE that confirmed the outbreak was due to poor infection control measures in particular with hand hygiene of staff. As a result the provider took immediate action to deep clean the environment, changed the laundry facilities and provided staff with refresher training on hand hygiene and infection control.

Staff confirmed that they had recently received infection control and hand hygiene awareness training and that this was helpful. They were able to tell us the procedures on the prevention and control of infections. We saw staff had a supply of protective equipment including aprons, gloves and there were antibacterial hand gel available for staff and visitors throughout the service.

We spoke with a senior domestic who showed us the cleaning schedules in place and the supply and safe storage of cleaning products. The senior domestic was knowledgeable about the action required to maintain a clean and hygienic environment. This included the risks associated with cross contamination and infection. We found the environment was free from hazards and noted both communal rooms and individual rooms we saw were clean and hygienic.

Good

Is the service effective?

Our findings

People we spoke with told us that they thought staff were sufficiently skilled to meet their needs. Some people said that there were care staff who were particularly liked and who responded to people in positive ways. One person said, "Now, he's a good-un, he is. He knows what he's doing." People's relatives were confident that care workers and nurses were knowledgeable and skilled at providing effective care to people.

Staff told us that they had received an induction when they commenced work at the service and this included training and shadowing of more experienced staff. We saw an example of completed and planned induction plans that confirmed what we were told.

We saw the training plan for all staff that identified training and timescales for completion. Staff told us that the training programme was varied to meet people's needs. However, some felt that training such as dementia care, needed to be more in depth to provide them with the required skills to meet people's needs. The service manager told us that they had identified the need to further develop staff's skills and knowledge in dementia care. They said that a new manager was due to start at the service shortly and that they had specific training, experience and skills in dementia care. Also, they were in the process of completing further training at degree level in dementia care. They said they would use this knowledge to develop best practice based on recent research. This showed the provider had assessed the training and development needs of all staff.

A GP told us they found the nursing staff were caring and committed and showed enthusiasm to improve their skills. The senior manager showed us a training programme that the NHS clinical commissioning group had developed. This was for nurses employed within nursing homes. The provider had made this information available to nursing staff and was supporting them to access this training.

Staff told us that under the leadership of the service manager formal and informal support had greatly improved. Staff said they had received opportunities to discuss their training and development needs and asked if they had any issues or concerns. Staff comments included, "Improvements have been made to support the staff. We are able to discuss, raise concerns and we feel listened to."

And, "Since the service manager has been here we have had supervision meetings, I have my appraisal booked and staff meetings are more frequent." We saw records that confirmed what we were told. This demonstrated staff were supported and received opportunities to review and develop their practice.

We saw that staff asked people for their views before they provided any type of care intervention. People's plans of care instructed staff to always ask for the person's consent every time they were supporting with personal care.

Plans of care had not always been signed to demonstrate people's agreement to their plans; however a recent audit by the provider had identified this. We saw that copies of representative's legal authority to manage people's money were held in people's care records. This showed the provider had ensured people were appropriately protected.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to care and support. It ensures people are not unlawfully restricted of their freedom or liberty. We saw that where people were being deprived of their liberty it was done in their best interests in accordance with the law. Conditions of people's DoLS had been progressed. For example, one person had been reviewed by a psychiatrist and applications were being made to fund increased supervision for the person.

Procedures for the administration of medicines to people who lacked capacity to make an informed decision were followed. We looked at two medicine administration record charts which stated that people were to be given their medicines concealed in food or drink. This is called the covert administration of medicines. This is where medicines are given to people without their consent or knowledge. We found that Best Interest procedures had been followed, with evidence of signed agreement between all interested parties.

We saw further examples where people's mental capacity to consent to their care and treatment had been considered and best interest decisions made. However, this was not consistent and it was not always evident how specific decisions had been made in each person's best interest. We discussed this with the service manager who showed us documentation they were in the process of implementing to improve practice.

Good

Is the service effective?

People told us they received sufficient to eat and drink and that the menu provided choices. We observed people received their lunchtime meal. The food was nicely presented, was of good portion size and looked appetising. We saw people were offered drinks and snacks during the day and when people asked for a drink staff provided this without hesitation. People's food and fluid intake was assessed and plans of care advised staff of people's needs to keep them well.

The cook was aware of people's nutritional needs and preferences, including if people had health conditions that were affected by their diet and known allergies. The menu appeared to be nutritionally balanced and offered people a choice of what to eat. Food stocks were plentiful and where people required a high calorie diet appropriate food such as full fat milk, cream and cheese was available.

People's hydration was monitored including their weight. When concerns were identified about people's health appropriate referrals were made to healthcare professionals. We spoke with a home enteral nutrition dietician. This is a nurse specialised in caring for people who have feeding tubes. They told us that staff were "very attentive" and "informative" and made timely referrals and followed recommendations they made. We saw an example where a person was referred to the dietician for weight loss. They were prescribed supplements to aid weight gain and to have regular weight checks. This was in evidence.

People told us that they were supported to access healthcare services when required. One person told us they had regular physiotherapy as well as visits from a district nurse. We also saw examples of referrals to external healthcare professionals such as occupational therapy and the dentist. This showed people's health was monitored and appropriate action was taken when concerns were identified.

Where people had specific health conditions comprehensive plans of care had been developed to inform staff of how to meet people's needs. For example where people had a respiratory plan of care due to having asthma, this detailed that they should be nursed upright to aid breathing and that they were prone to chest infections. They were also prescribed, and received a salbutamol inhaler. This was in their room and was attached to an easy-breathe device. This demonstrated staff were knowledgeable of inhaler technique as the inhalers are best administered via this but are not always used.

Good

Is the service caring?

Our findings

People we spoke with including relatives were positive about the approach of staff and described them as caring, kind and respectful. One person told us, “They [staff] are lovely boys and girls here very caring.” Another person said, “They’ll do anything for you. They do my nails for me in fact they need doing now.” A relative praised a particular male care worker, saying, “He’s lovely, he is. Write that down. You can get no greater praise than that.”

People told us that on the whole staff met their needs in a timely manner. One person said, “It depends, sometimes you have to wait for someone [staff] coming, other times you catch their eye straightaway and they come.” Another person told us, “Well, sometimes they are very busy with someone else, but they do try their best." and, “I press the buzzer or sometimes they are passing the door. I’d say you don’t have to wait long at all.”

We found people’s requests for assistance were responded by staff on the whole within an appropriate time. For example, we observed call bells being answered by staff within a short space of time. We noted one occasion when the call bell went to emergency mode and nursing staff responded. We noted that a person who chose to be in their room was calling out, staff promptly checked to see if the person required assistance. We observed that staff were constantly busy supporting people with their needs. However, we saw examples where staff engaged with people in meaningful conversation. This showed that staff’s interactions with people were not just task led, that people were treated with compassion and respect.

We observed care interventions by staff during our inspection. Staff were attentive, caring and respectful towards the people they supported. We saw staff used good communication skills when talking with people. For example, staff got down to eye level with people when communicating and used people’s preferred names. People were spoken to in a caring and appropriate way, using humour, empathy and appropriate touch to facilitate communication. People seemed relaxed and at ease chatting to staff. We saw a person who was vocalising and becoming distressed. Staff calmly approached the person and began talking to them which calmed the person down. This meant staff took action to help prevent people from becoming distressed.

We found the meal time experience for people was unhurried, relaxed and calm. Where people required assistance and prompts with their meals staff were attentive to people’s needs. Staff sat by people when they were supporting them to eat. They gave people their food at a pace that was appropriate to the person’s needs. We saw that pictorial menus were provided to support people with communication needs to assist people to make informed choices.

The senior manager shared plans they had developed to introduce a keyworker system. This meant that people would have named staff that would have additional responsibility in their care. The service manager said this was to build on the positive relationships people had developed with staff. Additionally, ensure greater consistency and continuity in the delivery of care and improve communication with people’s relatives and representatives.

Further observation of positive engagement by staff included, a person asked a staff member what time was lunch. The staff member was quick to respond with the time. We observed a member of staff talking with a family visitor. At the same time, another nearby person looked at the staff and smiled. The staff member gently stroked this person’s hair as it was sticking up. It was a caring and natural response. The person smiled ever more. We saw how a person was confused and disorientated and a member of staff reinforced in a gentle manner what the present day was. This was seen to reassure the person.

Our observations of the care and support staff provided to people showed they were aware of people’s needs, routines and preferences. Staff gave people choices with everyday decisions and included people in discussions about their care and treatment as fully as possible. A person told us, I like it here.” We also saw good examples where staff showed dignity and respect towards people. We saw staff gently talking with people whilst offering drinks and asking their preference of milk and sugar.

Staff gave their view about the quality of care provide, One member of staff said, “I think it is good quality care. We are trying to do our best, we have noticed a lot of improvement but there is not enough staff as we struggle sometimes.” Another staff member said, “Most people have high dependency needs, we don’t have time to really spend with people. People’s needs are met but the quality of time with people is affected.”

Good

Is the service caring?

Staff also gave us examples of how they protected people's privacy and dignity these included, knocking on doors, covering people when delivering personal care and ensuring women had blankets over their legs when they were being hoisted. Our observations of staff supporting people with their mobility needs showed that people's dignity was respected. Staff provided reassurance and explanation to the person they were supporting.

Staff also told us how they supported people to make every day decisions. People's plans of care provided staff with guidance of how to include people and their relatives or representatives as fully as possible. We saw examples where people and their relatives or representatives had been included in discussions and decisions. This demonstrated that staff were aware of their responsibility to support people in making lifestyle choices.

We noted that support plans were also used as a tool to remind staff about the importance of promoting people's choice, respect, and dignity and independence. For example, we saw that people had access to special cups and cutlery. Some people had plate guards to enable them to retain their independence with eating. This was in line with their plans of care. This showed the provider had a commitment to deliver a service that centres on and responds to the people who use it.

The provider had ensured people had information about independent advocacy information. This was on display for people. We noted that the service manager was developing this information in an alternative formats to enable people with communication needs to access it.

Relatives told us that there were no restrictions on when they visited and that staff were welcoming, friendly and approachable. People had a choice of where they could meet with their visitors that promoted independence confidentiality and privacy. This included people's rooms, communal lounges, dining rooms or a spacious garden.

People that used the service and staff could be assured that confidential information was appropriately and securely stored. Confidential and sensitive information was shared on a need to know basis.

Good

Is the service responsive?

Our findings

Before people moved to the service their needs were assessed to ensure the service could meet people's individual needs. Not all people we spoke with could recall their involvement in the development of their plans of care. One person said, "Oh, my daughter deals with all that." Two relatives told us they could recall being involved in the initial setting-up of their relative's plan of care. One could recall being involved in a recent review. Another relative said they had contributed to the assessment and planning of their relatives care. They also said that before their relative's needs had changed they had been involved as fully as possible.

People's care records contained documents that contained details of people's likes, dislikes, preferences, history and preferred diet. Additionally, people's preference to male or female staff for personal care was recorded. This information provided staff with the required knowledge to provide care and treatment that was personalised to meet people's individual needs. Some information was more comprehensive than others. However, we were aware that people's care records were being reviewed and audited by nursing staff and the service manager. This was to ensure they were accurate and reflective of people's needs. We saw an action plan the provider had developed that showed required improvements the provider was working on. This stated that people's care records would all be updated by June 2015.

People's personal preference for how they would like to be given their medicines was clearly documented. We saw that each person had a medicine 'preferences section' with their medicine administration records which gave instructions on exactly how each medicine should be given. The information provided was person centred, specific, detailed and of a very high standard. This ensured that their individual needs were being met.

We saw examples where people's choice with regard to their religious or spiritual needs had been considered and respected. For example, a local community religious group visited the service to provide worship for people to participate in. We also saw that some people's rooms included significant items of importance associated with their chosen belief or religion.

Staff we spoke with showed an awareness and good understanding of people's routines and preferences including what was important to them. We observed a staff handover where people's needs were discussed. We noted how staff shared important information about people's needs with colleagues. For example, a discussion was had about a person's behaviour. A member of staff told other staff what this meant for the person, the history and association behind the meaning. This demonstrated a person centred approach by staff as they had an understanding of people's diverse needs.

We found examples that showed staff provided personalised care. For example, Where people had been assessed as requiring pressure relieving equipment we saw that these were in place. One person's care records stated the person liked to listen to the radio, we found the radio was playing in their room on an appropriate channel. Another person's care records stated they liked to stay in the room and watch television. We found them watching television in their room.

People's plans of care were reviewed and updated when changes occurred. For example, we saw how a person's plan of care for their percutaneous endoscopic gastrostomy (PEG) feeding tube had been updated. This followed a previous incident whereby the PEG had accidentally locked. Nursing staff had responded and taken appropriate action to improve care and treatment.

A relative told us that until recently activities were "pretty good". A person said they attended a knitting club and a church service in the church hall.

Whilst people's interests and hobbies had been identified and recorded we did not see during our inspection that activities for people to participate in were offered. People were seen to watch television in the communal lounges or they remained in their room. Whilst one communal lounge had a variety of magazines available, there were limited activities readily available to provide stimulation and occupation for people. The service manager told us that the provider employed two activity coordinators who were unavailable at time of our inspection.

Some people living at Castle Donington Nursing Home were living with dementia. The provider had considered people's needs in relation to the environment. For example, some people had their name on their room door and others had a photograph. Illustrations on room doors

Good

Is the service responsive?

indicated their use such as bathroom, shower and toilet. This assisted people to orientate themselves around the service. There were visual displays around the service to indicate the seasons. These were colourful and interesting and had items associated with spring. There were clocks around the service and notice boards advising people of the day and time. However, one clock was an hour behind and the notice on a board read, 'What's on Monday?' the day was actually Wednesday. The service manager told us that they had plans to review and further develop the environment to make it more appropriate for people living with dementia. In addition when people had been allocated named keyworkers, plans were in place to develop personal memory boxes for people to enable reminisce opportunities.

We observed the support provided by staff towards a person living with dementia who became agitated and distressed. The intervention by staff had a limited positive affect on the person's anxiety. Staff were not seen to use distraction techniques that may have reduced the person's anxiety. We looked at this person's plan of care and found there was no clear guidance for staff of how to manage and respond to periods of distress or agitation. This example showed a limited understanding and awareness of how to respond to this person at a time of high anxiety. We discussed this with the service manager who agreed to discuss this with the nursing staff.

The provider had a complaints policy and procedure that was available for people and their relatives or representatives. This was also provided in an easy read language format for people that had communication needs. Records showed that nine written complaints had been received since our last inspection. These had all been investigated and concluded. This showed the provider had a system to record, investigate and respond to complaints. This enabled them to identify common themes and patterns and any action required to improve standards.

Is the service well-led?

Our findings

At our last inspection we found that the registered manager had not protected people against the risk of unsafe care and treatment due to concerns about the maintenance of people's records. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that the provider had taken the required action to meet this breach. Daily records showed that checks and observations were made in line with people's plans of care. The provider had developed improved systems and processes to checks records were completed accurately and monitored appropriately.

A concern people using the service and relatives had was about the leadership of the service. Some people had resided at the home for a length of time had experienced numerous changes with registered managers leaving. They said this was a concern and did not give them confidence. The service manager told us that the registered manager was no longer working at the service.

Staff also told us that they had experienced some previous difficulties with the leadership of the service. They said that they had not always felt supported or received the correct guidance and information in relation to best practice.

People, relatives and staff agreed that the provider had taken recent action to improve standards and that the service manager was supportive, approachable and gave them good leadership.

The provider had various audit systems and procedures in place that monitored the safety and quality of the service. For example, the provider had started a refurbishment plan of the service. We were satisfied that the provider had taken immediate action to address the issues relating to infection control. However, we were concerned that the internal systems and audits had not identified these concerns. At the time of our inspection the service manager told us that a new manager had been appointed and was due to start at the service shortly. We identified that for the recent improvements to be sustained, the new manager would require sufficient time to do this.

Meetings for people and relatives were arranged to enable people to express their views and opinions about the service. It was also used as an opportunity for the provider to exchange information with people about the service. We saw a meeting record dated April 2015 that showed recent issues and concerns were shared with people. The provider had also informed people of the action they had taken to improve standards. For example, people had been informed about the changes affecting staffing, including the management of the service and changes to the environment.

The provider also sent people an annual questionnaire as an additional method to share their experience of the service. We saw feedback had been analysed and what the response was from the provider. This was displayed for people to see in a 'what you said' and 'what we did' notice board. In addition we saw our last inspection report was displayed with a copy of the action plan the provider had developed in response to the required improvements. This showed the provider was open and transparent with people.

Staff told us that due to recent changes they felt more involved in discussions and decisions about how the service developed. Comments from staff included, "Communication has improved, we are working better as a team." Another staff member told us the changes the provider had made to the staffing arrangements in the service. They told us, "Staff skills and experience have been reviewed. Staff work in the areas that best suit people's needs."

We looked at staff meeting records and saw that there were discussions about the standards of care the provider expected and the action required of how these were to be met. This showed the provider had identified areas of improvement and was able monitor the progress.

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that since our last inspection the provider had notified CQC of changes, events or incidents as required.