South Coast Nursing Homes Limited

Abundant Grace Nursing Home

Inspection report

Abundant Grace Nursing Home
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Abundant Grace Nursing Home provides nursing and personal care for up to 67 older people. The home is modern and purpose-built over two floors. The home was laid out in a 'racetrack' style, which meant people who liked to walk could do so without encountering barriers, and the corridors were wide enough to allow and encourage this. There were 65 people living at the home at the time of the inspection who had a range of complex health care needs which included people who have had a stroke and diabetes. People on the first floor were living with dementia and some of these also had complex healthcare needs. People required varying levels of help and support in relation to their mobility and personal care needs.

There is a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was known as matron and will be referred to as matron throughout this report.

The home had been last inspected in June 2015 where we found the provider was meeting the regulations. Due to a number of concerns raised about the safety of people and the care they received we brought forward the scheduled inspection to the 28, 29 November and 1 December 2016, so we could ensure that people were safe and receiving appropriate care.

Staff had a good understanding of the risks associated with caring for people at the home. However, risks associated with managing people's pressure areas required review. A number of people had fallen at the home and some people were at risk of falling. Although measures were in place to address this we made a recommendation that the provider continue to robustly analyse and review people to ensure the number of falls at the home are minimised.

Aspects of medicine management needed to be improved. There was no evidence people received topical creams as prescribed and where people's medicines had been crushed guidance had not been sought from the pharmacist. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, best interest meetings were not always in place when specific decisions were made for example when people required covert medicines.

People were supported by staff who were kind and caring. They had a good understanding of people's individual needs and choices. This enabled them to provide good person-centred care. However people's records did not always reflect the care they required or received.

There were enough staff on duty who had been appropriately recruited to meet people's needs.

Staff understood the procedures in place to safeguard people from abuse. They were able to tell us about different types of abuse and what actions they would take to raise their concerns.

People received care from enough suitably trained staff who had the skills to perform their roles. Staff were well supported through the training and supervision process. The nurses told us they received clinical training and the guidance they needed to maintain their skills and competencies.

People's nutritional needs were met and people could choose what to eat and drink on a daily basis. The meal times were a sociable occasion and people were supported by staff in an appropriate way. People were supported to have access to see their GP or other healthcare professional when they needed to. This ensured their health needs were met.

There were quality assurance systems in place to assess the quality of the service provided. However, these were not always effective and had not identified all the shortfalls we found.

There was an open culture at the home, the management team were approachable and staff said they felt supported. Staff had regular meetings and were asked for ideas on the running of the home.

We found a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Abundant Grace was not consistently safe.

Staff had a good understanding of the risks associated with caring for people at the home. However, risks associated with managing people's pressure areas required review.

Aspects of medicine management needed to be improved. There was no evidence people received topical creams as prescribed and where people's medicines had been crushed guidance had not been sought from the pharmacist.

There were enough staff on duty who had been appropriately recruited to meet people's needs.

Staff understood the procedures in place to safeguard people from abuse.

Is the service effective?

Requires Improvement

Abundant Grace was not consistently effective.

People received care from enough suitably trained and supported staff who had the skills to perform their roles.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. However, best interest meetings were not always in place when specific decisions were made.

People were provided with a choice of healthy and nutritious meals each day.

Staff ensured people's health care needs were met and they had access to relevant healthcare professionals when required.

Is the service caring?

Good

Abundant Grace was caring.

Staff communicated clearly with people in a caring and supportive manner. They knew people well and had good

relationships with them.

People were treated as individuals and staff respected people's dignity and right to privacy.

People were encouraged to express their views and to make choices.

Visitors were made to feel welcome and could visit the home whenever they wished.

Is the service responsive?

Good

Abundant Grace was responsive.

People's care was personalised to reflect their needs and choices.

A range of activities were provided that met people's needs and interests. People had the opportunity for social interaction with staff on a regular basis throughout each day.

There was feedback from people and their representatives about the service.

Is the service well-led?

Requires Improvement

Abundant Grace was not consistently well-led.

People's records did not always reflect the care they required or received.

Quality assurance systems were in place but these were not always effective.

The staff told us they felt supported and listened to by the provider and matron.

Abundant Grace 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 was an unannounced inspection on 28, 29 November and 1 December 2016. It was undertaken by an inspector 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.

Some people who lived in the home were unable to verbally share with us their experiences of life at the home because of their dementia needs. Therefore we spent a large amount of time during our inspection observing the interaction between staff and people and watched how people were being cared for by staff in communal areas.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, staff files and information relating to the upkeep of the premises. We also looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with ten people who lived at the home, six visiting relatives, and sixteen staff members including a director, registered manager and deputy manager. The registered manager was known as matron and will be referred to as matron throughout this report. We also received feedback from three visiting health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Abundant Grace. One person said, "I feel safe, the staff are always popping in to see if you are ok." Another person said "I couldn't be more safe." A visitor told us, "My relative is safe here, and we are happy with the care they receive." People told us they received their medicines when they needed them. One person told us, "Medication is all attended to, I get whatever I need."

However, we found aspects of the service were not consistently safe.

Concerns had been raised with us prior to the inspection that a number of people had fallen and these falls were unwitnessed. Assessments were in place and actions had been taken to protect people who were identified at risk of falling. For example some people had pressure mats on the floor or on their chairs which alerted staff if people moved from their bed or chair without contacting staff. People who were at risk of falls were checked by staff every 30 minutes. Following a fall, incident and accident forms had been completed and when required information was used to update the care plans and risk assessments. One person had been identified at risk of falling when they needed to use the toilet. Each time staff checked on the person they asked if they needed the toilet and supported them if necessary, which was recorded. The matron had identified some people were prone to urinary tract infections and this increased their risk of falls. Staff tested their urine each week so that action could be taken as soon as possible if an infection was detected which may help prevent further falls.

The matron was aware of the concerns but also clear that people should be supported to take well thought out risks to maintain their independence. She explained some people who had fallen had been assessed as not at risk of falling when they moved into the home. The matron gave us an example of one person, assessed at low risk of falls, who had not been able to mobilise independently for some time before to moving into the home. As this person's condition improved their confidence increased and they wished to become more independent and this had meant they were at a high risk of falls.

During the inspection we identified some people moved their pressure mats or stepped over them which did not alert staff. We identified this to the matron who took immediate action. There was ongoing analysis of falls to identify any themes and trends across the service. We recommend the provider proactively analyses falls to identify themes and trends and continues to explore different measures and ideas to ensure the number of falls at the home are significantly reduced.

There were a range of environmental and individual risk assessments in place for example in relation to people's mobility and skin integrity. Staff we spoke with had a good understanding of the risks associated with supporting people. Risk assessments had identified people were at risk of pressure area damage. There was information in care plans about the support people required to maintain their pressure areas. This included information about position changes and pressure relieving equipment such as air mattresses or cushions. However, there was no information about the pressure settings for people's air mattresses and there was no information in people's room charts although these had been ticked as correctly set. We asked

staff how they knew what setting the mattresses should be on. They told us these were set according to people's weights. We checked this with people's records and found the mattresses had not been set correctly. Care plans informed staff whether people required bed rails to be used but this information had not been recorded in people's room charts. Room charts were completed and stated that bed rails were in the 'correct position' but there was no information to show what this was. We raised this as an area to be improved and to ensure this was addressed promptly.

Some people chose to take risks in relation to what they did during the day. This was recorded and demonstrated that the person was fully aware of the risks they were taking and possible consequences. Staff had a clear understanding of the support this person required. There were a number of fire checks and a fire risk assessment had taken place. Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs and the assistance required in the event of an emergency evacuation.

Some people required care in relation to a health related condition such as diabetes, epilepsy, or catheter care. These risks were well managed. Care plans contained information to ensure people's health needs were met appropriately. For people who were living with diabetes there was information about the medicines they had been prescribed, when their blood sugar levels should be checked, what were normal levels for each individual and what action staff should take if the levels were not within normal range for the individual.

Aspects of medicine administration needed to be improved. Some people required topical creams to be applied. Some creams were to maintain good skin health for example to prevent skin becoming dry. Others had been prescribed for a specific health need such as a skin infection. Nurses completed the medicine administration record (MAR) to show the cream had been applied by the care staff. However, there were no body maps in place to show where to apply the cream and care staff had not completed any records to demonstrate creams had been applied as prescribed. Some people required their medicines to be crushed to enable them to take them. Crushing medicines may alter the way they work and make them ineffective. Staff should always ask for a pharmacist's advice before they crush any medicines. There was agreement from people's GP's but no evidence any discussions had taken place with the pharmacist to ensure these medicines had been used appropriately. We raised these issues with the matron as an area that needs to be improved.

Medicines were stored in locked trollies which were not left unattended when in use. Medicines Administration Records (MAR) charts were not signed until medicines had been taken by the person. These had been completed to show when medicines had been given or why they had been omitted. MAR charts contained information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. Medicines were ordered, stored and disposed of safely. The nurses received regular training and there was regular checking of their competency to administer medicines. Some people had been prescribed 'as required' (PRN) medicines, such as pain killers. The nurses had a good understanding about the medicines people had been prescribed and why they may need them. One person told us, "If I need painkillers I just press the bell and nurse will get them."

People were protected, as far as possible, by a safe recruitment system. Appropriate checks were completed before staff started work to ensure they were of suitable character to work at the home. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were copies of other relevant documentation including references, interview notes and Nursing and Midwifery Council (NMC) registration documentation in staff files. There were regular checks in place to ensure nurses who worked at the home had maintained their registration which allowed them to work as a nurse. One visitor told us,

"They know how to select staff here, they are all so friendly and caring."

Staff received safeguarding training and regular updates. They told us about steps they would take if they believed people were at risk of abuse or harm. Care staff told us they would report to their senior on duty and escalate their concerns through the company if they felt issues had not been addressed. Staff were aware of their responsibilities to report any concerns and were aware of the external organisations they could report to if their concerns had not been addressed appropriately.

Concerns had been raised with us prior to the inspection that people were not attended to in a timely way because there were not enough staff on duty. Some people and visitors told us that on occasions they had to wait for some time before their call bell was responded to. One visitor said, "The only negative thing I have to say is the amount of time we sometimes have to wait." Another visitor told us, "Mum has had to wait up to five minutes, it's too long." A further visitor said, "The bells ring a lot they seem to go on a long time." The matron explained to us that although it sounded like bells rang for a long period of time it did not mean it was the same bell ringing continuously. There were panels on the wall which showed which bell was ringing, so that staff could identify who was calling. The matron and director told us they were able to analyse the length of time people waited for their call to be answered, although this was not working at the time of the inspection. There was no formal dependency tool to assess staffing levels these were based on staff knowledge of people's needs. The matron was aware when people's needs increased through feedback from staff, observation and assessment of people. Staffing levels would be increased if required. One person had increased needs at the time of the inspection and an extra staff member was working each day.

One staff member said, "Staffing levels are fine now the summer holidays are over." We found there were enough staff to support people safely. The rotas showed consistent staffing levels with nine care staff working on each floor in the morning, seven in the afternoons and two nurses each shift. There were dedicated, activities, housekeeping and laundry staff. During our inspection we saw people were attended to in a timely way although staff acknowledged if a number of people rang their bells at one time there would be a delay in answering them. One person said, "I've only got to press the bell then staff will come."

The home was clean, tidy and well maintained throughout with evidence of good attention to detail. Regular health and safety checks took place. These included environmental and maintenance checks, regular servicing for gas and electrical installations and lift and hoist servicing. The home was staffed 24 hours a day with an on-call system for management support and advice.

Requires Improvement

Is the service effective?

Our findings

People told us they were supported by staff who had the knowledge and skills to meet their needs. One person said, "The staff are well-trained and I'm looked after how I like to be looked after." Another person said, "You couldn't say that you're not looked after here because you are." One visitor told us, "My relative had a stroke and had difficulty in communicating verbally, staff are very patient, his speech is improving, it's much clearer and he's becoming more confident." People told us they enjoyed the food. One person said, "The food is excellent, I really can't complain."

We found aspects of the service were not effective.

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. DoLS applications for people who did not have capacity and were under constant supervision by staff had been submitted.

Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. We found that reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. The MCA states that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We identified that for certain decisions this had not been considered or referred for a best interest meeting and best interest decisions were not consistently in place. Some people had medicines administered covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. We saw best interest decisions had been recorded for some people but not everybody. One person who lacked capacity had bed rails in place, however staff had recorded this person had agreed to the use of bed rails. There was no information to demonstrate how the decision was made.

Another person had capacity and chose to make unwise decisions that could impact on their health and well-being. The care plan for the activity stated the person had capacity, when the person engaged in the risky behaviour staff recorded that they had asked the person if they understood the risk. This person was living with complex health needs and there was no information to demonstrate how staff would know the person still had capacity to make the decision. This told us mental capacity assessments whilst undertaken were not decision specific and were not recorded in line with legal requirements. We raised these with the matron as areas that need to be improved.

Not everybody had information in place about whether they had a power of attorney and what this covered. The matron told us this had been identified and was being addressed.

Staff received the training and support they required to enable them to meet people's needs. They completed an induction when they started work at the home and also undertook the Skills for Life Care Certificate training which familiarises staff with an identified set of standards that health and social care workers apply in their daily working life. One staff member told us they felt well supported throughout the induction process. As part of the care certificate staff received regular supervision and observation to ensure they were competent to provide the care and support people needed which staff told us they found useful.

Staff received regular training and updates in subjects relevant to the care needs of people they were supporting. This included safeguarding, dementia, moving and handling and mental capacity. In addition care staff were able to undertake further training for example the diploma in health and social care at various levels. Staff told us they identified further training during supervision to support them in their roles.

Nurses received regular clinical training and updates, this included wound care, catheter care and diabetes. There was a clinical lead for the provider who worked with the nurses and ensured they had the appropriate clinical knowledge, skills and competencies. Nurses told us if they had any clinical concerns or identified areas they needed support or further training this would be provided. One nurse told us, "I couldn't ask for any better support here, if I need more training or support I only have to ask, the clinical lead couldn't do more for me." Nurses were supported by the training team in meeting the new requirements relating to nurse's continued registration. These requirements ensure registered nurses meet a certain standard in order to continue to practice.

There was an ongoing supervision programme and staff told us they received this regularly. Staff told us they found this useful as it gave them an opportunity to discuss any issues and identify any training needs. Staff said they could discuss concerns with the matron or senior staff at any time. The matron told us there was no appraisal system in place but regular evaluation of staff performance took place during the supervision process.

People were supported to have enough to drink and eat and their nutritional risks were managed well. Their nutritional needs had been assessed and were regularly reviewed. When risks had been identified these were reflected within care documentation. Where people had been identified at risk of dehydration or malnutrition records were in place to monitor their intake. People were weighed regularly which enabled staff to identify people who were at risk of weight loss or malnutrition. Where appropriate people had been referred to the GP, speech and language therapist (SaLT) or dietician. There was guidance in place and staff had a good understanding of people's nutritional needs and risks.

People were given a choice of freshly cooked nutritious meals each day. The chef had a good understanding of people's individual nutritional needs and there was updated information available in the kitchen. Staff knew people well and where people were less able to make decisions and choices about what they liked to eat and drink staff were able to support them. The chef and director were in the process of developing pictorial menus to help people make their choices. We were shown samples of the pictures which clearly reflected the meal being provided. There was information about people's dietary needs for example if they required a pureed or diabetic diet. We saw these were provided appropriately. The chef was passionate about ensuring people received food they could eat and enjoyed. He was aware that mealtimes were an important part of people's day and should be an enjoyable experience. The chef told us, "Just because people are in a care home doesn't mean they shouldn't experience new things, if they were at home and went out for a meal they would try different things on the menu. That's what we try to do here."

People chose where to eat their meals. One visitor said, "My relative ate in the dining room a few times but didn't like it so stays in their room." They added that staff regularly asked their relative if they would like to join others in the dining room but they declined. Another person told us, "I stay in my room, my choice." A number of people sat in the dining room and others remained in their bedrooms. Dining tables were nicely presented and there was a copy of the menu displayed on each table. Where people required support with their meals this was provided appropriately. Staff sat at the table with people and supported them at their own pace. Staff encouraged and prompted people as necessary, they ensured people liked the food they were eating and checked they had eaten enough. Staff engaged with people they were supporting, and others at the table which helped make the mealtime a social experience. People were provided with a selection of hot and cold drinks throughout the day. One person told us, "There are always drinks, the jugs are kept full and I have orange juice or apple juice with my meals, and at any time that I want."

People were able to maintain good health and they received on-going healthcare support. There was a member of staff who was responsible for co-ordinating people's healthcare appointments and records confirmed that staff regularly liaised with a wide variety of health care professionals to ensure people received appropriate healthcare. This included the tissue viability nurses, speech and language therapists, GP and chiropodist and staff accompanied people to hospital appointments if needed. The nurses maintained good contact with the GP's and liaised with them regularly for advice for example if people's health needs changed. A visiting healthcare professional told us staff knew people well, they referred people to them appropriately and acted on the advice given. They told us staff proactively supported one person to complete their exercises and this had improved the person's range of movement.

Good

Is the service caring?

Our findings

The people who used the service told us that staff were caring, kind and considerate towards them. One person told us, "They're very good caring staff," another person said, "They are all very friendly, very friendly." Other comments included, "Staff will chat to you if you want to chat, it's up to you really." "Staff are all very kind and friendly, they listen to you when you want to talk," and "I've made friends here." A visitor told us about their relative, "Staff are attentive and caring, she gets good care. I go home and know she is well looked after."

Although it was busy there was a calm and relaxed atmosphere at the home. People were supported to spend their day as they chose and were involved in decisions about their day to day care and support. There was information in the care plans about the time people liked to get up and this was respected. One visitor told us their relative chose to spend their time in their bedroom. They said, "My relative prefers to spend time alone, they know they can go to the lounge or join in activities but they choose not to." The visitor told us although this was their relative's choice staff would remind them they could change their mind if they wanted to. Another person who preferred to remain in their room told us, "You're away from people, you've got your own room, your own door and space so you don't get bothered".

Interactions and conversations between staff and people were positive and there was friendly chat and good humour between people and staff. Staff knew people well and were able to tell us about people's individual care needs and preferences. People were familiar with staff and happy to approach them if they had concerns or worries. Staff were able to communicate well with people who were less able to express themselves verbally due to their dementia. We observed one person who was living with dementia was distressed. Staff approached them and spoke reassuringly. The person remained upset so the staff member held the person's hand and said, "Would you like to come with me and have a nice cup of tea." The person agreed and seemed comforted. Staff told us they knew why the person had become distressed and the best way of supporting them was to distract them and provide them with a focus. We saw this person later and they appeared much happier. There was a visitor to the home who had been recently bereaved. We saw staff stopped to talk with the person, offered their sympathies and ensured they were alright throughout their time at the home. This showed us people were treated with kindness and compassion by staff.

Staff maintained people's privacy. When staff were providing personal care bedroom doors were closed and staff told us they kept people covered as much as possible. We observed staff knocking on people's doors before entering their bedrooms and introducing themselves so people knew who was there. They gained consent from people before offering any care or support.

People were supported to maintain their dignity. People were well presented in clothes of their choice that were clean and well laundered. They were supported to maintain their own appearances in a way that suited them, for example wearing make-up and jewellery and men were supported to shave as they chose. People's bedrooms were personalised with their own belongings such as photographs and other memorabilia.

People were supported to maintain their independence as far as possible. One person said, "They (staff) do everything that they can for you but I do help I can't let them do everything." We saw some people who were at risk of falls walking around the communal areas. Staff told us although these people were subject to regular checks they kept an eye out for them. One staff member said, "We know when someone is walking around and we keep an eye out for them, we will walk with others." We observed staff supporting one person to return to their room. They told us this person had been walking for a while and had become weary so they were returning to their room for a rest.

People were able to maintain relationships with those who mattered to them. There were regular visitors at the home throughout the day. We saw they were welcomed by staff who appeared to know them well. One visitor told us, "I'm always welcomed here and offered tea and cake." Everybody had a telephone in their bedrooms which meant they could maintain contact with friends and family.

Good

Is the service responsive?

Our findings

People received the care and support they needed and chose. We saw care was personalised to people's individual preferences. People were able to choose how to spend their day, some spent time in their room, others in the lounge or took part in activities. People who were able moved freely around the home and others were supported by staff to do so. There were a range of activities taking place at the home and people were able to join in if they wished. Visitors told us they were regularly updated about their relative's health and care needs. One visitor told us, "Dad was recently unwell and we were phoned and updated on his health and progress." Another visitor told us they had recently been invited to a meeting which included the GP to discuss their relatives care.

Concerns had been raised with us prior to the inspection that people did not always receive the care and support they needed. We had been told people did not always have their call bell or a drink near to them and personal hygiene needs had not been met. At our inspection we found people's care needs were being met. There were charts in place in people's rooms which staff completed hourly to demonstrate people had their call bells in place and a drink of their choice. We found these charts had been completed. We looked at the charts for a few days prior to our inspection and these had also been completed. Staff told us about one person who had declined personal care, this had been recorded and there was a care plan in place to guide staff about how to support the person. Visitors we spoke with during the inspection told us their relatives received care that met their needs. One visitor told us their relative recently had a urinary tract infection. They told us staff responded well and developed a plan to ensure the person was gently encouraged to drink more. A monitoring system was also set up and was still in place. One person told us they had had a fall, they said staff were insistent they remained where they were until they were thoroughly checked over. They said, "They keep you on the floor for ages, you're not rushed, they asked me are you sore anywhere? Do you hurt?"

Pre-assessments took place before people moved into the home to ensure their needs and choices could be met. People, and where appropriate their representatives, were involved in developing their care plans and these were regularly reviewed. One visitor told us, "At the beginning I was consulted over my relatives care plan." Another visitor said "They always discuss my relative's care with me." Care plans included information about people's mobility, personal care, skin integrity and nutrition. For example mobility care plans included information about how people were able to mobilise. One person was unable to mobilise independently. The care plan informed staff the person was unable to stand and required two staff to support them to change position. There was also information about which equipment should be used to transfer the person, for example by using a mechanical hoist. Skin integrity care plans informed staff when a person was at risk of pressure area breakdown. There was guidance about what equipment was in use and how often the person should have their position changed. Care plans were not always person centred or detailed however people received care that was person-centred and reflected their individual choices and preferences. This was because staff knew people well; they had a good understanding of them as individuals, their daily routine and likes and dislikes.

There were dedicated activity staff and a busy activities programme in place and we saw people were busy

throughout the day. There was an activities room where art and crafts could take place and we saw this during the inspection. There was a small group of ladies who enjoyed knitting. We observed they spent the morning together knitting, chatting and drinking their tea and coffee. They were supported by staff as needed. Staff told us people were supported to knit meaningful items for example there had been a lot of scarves made which people then used when they went outside during the colder weather. One activities staff member told us the scarves had been particularly useful when people went out to the bonfire in November. A choir had been formed and during our inspection people were practising Christmas carols to perform as part of a Christmas concert. We observed some people, who due to their physical disability or living with dementia, were unable to be physically involved in the group activities. However, these people were part of the group and observed. Staff told us about one person, "Although they are unable to join in physically they like to be part of the group, we can tell they are enjoying themselves." We saw this person and although they were unable to communicate with us verbally they appeared to be enjoying themselves. People were happy with the choice of activities on offer and told us it was individual choice as to whether they got involved or not. Some people told us they preferred to spend time in their rooms. Two people said they enjoyed watching the birds and squirrels in the garden through their windows. Other people enjoyed reading, watching the television and doing jigsaw puzzles. We saw staff regularly asked people if they would like to take part in activities. One visitor told us, "They always ask my relative to join in but they are adamant they don't want to mix with other people which is fine, but I'm glad they keep asking." If people were unable, or chose not to take part in group activities then one to one activities were in place for them.

There was a complaints policy and procedure and complaints were investigated, recorded and responded to appropriately. People told us they would make a complaint if they needed to. A visitor told us they had raised a concern and staff had asked if they wished to make a complaint but they declined. They told us they were happy with the actions taken. There was one complaint that was being investigated at the time of our inspection.

People's views were sought and listened to through feedback surveys and meetings. There were monthly resident and relative meetings and minutes of these were displayed in the entrance hall. Some visitors we spoke with were not aware of the meetings, we discussed this with the matron who said she would address this to ensure people were aware and could attend if they chose to. One visitor told us, "I think that's something I'd like to come to, it would give me a chance to know what's going on at the home." Records showed people were asked about their view of the food and issues about laundry were discussed. As a result of feedback the chef was developing a wider range of desserts for people who were living with diabetes.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they found the home was well-led. Comments included, "It's managed very well I think," "It runs smoothly," "There's a good atmosphere" and "I find the staff attentive, friendly and helpful." Staff said they were happy working at the home and felt well supported.

We found aspects of the service were not well-led.

People's records were not always accurate or consistent and did not contain all the information staff needed to look after people. One person's medicine care plan stated they were unable to take anything orally however their eating and drinking care plan contained information about how staff should support this person at meal times. Some people who had wounds had wound care plans in place, other people's wound care was recorded on an evaluation sheet without a care plan. Activity care plans did not include all the information about what people liked to do. One person's activity care plan stated what the person liked to do but the monthly evaluation stated the person 'continued to enjoy attending church.' This had not been included on the care plan. The care plans were not always person-centred. A pain care plan for one person who was less able to express themselves verbally informed staff to observe the person's facial expression to determine if they were in pain. However, there was no further information about how the person may display these expressions. Where people did not have capacity there was no information in the care plans about how they were able to make daily choices for example what to wear or how they liked to look each day. There was limited evidence of people or their representatives being regularly involved in care plan reviews.

Records of people's daily activities were not individualised and did not demonstrate whether each person had participated or engaged in the activity. Daily records did not demonstrate people's well-being, mood or what they had done each day. Where people required one to one activities there was no information about how and when this was provided. PRN protocols did not contain all the information staff needed. For example one person had been prescribed a medicine to prevent constipation but there was no information for staff to understand when this may be needed. This did not impact on people because staff knew them well and were able to tell us in detail about the care they needed. However, the lack of guidance could leave people at risk of receiving inappropriate or inconsistent care.

Although there was a quality assurance system in place and audits took place they had not identified all of the shortfalls we found. The medicine audits had not identified the PRN protocols did not contain all the information required. Care plan audits had not identified mental capacity assessments were not decision specific and did not include information about how decisions were made. The care plan audits had not identified people's care plans were not person-centred. There was no system in place to identify whether air mattresses were on the correct setting. Some shortfalls had been identified for example the medicine audit had identified cream charts had not been completed and PRN guidance was not in place for some people. However, it was not clear what action had been taken to address these concerns. An activities audit identified the activities people had engaged in throughout the month however there was no further analysis to demonstrate why one person who did not participate in group activities had only engaged with one to

one activities on three occasions during October. There were a range of policies in place however the medicine policies did not contain consistent guidance in relation to covert medicines.

Prior to the inspection a number of people had raised concerns with us that minor concerns they raised were not addressed. This included issues such as missing laundry or call bells not nearby. Although official complaints were responded to there was no system in place to record minor issues and identify themes and trends across the service which would enable the provider to address issues before they became complaints.

Throughout the inspection we observed people's care plans and records were left unattended at the staff base on each floor. One visitor said, "I've seen care plans out a lot, I know staff are around but I wouldn't like to think someone could pick up my relatives notes and read them." We also found that staff were unable to locate people's topical cream charts for one floor. This had not been identified by any of the management team.

The provider failed to have effective systems and processes in place to assess and monitor the quality of the services provided and ensure people's records were accurate and complete. This was a breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director showed us an audit tool that was due to be introduced which would help to ensure nursing care plans were current and reflected people's assessed needs.

There was an open culture at the home, the matron and deputy manager worked at the home each day. They were visible around the home and knew people and staff well. Staff told us they felt supported by them and by the director who they told us they could approach at any time. Whilst all staff told us they felt supported, the nurses told us they were particularly impressed by the support systems the provider had introduced for them in relation to clinical training and supervision. One nurse told us, "You couldn't ask for more." If necessary the matron and deputy manager would work a shift at the home and the deputy manager had recently worked some night shifts which had given her insight into the risks associated with supporting one person.

Staff were aware of their individual roles and responsibilities and knew who they could contact if there were any concerns. They were updated about people's care and support needs at the start of each shift. Staff were regularly updated by colleagues throughout the day. There were regular staff meetings to provide the opportunity for staff to feedback about the day to day running of the home. Staff were also updated about issues at the home and reminded about their individual responsibilities.

There was an emphasis on developing the service and the provider had recently secured placement for student nurses to work at the home. This started during our inspection and we were told about the appropriate support systems in place for the students.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective systems and processes to assess and monitor the quality of the services provided and had failed to ensure people's records were secure, accurate and complete. 17(1)(2)(a)(c)