

## A Spellman Steeton Court Nursing Home

### **Inspection report**

Steeton Hall Gardens, Steeton Keighley BD20 6SW Tel: 01535 656124 <u>Website:</u> www.steetoncourt.co.uk

Date of inspection visit: 21 September 2015 Date of publication: 01/10/2015

### Ratings

### Overall rating for this service

Is the service responsive?

### **Overall summary**

Steeton Court Nursing Home provides accommodation and nursing care for up to 71 older people at any one time. On the date of the inspection, 21 September 2015, 65 people were living in the service.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection on 21 May 2015 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found care was not consistently delivered to meet people's individual needs and preferences as some people on the 1st floor were receiving bed baths as early as 4.30am. Staff told us the reason for this was to take pressure off day staff. However this demonstrated a task orientated culture and a lack of a personalised approach to care. At this inspection we found improvements had been made and ways of working changed to ensure a more person centred approach to the delivery of care and support. People now got up and received assistance with personal care at times that met their individual needs and preferences.

Good

Good

At the last inspection in May 2015, we found pressure relieving mattresses were not always on the correct weight setting increasing the risk they would not be effective. At this inspection we found systems had been put in place to ensure mattress settings were regularly checked. We found these systems had been effective and mattresses were now correctly set.

We found where we had identified gaps in care plans in the May 2015 inspection; these had been addressed through the creation of appropriate and personalised care plans.

### The five questions we ask about services and what we found

We always ask the following five questions of services.

#### Is the service responsive?

The service was responsive. The provider had addressed the concerns we noted in the last inspection	
and there was now a more person centred approach to the delivery of care and support.	

Good

Systems were in place to check pressure relieving mattresses were correctly utilised to help ensure they were effective in reducing the risk of pressure sores.



# Steeton Court Nursing Home

### 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 had made improvements following the May 2015 inspection where we found a breach of one regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014.

This inspection took place on 21 September 2015 and was unannounced. The inspection team consisted of one inspector. During the inspection we spoke with three people who used the service, the registered manager, three registered nurses and one care worker. We reviewed specific areas of 20 people's care records.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed all the information held about the provider.

## Is the service responsive?

## Our findings

At the last inspection on 21 May 2015 we found a breach of Regulation 9 regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found care was not consistently delivered to meet people's individual needs and preferences as some people on the 1st floor area were receiving bed baths as early as 4.30am. Staff told us was done to take the pressure off day staff. However this demonstrated a task orientated culture and a lack of a personalised approach to care.

At this inspection we found improvements had been made. Staff we spoke with told us there was no longer a requirement to ensure a certain number of people were got up before the day shift started. They told us there was now a more person centred approach to assist people in line with their individual needs and preferences. Care records we viewed confirmed this to be the case, showing people were regularly checked throughout the night and then offered assistance with personal hygiene, washing and dressing when they needed it. Three people we spoke with also told us they were able to get up when they wanted to.

At the last inspection in May 2015 we found pressure relieving mattresses were not always set correctly, which meant there was a risk they may not be effective in helping to reduce the risk of skin breakdown. At this inspection we found a robust system had been put in place to regularly check mattresses to ensure they correctly set. Records we viewed confirmed these checks were taking place. We looked at a sample of nine mattresses and found them to be on the correct setting indicating this system was effective.

At the last inspection we found some care records were missing key documents. We found this had been addressed by the Registered Manager and appropriate plans of care were now in place. Care records we looked at were subject to regular review and kept up-to-date. A more robust system of checking care records had been put in place to reduce the risk of future deficiencies in care planning.

## Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

## **Enforcement** actions

The table below shows where legal requirements were not being met and we have taken enforcement action.