Liberty Healthcare Solutions Limited

The Fountains Nursing Home

Inspection report

Victoria Park
Swinton Hall Road, Swinton
Manchester
Greater Manchester
M27 4DZ

Tel: 01617945814

Date of inspection visit:
18 May 2016

Date of publication:
12 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on Wednesday 18 May 2016.

We last inspected The Fountains Nursing Home in October 2015 which was given the rating of 'Requires Improvement' overall and in each of the five key questions against which we inspected against. These included Safe, Effective, Caring, Responsive and Well-led. During this inspection we identified several breaches of regulations with regards to Safe Care and Treatment, Good Governance and Staffing. We issued a Warning Notice due to concerns about staffing levels.

The Fountains Nursing Home is in Swinton, Salford and is owned by Liberty Healthcare. It provides residential and nursing care, as well as care for people living with Dementia. The home provides single occupancy rooms with en-suite facilities and is registered with the Care Quality Commission (CQC) to provide care for up to 98 people.

There are four units at the home, known internally as Parkview (Residential Dementia), Garden Rooms (General Residential), Victoria Suite (General Nursing) and The Lowry (Dementia Nursing). At the time of the inspection there were 86 people living at the home, across the four units.

People who used the service told us they felt safe. We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. All the staff we spoke with demonstrated they had a good understanding of the types of abuse and the procedure to follow if they suspected that a person was at risk.

At the previous inspection, we had concerns about staffing levels at the home. At this inspection we still had concerns about night time staffing numbers on the Lowry unit, mainly in relation to how staff monitored people who were up early in the morning. We saw the unit was staffed by a nurse and two care assistants during the night. The manager said there should be a staff presence in the lounge at all times, however we observed this was not the case during the inspection. We observed one of the people in the lounge during this period had been involved in a high number of altercations and incidents when we looked at incident records. This could place people at risk.

We looked at how medication was handled on each of the four units at the home. Overall we found medication was given to people safely, however we found there was no guidance available for staff about when or where to apply creams. This would be important due to agency staff working at the home. We also found that the home had not sought GP's authorisation for the use of a specific homely remedy for people living at the home. We raised these issues with the home manager.

We checked to see that the environment was safe for people living at the home. At the last inspection sluice room doors were left unlocked which posed a risk to people. At this inspection on two occasions on the Lowry unit, we saw the food supplement 'thick and easy' was left unattended on the trolley whilst the drinks

round was in progress. This was in an area where people were mobile. We also saw the kitchen door in the Lowry unit was left unlocked on one occasion, an area where there was a hot water dispenser. Staff on the unit said this door should be locked. This could present the risk of people scalding themselves. We also raised these issues with the home manager.

We saw people had risk assessments in their care plans. We saw these were regularly updated and covered areas such as mobility, nutrition and pressure care managements. This provided staff with clear guidance about how to mitigate any potential risks to people.

We noted there was a strong smell of urine on the Lowry Unit, throughout the course of the day. Staff said this was because certain people often urinated in corridor areas as they walked around the unit. The environment was also still in need of updating in areas where carpets were stained and worn, as well as skirting boards which were scratched and damaged. We were told improvement to the environment were on going and that this work was being scheduled.

Staff told us they had enough training available to them and felt supported to undertake their roles effectively. We saw staff had completed training in areas such as safeguarding, moving and handling and health and safety. At the last inspection we saw staff hadn't completed training related to DoLS and behaviours that challenged. We saw staff still hadn't completed training in this area during this inspection. The manager said she had prioritised getting all mandatory training up to date first and that this would be scheduled following the inspection.

We saw improvements had been made to make the environment more 'dementia friendly', particularly on the Lowry Unit, which was one of two dementia units at the home. We saw themed corridors had been introduced along with pictures of famous actors, the queen, sporting memorabilia, famous singers and sensory objects people could touch. This would help people to become more familiar with the environment they lived in.

People living at the home told us they received enough to eat and drink. We observed the meal time experience on three of the four units at the home to establish how people's nutritional needs were met. We saw people had their own nutrition care plans and risk assessments available, which detailed any information staff needed to be aware of.

The service worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a good working knowledge of capacity issues and DoLS.

People told us they felt staff were caring, as did relatives we spoke with. We saw staff displayed a good understanding of people's needs and treated people with dignity and respect.

Care and support plans contained person-centred information which detailed people's likes, dislikes, personal preferences and life and social history. We saw the home had even gone to the extent of sourcing different photographs of people from earlier in their lives and stored these with individual life history records. The manager said she aimed to introduce these across all care plans.

There was a complaints policy & associated procedure and information about how to make a complaint was available. There was also a comments and suggestions box located in the reception of the home.

The home had a manager, although they were not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager had introduced a number of audits and quality assurance checks within the service. These covered areas such as medication, care plans, weekly weights, pressure areas, bedrails and continence. The manager also closely monitored any incidents that occurred. This was an area we felt had improved since the last inspection.

Staff said they felt the home was well-led and had seen improvements and changes since our last inspection.

We saw staff had regular opportunities to voice their opinion and raise concerns. We saw meeting minutes were available from team meetings that had taken place.

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

Not all aspects of the service were safe.

We still had concerns about night time staffing levels on the Lowry unit.

There wasn't always sufficient information available for staff about where and when to apply creams to people when they needed them. We also couldn't see evidence the home had sought advice from GP's about homely remedies.

We identified several risks such as 'thick and easy' being left accessible in lounge areas. A kitchen door was also left unlocked with access to a hot water dispenser. There was no risk assessment available in relation to this.

Is the service effective?

Good

The service was effective.

The service worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff said they had enough training and support available.

People said they had enough to eat and drink and saw records were maintained by staff.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives felt staff were kind and caring.

People said they were treated with dignity and respect by staff.

Is the service responsive?

Good

Care plans detailed people's likes, dislikes and personal preferences. Staff had also made a good effort to source

photographs about people's previous life experiences.

There was an appropriate, up to date complaints policy. People told us they
had no complaints, but were confident any concerns would be dealt with
promptly.

People who used the service were supported to participate in activities if this was what they wanted to do.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led

There was a manager in post, but they were not yet registered with the Care Quality Commission.

Audit and quality assurance had improved since the last inspection.

Staff said they thought the service was well-led and felt supported to undertake their roles.

The Fountains 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.

We carried out this unannounced inspection on Wednesday 18 May 2016. The inspection team consisted of three adult social care inspectors from the Care Quality Commission and Specialist Advisor. Our Specialist Advisor was a registered nurse.

Before the inspection we reviewed all of the information we held about the home. This included notifications sent to us, safeguarding incidents, unexpected/expected deaths, serious injuries which had occurred and previous inspection reports. We also contacted other agencies involved with the home. This included the local Safeguarding team, Health watch, Environmental Health, CCG (Clinical Commissioning Group) and Infection Control.

During this inspection we spoke with the following people: six people who used the service, six relatives, the manager, the chief executive, the home owner and 12 care staff which included both care assistants and nurses (day and night). We also spoke with a domestic, the activities co-ordinator and two visiting health care professionals.

We looked at the following documentation: 13 care plans and associated documentation, 10 staff files including recruitment & selection records, a variety of training & development records, audit & quality assurance, policies & procedures and safety & maintenance certificates. We also looked at how medication was handled on each of the four units of the home.

Requires Improvement

Is the service safe?

Our findings

The people who were able to communicate with us, told us they felt safe living at The Fountains. Not everybody was able to tell us their experiences of living at the home, mainly due to living with different stages of dementia. One person living at the home told us; "I've no concerns about my safety. All the staff have been very good with me so far".

During the inspection we spoke with visiting relatives who told us they had no concerns about safety within the home. One relative said; "No concerns about [person's] safety. [Person] is living with dementia, poor hearing, double incontinence and is not mobile. They have discussed all the risks with me. Staff use a hoist for transfer, there are bedrails in place as [person] wouldn't climb but [person] would roll out of bed. [Person] is at risk of choking but has a pureed diet." Another relative said; "I think people are safe. There is a security mat at the door to alert staff if anybody enters the bedroom. I feel better and think [person] is as safe as can be as we don't want the door shutting all the time."

We checked to see if there were sufficient staff available to care for people safely. Staffing levels on Lowry during the day had increased from four to five care assistants, with the introduction of a senior carer since the last inspection. This was in addition to a nurse. At night there was a nurse and two care assistants to care for 22 people. Staffing levels on Victoria consisted of six care assistants and two nurses during the day and a nurse and three care assistants at night. A senior carer role had also been introduced on this unit to care for 29 people. Both Park View and Garden Rooms were staffed by a senior carer and one care assistant at night, with an additional care assistant available during the day. This was to provide care to 13 and 22 people respectively.

At the previous inspection, we had concerns about night time staffing levels on the Lowry unit, mainly in relation to how staff monitored people who were up early in the morning. We saw the unit was staffed by a nurse and two care assistants during the night. The manager said there should be a staff presence in the lounge at all times when people started getting up, however we observed this was not the case during the inspection. We observed one of the people in the lounge during this period had been involved in a high number of incidents and altercations when we looked at incident records which had the potential to place people at risk.

We asked the staff on the Lowry unit for their opinions on the current night time staffing levels. One member of staff said; "I don't feel there is enough staff. We tell them all the time, we have even wrote letters stating this. We can't manage to get things done on time." Another member of staff said; "I don't think there is enough staff. We are rushed doing things. It's frustrating, we need to do more but time is limited. At night, there are only three of us but we need at least four people to support people to bed." A third member of staff said; "It can be very difficult on this unit. Nurses don't always help so that only leaves two of us. Sometimes people fight and get into confrontations. We can't monitor people in the lounge as well as support people who need to get help getting out of bed."

When looking at incident records, one person in particular had been involved in a number of altercations

such as throwing televisions at people and grabbing hold of people and throwing them to the floor. This person was also on regular observations during the day due to their behaviour and was one of the people left unsupervised during in the lounge area. We arrived on the Lowry Unit at approximately 6.40am and carried out observations until day staff came on duty at 8am. During this period, we saw the lounge area was left unsupervised on two separate occasions for approximately 10 minutes. Staff said they had needed to leave the room to support people getting out of bed. These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing.

We looked at how medication was handled on each of the four units of the home to ensure this was done safely. This included the storage and handling of medicines as well as Medication Administration Records (MARs), stock and other records for people living in the home.

We found medicines were stored securely in a locked trolley which was in a locked treatment room. Medicines that required refrigeration were stored within a medicine fridge and the room and fridge temperature had been recorded consistently.

We observed people being administered their medicines. This was done sensitively, with consent obtained from the person before the medicine was administered. We saw arrangements in place on Lowry for one person who was receiving medicines covertly (hidden in the person's food or drinks without the person's knowledge). Medicines are generally only administered in this way if the person actively refuses medicines that are required to maintain their health and wellbeing and they lack the capacity to understand the consequences of refusing them. Decisions to administer medicines covertly in a person's best interest should include relevant health professionals such as the person's doctor and pharmacist, and be made in line with the principles of The Mental Capacity Act 2005. This is legislation to protect and empower people who may not be able to make their own decisions. We saw that discussion had taken place with the person's GP, social worker and nearest relative before the decision to administer medication covertly had been made.

Medicines on Lowry and Victoria were administered by the nurse. We saw the MAR charts were organised, contained a picture of the person, allergies and medicines to be administered. We also saw PRN (when required) protocols had been introduced, which had been a concern at our previous inspection. We found that there were homely remedies in use at the home. A homely remedy is another name for a non-prescription medicines available over the counter in community pharmacies, used in a care home for the short term management of minor, self-limiting conditions, such as toothache, mild diarrhoea, cold symptoms, cough, headache, occasional pain, etc. We found that the home had not sought GP's authorisation for use of a specific homely remedy for individuals. We also found that the home did not have cream protocols in place.

Prescribed creams were documented on the MAR but when we asked to see records of where the creams should be applied, for example body maps or specific guidance, we were told that there was no additional guidance for staff about when or how to administer creams. This would be important due to the use of agency staff at the home, who may not have sufficient guidance about how to apply creams safely, or knowledge of each individual person. These issues meant there had been a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We looked at how the home assessed and mitigated risk. We saw people had risk assessments in their care plans. We saw these were regularly updated and covered areas such as mobility, nutrition and pressure care

managements. This provided staff with clear guidance about how to mitigate any potential risks to people and any control measures they needed to follow.

On two occasions on the Lowry unit, we saw the food supplement 'thick and easy' was left unattended on the trolley whilst the drinks round was in progress. This was in an area where people were mobile and could have accessed it unsafely. A patient safety alert was issued by NHS England in February 2015 in relation to risk of asphyxiation through accidental ingestion of thickening agents. We also saw the kitchen door in the Lowry unit was left unlocked on one occasion, in an area where there was a hot water dispenser. Staff on the unit said this door should be locked. This could present the risk of people scalding themselves if they walked into the kitchen unsupervised. We also raised these issues with the home manager. These issues meant there had been a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment.

We saw there were appropriate systems in place to safeguard people from abuse. Staff also displayed a good understanding of how they would report concerns. One member of staff said; "Safeguarding could be neglect and staff having poor attitudes towards residents. If people's hygiene status isn't too good that could be neglect. If I suspected safeguarding, I'd report to person in charge/management. If urgent concerns or nothing was being done. I'd be whistleblowing to CQC." Another member of staff said; "If people are mishandled or mistreated that would be abuse. Financial, physical and emotional abuse are some of the types that can occur".

We noted there was a strong smell of urine on the Lowry Unit, throughout the course of the day. Staff said this was because certain people often urinated in corridor areas as they walked around the unit. The environment was also still in need of updating in areas where carpets were stained and worn, as well as skirting boards which were scratched and damaged. We were told improvement to the environment were on going and that this work was being scheduled.

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. We saw that appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at 10 staff personnel files. Each file contained job application forms, interview questions, proof of identification, a contract of employment and suitable references. A Criminal Records Bureau or Disclosure Barring Service (CRB or DBS) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevent unsuitable people from working with vulnerable adults.

We discussed cardiopulmonary resuscitation (CPR) with two of the nurses who were working at the home, who displayed a good understanding in this area. We were told; "I did CPR training in November 2015. If I was concerned somebody was not breathing, I would look for the vital signs and would call an ambulance. As the nurse, I would commence CPR and I would continue CPR until the paramedics arrived. I would need to make sure the person did not have a 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place first." Another nurse said; "If a person was unresponsive, I would initially check whether a DNACPR was in place. If not, I would automatically start CPR until the paramedics or an ambulance arrived. If care staff found a person unresponsive on here, they would come and get the nurse."

Good

Is the service effective?

Our findings

We looked at induction and training & professional development staff received to ensure they were fully supported and qualified to undertake their roles. We looked at 10 staff files and saw that staff recruited recently had undertaken an induction programme and completed mandatory training. We found new staff were given the opportunity to shadow more experienced colleagues before working unsupervised and were also required to complete a formal probationary period. We asked staff about their experiences during their induction period. One member of staff said; "It covered mandatory training for the first few weeks. I found it really good and really helpful. You are encouraged to work on different areas to get different experiences." Another member of staff said; "I had an induction for three or four days and this was signed-off by managers before I worked alone."

Staff told us they had enough training available to them and felt supported to undertake their roles effectively. We saw staff had completed training areas such as fire safety, dementia, safeguarding, moving and handling and health and safety. At the last inspection we saw staff hadn't completed training related to the Deprivation of Liberty Safeguards (DoLS) and behaviours that challenged. We saw staff still hadn't completed training in this area during this inspection. The manager said she had prioritised getting all mandatory training completed first and that this would be scheduled following the inspection. One member of staff said; "Never done MCA/DoLS but we know who has a DoLS in place. Each person has different degrees of capacity and depends on the guidelines detailed in the authorisation."

We asked staff for their view of training and support within the home. One member of staff said; "I feel up to date with training. Recently I have done moving and handling, food hygiene, dementia, fire safety and safeguarding. I feel I have done quite a lot actually. I feel very supported. I can approach the manager and nurses with any issues." Another member of staff told us; "Training is okay. We're supported to do extra as well. I'm currently doing NVQ 3 also."

We saw staff supervision was an area of improvement since the last inspection. Since then, the manager had created a 'supervision matrix' in the office which showed staff would receive a minimum of three to four supervisions each year plus an annual appraisal. One member of staff said; "They are usually every three months and they always seem to take place. A lot more than they used to." Another member of staff said; "In the time I have been here they happen when they should. It's a good opportunity to discuss problems in the workplace."

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 procedure for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated effective systems to manage DoLS applications. In instances where people were deemed not to have capacity to consent to living at the home, the registered manager had completed standard authorisations which had been submitted to the local authority. There was a current policy in place detailing procedures. All the staff we spoke with were able to identify who was subject to DoLS.

We saw where one decision had been made in a person's best interests about medicines administration. This was made in consultation with their GP and a family member because the person did not have the capacity to make this decision themselves. The decision making process for this was well planned and recorded. We saw people's consent had been obtained to receive care and treatment. People's nearest relative had signed consent forms and we observed staff asking people for consent throughout the inspection. For example, we heard staff obtain consent before supporting people with medication.

We saw improvements had been made to make the environment more 'dementia friendly', particularly on the Lowry Unit, which was one of two dementia units at the home. We saw themed corridors had been introduced along with pictures of famous actors, the queen, sporting memorabilia, famous singers and sensory objects people could touch. This would help people to become more familiar with the environment they lived in. We also saw there were coloured hand rails, toilet seats and toilet handles. People's bedroom doors also resembled real front doors. This would assist in making it easier for people to locate and identify them when needed.

People living at the home told us they received enough to eat and drink. We saw people had their own nutrition care plans and risk assessments available, which detailed any information staff needed to be aware of. We also saw staff maintained accurate records of what people had drank and eaten. There were also consistent records of when people were weighed whether that be each month or weekly. This would make it easier to identify if people were at risk of any significant weight loss and enabled the service to respond appropriately. We also saw the home worked closely with other health care professionals such as dieticians and speech and language therapists (SALT).

We observed the lunch time meal on three of the four units at the home (Park View, Victoria and The Lowry). We saw people were supported 1:1 if they required support with eating for example on the Lowry Unit. We noted care staff sat down, took their time and provided verbal instruction as to what they were doing. The meal time was relaxed and not rushed. When entering the dining room, people were asked where they would like to sit and offered choice.

We saw lunch was the choice of a full English breakfast or soup and sandwiches. The evening meal was shepherd's pie or chicken fricassee with potatoes mash and vegetables, chocolate sponge and cherries or cooked summer fruits. Where people required support with eating in their bedrooms, mainly on Victoria Unit, we saw staff worked well, with a co-ordinated approach to ensure people received appropriate support to eat and drink. One person said to us; "The food is really very nice. You get a choice of what to eat and staff come in every day with the choices. I have a meal or a sandwich."

Whilst speaking with staff on The Lowry, all staff were able to state who required thickened fluids and the consistency of which they needed to be served. Staff were also aware of any specialist dietary requirements such as people who were diabetic, or were on a soft/pureed diet. This showed us staff had a good understanding of people's nutritional needs.

Good

Is the service caring?

Our findings

The people who were able to, told us they liked living at The Fountains. Not everybody was able to tell us their experiences of living at the home, mainly due to living with different stages of dementia. One person living at the home told us; "I've not been here that long but everything is going well and as I expected." Another person said; "I like living here. I would say they look after people well."

The visiting relative we spoke with told us they were happy with the care being provided at the home. One relative said; "I'm happy. Very happy with the care provided. The staff on here, they are wonderful. They truly are. I wouldn't change any of them for the world." Another relative said; "It's absolutely brilliant. The staff are angels. They really are." A third relative added; "The staff really look after [person]. [Person] thinks that they are in a hotel. They're smashing the staff on here. I'd give them the earth if I could." A fourth relative also told us; "I'm happy. The staff are absolutely brilliant. I couldn't ask for better people. The staff really care and look after them."

People living at the home said they felt treated with dignity and respect by staff. Visiting relatives also felt the same when we asked them. Staff were also able to describe how they did this when delivering care. One person said: "Staff are always respectful with me in general." A visiting relative also said; "The staff are always respectful to the people living here and relatives." A member of staff also told us; "We always cover people up and close curtains. We get to know people's signs around continence. You may have asked [person] and they'll say that they don't need to go but you can see them clutching themselves. I gently and quietly persuade them to just try in that case." Another member of staff told us; "When I'm doing personal care I always ask the person first and ask their permission. I close any doors and cover up any parts of the body not being washed. You always need to speak to people before doing anything."

We observed staff tried to promote people's independence where possible. For example, encouraging people as much as was safely possible to eat their own meal at lunch time, even though they were described as needing support from staff. We saw staff placing knives and forks in people's hands to encourage them to eat. A visiting relative also said to us; "I would say they do encourage people to do things. "[Person] gets their soup in a mug so that they can manage it themselves." A member of staff also added; "It's very important that we encourage people to do as much for themselves as possible."

During the inspection we observed a number of caring and polite interactions between staff and people who lived at the home. One on occasion we heard a member of staff say to a person when they entered the room; "Good morning, how are you today and what would you like for breakfast." On another occasion a staff member spent approximately 30 minutes in the lounge sitting closely to a person stroking their hands and talking quietly about various issues such as their relatives who they had seen whilst out in the community. We also overheard several staff members throughout the day talking politely to people and explaining how they were going to deliver care such as when using the hoist. At one point however, we observed a member of staff sat in the lounge watching television, which was a missed opportunity for interaction, as there were six people in the room, unengaged in conversation or stimulation. We raised this with the manager.

We looked at how care was provided to people approaching the end of their life. We saw the home were engaged with the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. At the time of the inspection there was one person receiving end of life care. We noted this person had an appropriate end of life care plan in place detailing things of importance to them. A visiting end of life professional told us; "The end of life care is ok and staff on the unit are taking my advice, albeit slowly." The nurse on shift on the unit then entered the room and spoke with a visiting relative, to update them on any developments and was observed to display care and compassion. The nurse explained to the relative about any recent meetings with the GP and that all unnecessary medication had been discontinued. Only pain relief was being given when necessary. We were told by the relative; "Mum is not in pain and seems to be very calm."

Good

Is the service responsive?

Our findings

The visiting relatives we spoke with felt the service was responsive to people's needs. Relatives said they were involved in the initial assessments process when their relative first moved into the home and were invited to reviews. One relative said; "I was involved in the initial assessment and was asked to tell them all about [person's] life and health needs. I am always invited to reviews. I am here several times a week so staff always update me and ask for my views on things when I'm here." Another relative said; "I was involved in the pre-assessment and provided details of the care and support needed."

We saw each person living at the home had their own care plan. This provided staff with guidance and information about people's care needs and covered areas such as behaviour, cognition, communication, mobility, nutrition, continence, skin integrity, personal care/hygiene, breathing and night time care. We saw these were reviewed and updated at regular intervals or when people's needs changed and had been updated as recently as April 2016.

At the last inspection we raised a concern about people's life history's not being captured in care plans. We saw the provider had made good progress in this area with detailed documents available in people's care plans. This document was called 'My life Story' and detailed an introduction to people's life, families, employment, significant relationships, social interests, places of interest, likes/dislikes and hobbies/interests. We noted that in several of the life stories, staff had even gone to the extent of sourcing photographs to go with each section and had consulted with families about this process. This would help and guide staff to provide care based on people's interests and choices.

We looked at what activities were in place and observed how people were stimulated throughout the day. The home had two designated activity co-coordinators. We noted from looking at the activity schedule that some of the available activities included board games, nail care, arts/crafts, ball games, sing along, and jigsaws. At one point on the Lowry Unit, we observed the activity co-ordinator asking people if they would like to go into the dining room and do an art activity, which several people, chose to do. There was also 'pet therapy' available in the home and again, several people engaged with this. The activity co-ordinator said; "I try to work with individual people as well as doing group activities. I've done bingo downstairs today. We have pet therapy this afternoon. I have 42.5 hours for the whole of the building so it's a bit pushed sometimes but I know people very well."

We looked at how the service managed complaints and saw a complaints policy was in place. The policy clearly explained the process people could follow if they were unhappy with any aspect of the service. Information about to raise a concern was also contained within a 'welcome pack' which was placed in peoples' rooms. We saw an appropriate response had been given to any complaints on file.

We looked to see how the service managed people's pressure care. We saw pressure risk assessment tools were consistently completed. Body maps detailed people's skin breakdown and graded the nature of the sore to enable continued monitoring, When people had been identified as being at risk, we saw that people were seated on pressure relieving cushions and mattresses to provide a reduction in pressure on vulnerable

areas such as heels and the sacrum.

We looked to see how people's continence was managed and whether people were encouraged to maintain their continence. We observed people being discreetly asked whether they required support to the toilet and we looked through people's care records to ascertain how this was promoted at night. We saw night checks were undertaken at set intervals and staff signed when people's continence needs had been addressed. The day staff did not follow any set protocol when promoting people's continence but actively encouraged people to try for the toilet. When people asked for the toilet, staff were responsive and accompanied them straight away. We did not observe anybody shouting out to go to the toilet or indicating that they had experienced an accident. This indicated that people's continence needs were appropriately managed.

We saw personal care records were completed detailing when people's personal care and oral health had been supported. We saw people's personal preference as to whether they received a shower or bath was captured. Staff also demonstrated that they were aware of people's personal preferences and adhered to them when attending to people's personal care. For example, we saw that it was documented that one person only wanted their care tasks to be supported by a male carer. We looked to see that this had been accommodated and found that a male carer had consistently supported this person.

Requires Improvement

Is the service well-led?

Our findings

The home had a manager, although they were not yet registered with the Care Quality Commission (CQC). The home had been without a registered manager for approximately 12 months. 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 staff we spoke with said they felt the service was well-led. One member of staff said; "The manager is really good. She takes the time to speak with us and is always encouraging us to do the best we can. The manager is positive and it seems to have a knock on effect." Another member of staff said; "The manager is very supportive." A third member of staff said; "It's an improved home. It's not in the same place as when you last came. The implementation of seniors has improved the running of the unit." A fourth member of staff also said; "I think the manager is good and feel they would listen to me if I had any concerns."

We asked visiting relatives for their views of management and leadership within the home. One relative said; "Management seems very good." Another relative added; "Management are brilliant. Knock on their door and they find time to speak to you." A third relative added; "The managers door is always open. The nurses are great. If I did have a problem, it would always get sorted out. It's a good home." When we asked a fourth relative about leadership we were told; The manager has made improvements since starting. The environment has drastically improved thanks to the activity coordinator on Lowry. It's bright and I like it that [person] can see it."

The staff we spoke with said they liked working at the home and improvements were being made. Staff also described feeling valued. One member of staff said; "I've worked here for nine months and we get really good training. The manager is very focussed on bringing the home up to where it needs to be." Another member of staff said; "I do feel valued. The manager does say thank you to us. The owners visit and speak to us as well. I've seen big improvements in here since October 2015 at the last inspection. There's been a lot of input, big changes and I feel that we are getting there. It's made a big difference to the care and we work better and feel like a team." We were also told; "It's a stressful but rewarding unit. It's a nice team, nice unit to work and the staff really understand the needs of people living with dementia."

We looked at how information was shared with people who used the service and their relatives and we saw that resident & relatives meetings took place on each of the units. This was evidenced through minutes of meetings being recorded. We could see that a variety of topics where discussed during these meetings and that people were able to share their views and experiences. We noted some of the topics for discussion included activities, the environment, meal times and if people had complaints. The manager told us they had sent out a survey but received a poor response with only three surveys being sent back. We noted all three surveys made positive comments about the services being provided.

We saw audits and quality assurance checks were done regularly and up to date. These covered areas such

as care plans, medication, pressure sores, continence, weights, bedrails and the nurse call bell system. We noted these had been completed as recently as April 2016. We saw the audits picked up any areas for improvement and made recommendations about any action that needed to be taken.

The home also ran a Carers Forum. This was held on the first Wednesday of every month and was attended by the manager, staff, residents and family members. This provided an opportunity discuss things that were working well, or could be improved. We saw that staff meetings were held across each of the four units. Staff told us they were able to contribute to agenda items and that staff meetings were useful and productive. One member of staff said; "We have regular team meetings. I don't always come in for them but you can read the content following the meeting."

Providers are required by law to notify CQC of certain events in the service such as deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included; safeguarding, complaints, whistleblowing, and medication. This meant that staff had access to relevant guidance if they needed to seek advice or clarity about a particular area.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure risks around the home were mitigated effectively. Appropriate systems were not always in place to ensure people received their medicines safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff available to meet people's needs safely.