Czajka Properties Limited

Staveley Birkleas Nursing Home

Inspection report

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Nab Wood
Shipley
West Yorkshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Staveley Birkleas Nursing Home provides accommodation and nursing care to a maximum of 60 people who are living with physical disabilities. All the accommodation is in single rooms and the service is located in the residential area of Nab Wood, in Shipley, West Yorkshire. At the last inspection on 1 September 2014, the home was compliant with the standards we looked at.

We inspected the service on 8 September 2016 and it was unannounced. On the day of the inspection 55 people were living at the home.

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 2008 and associated Regulations about how the service is run.'

People and relatives we spoke with told us the service delivered good quality care and they did not raise any significant concerns with us. People said they felt safe and secure in the home and there were plenty of activities. They said care and support provided was appropriate and met their individual needs. However some people raised concerns that the quality of the service was not always maintained at weekends.

The risks to people's health and safety were assessed and clear plans of care put in place which were well understood by staff. People were appropriately involved in the risk assessment process. Staff understood how to identify and act on any safeguarding concerns.

Overall, we concluded medicines were safely managed. People received their medicines as prescribed and medicines were stored securely.

Overall, we concluded there were sufficient staff to deliver timely care to people. People provided mixed feedback about staffing levels with some people and staff saying staffing levels were stretched at the weekends. Safe recruitment procedures were in place.

The premises was safely managed. There was appropriate communal areas for people to spend time and the required maintenance and safety checks took place on the building.

Staff had access to a range of training which was provided at periodic intervals. Staff said training was appropriate and gave them the skills to meet people's individual needs.

People told us the food was good and that they had sufficient choice. We found mealtimes to be a pleasant experience. Nutritional needs were assessed and action taken to address any nutritional risks.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of

Liberty Safeguards (DoLS). People reported choice and control over their daily lives.

People and relatives spoke highly of staff and said they were treated with dignity and respect and their privacy was respected. This was confirmed by our observations of care and support.

Care records provided information of people's life and personal histories had been obtained to help staff better understand people. Staff we spoke with had a good understanding of the people they were caring for.

People's needs were assessed and clear and person centred plans of care put in place. People told us the service delivered appropriate care that met their needs.

A programme of activities was in place, provided by an activities co-ordinator. People spoke positively about the activities on offer at the home.

A system was in place to record, investigate and respond to any complaints. People said they were very satisfied with the service, but were confident action would be taken to address any concerns.

People were listened to and their opinions used to make positive changes to the service.

Systems to assess, monitor and improve the service were not sufficiently robust. Some audits were carried out, but not at regular frequencies and the actions arising from audits were not always signed off.
Although we established appropriate care was delivered by the service, care records did not always contain accurate or complete information.

We found one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back 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?

Good

The service was safe.

Medicines were safely managed and people received their medicines as prescribed.

Risks to people's health and safety were assessed and clear plans of care put in place which were understood by staff. People and relatives were positively engaged in their risk management

Overall we concluded there were sufficient staff deployed although some people said staff were not as responsive at weekends.

The premises was well maintained and kept in a safe condition.

Is the service effective?

Good

The service was effective.

Overall, people said staff had the right skills and knowledge to care for them. Staff received regular training and said they felt well supported by management.

People praised the food provided by the home. We saw there was sufficient choice and people were supported appropriately where they needed assistance.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were assessed and clear plans put in place. Advice from external health professionals was regularly sought and incorporated into plans of care.

Is the service caring?

Good

The service was caring.

People and relatives said staff were kind and caring and treated

them well. This was confirmed in interactions we observed where staff comforted people when they became distressed. The service respected people's privacy.

Staff knew people well and had sought information on their life histories to help better understand the people they were caring for.

People were listened to and their opinions used to make positive changes to care and support.

Is the service responsive?

Good

The service was responsive.

People and relatives told us people's care needs were met. People's needs were assessed and plans of care put in place. Checks took place at required intervals to check people's well-being.

A range of well received activities and outings was in place organised by an activities co-ordinator.

A system to log, investigate and respond to complaints was in place. People said they felt able to raise concerns with the management.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits and checks were not carried out at consistent intervals. We found some inaccuracies in care records. We received assurance from the provider that these issues would be promptly addressed.

People spoke positively about the overall quality of care provided by the service. We found an open and honest culture with the provider and management team committed to continuous improvement.

Staveley Birkleas 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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 September 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor nurse who specialised in mental health and the Mental Capacity Act (MCA), 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.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with twelve people who used the service, eight relatives, two registered nurses, nine care workers, the chef, catering supervisor, activities co-ordinator, a unit manager, a senior manager and the registered manager,

We looked at elements of seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team. We also spoke to a health professional who has contact with the service.

As part of the inspection process we reviewed the Provider Information Return (PIR), which the provider completed prior to the inspection. This asks them to give key information about the service, what the service does well and what improvements they plan to make.

Good

Is the service safe?

Our findings

People who lived at Staveley Birkleas Nursing Home were very clear in telling us that they felt safe. For example one person told us "I know that I am at risk because of my illness but the staff here are second to none and they ensure the risks are kept to the minimum." A second person told us "I am happy here, I feel happy in myself, secure, can do what I want, they are calm with me," and a third person said, "I feel happy here, when I walk back to the building, I feel very much safe, its home for me." People said they were treated well by the staff team.

Staff told us they had received training to help them identify how abuse could occur. Our discussions with staff demonstrated their depth of knowledge and they were able to give us examples of abuse and understood how to report any concerns they may have. This provided assurance that any concerns would be quickly identified and investigated. We saw where safeguarding incidents had occurred, appropriate referral had taken place to the local authority and actions put in place to help keep people safe. Safeguarding was discussed at resident and staff meetings and through the staff supervision process to enable multiple opportunities for concerns to be raised.

We saw evidence of robust risk assessment processes which managed risks to people. Records showed that people, or where appropriate, their relatives, had been involved in decisions around risk. These included where people were at risk of developing pressure sores, at risk of falls and exhibiting behaviours that may challenge. The care plans we viewed showed how risks could be mitigated which gave staff clear guidance on how to support people to remain safe. For example, we saw one person had a history of displaying behaviours that challenge whist being given personal care. The care plan reflected staff's past experiences of finding clear and constant communication helped to diffuse these situations. This showed staff were using reflective practice to minimise risks to individuals and to themselves. Staff understood the risks posed by the people we asked them about. For example one person required a specific regime in place during assistance with eating to reduce the risk of choking. The staff member we spoke with demonstrated they understood the plan of care which helped to keep them safe.

We saw risk assessment processes were well thought out. For example, staff felt a person was at risk of falling out of bed. The initial assessment indicated bed rails were the preferred method of providing a safe environment. However following discussions with relatives who had a personal perspective to add, it was decided through a best interest process that bed rails were not the ideal way of mitigating the risk. This showed staff were engaging with relatives to determine the most effective of care based on their personal longstanding knowledge of the individual.

People who lived at Staveley Birkleas Nursing Home were all very clear in telling us that they were very happy with the building including their room and the cleanliness. One person told us "The view from my bedroom is amazing, I can feel and smell the fresh air." The premises was well maintained and homely and there were sufficient communal areas for people to spend time. We were able to observe bedrooms which were appropriate for their use, personalised, bright and clean. Safety checks on the building took place such as the fire, water, electrical and gas systems to help provide assurance it was safe. The risks associated with

the environment and major events had been identified and reviewed on a regular basis. The service had identified events that could have a major impact on people. For example many people were unable to mobilise without the help of staff. We saw Personal Emergency Evacuation Plans (PEEP) were in place which described each person's needs in the event of a fire.

We saw the food standards agency had inspected the kitchen and had awarded them five stars for hygiene. This is the highest rating which can be awarded and meant food was being prepared and stored safely and hygienically. We found the home to be clean and hygienic.

Overall, we found medicines were safely managed. People told us they received their medicines on time. Medicines were administered to people by trained nursing staff. No person at the home had been found to have the capacity or physical ability to self-medicate. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were correctly stored and dated upon opening. All medication was found to be in date.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed by a nurse.

We observed a registered nurse whilst they conducted the morning medicine round to 24 people. We saw the medicines were given safely and people were sensitively helped to take their medicines. However constant interruptions which required the input of the nurse significantly delayed the medicine round. We commenced our observations at 0805hrs and witnessed the last person receive their morning medicine at 1210hrs. This delay had the potential to compromise some people who required a second administration of the same medicine at lunchtime. Our discussion with the nurses and management team gave us confidence the issue would be addressed without delay.

We saw all 'as necessary' (PRN) medicines were supported by written instructions which described situations, frequency and presentations where PRN medicines could be given.

We saw the provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, a number of people at the home had a diagnosis of epilepsy which significantly disrupted their lives. These people were prescribed Buccal Midazolam. The administration of the medicine was tailored to each person's specific needs. Scrutiny of care plans and a discussion with a nurse demonstrated the safe and effective use of Buccal Midazolam in line with NICE guidance (CG137) – "Epilepsies - diagnosis and management".

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet providing assurance people had received their medicines consistently as prescribed. We examined records of medicines no longer required and found the procedures to be robust and well managed.

Overall, we concluded there were sufficient staff deployed to ensure safe care. During the day a nurse was allocated to each of the three floors supported by a team of carers. Care was overseen on each floor by a number of managers, the structure of which was currently under review. We received mixed feedback about staffing levels from people, relatives and staff. Most people told us that there were enough staff to ensure safe and prompt care. For example comments included
"I use the buzzer, they come almost immediately" and "The management are using a new buzzer system, after 6 mins it gets louder, then gets louder, they always come" and a relative told us "always enough staff who are always nipping in to see her." However some people and staff told us that staffing levels were not always maintained at weekends. On reviewing staff rota's we could not establish any clear evidence that staffing levels were depleted at the weekends, although staffing levels did sometimes vary from day to day, which management told us was down to last minute sickness. We saw wherever possible staff shortages were mitigated by use of agency staff. We asked senior management to review weekend staffing levels, given the sentiment from some staff and people who used the service. We reviewed the response times to the nurse call system on the computerised logger and found calls were responded to promptly. Charts such as turn charts and hourly checks were consistently completed in line with people's plans of care indicating there were enough staff to ensure these were carried out at the required time intervals.

Safe recruitment procedures were in place. New staff were invited to 'Taster days' where they worked a shadow shift. This helped ensure staff were suitable for the role. Records showed that new staff were required to attend an interview, disclose their previous work history and qualifications, undertake a Disclosure and Baring Service (DBS) check, provide references, and prove their identity. However we did find that the provider did not retain on file confirmation of staff identify which is a requirement. We saw interview records were in place which provided evidence staff character and suitability was assessed. Records showed where people had declared criminal offences during the recruitment process the nature of the convictions had been investigated and a risk assessment undertaken to determine whether the person was suitable to work with vulnerable people. Staff we spoke with confirmed that these recruitment checks took place.

Good

Is the service effective?

Our findings

Overall we concluded staff had the right skills to meet people's needs. People and relatives told us they thought the majority of staff were trained to be able to meet their needs or their relative's needs. One person told us "all pretty good, in fact excellent," another person said "They are confident in what they do." Some people said that new staff were not always fully competent, for example one person told us "Sometimes staff don't know what to do, these are new ones and a relative told us " Nursing staff are excellent, they know what they are doing, new care staff are a problem." We received mixed feedback about the continuity of staff with some people saying there were too many changes in staff. Some relatives told us that continuity of staff had been a problem but had recently improved. We saw that a large number of new staff had been recently recruited who were now becoming established. Staff were now assigned to set floors where possible within the home which had helped improve consistency and knowledge about the people they were caring for. Staff we spoke with had a good understanding of the people they were caring for.

New staff were required to undertake a four day induction at the provider's training centre. This covered mandatory training topics such as moving and handling, safeguarding, health and safety and fire. This was followed by a one day induction to the home and three days of shadowing an experienced member of staff.

Staff received periodic training updates in mandatory topics to maintain their skills and knowledge. This was monitored through a training matrix by a dedicated training officer. We found training was mostly up-to-date. Staff had received additional specialist training to help ensure they could meet the varied needs of people living in the home. This included training on Huntington's disease, tissue viability, epilepsy and tracheostomy. Checks on staff knowledge in topics such as moving and handling, and safeguarding were undertaken to help ensure staff had retained the required knowledge. Staff we spoke with confirmed they had received training to help them meet people's individual needs. This included training on the use of specialist equipment.

Staff received supervision and appraisal which asked them about any concerns and discussed their developmental needs. New staff were also asked to provide feedback on the service. We did find that some staff were overdue supervision meetings, a senior manager told us they would prioritise bringing this up-to-date.

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 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.

Staff were able to tell us how the MCA and DoLS applied to their day to day work. For example, they said they always assumed people had capacity to make choices about their day to day lives. They told us the DoLS were in place to protect people and enable decisions to be made in their best interests so that they could receive the care and support they needed.

We saw the service had submitted seven standard DoLS applications to the supervisory body over the preceding nine months yet none had been progressed by the supervisory body. We saw the manager had a detailed record of conversations with the supervisory body regarding the delays. During our inspection we saw evidence of other people who may be in need of consideration for an authorisation to be made. Our discussion with the manager showed they had identified a similar cohort of people and they were in the process of assessing people with the likelihood of an application being made.

During our observations of medicine administration we were made aware two people were receiving their medicines covertly. An examination of both care records showed correct procedures had been applied to ensure the medicines were administered within current guidelines. We saw best interest meetings had occurred involving the GP, family members, a community psychiatric nurse, pharmacist and care staff with personal knowledge of the individual. Documents demonstrated a clear treatment aim of covert medicines along with the required benefits to the person's health. Our examination of the process to administer covert medicines proved the manager had an excellent understanding of the procedures and knew how to use them for the benefit of people at the home.

People said staff asked for consent and gave them control over their lives. Information in care records showed staff respected people's right to refuse care and treatment.

We spoke with the manager about the use of restraint and any policy documents to underpin restraining methods. We were told all forms of restraint were not a feature of the service. Any need to protect people or staff from harm was provided by attempts to de-escalate situations. Our subsequent discussions with care staff showed the philosophy of care was well understood.

We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

Most people spoke positively about the food provided by the home. Comments included "Food is excellent, cooked properly, warm, like I have at home" and "Food is good, I am fussy with food, they do look after me." A third person said "Good food, in the mornings I like something different, the chef provides this to me." Another relative told us "[relative] is always fed well." They told us that the meals and drinks were always of the required consistency.

People confirmed they had a choice of meals. One person told us "The chef comes and asks us every day in the morning what we want to eat." Another person said "I like hotdogs for breakfast, they always give it to me, if non left, manager goes and gets some for me."

During the morning we heard people being offered a choice of breakfast. We observed the meal service at lunch time. Tables were nicely set and people were offered a choice of cold drinks. There were condiments on the table and gravy was served separately so that people could decide how much, if any, they wanted. There was a choice of main course, one person was having difficulty deciding what to eat and the chef

wheeled the hot trolley over to the table so that the person could look at the food on offer before choosing. We saw the chef had used vegetarian sausages to create a vegetarian version of the Toad in the Hole so that people who chose a vegetarian meal could have the same as other people. When people had pureed food each component of the meal was pureed and served separately so that people could experience different colours and flavours. People told us they enjoyed the food.

We observed staff supporting people to eat and drink. Overall staff provided appropriate support, assistance and encouragement. One of the staff started by telling the person what the food was and continued to talk to the person throughout the meal gently encouraging them to eat. However, we did note another staff member missed the opportunity to engage with the person and barely spoke with them during the meal. Portions were large and there were a variety of fresh food provided. It was noted that there were plenty of staff around to assist people.

We saw the menus were displayed and they included information about food allergies. We spoke with one of the chefs and found they had information about people's dietary needs and preferences. They were able to tell us how the catered for a range of people's individual needs included diabetic, low fat and high protein diets, vegetarian and Halal. We spoke with the catering supervisor who oversaw the catering arrangements at Staveley Birkleas and other homes operated by the provider. They explained how they changed the menus three times a year and how they consulted with people who used the service about the menus. They also monitored the nutritional content of the menus. In addition, they told us they catered for special events for people who used the service such as birthdays and wedding anniversaries.

People's nutritional status was assessed and people's weights were monitored either weekly or monthly depending on the degree of risk. When people had experienced unplanned weight loss or gain referrals were made to other health care professionals involved in their care, such as their GP or a dietician.

When people had PEG (Percutaneous Endoscopic Gastrostomy) feeding regimes in place we found there were clear instructions for staff to make sure people were supported safely. When people be unable to eat or drink for medical reasons staff we spoke with were aware of this.

We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community nurses, specialist nurses in diabetes and skin integrity, speech and language therapists, dieticians and dentists. We saw evidence of a multi-disciplinary team approach to the delivery and planning of care. For example, in one person's records we saw they had regular support from a physiotherapist, a dietician, a speech and language therapist and a tracheostomy nurse specialist.

The home had made adaptions to the premises to help meet the needs of people who lived there. For example there were areas of the home designated for activities to help meet people's social needs. A sensory room had recently been created with a range of lights, sounds and games designed to stimulate a range of senses. We saw this was well used during the inspection. In addition, a recent large external decking area had been installed to ensure that people with physical disabilities had a safe external place to access. This had been created through funds partially raised by staff undertaking a charity walk as well as funds from the provider. Many people in the home were unable to mobilise without the help of aids. We saw all bedrooms were equipped with ceiling mounted hoists which enabled people to be effectively and safely moved from bed to bathroom or chair. This provision also meant people did not have to wait for a mobile hoist to be available to meet their needs.

Good

Is the service caring?

Our findings

People we spoke with felt cared for living at Staveley Birkleas Nursing Home. One told us, "I am very comfortable and extremely well looked after." Another person told us "Staff are really helpful, can talk to them anytime." A third person told us "I am cared for very well, I am very vocal, will let them know if I am not happy."

People said that staff treated them well and provided care and support in a kind and compassionate way. For example one person told us "They are excellent to me, they talk to me like I am a human being. I am [name of resident], not just a person in a wheel chair." A second person said "They always talk politely with me, even if I am rude." A relative told us "[staff member] always cares for me when I am upset, they will come and ask me how I am, they do so much to help" and another relative told us "They really care for my family member, they treat us with the utmost respect and with dignity. They understand my family member's needs." Two people did however tell us they were frustrated that items had gone missing from the laundry service and not been returned to them.

We observed care interactions that were kind, patient and sensitive. We observed care workers speaking kindly and supporting people to eat their meal with gentle encouragement. We observed a person who was crying and the care worker came quickly to comfort. We observed appropriate interactions of reassurance during moving and handling when care workers were assisting people into the dining room. We also observed people who wanted to mobilise independently, allowed to do so. We observed people looked well clean, well-groomed and well cared for, for example we saw people's finger nails were clean and many of the ladies had their nails painted. This indicated the service was meeting their personal care needs.

A new set of values had been recently introduced into the home which were understood by staff. These focused on ensuring people were treated with compassion and in a respectful and kind manner. These were to be discussed and monitored through staff supervision and helped to ensure staff provided dignified and respectful care.

Each person who used the service had assigned a named nurse and key worker. These were the first point of contact for these people, and allowed named staff for people to develop good, positive relationships with. People confirmed that key workers involved them in their care and treatment. For example one person said "The key worker always brings my care file, we discuss my care plan as it changes all the time." Another person told us they had been very specific about their needs and the care staff were diligent and conformed with their wishes and care plan.

Staff were assigned to set floors within the home to promote consistency and allow the development of positive caring relationships between staff and people. We spoke with two members of care staff to gauge their knowledge and understanding of people's needs. They were able to tell us about people and the circumstances that had brought them to the home. They were fully aware of people's life histories and care needs and demonstrated a good knowledge of the people they supported. For example, one person was known to become distressed during certain care interventions. The care plan described a detailed course of

action for care staff to take. The care staff we spoke with were able to accurately describe the de-escalation regime. In another example, in the person's care records there was a list of equipment which they needed to take with them when they went out. When we asked staff about this they knew what equipment the person needed and why. This demonstrated that staff knew people well.

The service promoted people's independence. One staff member said "We treat residents as one big family, they come and go as they please, we try to make them as independent as they can be."

Care and support plans focused on promoting and/or maintaining independence. We saw equipment such as plate guards were utilised to allow people to be as independent as possible at meal times. People told us they were encouraged to do things for themselves for example accessing the local community. One person told us "I have a great life outside the home, I can come and go as I please. I attend the local church, I go to local shops."

People were encouraged to voice their opinions about their care and support. This included through formal means such as meetings with key workers, resident meetings and periodic surveys of care as well as more informally through contact with staff on a daily basis. People reported they had choice and control over their daily lives. For example one person told us "It's up to me when I want to get up, or go to sleep" and another person told us "I go to bed when I want to, If I get up late, I still get breakfast." People said that staff always asked before delivering or offering personal care. Care records clearly set out how to support people to make decisions and ensure their voices were heard. Communication care plans were in place which provided staff with information on people's individual needs. Communication plans were tailored to the needs of the people who used the service. For example staff had made up flashcards for one person who had difficulty communicating verbally to enable them to communicate their needs to staff. Observations confirmed people were offered choices about their day to day lives. For example, we saw one person in a wheelchair in one of the lounges being asked by staff if they wanted to have their breakfast in the lounge or dining room.

People and relatives reported no restrictions on visiting. People said the service helped them keep in contact with their relatives, for example one person told us "They have helped me to speak to the hospital about my poorly mum."

People reported staff respected privacy and that this had notably improved in recent times. We observed that each door had an engaged sign on it, we were informed by people most of the time it was adhered to. For example one person said "They now knock, in the past did not knock, they used to walk straight in." We observed many positive interactions between staff and people living in the home and overall consideration was given to people's privacy and dignity. However, we observed two occasions when a member of staff compromised people's privacy by providing support in a communal area where other people were present. On both occasions the staff member failed to consider the persons privacy and dignity and did not offer the opportunity to go somewhere more private. We raised this with the management team to investigate.

Reasonable adjustments were made to meet people's individual needs with regards to privacy. We saw on occasion a person did not want care staff to enter their room without warning. An entry button had been installed outside the room which gave the person a visual prompt that staff would be entering. Another door had a sign on display which stated the person's preferred time for staff to enter their room to give their medication and reminded staff to lock before entering. This showed us the service valued people's right to privacy.

Good

Is the service responsive?

Our findings

People and relatives told us care was appropriate and met their individual needs. One relative told us "Fantastic, quality of care is really good." People who used the service and people giving care were clear in telling us Staveley Birkleas Nursing Home was effective in achieving the outcome of providing a good life to people and connecting with activities within the community.

People's needs were assessed before they moved into the home and this was translated into care plans which covered areas such as mobility, continence, eating and drinking and any specific area of need. For the most part we found people's care plans contained clear information about the support they needed and included information about what people could do for themselves. For example, in one person's records we saw they were able to clean their own teeth and wash their hands and face but needed support with other areas of personal hygiene. In another person's records we saw they liked to be involved in care procedures, for example by opening the packages which contained the suction tubes. This showed people were supported to maintain their independence. We did find some care plans were not always updated to reflect changes made to their care and support plan. However when we spoke with staff they were aware of the changes, providing us assurance that the service was responding to their changing needs. The care records showed people who used the service, their relatives and carers were involved in making decisions about their care and treatment. This was confirmed by the people we spoke with.

Many of the people who used the service had complex needs and needed a range of equipment to support them to maintain their safety and independence. This included the use of suction, cough assists and NIPPVs (Non-invasive positive pressure ventilation). The staff we spoke with confirmed they had received training on the use of this equipment and were able to talk confidently about how to use it. This provided us with assurance staff were able to meet these people's needs.

Each person had a passport in their room which recorded their daily care and support. This was well received by relatives we spoke with, for example one person told us "I can check this anytime, this gives me great confidence now."

We looked at the care records for one person who was diagnosed with a mental disorder, was at risk of harm, may tend to neglect themselves and had a history of having being detained under the Mental Health Act 1983 (MHA). As such this person's care was influenced through a Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw care plans had been constructed to reflect the outcome of CPA meetings which had involved the person, their family and carers, as well as professionals involved in the person's health and social care needs. We saw the CPA meetings were reviewed every six months. We saw as a result the person was regularly assessed by a community psychiatric nurse (CPN). We saw there to be a close working relationship between the care staff and the CPN.

We found the service had made reasonable adjustments to meet people's individual needs. For example one person who used the service was hard of hearing, and could not hear staff knocking at the door. A light

had been installed so they could be notified if staff were at the door. They also had a special device which notified them if the fire alarm was activated. Tailored communication techniques and aids were also used to help meet people's needs. Throughout the inspection we observed people being given choice in how they wished to spend their day. These choices extended from what and when they wished to eat, to how they wanted their rooms decorating. For example one person supported a particular football team. At the person's request the room had been decorated in the football club colours.

People generally spoke positively about the activities. One person said "They take me bowling, to the cinema on many occasions." A relative told us"[relative] can do what she wants, lots of different activities" An activities co-ordinator was employed to help ensure people's social needs were met. They were spoken very highly about by people who used the service. We spoke with them, they demonstrated a dedication to providing people with a well thought out and varied range of activities. They told us "We give a lot of support to the service users who come with very complex problems. We go around daily to residents and try to find out any new activities to add to the list, we involve them all the time."

Regular outings took place which helped maintain links with the local community and trips further afield took place once a week. Within the home activities consisted of games, quizzes, music and group and individual work. The activities co-ordinator told us how they had slowly built up relationships with people gaining their trust. They demonstrated a good understanding of the people we asked them about and how to meet their social needs. We observed the new sensory room and the new games room which also had sky sports, tablets and games such as chess and draughts. There was also an' in house' salon room for people and a stylist came in twice a month. People told us that activities were discussed through monthly resident meetings. One person said although the home did not hold religious events within the home they had been supported to attend a local church.

People told us they had no cause to complain but said that if they did raise issues they were dealt with. One person told us "I am aware of how to make a complaint, I go straight to management." Another person told us they knew who to talk to if they had any concerns and said they would feel comfortable and confident in doing this. They were however keen to stress they had no complaints and were entirely happy living at the home. People were instructed on how to complain through notices around the building and through the service user guide. A system was in place to record, investigate and respond to complaints. This included formal written complaints and verbal complaints. We looked at a sample of recent complaints and saw that these were all logged and responded to within appropriate timescales. Where appropriate, the lessons learnt and preventative measures had been recorded.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place. The home had submitted statutory notifications to the Care Quality Commission such as allegations of abuse and serious injuries. This helped us to monitor events occurring within the service.

Some systems were in place to assess and monitor the quality of the service but these were not consistently applied. Documentation showed managers walkarounds were required to be completed once a day. We found none had been documented since 9 February 2016. A senior manager confirmed "don't always document walkarounds but we do need to start documenting." There was also a lack of medicine management audits undertaken since December 2015. Audits in health and safety, record keeping and infection control were conducted but not at consistent intervals. There was also a lack of care plan audits undertaken and we found some inconsistencies in care plan documentation. A senior manager told us "We do need to get on top of audits within the home." In addition a comprehensive quality audit had been carried out in June 2016, with a number of issues identified, however there was no action plan in place or evidence that the actions had started to be addressed. We saw the provider's service improvement plan had identified that a more structured approach to audit was required and a senior manager assured us they would prioritise this.

We also found there was a lack of adequate monitoring of a staff member's performance through the use of systems such as supervision and competency assessment, following the identification of concerns over their practice.

Although we established appropriate care and staff understood people's plans of care and changes in their needs we found some inaccuracies in care records. For example one person's social activities plan made reference to their now deceased relative. Another person's eating and drinking care plan did not reflect the care they were now receiving and some care plans were not signed or dated. Food and fluid charts were also not always completed to a high standard and although input and output was regularly reviewed and audited on the 1st floor, this was not the case on the ground floor.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A system was in place to log, investigate and respond to accidents which occurred within the service. We saw these were subject to analysis to identify any themes or trends. Where appropriate, preventative measures were put in place to learn from incidents and prevent them from re-occurring.

The computerised nurse call system logged the response times to routine and emergency assistance calls. This could be monitored by the provider as part of a system to assess staffing levels. At present this was not subject to any analysis to look at average response times, however the management team told us the system was newly implemented and this was something they were looking to do in the future.

Regular staff meetings were held which were an opportunity to discuss performance issues with staff to improve the quality of the service. These discussed areas such as staff attitude, practice, and infection control.

People and relatives spoke positively about the way the home was run. They said that management listened to them. For example one person told us "Management do listen, I always manage to see them when I visit." A second person said "They do listen, I raise points at the resident meetings, they do listen." One relative told us "Very helpful management, if any little problem, just go in and see someone, very helpful. Staff also told us they felt well supported and that management were approachable and listened to any concerns they may have.

People told us they were generally satisfied with the quality of the service provided. For example one person told us "When we walked in, it felt right, I won't hesitate to recommend this home to other people." However a number of people told us that the quality of the service was not as good at weekends. For example one person told us "Weekends are a problem, staff look tired – they are fed up." A second person said "Sometimes I am not able to have a bath at the weekends, they say not enough staff sometimes they say not enough towels, those bath towels." A third person said "Always problems at weekend agency staff some good, some bad." This demonstrated people had experienced inconsistencies in the overall quality of the service. We also found the administration of medicines required better organisation within the home. The nurses administering medicines were subject to constant interruption during the round which prolonged the medicine round and increased the likelihood of mistakes. We raised these points with the registered manager and provider during feedback to ensure they were investigated and resolved.

A number of people told us that the service had improved in recent months. For example one person told us "I have been here for many years, there have been staff who did not like working here - they have gone." Another person told us "last 6 months a great improvement." A senior manager we spoke with told us about a number of positive initiatives made over recent months including new staff, assigning staff to set floors and changes to the management structure. Further positive changes were planned to the home driven through the implementation of a service improvement plan.

We observed a positive and open culture within the home with people and staff getting on well. The registered manager and senior manager we spoke with were open and honest with us about the current quality of the service and improvements that were needed. Areas we identified for further development such as care records, better audit systems had been identified by the provider. The home had recently introduced a new mission statement, vision and set of values. Staff we spoke with had received training and information on these values and were aware of what they meant. Staff understanding of these values was continuously monitored by the senior management team.

People told us that regular resident meetings took place for example one person said "We have meeting's every month and the activity co-ordinator always speaks to us about activities."

We looked at the minutes from these meetings which provided assurance people's views were sought on the service in areas such as staffing levels, activities and food. Clear actions were put in place to address people's comments or concerns. People and their relatives were periodically asked for their views on the quality of the service through annual surveys.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1)Systems or processes were not always established and operated effectively to: (2a)Assess, monitor and improve the quality of the service. (2b)Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. (2c)Maintain securely, an accurate and complete record in relation to each service user.