Swinton Hall Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 06 January 2016.

Swinton Hall Nursing Home is a privately owned nursing home close to the A580, East Lancashire Road and is within easy access to the cities of Salford and Manchester. The home is registered to provide accommodation with personal and nursing care for up to 62 people across three units. The home comprises of a nursing unit, a 15 bed continuing care unit to support people with complex nursing needs, the terminally ill and physically disabled. The home also has a dedicated 18 bed unit providing accommodation for people living with dementia, otherwise known as the Snowdrop Unit.

There was no registered manager in place at the time of our inspection, though a temporary manager was present on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At the last comprehensive inspection carried out in February 2015, we identified concerns in relation to the recruitment of fit and proper persons and the risks associated with the proper use and maintenance of equipment. Following a further focused inspection carried out in May 2015, we found that the service was then meeting the requirements of regulations in respect these matters. As part of this visit we checked to see whether the improvements made had been sustained by the service.

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

As part of the inspection we checked to see how the service managed and administered medication safely. We looked at a sample of 20 medication administration records (MAR), which recorded when and by whom medicines were administered to people who used the service. We found that records supporting and evidencing the safe administration of medicines were not always complete and accurate. We found a number of signature omissions in these records.

In records we looked at relating to the administration of prescribed creams we found repeated gaps and omissions. This meant the service could not demonstrate that the medication had been administered in line with people's prescription.

In the nursing unit we found fridge temperatures for two fridges had not always been recorded and found repeated omissions for the month of December 2015. If medicines are not stored at the correct temperature they may be not be safe to use.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication.

During our last inspection we made a recommendation regarding people being given opportunities to take part in activities they enjoyed and met their personal preferences. During this inspection we observed an activity session taking place in the Nursing Unit dining room, with the stand-in activities co-ordinator and two residents sitting at a table colouring in a craft book. The staff member was chatting amiably with the people whilst helping them. We did not witness any other activities to stimulate people taking place during our visit.

We discussed with the Registered Mental Health Nurse (RMN) in the Snowdrop Unit about the availability of dementia appropriate activities within the unit. We were told that the activities co-ordinator was on long term sick leave. In the meantime, another member of staff, from the nursing unit upstairs, had visited the unit on a number of occasions to assist with activities. However, that individual was also currently off with sickness. The RMN told us that they did not know the timetable for any planned activities for people who used the service.

Behaviours by people with dementia need to be seen by staff as expressions of how the individuals are experiencing the world around them so that staff can attempt to meet those needs by appropriate care and activity. We found no record of any activity needs documented in any care plans we looked at.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care, because the service failed to provide care and treatment that met individual needs and reflected personal preferences.

People we spoke with told us they felt safe and were satisfied with the quality of care they or their loved ones received at Swinton Hall Nursing Home.

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.

As part of the inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We found there were sufficient numbers of staff on duty during the day to support people who used the service. We spoke to both staff and people who used the service and their relatives, who on the whole, did not raise any concerns about staffing levels throughout the home.

We looked at a sample of 15 care files to understand how the service managed risk. We found the service undertook a comprehensive range of risk assessments to ensure people remained safe.

The service had a dedicated training coordinator with training facilities on site. We spoke to the training coordinator who explained the induction programme all new staff received, which included attaining a mandatory 'Level 2 Certificate' in preparing to work in adult social care. This certificate provided a foundation and 20 credits towards a Level 2 Qualification Credit Framework (QCF), which all staff were required to undertake after their probationary period and induction.

All staff we spoke with confirmed they received regular supervision, which we verified by looking at supervision records. Supervisions and appraisals enabled managers to assess the development needs of

their staff and to address training and personal needs in a timely manner.

We found that while most staff had received training in the MCA and DoLS, some nurses we spoke with on the Snowdrop Unit were unaware of the process of requesting DoLS assessments and their purpose. Care staff we spoke with were able to explain the principals of the legislation to us.

Through our inspection, we saw staff seeking consent from people before undertaking any tasks such as delivering personal care or support with eating. Staff took their time to explain to people what they wanted to do, which demonstrated a very kind and caring culture.

We have made a further recommendation about dementia friendly environments.

We found that individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and eating needs had been assessed and catered for by the service. We observed the lunch time experience in the nursing and Snowdrop Units and noted a pleasant, calm and amiable atmosphere that was generated by the manner in which care staff interacted with people.

We found staff treated people who used the service with kindness and compassion in their day to day interaction.

Throughout our inspection we observed that staff treated people with dignity and respected their privacy. Staff appeared unflustered if people demonstrated anxiety. At all times they appeared patient and enthusiastic in their work.

The home was also a member of 'Care Aware Advocacy Service,' which was a 'one stop shop' for people and families to seek independent advice and support.

The home was part of the Six Steps End of Life Care programme. This programme is intended to enable people to have a comfortable, dignified and pain free death.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care.

We found that the service routinely listened to people to address any concerns or complaints. We looked at customer satisfaction survey questionnaires for 2015 and the analysed results. On the whole people were very complimentary about the quality of services delivered.

We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided. However, we questioned the effectiveness of some audits such as medication in light of the concerns we identified. The last medication audit undertaken was dated July 2015. A number of audits were also not being consistently applied.

We looked at minutes from staff meetings and staff questionnaires that had been completed. Where issues were raised, there was no evidence to demonstrate how the service had responded to these issues.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included; safeguarding, whistleblowing, consent, medication and supervision.

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 found that records supporting and evidencing the safe administration of medicines were not always complete and accurate.

People we spoke with told us they felt safe and were satisfied with the quality of care they or their loved ones received at Swinton Hall Nursing Home.

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective. We found training needs of all staff were effectively addressed and planned by the service.

We found that while most staff had received training in the MCA and DoLS, some nurses we spoke with on the Snowdrop Unit were unaware of the process of requesting DoLS assessments and there purpose. Care staff we spoke with were able to explain the principals of the legislation to us.

We have made a recommendation about 'dementia friendly' environments.

Is the service caring?

Good

We found the service was caring. We found staff treated people who used the service with kindness and compassion in their day to day interaction.

Throughout our inspection we observed that staff treated people with dignity and respected their privacy. Staff appeared unflustered if people demonstrated anxiety. At all times they appeared patient and enthusiastic in their work.

The home was also a member of 'Care Aware Advocacy Service,' which was a 'one stop shop' for people and families to seek independent advice and support.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. We witnessed limited activities and stimulation for people that met individual needs and reflected personal preferences.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care.

We found that the service routinely listened to people to address any concerns or complaints. We looked at customer satisfaction survey questionnaires for 2015 and the analysed results. On the whole people were very complimentary about the quality of services delivered.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led. We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided. However, we questioned the effectiveness of some audits such as medication in light of the concerns we identified

The service undertook regular supervision with staff. We looked at minutes from staff meetings and staff questionnaires that had been completed.

The home had policies and procedures in place, which covered all aspects of the service.

Swinton Hall Nursing Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 06 January 2016 and was unannounced. The inspection was carried out by one adult social care inspector, two specialist advisors and an expert by experience. A specialist advisor is a person with specialist knowledge regarding the needs of people in the type of service being inspected. Their role is to support the inspection. The first specialist advisors was a GP with experience in many medical disciplines, primary care, hospital medicine and specialist experience in mental health particularly care of the elderly. The second specialist advisor was Social Worker with experience in adult and dementia care. An expert by experience is a person who has experience of or caring for someone who uses this type of care service.

Before undertaking the inspection we reviewed information we held about the home, which included statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority, local commissioning teams and infection control. We reviewed previous inspection reports and other information we held about the service.

At the time of our inspection there were 50 people living at the home. We found that there were 30 people receiving nursing care on the nursing unit, 14 people receiving support on the continuing care unit and six people residing on the dementia unit, otherwise known as the Snowdrop Unit. Throughout the day, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and treatment rooms. We looked at people's care records, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the service.

During the inspection, we spoke with five people who used the service and eight visiting relatives. We found a number of people could not carry out a full and meaningful conversation with us regarding the services they received as they were living with different stages of dementia.

We also spoke with the temporary manager, the service operations director, five registered nurses, two senior care staff members, nine members of care staff, the training coordinator and administrative assistant.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and were satisfied with the quality of care they or their loved ones received at Swinton Hall Nursing Home. One person who used the service told us, "I feel well looked after, I'm quite safe. If I need anyone, it doesn't take a long time for someone to come." Another person who used the service said "Of course I am safe. When they use a hoist to lift me in and out of my chair they let me know what's going on and what they're doing, I feel very safe. I like it here, it's very hygienic."

A visiting relative told us, "He's safe and well looked after here, it's so much better than when he was in the hospital. I think there is enough staff, when he buzzes for them, he doesn't need to wait long, and they're here straight away. They look after his medication for him and make sure that he gets it on time. His morphine is all locked away." Another visiting relative said "My relative is safe in here, she can't go walking about. She wouldn't let anyone bully her. I've no concerns about her medication, she gets what she needs. Her clothing is always clean and she's well groomed, I can't fault the cleanliness here, either on a personal level, or in terms of her room and the home in general."

Other comments from relatives included, "I'm delighted he's here, when he first came out of hospital, he was not expected to live for more than two weeks and that was two years ago." "He's really happy here, very content and very safe. There never seems to be a shortage of staff and they seem to make time to stop and have a little chat." "She's happy here, very safe. She's diabetic, on top of everything else and they look after all her medicines. Her room is kept clean and her bed is beautifully made up." "The home is very good, he needs 24 hour care and they're watching him all the time. There seems to be enough staff, but he has one-to-one care."

As part of the inspection we checked to see how the service managed and administered medication safely. The service used a 'blister pack' system for the people who used the service to store their medication. A blister pack is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the home. The pack has a peel off plastic lid that lists the contents and the time the medication should be administered.

We looked at a sample of 20 medication administration records (MAR), which recorded when and by whom medicines were administered to people who used the service. We found that records supporting and evidencing the safe administration of medicines were not always complete and accurate. We found a number of signature omissions in these records. This meant records could not be relied on to demonstrate that people had received their medication safely and in line with their prescription.

In records we looked at relating to the administration of prescribed creams we found repeated gaps and omissions. This meant the service could not demonstrate that medication had been administered in line with people's prescription. We found there was limited information recorded to guide staff as to where to apply creams to ensure people were given the correct treatment, such as the use of body map charts.

In one example we looked at for topical creams, the instructions recorded that medication should be

applied three to four times a day. Administration records stated 'carers to apply,' which meant it was not possible to ascertain if the medication had in fact been applied. In another example, instruction stated that staff were to administer a prescribed mouth wash when undertaking oral hygiene, however no records existed to demonstrate that the medication had in fact been administered. We spoke to the manager about these concerns, who took immediate steps to address these deficiencies.

In the nursing unit we found fridge temperatures for two fridges had not always been recorded and found repeated omissions for the month of December 2015. If medicines are not stored at the correct temperature they may be not be safe to use.

A small number of medication records did not have the picture of the person who used the service. This was relevant on the day of our inspection as the service were using agency nursing staff who did not know the people who used the service. The absence of a picture increases the risk of wrongful identification especially if the person is unable to communicate verbally.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication.

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 six staff personnel files. Each file contained job application forms, interview questions, proof of identification, a contract of employment and suitable references. A CRB or DBS (Criminal Records Bureau or Disclosure Barring Service) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevents unsuitable people from working with vulnerable adults.

During the inspection we checked to see how people who lived at the home were protected from abuse. Staff that we spoke with were all able to explain to us the principles of safeguarding and what action they would take if they had any concerns. We found that all staff had received training in safeguarding vulnerable adults, which we verified by looking at electronic training records that were maintained by the training coordinator. We also looked at the home's adult and child safeguarding policy together the local authority safeguarding policy that was available to all staff.

Staff we spoke to where able to tell us what action they would take if they had any concerns that people were being abused. One member of care staff told us, "If I had any concerns that someone was being abused I would report it directly to the management, or depending on the circumstances directly to social services or even CQC." Another of care staff said "If I had any safeguarding concerns, I would record my concerns and report it immediately. People are safe here in my view."

As part of the inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We found there were sufficient numbers of staff on duty during the day to support people who used the service. We spoke to both staff and people who used the service and their relatives, who on the whole, did not raise any concerns about staffing levels throughout the home. One member of staff told us, "I have no concerns for residents with night time staffing numbers, people are well looked after and safe." Another member of staff said "With staffing it's ok unless people are off sick, but people are staff." Other comments included, "Moral has lifted with the girls since the new manager has started, staffing levels are better and staff are generally happier."

We looked at staffing rotas and spoke to the manager, about how staffing numbers were determined. The manager told us that the service did not currently use a staffing dependency tool to determine minimum staffing levels, however they intended to review the current arrangements and consider appropriate dependency tools.

We looked at a sample of 15 care files to understand how the service managed risk. We found the service undertook a comprehensive range of risk assessments to ensure people remained safe and were reviewed each month. These included nutritional, continence, skin integrity, oral, personal evacuation plans and falls. Risk assessments were also undertaken for when people required the support of equipment such as 'turntables', hoists and wheelchairs. We hound the service also undertook a range of environmental risk assessments such as use of hazardous substances and electrical equipment to ensure both people and staff were safe. We found that risk assessments provided clear guidance to staff as to what action to take to ensure people remained safe.

Requires Improvement

Is the service effective?

Our findings

As part of this inspection, we checked to see how the service ensured that staff had the required knowledge and skills to undertake their roles. People told us that they believed staff were well trained and competent in their roles. One person who used the service told us, "I feel like they know what they're doing. They keep coming past and checking on me." Another person who used the service said "Yes, they're competent and seem adequately trained." A visiting relative told us, "We've been able to make his room very pleasant and personal with photos etc. The staff seem to work as a team across the Units."

The service has a dedicated training coordinator with training facilities on site. We spoke to the training coordinator who explained the induction programme all new staff received, which included attaining a mandatory 'Level 2 Certificate' in preparing to work in adult social care. This certificate provided a foundation and 20 credits towards a Level 2 Qualification Credit Framework (QCF), which all staff were required to undertake after their probationary period and induction. The training coordinator told us that all non-care staff, such as domestic and cooks, had undertaken awareness training in dementia. Care staff and nurses undertook training to attain a dementia certificate, which provided 19 credits towards QCF level two and three. Staff also undertook annual mandatory training in a number of areas such as manual handling, fire safety and Mental Capacity Act (MCA). We found training needs of all staff were effectively addressed and planned for by the service.

One member of care staff told us, "As part of my induction I had to do course work such as first aid, manual handling and safeguarding. I then did a period of shadowing." Another member of care staff said "My induction course, I felt over whelmed with all the information I had to know, but it was valuable. We did classroom based training in Health and Safety, infection control, safeguarding, record keeping and MCA. I then did a period of shadowing more experienced staff and I did feel prepared to undertake my role."

Other comments from staff regarding the training they received included, "I have training every year, recently completed fire safety and manual handling. I've just finished my Level two QCF." "Everything I need training wise I feel I'm given. I have done level two and three dementia, MCA and Deprivation of Liberty Safeguards (DoLS). Training is organised well here. Most of it is in house training, with some e-learning. I have recently done 'break away' training, specifically for people on the Snowdrop Unit and is about detaching yourself from people who grab you and to deescalate the situation." "We definitely get plenty of training mainly in house with the training coordinator." "The training is very good. Just completed safeguarding again. I have completed Level 2 QCF and about to start Level three."

All staff we spoke with confirmed they received regular supervision, which we verified by looking at supervision records. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner.

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. At the time of our inspection, there were a number of people living at the home who were subject of a Deprivation of Liberty Safeguards (DoLS) authorisation.

We found that though some DoLS applications had been made and authorisation granted, there was no record held in the main office or on the Snowdrop Unit, which would enable the process of applications to be monitored effectively. We spoke to the manager, who agreed a central record for monitoring purposes would be an effective means to review all records. We found that while most staff had received training in the MCA and DoLS, some nurses we spoke with on the Snowdrop Unit were unaware of the process of requesting DoLS assessments and there purpose. Care staff we spoke with were able to explain the principals of the legislation to us.

Throughout our inspection, we saw staff seeking consent from people before undertaking any tasks such as delivering personal care or support with eating. Staff took their time to explain to people what they wanted to do, which demonstrated a very kind and caring culture. However, we found limited evidence of any documented and written consent from the person who used the service, or their representative, for the care and treatment provided by the home. We raised this issue with the temporary manager who stated they would review care files to ensure consent was document clearly.

When we undertook our last Inspection in February 2015, we made a recommendation that the service explored the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'. At that time though the home did not specialise in care for people living with dementia, a number of people who used the service had varying degrees of dementia, especially within the nursing unit. Since that time, the home had now introduced a dedicated 18 bed unit providing accommodation for people living with dementia, otherwise known as the Snowdrop Unit. On the day of our visit, we found that the environment remained significantly unchanged since our last visit in February 2015.

During this inspection we found that the home to be clean and free from unpleasant odours, but still did not have adequate signage features to help orientate people living with dementia. There were also limited resources available to provide stimulation and promote a feeling of wellbeing for people throughout the home. This was particularly relevant within the Snowdrop Unit, where we found an activity room, which was currently used for storage. We spoke to the current manager about these concerns, who provided us with an action plan to address these areas of concern with a target date of February 2016. This included the planned introduction of sign posting for corridors, colour coding in the main corridor, use of memory boxes, a therapy room for sensory items, themed individual door displays for orientation and suitable music to reflect moods and outdoor sounds.

We have made a further recommendation that the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly', especially in light of the dedicated 18 bed unit providing accommodation for people living with dementia.

We found that individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and eating needs had been assessed and catered for by the service. People who were identified as at risk of malnutrition had been referred to dietician services for further advice and guidance. We found little evidence within the care files we looked at of food preferences being documented.

People told us they enjoyed the food provided by the home and were given choices. One person who used the service told us, "I feel like they know what they're doing. They keep coming past and checking on me. I can feed myself. The food is good and there's plenty to eat and drink." Another person said "The food has

been brilliant. You get a choice and they're always coming around offering drinks." One visiting relative said "My relative is on a soft diet, but she doesn't like mashed potatoes and they were always giving her that. That's been sorted now and she likes her food and has put on weight."

Other comments about the quality of food included, "He can be a bit awkward and choosy about his food, but we bring in plenty of treats. The home is meeting all his needs." "The food here is good and it's all cooked on site. I used to be a Master Butcher and it's good meat." "I like the food here, but if there's something I don't like I don't eat it and they'll get me something else."

We observed the lunch time experience in the nursing and Snowdrop Units and noted a pleasant, calm and amiable atmosphere that was generated by the manner in which care staff interacted with people. We found staff to be sensitive, caring and offering person centred care. For example, one person declined their lunch. The member of care staff gently suggested keeping this in the fridge for later. Another member of staff then offered the person lunch again a few minutes later in order to encourage them to eat and responded appropriately to their expressed wishes.

We saw another person was offered a sandwich, which the member of care staff realised contained an ingredient, which the person could not tolerate. We saw the member of staff make efforts to replace the sandwich and to reassure the person concerned. Another member of staff asked a person if they would like an apron, which demonstrated sensitivity and personalised care at meal times. The dining area was clean at all times.

We found people had access to other healthcare professionals to make sure they received effective treatment to meet their specific needs. Care plans detailed communication with other health care professionals such as bladder and bowel, speech and language therapist (SaLT), dieticians, GP's, district nurses and tissue viability teams.

Good

Is the service caring?

Our findings

We found staff treated people who used the service with kindness and compassion in their day to day interaction. One person who used the service said "They're quite respectful, kind and caring. That's not a particular person, it's whoever happens to be there, they're all like that. They know what I like and don't like." Another person who used the service told us, "The staff are lovely, they're very kind and friendly." A visiting relative told us, "The staff are brilliant. They might be busy, but they will always get back to me. Even though they're busy, they're nice, relaxed, but still on the ball and calm. They talk to us like human beings, have a joke with us etc."

Other comments included, "I can't fault the staff, they're all kind and caring, but still respectful." "The staff are very approachable, whatever needs doing, they'll sort it. They take pride in what they do. They're passionate about what they do. They also show great compassion, not just with us, but I've seen them with other families." "The staff are lovely, very kind and caring. My relative is treated with respect at all times, they're kind and courteous, they're lovely with him. Nothing is too much trouble, if I've any queries, I'll just ask and they'll give me the answer. When they are using the hoist, they're always talking to him, explaining what's happening and making sure he's OK." "The staff are very good, very obliging. They make me feel very welcome as well." "The staff are very good, very approachable. He's well looked after."

Throughout our inspection we observed that staff treated people with dignity and respected their privacy. Staff appeared unflustered if people demonstrated anxiety. At all times they appeared patient and enthusiastic in their work. We saw one member of care staff offered a person a drink, after they had declined food. This member of staff then spent time with the person, offered them a newspaper and tried gently to open conversation without seeming hurried. We also observed the interaction between a member of staff and a person who used a wheelchair. We saw that the person looked happy, they were laughing and it was clear that they maintained a good relationship with that member of staff.

As part of the inspection we checked to see how people's independence was promoted and spoke with staff about their approach. One member of staff told us, "With encouraging independence, for example I have just supported a lady getting up. I encouraged her to wash and dress herself as she has the capacity and can do. I let them do little things at first so that they become more confident in themselves as a result." Another member of staff said "Personally, everything I do with people, I will always encourage them to do as much as they can. One lady always tells me she can't, but with a little encouragement and patience, she will have a good go."

A number of staff told us how they were passionate about providing quality care and treatment for people. Comments from staff regarding the quality of care provided included, "I have no concerns about the quality of care delivered here." "Lots of ladies here have dementia, so I encourage them as much as possible to do things themselves. With dressing I show them the clothes they have and let them choose. I always try to promote their independence all the time." "I always make sure people's doors are closed when delivering care. People are entitled to their privacy and I cover them up with a towel when washing them. It is very important to respect people at all times as that is I would expect to be treated."

The home was also a member of 'Care Aware Advocacy Service,' which was a 'one stop shop' for people and families to seek independent advice and support. This included advice on social service assessment procedures, assessing support of local support groups and end of life wishes in respect of enduring/last powers of attorney.

The home was part of the Six Steps End of Life Care programme. This programme is intended to enable people to have a comfortable, dignified and pain free death. We found that nursing staff had received appropriate training such as in 'syringe driver procedures.' We found that the home also had close links with Mac Millan nurses.

Requires Improvement

Is the service responsive?

Our findings

We asked people who used the service and visiting relatives whether they thought the service was responsive to their needs and whether they or their loved ones received any stimulation. One relative told us, "They have arranged for me to join my relative for lunch twice a week, and we take her out regularly with the family, as well. We just let them know so that they can get her ready. She joins in some of the activities, she enjoys the craft work, it's something for her to do." Another relative said "We can come and go when we want, all the time we are made very welcome. The doctor wanted my relative to go back into hospital, but didn't want to and the home managed to sort out the medical issue. We had a good chat with the home before coming in, about how he was to be looked after including end of life. We are confident that they've taken notice of us and it's in his care plan. The home have been very supportive as well as the Church, the Vicar has made a number of visits."

Other comments included, "That's the only downfall of the home, there's no stimulation. I've not seen anyone doing any activities, not just with my relative, with anyone. We've brought some bits into her room, photos and so on, and we've brought in a bookcase with books. She's quite a reader. Anything she needs, she can have." "We had a good chat before he came in and we're confident that they know what he wants and needs. We feel very well supported." "We did have a slight issue in that some of the other residents require one-to-one care, but the agency, which supplied their carers wasn't very good. This meant that when a carer didn't turn up, this would have an impact in that one of the permanent carers would have to provide the one-to-one care and there'd be a shortfall. We brought it to the owner's attention, and they've changed the agency and it's much better now."

During our last inspection we made a recommendation regarding people being given opportunities to take part in activities they enjoyed and met their personal preferences. During this inspection we observed an activity session taking place in the Nursing Unit dining room, with the stand-in activities co-ordinator and two residents sitting at a table colouring in a craft book. The staff member was chatting amiably with the people whilst helping them. We did not witness any other activities to stimulate people taking place during our inspection.

We discussed with the Registered Mental Health Nurse (RMN) in the Snowdrop Unit about the availability of dementia appropriate activities and stimulation within the unit. We were told that the activities co-ordinator was on long term sick leave. In the meantime, another member of staff, from the nursing unit, had visited the unit on a number of occasions to assist with activities. However, that individual was also currently off with sickness. The RMN told us that they did not know the timetable for any planned activities for people who used the service.

We spoke with the RMN regarding a person who was currently being assessed by a psychologist to assist in the management of aggressive and agitated behaviour. The RMN referred to this person as having "problematic behaviour". They described how this person's behaviour had improved, but no reason for the change has been clearly identified. Dementia specialist training for staff in a residential setting, should enable staff to better understand what individuals may be expressing in terms of their emotional feelings

and to seek to meet those needs with specific activities and care. Behaviours by people with dementia need to be seen by staff as expressions of how the individuals are experiencing the world around them so that staff can attempt to meet those needs by appropriate care and activity. We found no record of any activity needs for people documented in any care plans we looked at in the Snowdrop Unit.

One member of staff told us, "Activities are generally limited, there isn't much variety for people, but we do have singers come in and a number of events over Christmas." In one care file we looked at the activity log for the person recorded the following activities, '01 September 2015, had communion. The next entry dated 23 November 2015 stated 'chatted with staff' with no further entries.' If was therefore not possible to determine the level and extent of activities / stimulation available to people residing at the home.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care, because the service failed to provide care and treatment that met individual needs and reflected personal preferences.

As part of this inspection we 'case tracked' five people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and wellbeing were being appropriately managed by the service. In the continuing care unit we found that people received care and treatment appropriate to their needs.

We reviewed how falls were dealt with and saw that the new manager maintained an audit of falls to determine any patterns. In one example we looked at we found that a falls prevention plan had been formulated for the person, but no discussion or contact had been made with other professionals such as the GP or falls clinic to help identify possible causes and consider other preventive measures. We discussed this matter with the manager, who assured us that this would be addressed.

We spoke with the nurse in the Snowdrop Unit, about how care staff knew when and where to look for pressure areas. The nurse was not sure, but when we spoke to a senior member of care staff they confirmed they had received training, which taught them where to look each time they changed and washed a person at risk.

At the time of our inspection, there were only six people residing in the Snowdrop Unit, with other beds in the unit used by people requiring nursing care. When we spoke to the nursing staff about who was responsible for 'nursing patients' in the Snowdrop Unit, we were told it was the responsibility of the registered mental health nurse, who was located in the unit. We raised our concerns with the manager about the competency of mental health nurses to provide treatment to people requiring nursing care. The manager was clear that people requiring nursing care were the responsibility of registered nurses on the nursing unit and would immediately address the confusion with staff.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care. We looked at the complaints file during the inspections and found that any complaints had been properly responded to, with a response given to the complainant. Comments from people and relatives included, "I've never had to make a complaint and wouldn't know what to do, but I'd speak to staff first and take it from there." "I've never had to make a complaint, if I had to, I'd speak to the nurse in charge and fill in a complaints form."

We found that the service routinely listened to people to address any concerns or complaints. We looked at customer satisfaction survey questionnaires for 2015 and the analysed results. On the whole people were very complimentary about the quality of services delivered. Comments from responses included, "Never had

cause to complain," "We have found staff are always ready to help in any way they can," "Very satisfied, a good service given constantly" and "I think quality of care in very good indeed."

We looked at minutes from 'relative support group meetings,' with the last one having taken place in November 2015. Issues discussed included safeguarding, mental capacity, power of attorney and activities coordinator.

Requires Improvement

Is the service well-led?

Our findings

At the time of our visit, there was no registered manager in place. A temporary manager had been in post for approximately three weeks following the resignation of the previous registered manager and was present through the inspection. 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.

Following our inspection, we were informed by the operations manager that a new manager had been appointed by the service, who would commence registration with CQC imminently. The current temporary manager had been appointed as Clinical Lead for the service.

During the inspection we asked staff, relatives and people who lived at the home for their views about the leadership of the service. One person who used the service told us, "I like the temporary manager she's very friendly." Another person said "I don't know who the manager is, but I'm quite content here." Other comments from relatives included, "All the management are very approachable, we wouldn't have any qualms about seeing them. He's very comfortable here." "My relative didn't like it here at first, it took her a while to get used to it, but she seems quite happy now. I filled in a Questionnaire just before Christmas and my only concern was the lack of stimulation. I chose this home partly on the basis of my first impressions here, which was of the cleanliness and the cheerfulness of the staff." "He's very contented here and very comfortable. The temporary manager is excellent and has a very real presence around the place. I see the owner in here every day, she lives in the house nearby. I thank God every day that we're in here, he's just so comfortable." "The management is very approachable." "I didn't realise that Matron (previous manager) had left. It's still just as good though." "We've no issues with the home, but wouldn't hesitate to bring anything to their attention."

We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided. These included regular fire systems checks, environmental audits, bed rail checks, wheel chair audits, window restrictor checks and mattress and pressure relief. We looked at audits for falls, DoLS assessments, safeguarding, end of life, first aid equipment, infection control, hand hygiene, medication and accidents. However, we questioned the effectiveness of some audits such as medication in light of the concerns we identified. The last medication audit undertaken was dated July 2015. A number of audits were also not being consistently applied.

When we spoke to the temporary manager who acknowledged that auditing had not been consistently undertaken during the period leading up to the resignation of the last manager and that they were currently addressing those issues. The manager told us of their plans to improve the service provided and was in the process of reviewing all the administrative, practical processes and procedures to improve those systems where necessary. The temporary manager also explained how they intended to improve the recording and monitoring of both accident records and DOLS referrals and authorisations.

The service undertook regular supervision with staff. We looked at minutes from staff meetings and staff questionnaires that had been completed. Where issues were raised, there was no evidence to demonstrate how the service had responded to these issues.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included; safeguarding, whistleblowing, consent, medication and supervision.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, 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.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service failed to provide care and treatment that met individual needs and reflected personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not protected people against the risks associated with the safe management of medication.