Marantomark Limited

St George's Nursing Home (Oldham)

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

St George's Nursing Home cares for up to 77 people who require nursing and personal care. The service was divided into six specialist units caring for people living with dementia, older adults, younger adults, people with physical disabilities and mental health needs. There were 71 people using the service at the time of the inspection. The service had re-registered with a new provider in July 2014 and this was the first time we had inspected the service since then.

The inspection was carried out on 4 and 5 October 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor.

A registered manager was in post and had registered with the Care Quality Commission in June 2016. 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.

We found shortfalls in the administration of medicines as policies and procedures for the safe storage, administration and recording of medicines were not always followed. We also found that some areas of the home were not kept satisfactorily clean, and that hazardous substances were not always stored safely. The registered manager had addressed some of our concerns by the second day of the inspection.

Staff had received training in the safeguarding of vulnerable adults and the service followed the protocols set out by the local authority for the recording and reporting of incidents of a safeguarding nature.

There were suitable numbers of staff on duty, and safe staff recruitment processes were in place which helped to protect people from abuse. There were some staff vacancies and recruitment was in progress to fill these. Where agency staff were being used, the registered manager tried to book the same agency staff to provide consistency and continuity of care.

Systems were in place to assess and monitor the safety of the premises and equipment. Individual risks to people were also assessed and plans were put in place to mitigate these.

Staff received regular training, supervision and appraisals. A new system had been put in place to ensure these were brought up to date by the new registered manager, as a number had been out of date. We found that progress was being made in this area and staff told us they felt well supported. A training facilitator worked in the service and was responsible for planning and delivering training. Specialist trainers were brought in to provide training related to specific needs, such as particular medical conditions or specialist equipment. There were some gaps in training but there were plans in place to address these. The standard of training materials and resources was high.

The service was working within the principles of the Mental Capacity Act and applications had been made to the local authority to deprive people of their liberty in line with legal requirements. Decisions taken in the best interests of people were not always appropriately recorded or reviewed on a regular basis.

People were supported with eating and drinking, and special diets were catered for. Nutritional assessments were carried out, and where people were found to be losing weight, specialist input was sought. There were mixed views about the quality of the food, and we were told that the contract with the external catering company was due to end, and that catering would be provided by the provider's organisation in the near future. We reviewed food and fluid records and observed staff completing these. We found that they were not always completed accurately and that there were some gaps in records.

The premises were generally clean and tidy, and there was access to outdoor space with supervision. Gardens were well maintained and tidy. There was a rehabilitation kitchen, hairdresser and old fashioned sweet shop on site. The design supported the needs of people living with dementia, including good use of signage to support way finding. Some towels and bedding although clean, were worn, and the registered manager told us she had recently ordered replacements.

Staff were observed to be kind and caring in their interactions with people throughout the inspection. The units we visited were calm and staff communicated with people in reassuring tones. We observed that when people became upset, staff intervened quickly. We observed people interacting with staff with warmth and humour, and they told us that they felt well cared for and that staff were nice. People's privacy and dignity was respected and promoted.

Care plans were in place which contained person centred information. These varied in quality and format and it was not always easy to locate the most up to date information. The registered manager had set up a working group to review, streamline and standardise care records. We found that essential information and care plans to meet people's needs was available in the main but that care plans needed to be further developed. We have made a recommendation about this.

A number of activities were available to people. We observed people taking part in activities during the inspection and they were well supported by staff to take part. Three activity coordinators were in post which meant that activities could take place over seven days per week.

A complaints procedure was in place and a log of any complaints was maintained. We saw that complaints received had been responded to appropriately by the manager. Systems were being improved to capture low level issues to improve the quality of the service by addressing concerns at the earliest opportunity.

We found shortfalls in some aspects of the management of the service. Systems for monitoring the quality and safety of the service were not sufficiently robust to pick up some of the concerns we identified during the inspection. The registered manager was keen to address issues we identified as soon as possible. They had made improvements in a number of areas and told us they planned to use the inspection outcome as a benchmark from which to continue to make improvements.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not always managed safely and some potentially hazardous substances were not always stored securely.

Safe recruitment practices were followed which helped to protect people from abuse and there were suitable numbers of staff on duty.

Staff had received training in the safeguarding of vulnerable adults and incidents of a safeguarding nature were appropriately logged and alerted by the service.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff worked within the principles of the Mental Capacity Act but best interests decisions needed to be more clearly documented and reviewed on a regular basis.

Staff received regular training, supervision and appraisals. A training coordinator was in post who delivered and planned training. Specialist training was provided by external trainers where necessary.

People were supported with eating and drinking. Staff supported people sensitively and discreetly but did not always document food and fluid intake accurately.

The premises had features of dementia friendly design and décor. Some towels and bedding were worn and needed to be replaced.

Is the service caring?

Good

The service was caring.

People and relatives informed us that staff were caring.

Interactions between people and staff were positive. Staff spoke

with people respectfully. The privacy and dignity of people was maintained.

Staff were involved in a project to improve care at the end of life. Where people did not have family or friends able to visit, staff made a point of ensuring they were never left alone as they approached the end of their lives.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People and relatives told us that needs were responded to appropriately by staff.

Care plans were in place which contained person centred information and care plans related to individual needs. These varied in quality and detail and were in the process of being reviewed and streamlined.

A variety of activities were available and activity coordinators worked over seven days per week to facilitate this.

A complaints procedure was in place and a record of complaints kept. These were responded to promptly and professionally by the registered manager.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

Records relating to people's care and treatment were not always accurately maintained, and audits were not always sufficiently robust to pick up on quality and safety issues in the service.

An action plan was in place to address issues identified by the registered manager and an independent consultant and we observed that progress was being made in a number of key areas.

Staff told us they felt well supported by the manager and that morale was good in the service.

Systems to seek the views of relatives and staff were in place. Surveys and methods to elicit the views of people who used the service were being developed.

St George's Nursing Home (Oldham)

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.

The inspection took place on 4 and 5 October 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection and have specialist knowledge in a certain area. The specialist advisor on this team had a background of working with older people including those with physical and mental health related conditions and was a qualified nurse.

We spoke with the registered manager, four people who used the service, four relatives, five nurses, six care staff, one home maker (staff responsible for certain tasks such as setting tables and making beds), one activities coordinator, a training facilitator, a cook, a pharmacy technician and maintenance staff member. We received information from the Clinical Commissioning Group and took this information into account when planning our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

We checked the management of medicines and found that procedures for the safe storage, administration and recording of medicines were not always being followed. On the first day of the inspection, we found a number of creams and lotions in use which were out of date, some of which had been dispensed in 2013 and 2014. This meant that they were not suitable for use. We spoke with the registered manager about this and these had been removed and discarded by the second day of the inspection.

Dates of opening of certain medicines were not always recorded on medicine administration records [MARs] or on all creams in use. We saw a record that this had been raised with nurses previously by the pharmacy technician who visited the home on a regular basis. There were also a number of gaps in MARs which meant that it was unclear whether medicine had been administered.

Controlled drugs [CDs] are medicines which are liable to misuse, and are therefore subject to more stringent storage and administration procedures. A controlled drugs log book contained a number of entries which contained only one nurse's signature. The policy in the service was for two nurses to sign when these drugs had been administered. We checked the stock balance of four CDs and found the correct amount. They were in date and correctly stored and labelled. A medicine trolley was not secured to the wall in one unit, and a medicine fridge was left unlocked. We noted that both of these issues had been picked up during audits by the pharmacy technician in June 2016 so we did not consider that this was an isolated occurrence.

Protocols were in place for the administration of as required medicines. These medicines are given on an ad hoc basis for pain, anxiety or constipation, for example. Protocols advise staff under which circumstances and how often they can be given. We found that the level of detail on these varied with some containing insufficient information, while others were quite detailed. This meant that advice to staff was not always clear.

We observed that a nurse signed for three people's medicines, which she had administered a short time earlier. MARs should be completed immediately following the administration of medicines to ensure an accurate timely record is maintained. We observed other nursing staff administering medicines appropriately during the inspection. We found two tubs of prescribed food thickeners which had been left in people's rooms, one of which had the lid off. These were accessible to people who walked around the unit and were potentially hazardous if accidentally eaten as they can cause choking.

We read meeting minutes in which the registered manager reminded staff that these products should be stored safely. In addition to this we found denture cleaning tablets which were accessible in people's bathrooms. These can also be hazardous if swallowed. We did not see any risk assessments related to the storage of these so it was not clear whether it was safe for people to have unrestricted access to these products.

This was a breach of Regulation 12. Safe Care and Treatment

We found that the cleanliness of rooms and equipment varied between units. In one unit a person who used the service told us they were particularly happy with the cleanliness of the service and said, "It's clean, really clean. That's very important to me." A relative in another unit told us they were happy with the cleanliness and condition of their relation's room. We found, however, that some areas of the home were dirty and infection control procedures were not always followed. We looked in the bedroom of one person and found that medical equipment and dressings were not hygienically stored, and that surfaces were dirty and sticky. This posed an infection control risk. In other rooms a number of plastic bedrail bumpers and chairs were also marked and there were crumbs and debris under some seat cushions. One shower room contained toiletries and tubes of opened toothpaste with no name which meant that staff could not be sure which toiletries belonged to individual people, or suggested that supplies were being used communally. A toilet seat was scratched, exposing the wood below which meant that it could not be cleaned satisfactorily. Used disposable razors were also found in an unlocked cupboard and on a windowsill and a basin. The unnamed toiletries and razors had been removed and a new toilet seat was purchased by the second day of the inspection. These issues had not been picked up by the registered manager but they told us that they would add spot checks on the cleanliness and safety of each unit to their routine audits.

Staff told us, and records confirmed they had received training in safeguarding of vulnerable adults. We spoke with staff who told us, "I am not worried about anyone; people are safe living here. " They told us that any concerns they had about people were acted upon promptly by nurses and that they knew how to whistleblow if they had to. All incidents of a safeguarding nature were recorded and graded according to the seriousness of the incident, in line with the local authority safeguarding protocol in place. Lower level incidents were logged and we saw that more serious concerns were alerted to the safeguarding team. Staff training included an interactive session supported by a film to raise awareness and also a work book. The work book took staff through different types of abuse and there was a quiz at the end. Where staff did not gain a satisfactory pass mark they were supported by the training facilitator until they achieved this. This meant that staff were supported to meet the required standard knowledge base.

There were suitable numbers of staff on duty during the inspection. We had mixed feedback about staffing levels from staff. Some staff felt that they had to work harder due to the number of agency staff working on their unit. Other staff told us that the staffing was satisfactory and they had no concerns about meeting the needs of people. We observed that staff supported people in a calm unhurried manner. In each unit we visited there were staff present and available in the communal areas at all times. There were a number of vacancies for nursing and care staff and recruitment was in progress. A new nurse was due to start work in the home. During our inspection we observed the registered manager checking the staffing levels in one unit where a person was unwell and staff were providing one to one observation. They were asked if they needed any additional support and said that they would contact another unit for help if required. Where agency staff were used the registered manager told us that she tried to book the same staff member for consistency. A relative told us that their relation needed support when they became upset and said, "There is always someone there to sort out any problems she has and to talk to her and calm her down."

Staff recruitment procedures were in place which protected people from abuse. Staff records showed that recent applicants had been screened by the Disclosure and Barring Service (DBS). DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. This helped to protect people from abuse. Two references were obtained for each applicant, and there were no unexplained gaps in employment. The identity of applicants was also verified.

Individual risks to people were assessed and care plans were in place which were up to date and regularly reviewed. These plans related to risks associated with moving and handling, falls, use of bedrails, nutrition, mental health and behaviour and pressure ulcers. This helped to maintain the safety of staff and people

who used the service. Incidents and accidents were recorded and were analysed on a regular basis by the manager to check for patterns or trends to help to prevent reoccurrence.

Emergency contingency plans were in place including where people would be evacuated to in the event of a problem with the building. Regular checks on the safety of the premises were carried out by maintenance staff including water temperatures, passenger lift, mobile hoists and wheelchairs, window restrictors, and fire safety equipment. Staff were trained as fire wardens to take charge in the event of a fire in the service. Safety tests had been carried out related to gas and electrical safety, and a legionella risk assessment was in place. The laundry contained industrial washing machines and tumble driers. Laundry was separated and washed appropriately to avoid the spread of infection.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the care they received at St George's. One person told us, "I am happy here. I have been to other places and this is my favourite; I feel well looked after."

We observed people being supported during meals. Staff sat at eye level with people who required maximum support, and we saw a number of examples of staff gently prompting and encouraging people who were reluctant to eat. Some people were easily distracted from their meals and staff reminded them to eat and encouraged them back to the table if they left. Meals were sent to the units for people who required support first, to enable staff time to assist them. People received their chosen meal but staff told us that sometimes they changed their mind and there was always an alternative option.

Special diets were also accommodated for example pureed meals for people with swallowing difficulties and fortified meals for those losing weight. We visited the kitchen where staff showed us a list of special diets and told us that they were aware of people who were at risk of losing weight. We spoke with the head cook who told us, "We can add cheese and cream to meals to supplement them." A four weekly menu cycle was in place. The head cook told us that they visited the units on a regular basis to check the satisfaction with meals. We heard mixed feedback about the food. Three staff members told us that the food could be "Hit and miss." This meant that they found the quality of the meals inconsistent. A complaint had also been received about the quality of meals provided. We asked two people who said they enjoyed the meals. One relative also told us that the meals appeared good. An external contractor was in charge of catering in the home and we were told by the head cook and registered manager that this contract had been ended and that responsibility for catering would return to the home in December 2016.

Nutritional assessments were carried out and people's weights were monitored. In the care files we checked, we found that weights were generally stable but that when there was any loss, this was acted upon and professional advice was sought from a GP or dietician where necessary.

We checked records related to eating and drinking. We found that there were gaps in records and that in one unit, no evening meals had been recorded for the evening before our inspection. We later checked the records again and found that these had been added in retrospectively. In another unit, we observed staff recording the fluid intake of people. One staff member told another that people had all had drinks except one person. The staff member recorded that they had all taken 200 millilitres which was not an accurate reflection of what was taken by each individual. We observed that some people had not finished their drink or had been given a second drink. The total amount of fluid taken daily was not calculated, and individual targets had not been set for people. In a third unit, no charts were in place as the nurse said no one required their fluid intake to be monitored.

We observed staff completing food charts after lunch. We saw that one person ate the filling of their sandwich only and left the bread, but staff recorded that they had eaten a sandwich. Another person ate an item of food which was not recorded at all. Another person ate half of their portion and it was recorded that they had eaten a hash brown on toast. The quantities that people were eating and drinking were therefore

not accurately recorded.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training in the Mental Capacity Act and DoLS and a number of people had DoLS in place. Some applications for DoLS had been submitted and were awaiting the outcome. Information was available about consent, and it was clear from some records the level at which people could consent or make choices when they lacked capacity. Choice was promoted in areas such as choosing clothes and meals, and where complex choices could not be made this was recorded.

We heard staff discussing a best interests issue, including that a medical appointment for one person who was approaching end of life may be unduly burdensome and distressing. It was planned that a best interests meeting would take place in order to discuss this, as the person lacked capacity. We saw the documentation of best interests decisions was inconsistent, particularly where a decision had been made in another setting prior to the person's move to St George's. We found that there was a shower chair with lap straps and we asked the registered manager whether these were used when showering people. She reported that they were not in use, and she requested that they were removed. The service was acting within the principles of MCA but some specific decisions needed to be documented more clearly and reviewed on a regular basis.

This was a breach of Regulation 17. Good governance.

Staff records showed that they received regular training. We observed that training in the safeguarding of vulnerable adults was being delivered in the home on the first day of the inspection, and training in the prevention and control of spread of infection was being delivered to staff on day two. An in-house training facilitator was in post. They had undertaken additional training in order to deliver a number of training sessions in-house, including; MCA, safeguarding, infection control, moving and handling, equality and diversity, first aid and dementia. Other staff were also trained 'trainers' and we saw certificates confirming they were able to deliver training.

The resources used to deliver in house training reflected recent changes in legislation which demonstrated the provider sought to keep up to date with current best practice. A resuscitation doll was available for use in first aid training. The dementia training was comprehensive and described the types and stages of dementia as it progresses through time, but also helped staff to understand the subjective experience of people with a dementia related condition. Specialist training was carried out by external trainers including training in the care of people with a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines. Training in the use of oxygen therapy and 'managing violence and aggression' (MVA) were also delivered by specialist trainers who visited the service. We read staff feedback forms which were provided following each training session. These were very positive overall and demonstrated that staff had found the training beneficial and interesting.

The manager told us that staff supervision and appraisal had not been happening on a regular basis when she took over and that she had introduced a new system to address this. We observed staff supervision records and found that detailed supervision notes were recorded. The manager was aware that they were not all fully up to date but we could see that progress was being made in this area. We spoke with a member of staff who told us, "I have had supervision and feel well supported. We have regular briefings and team meetings which also feel like supervision." There were systems in place to monitor that nurses employed by the service had current and valid registration with the Nursing and Midwifery Council (NMC) which ensured nurses were legally able to practice.

Health needs were assessed and we saw that care plans were in place to meet the physical and psychological needs of people. Additional support from visiting professionals had been sought, where necessary. Care plans relating to specific ailments or conditions were available.

The design of the environment was dementia friendly. There was good attention to signage and orientation and signs and photographs were used which had meaning to people that used the service. Murals and wall art added interest to corridor areas. We noted that some carpets were stained, and that towels were tatty and worn although clean. Some bedding was quite faded. The registered manager showed us that she had arranged to have the carpets professionally cleaned, and the cleaners arrived during the inspection. Orders had also been made to replace worn towels. There was mild malodour in some bedrooms but the manager was aware of the areas requiring attention and a plan was in place. The grounds were neat tidy and accessible to people with supervision.

Good

Is the service caring?

Our findings

All of the staff we met during the inspection were kind and caring in their responses to people and visitors. People told us that they felt well cared for and told us, "The carers really do care here. [Name] is an excellent nurse. Some of the carers are saints and they couldn't look after us any better; they couldn't aim any higher." Another person told us, "They are all good, it is all fine, they are nice people." A relative told us, "They (staff) can't do enough. They are affectionate; they kiss them and make them feel wanted. I can't praise them enough for what they do." We observed a nurse stroking a frail person tenderly on the cheek. The person smiled and said "Thank you", the nurse smiled back and said, "You're welcome."

We were unable to ask some people directly about their experience of care, particularly those with a dementia related condition. We observed, however, that most people displayed signs of psychological wellbeing. They were alert and responsive, interested in their surroundings, and interacted with staff displaying warmth, affection and humour. When people became distressed, staff quickly intervened. Most units cared for people with the potential to experience behavioural disturbance and distress due to a variety of reasons. We found that despite this, the units were calm and the approach of staff was quiet, gentle, and reassuring. Noise was limited as this could be a trigger to distress for some people, and there were signs reminding staff and visitors not to allow doors to bang.

Staff assisted people at mealtimes sensitively and discreetly. People were gently encouraged to eat, we observed one staff member who said, "Come on, I must be able to tempt you with something." One staff member guided one person to the table and said, "Come on, that's the way, feel for the chair behind you and sit down. That's brilliant." The person was quite anxious and the staff member explained what was happening to them every step of the way. When one person was helped away from the table, a staff member asked them, "Where would you like to sit? The person replied, "I have no idea." The staff member suggested, "Why don't we sit you over here beside your friend."
People were offered choices throughout both days of the inspection, including whether to participate in activities, what to eat and drink and where to sit for example. A large number of people lacked capacity to be involved in the care planning process but family carers were consulted and attended reviews regarding care to act as an advocate for their relative. No one was accessing a formal advocacy service but contact details of advocates were displayed in some units.

The privacy and dignity of people was maintained. We observed people knocking before entering people's bedrooms and we were introduced politely to people as we were shown around. People were provided with clothing protectors where necessary at mealtimes, and helped to wipe their face or hands following their meal, which helped to maintain their dignity. The relatives of one person had been contacted by staff to see if they could bring some headphones to enable their relation to take telephone calls privately because currently staff were holding the telephone to their ear which they noted meant that privacy was compromised.

Nursing staff received training in end of life care. They had recently signed up to a programme called 'six steps', and there was a six steps champion in the home. Six steps is a programme which sets out essential

steps to provide seamless care towards the end of life. We spoke with one nurse who told us, "We pride ourselves on our end of life care. It isn't just about learning to use a syringe driver and administering drugs, it is about the bigger picture. We support families; we provide emotional support, we provide a couch they can sleep on and we provide meals for them. We tell them what to expect including why the coroner is involved if someone has a DoLS in place so this doesn't upset them." Local coroners conduct a formal inquest for every person who dies whilst under a Deprivation of Liberty Authorisation. Staff recognised that this could be a sensitive topic so told families about this so that they were prepared. We read a number of cards thanking staff for their compassion and kindness including at the end of life. Staff told us that when no family members were able to sit with people, staff devised a rota to ensure that someone was with the person until they died. One staff member told us, "They are never left. We read to people, play music and talk to them. Everyone pulls together on other units when someone is dying."

Requires Improvement

Is the service responsive?

Our findings

We spoke with people who told us their needs were responded to. One person told us. "It's not home but they are nice to me. I look after myself but they help me if I want them to. They check I am okay lots of times."

Pre admission assessments were carried out before people moved into the home to ensure that their needs could be met by the service. We overheard a nurse speaking to the registered manager about a new admission and expressing concerns that they did not have all of the information they needed to admit the person safely. Consideration was then given to whether the admission should be delayed which demonstrated that care was taken when moving new people into the home to ensure their safety and wellbeing.

Care plans were in place for each person and some contained detailed person centred information including very specific information about how to care for people. The quality and detail of care plans varied, and some information was missing from care records or difficult to locate. Old information was filed alongside current information which also made files bulky and difficult to identify the most up to date information. We judged that care plans were in place for important assessed needs, and these were up to date and regularly reviewed. The registered manager told us, and we saw an action plan which confirmed that a group had been set up to review the format of all care records to streamline records and to standardise files across each unit.

We recommend that care plans are further developed to ensure they fully meet the needs of people who use the service.

Staff demonstrated a good understanding of the needs of people with dementia related conditions and mental health needs. Some people required consistent and carefully planned care in order to prevent them from becoming distressed. Practical guidance was provided to support staff with things that people might find difficult, such as accepting support with washing and dressing. Dementia training included various facts but also focussed on the subjective experience of dementia. Some staff had attended a virtual dementia tour where they wore outfits which caused problems with their vision and dexterity, and were then expected to carry out tasks. Staff had found this helpful, and told us that this helped them to respond to people as they had a greater insight into how they felt. Communication was adapted to support people with difficulty hearing or understanding the spoken word. We saw a whiteboard which said, "Good morning (name of person) it is time for breakfast."

A variety of activities were available to people. There were three activities coordinators in post, who worked across seven days a week. We saw activities advertised on notice boards and people taking part in various activities during the inspection. These included musical bingo, karaoke, and one to one time. People with varying abilities were supported by staff. During the musical bingo, most people sat next to a staff member. Staff provided support which helped them to be independent where possible, but did not allow them to fail publicly at the task in hand. Information about people's past life experiences and interests were recorded

which helped staff to target activities. Sensory activities which promoted the use of touch for example, were available for more frail people. Other people participated in more complex activities such as quizzes. An old fashioned 'sweetie' shop had been opened in part of the home which people enjoyed visiting. It contained jars of sweets and was decorated with old fashioned advertisement to add character and promote reminiscence. A rehabilitation kitchen was available for people to practice kitchen skills if required. This could also be used for activities. A hairdressing salon was also available and the activities coordinator told us there were plans to extend this to allow more space for "pampering" activities.

A complaints procedure was in place and was prominently displayed. A record of complaints was kept including responses. These had been responded to professionally by the registered manager and in a timely manner. The registered manager told us that systems were being improved to try to capture low level 'niggles' in order to address these promptly before they became more serious concerns.

Requires Improvement

Is the service well-led?

Our findings

We found shortfalls in the maintenance of records relating to people's care and treatment, including medicine records and food and fluid charts. Best interests decisions were not always clearly documented or reviewed on a regular basis.

Routine audits had failed to pick up a number of issues identified during this inspection related to the quality and safety of the service. Some areas of the home were not suitably clean and infection control procedures were not being followed on all units including in relation to the storage and use of personal toiletries. We also found that out of date creams were in use and that procedures for the safe management of medicines were not being followed by all staff.

This was a breach of Regulation 17. Good governance.

The manager was registered with CQC in June 2016 and had worked in the service previously as a nurse. They supported us during the inspection process and were open and honest about areas that required improvement in the service. A mock inspection had been carried out by an independent consultant who wrote a report for the provider. An action plan was then developed by the provider and registered manager. We saw the action plan and discussed progress to date with the registered manager. They told us, "We are not perfect but we are in a better place than we were and improving all the time." A relative told us, "I can see an improvement in the care." We confirmed that this was since the registered manager took over. We spoke with a member of nursing staff who told us, "I left the service for a while and came back after (name of manager) started. I was impressed by the structure and organisation when I returned. I had an in depth induction which I had never had before."

Staff told us that they felt well supported by the registered manager. One staff member said, "I feel totally supported. The manager has an open door." Another staff member told us, "I would usually go to the lead nurse first if I had any issues but if they weren't available I would go do the manager. She is approachable and will sort things out."

Following the mock inspection, a number of meetings had been set up to improve communication between teams. While some of the points discussed in the meetings had not been actioned by some staff there was evidence that these meetings were designed to drive up quality. The registered manager prioritised specific areas from the action plan and involved staff in helping her to achieve some of these goals, such as the reorganisation of care files.

A health and safety committee had been set up and included a variety of staff with different roles. One member of care staff told us they had been given opportunities to develop and to be involved in the running of the home. They said, "I am working my way up and doing more qualifications, I am also part of the health and safety committee. I am definitely well supported by the manager."

The views of people, staff and relatives were sought by using questionnaires and a suggestion box, and

relatives meetings had been held. Staff surveys were due to be carried out and the registered manager told us that surveys for people were overdue. They advised us however, this was in part due to having reviewed the previous surveys and a desire to make the surveys as meaningful as possible. The home cared for people with varying abilities and needs and it was therefore not appropriate to use a 'one size fits all' approach. The registered manager had been trained in an observational audit tool designed to assess the quality of the experience of people living with dementia, who were unable to tell staff their views about the care they received. They were exploring alternative evidence based options at the time of the inspection which could be used more easily.

Three staff we spoke with told us that morale was good in the home and that they worked well as a team in individual units and across the service as a whole. We observed staff supporting each other throughout the inspection and noted that the manager was aware of any issues related to staffing and individuals in each unit. Lead nurses sent the manager a weekly handover report which included information such as the use of agency staff, staff sickness, staff supervision and appraisals completed, 'service user' information including DoLS and capacity issues, hospital admissions, new use of bedrails or increases in the level of observation required for
people (restrictive practices). This meant that the manager sought to remain aware of what was happening in each unit across the service.

The service had good links with the local church and school which meant that people were supported to maintain contact with the local community.