St Mary's Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 1 and 2 November 2016. The inspection was unannounced.

The service provides accommodation, nursing and personal care for up to 56 older people who may live with dementia. Fifty-one people were living at the home on the day of our inspection.

The registered manager had been in post for almost three years. 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.

At our previous inspection in November 2015, we found a breach of the regulations, related to the number of skilled and experienced staff in post, which had an impact on all of the five questions we ask about services. We gave the home an overall rating of requires improvement and asked the provider to send us a report, to tell us how improvements were going to be made to the service. At this inspection, we checked whether the actions they had taken were effective.

Since our previous inspection, the registered manager had recruited additional staff. There were enough skilled and experienced staff on duty to meet people's care and support needs safely and effectively.

The registered manager checked staff's suitability to deliver care and support during the recruitment process. The premises were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

People were safe from the risks of harm, because staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies.

The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence.

People's needs were met effectively because staff had the necessary skills and experience and received appropriate training and support. Staff understood people's needs and abilities because they worked with experienced staff until they knew people well. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests.

People were offered meals that were suitable for their individual dietary needs and met their preferences. They were supported to eat and drink according to their needs. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health.

People were cared for by kind and thoughtful staff who knew their individual preferences for care and their likes and dislikes. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed and updated when people's needs changed.

Staff were guided and supported in their practice by a management team that they liked and respected. Quality audits included reviews of people's care plans and checks on medicines management and staff's practice.

Some improvements had been made in record keeping since our previous inspection, but further improvements were needed. Individual records were not completed consistently or sufficiently detailed to evidence that staff took the necessary actions to minimise risks to people's treatment and care. Audits of people's care and treatment needed to be more robust.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home and nurses were supported to maintain their professional qualifications and skills. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who had the skills and training to meet their needs. Staff understood their responsibilities under the Mental Capacity Act 2005. The registered manager understood their responsibilities under the Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain a balanced diet that met their needs and preferences. People were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff understood people's preferences, likes and dislikes. Staff promoted people's independence, by supporting them to make their own decisions. Staff knew people well and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff supported and encouraged people to maintain their interests, to socialise and to maintain relationships with the people that were important to them. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Improvements were required in recording how people were treated and cared for, to

enable nurses to ensure people's care and treatment was effective. The registered manager planned to implement additional checks and monitoring to ensure people received appropriate care and treatment. People and their relatives were encouraged to share their opinions about the quality of the service. Staff were encouraged by the provider's and registered manager's leadership to deliver a quality service.

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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 1 and 2 November 2016 and was unannounced. The inspection was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service.

The provider had completed a provider information return (PIR) before our previous inspection, so we did not ask them to resubmit this information. The PIR 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.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We spoke with 11 people and seven relatives about what it was like to live at the home. We spoke with four nurses, five care staff and six support staff about what it was like to work at the home. We spoke with the provider, registered manager and clinical lead nurse about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015, we had identified there were not enough skilled and experienced staff to support people safely. This was a breach of the regulation and we asked the provider to make improvements. At this inspection we found the provider had taken the action they said they would take and recruited additional staff. There were enough skilled and experienced staff on duty to meet people's needs.

The registered manager had recruited nine permanent staff since our previous inspection, including five care staff, domestic staff and nutrition and activities support workers. The clinical lead nurse had implemented a dependency needs analysis to determine how many staff were needed to treat and care for people on each shift. People's abilities and needs for support were analysed and scored to identify how many staff were needed to deliver the care safely. The registered manager told us they had also recruited an additional member of staff to work with night staff between 8pm and 12 midnight, to support people who did not like to go to bed early, or who did not sleep well.

People and relatives told us there were enough staff. One relative said, "There seems to be a lot of staff. They are always popping in." Staff told us that staffing levels had improved, because additional care staff had been introduced on shift some months previously. They told us they noticed the impact of having an activities coordinator made in supporting people's wellbeing. A nurse told us, "We are never short staffed. I don't need to wait for permission, but can phone the agency to cover any sickness absence. If the agency are unable to help out, the manager, clinical lead nurse or owner will help out." The registered manager told us both they and the provider had recently done a shift as support workers at the weekend, when two staff were unavoidably absent from work.

Staff were recruited safely and the provider checked they were of good character before they started working at the home. The provider showed us records of the checks that had been made of staff's suitability for the role. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

All the people and relatives we spoke with told us they felt safe at the home for many reasons. One person said, "It's the company here" and a relative said, "No-one can walk in here." We saw the front door had an external keypad, which meant only people known to the management could enter. Staff told us they had training in safeguarding and protecting people from the risks of harm or abuse. Staff told us, "Safeguarding means making sure people are free from abuse and neglect" and "We're all here to help (people). We don't want to see any harm coming to them. We would all speak up if there was a concern."

Another member of staff told us they had confidence in the provider's whistleblowing and safeguarding policies and procedures because they were effective. When they had reported some concerns to the senior, their concerns were shared with the clinical lead nurse and the registered manager, who referred the concerns to the local authority safeguarding team. The member of staff told us, "The process worked well

and I got feedback about what was done so I was reassured the person would be safe."

Staff told us people were supported to maintain their freedom and independence through effective risk assessments. One member of staff told us, "I support people to be safe. For example, [Name] sometimes wants to make a cup of coffee, so we help them with the hot water to prevent them spilling it on themselves." Where people had identified a preference that might be a risk to their health, but lacked capacity to understand those risks, nurses sought advice from other health professionals. For example, in the care plan for one person who lived with diabetes, staff had recorded, 'sugar free diet and likes chocolate biscuits – GP says this is fine.'

Nurses assessed risks to people's health and welfare and wrote care plans to minimise the identified risks. For example, for people who were unable to mobilise independently, their care plans described the number of staff and the type and size of equipment needed to support them safely. For a person who was at risk of sore skin, their care plan included a pressure relieving mattress and instructed staff to 'wash daily, apply barrier cream and to report any red patches to the nurse.' Staff told us, "Everyone has risk assessments and we follow these. I give information to the nurse for them to write the assessments."

Staff told us they recorded accidents, incidents and falls and reported them to the registered manager, who analysed them to identify any trends or patterns. During the previous month, the analysis had identified that people were at risk of accidents and falls in relation to their individual abilities, frailties and determination to maintain their independence. Actions taken to minimise the risks of a re-occurrence included referring people to other health professionals, to identity whether changes in their support could reduce the risk. The registered manager learnt from their analysis and took action to prevent similar accidents. For example, when one person had injured their thumb under a toilet seat, they had checked that toilet seats included appropriately sized rubber feet to maintain a safe gap between the seat and the porcelain.

Staff told us they had health and safety training and felt prepared to deal with emergencies safely. A member of staff told us their induction included learning about the emergency procedures, such as the routine to follow in the event of a fire alarm. All staff we spoke with, including an agency nurse, were able to explain the actions they would take in the event of an emergency, such as supporting people to move to safe zones behind closed fire doors, while they waited for the fire service. The registered manager had completed personal emergency evacuation plans for each person since our previous inspection.

The provider checked the premises were maintained to minimise risks to people's safety. Records showed external specialists regularly checked that essential supplies, such as water, gas and electricity were tested and maintained. Records showed equipment such as the lift, hoists and electrical items were regularly tested and serviced and there were emergency contact numbers for the equipment suppliers. Staff told us the provider responded promptly when they reported maintenance issues. A member of staff told us, "I identified that some floors in bathrooms had sunk and reported this to maintenance, because they were not level. I was happy that it was sorted out quickly."

Since our previous inspection, the provider had asked an external professional to conduct a health and safety audit of the premises. They had accepted the professional's recommendations to implement additional safety measures. For example, the water monitoring checks listed every tap in the building and identified the maximum temperature they should run at safely. Records showed two taps ran hotter than was safe and they had been temporarily shut off until the valves were replaced.

A nurse on each floor showed us how medicines were managed safely and in accordance with best practice. All medicines were delivered in their original packaging with information leaflets, which ensured nurses were

informed of the impact and possible side effects of a medicine. One nurse was responsible for counting how many medicines were in the store and for re-ordering to make sure people's medicines were always available. The nurse showed us the equipment and process they used to dispose of unwanted medicines and needles safely and the dates these items were collected by specialist waste contractors.

People's medicines were administered safely and staff sought advice from other health professionals when people were at risk of not taking their medicines regularly. One person who lacked capacity to understand the benefits of their prescribed medicines, had been referred to their GP. Records showed the GP had authorised staff to administer the person's medicines covertly in their best interests, that is, without their knowledge, , and this was recorded on the label. The pharmacist had confirmed it was safe to administer the prescribed medicines dissolved in drinks.

Everyone had an individual medicines administration record (MAR) with their photo attached, to minimise the risk of errors. Records showed staff signed when people's medicines were administered and recorded when people declined to take their medicines. There were written protocols for medicines that were prescribed 'as and when required' (PRN), which also explained how a person would signal their need and consent for medicines if they were unable to express themselves verbally.

Good

Is the service effective?

Our findings

People and relatives told us they thought the staff were well trained because people's needs were met effectively. People said, "They all do seem to know what they are doing", "I should think they are trained" and "I am not really sure, but they can help me."

Staff told us they felt effective in role and knew what to do, because their induction programme included being shown around the home, classroom based training with the in-house trainer, followed by shadowing experienced staff to get to know people. Staff training included moving and handling, food hygiene, dementia awareness and studying for the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life.

The trainer assessed staff's skills and competence against the fifteen standards of the Care Certificate. The trainer told us all staff continued to meet with them for an hour a week throughout their probationary period to check their progress. Staff were only signed off as competent after successful completion of the Care Certificate, which included observation of, and feedback about, their practice.

All staff training was tailored to meet their individual needs and the requirements of their role. The trainer told us the provider trusted their judgement in identifying the training each member of staff required, because of their professional experience as a nationally recognised qualifications assessor. A member of staff told us the trainer had arranged their training in the form of presentations and discussions because that was their preferred style of learning.

A nurse told us the trainer was, "Excellent, and the amount of training is brilliant." The nurse told us they had recently attended refresher training in privacy and dignity, person centred care and safe handling of medicines. They had also attended a wound management course with a local tissue viability nurse and 'react to red' training, delivered by a nurse from the local clinical commissioning group. Another nurse told us they used their training, reading and practice to inform the 'five reflections' they need to complete with an assessor, to revalidate their professional status. The clinical lead was qualified to assess and sign off nurses as 'competent' to ensure re-validation of their professional nursing qualification.

An agency nurse told us their agency checked they accessed their own training before sending them to the home. The agency nurse told us they had recently completed refresher training in first aid, resuscitation, giving injections and how to insert and manage a catheter. They told us the agency checked they maintained their professional competence through the nurse re-validation process,
All staff told us they felt supported because they had regular opportunities to discuss their practice and personal development at team and one-to-one meetings. They told us they were happy to make suggestions and they felt listened to. Staff told us, "The nurse does the supervision and I get feedback about my performance" and, "At monthly team meetings, we are told about compliments and how we can improve."

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had applied for a DoLS for 50 people who lived at the home, because they did not have the capacity to understand the risks associated with the restrictions to their liberty. At the time of our inspection, three DoLS applications had been agreed by the local supervisory board and the rest were in progress.

For people who lacked the capacity to make decisions about their treatment and care, decisions were made in their best interests, by a team of health professionals and the person's relatives. The registered manager told us when relatives told them they had the right to make decisions on their relation's behalf, they asked relatives to show copies of the court documents that gave them the decision-making power. This made sure decisions were made by a person who had the legal right to do so. A member of staff explained it as, "This is where an advocate or relative help out with decisions."

A relative told us they discussed the options to make sure their relation was safe in bed. They told us they had agreed that bed rails should be attached to the bed, in the person's best interests, to make sure they did not fall from the bed. The relative knew the registered manager had applied to the local supervisory board for the proper authority to restrict their relation's liberty in this way.

Staff understood they could only deliver care and support with people's consent. A member of care staff told us, "It's about looking after people's best interests and working in a person centred way and not enforcing our rules on them" and, "I ask, 'Is it okay if we go back to your room to do personal care?'" For people who were not able to give their consent verbally, their care plan described the hand signals the person would make which meant 'yes' or 'no'. Guidance for staff said they should ask twice, and ensure the person gave the same response each time, because this was their sole method of communication.

People told us, "The food is good" and "We have two choices of main course a day. They will make me something different if I don't fancy what is on the menu –you just have to say so." Relatives told us, "The food is lovely, if I say to the kitchen, [Name] fancies this today they will cook them. They do know what [Name] likes and dislikes" and "The food is brilliant and [Name] loves it absolutely, it's a real advantage of this place that it's all cooked in house. The food is varied and the decent meals they are feeding him are a real reassurance."

People were supported to maintain a balanced diet and to enjoy their meals. Nutritional support workers were employed on each floor to ensure drinks were always available and to make sure people's dietary needs and preferences were known and supported. At lunchtime we saw people were supported to eat where they chose, in the dining room, lounge or in their own room. We saw relatives were welcome to support their relatives to eat at lunchtime, which made the meal a social occasion.

For people who could not express their preferences verbally, staff showed them pictures of the meals on offer, so they could point to their preferred meal. The cook had worked at the home for 25 years and knew people's needs and preferences well. There were lists in the kitchen to remind staff about people's preferences, allergies and needs for assistance with meals. The cook dished up each person's meal by name

and staff took their meals directly to them on trays, so the meal was delivered while it was still hot.

Staff made sure people were supported according to their needs and in accordance with their care plan. For example, some people needed their meals pureed or cut up or to have adapted cutlery, to make it easier to eat. People who needed assistance to eat were assisted by staff sitting beside them. Staff spoke reassuringly with people who needed assistance and allowed them sufficient time between each mouthful to enjoy the taste and texture of their meals.

Staff made sure people who were at risk of poor nutrition were offered supplementary drinks in accordance with the recommendations of the dietician. Staff recorded when the drinks were offered, because they were prescribed by their GP.

A nurse told us they had training in how to administer food and fluid via a tube directly into the person's stomach. We saw there were clear written instructions about how to maintain and clean the equipment and guidance about the amount and frequency of administering food, fluid and medicines. The guidance included an emergency contact telephone number for the equipment supplier, in the event that the equipment malfunctioned.

People were supported to maintain good health and to access healthcare services when needed. All the people we spoke with told us they thought staff would get a doctor if they needed one. Relatives told us, "There doesn't seem to be any hesitation about getting a GP, then they let me know afterwards" and "The GP came to see [Name] the same afternoon (that staff called them). [Name's] health is well cared for here." One relative told us other health professionals involvement in their relation's care meant they received the health support they needed. They told us, "The GP comes twice a week and [Name] has physio and an air mattress, and doesn't get bedsores." Records showed people were referred to other health professionals, such as chiropodists and opticians, when needed.

Some nurses had recently attended training in how to recognise the signs of deterioration in people's health and how to identify the support they needed from other health professionals. Nurses who attended the training had shared their learning with other nurses and agreed to adopt two assessment tools that are used in NHS hospitals. The tools supported nurses to identify when changes in a person's breathing, pulse, blood pressure and kidney function were significant and how to communicate the situation in a clear, concise and focused manner to other health professionals, in order to obtain the support people needed.

Good

Is the service caring?

Our findings

People told us the staff were friendly and thoughtful. People told us, "Staff are pretty good. There are no problems I feel well looked after" and "The care I receive is excellent." Relatives told us, "The girls (staff) are great", "They are all very approachable and helpful" and "[Name] is well looked after with love and kindness." An agency nurse told us they saw that staff knew people well and treated people with respect and understanding. They said they would not want to work at a home if they were unhappy about how people were treated and cared for.

A relative told us their relation 'loved' the provider. When the relative said the provider's name, we saw the person smile and their eyes lit up as they repeated the name. One member of staff told us, "There is a good interaction and understanding of people. It is proper person centred care." Another support worker told us, "Person centred care means making sure the person you are caring for is the most important person in the room." A relative told us, "They are very good to me, just yesterday a carer talked to me at length about [Name] and how they were doing. I really appreciated that."

Staff were supported to develop positive, caring relationships with people by reading their care plans and regularly supporting the same people so they could get to know them well. Staff told us they got to know people while they supported them with personal care. A member of staff said, "We never, ever leave [Name] out of the conversation." Staff told us they talked with people and asked their families about what they would have liked before they moved into the home, to better understand them. Everyone we spoke with told us the staff knew their needs, likes and dislikes well.

Care plans included guidance for staff to support people's emotional wellbeing. For one person who was cared for in bed, and who was unable to speak, their care plan instructed staff how to support the person's understanding of where they were. The guidance for staff was to talk with the person about the day, the time and the weather and to check whether they felt well, had any pain and whether they were hungry or thirsty.

In another person's care plan, the guidance for staff explained how to re-assure the person if they become anxious by talking with them about their happier memories, for example, talking about the place they had most enjoyed living. The person's relative told us, "[Name] likes to remember their childhood. The staff reminisce with them now." We saw the activities coordinator spent time with another person in their room, stroking their head and talking to them in a comforting way because they were displaying signs of anxiety by shouting out.

Staff described how they put one people at their ease and reduced their anxiety. For example, for one person who had short-term memory loss, staff told us, "[Name,] has a letter in their pocket. When they ask why they are here, we tell them, but if they are still confused, we show them the letter they carry around and they understand again." For another person, staff told us if the person shouted out, they made them comfortable and, "We put their favourite music on. We go in and comfort them and tell them, 'everything's okay'." This reflected what was in the person's care plans.

Staff told us their own wellbeing was considered by the nurses in allocating them to support named people during their shift. They told us they came together several times a day to be re-allocated, to ensure all staff worked with everyone equally and to ensure individual staff remained enthusiastic by working with different people during their shift.

Staff told us their training included guidance on how to protect people's privacy and promote their dignity. Staff told us they knocked on people's doors before entering their rooms and made sure doors and curtains were closed when supporting people with personal care. Staff told us that one person had a stairgate on their doorway, after discussion with the person's relative, to protect their privacy, as this stopped other people from going into their room uninvited.

Relatives told us their relations were treated with respect and supported to maintain their dignity. For example, at lunchtime the tables in the dining room were covered with tablecloths and condiments were available for people to help themselves. People who were at risk of spilling their food were offered clothes protectors. When one person spilt food on their clothes at lunchtime, care staff supported them to change into clean clothes for the afternoon to maintain their dignity.

The clinical lead nurse told us most people and relatives were 'not ready' to have the difficult conversation about their preferences for how they wished to be treated and cared for at the end of their life. They told us only two relatives had felt able to share their views about end of life care. The questions they had considered were whether the person would prefer to be at home or in a hospital, whether their bedroom door and curtains should be open or closed, whether any particular music should be played and anything else that was important to them.

A member of staff told us they were supported to deliver end of life care. For example, staff took turns to sit with people during the final hours of their life. Staff told us as well as team discussions, there were leaflets and booklets for staff to read to ensure they understood what to expect at the end of a person's life. A senior member of staff told us they made sure they were available to support staff who may experience a delayed response to experiencing death at first hand.

Good

Is the service responsive?

Our findings

Some people and relatives told us staff knew and respected their preferences for how they spent their time. Relatives told us, "They put the TV on with [Name's] favourite DVDs and a head set" and "[Name] has own television and they can choose where they watch the football, in their room or in the lounge." However, a few people told us they would like to 'more to do'. A relative told us, "We do have the occasional (event), but not a regular outing programme or activities as such, like exercise to music."

The provider had already taken action to improve the type and frequency of events and activities at the home, by recruiting two activities co-ordinators. We saw a programme of events was posted up on the first floor, but was not prominently displayed or eye catching. The activities coordinator told us they would take action to improve the way they promoted and encouraged people to take part.

Another relative knew there had been improvements in encouraging people to maintain their interests and socialise. They told us the music they had brought in for their relation was always playing in their room when they arrived to visit. They told us (today) their relation had spent the morning in the lounge with other people and staff listening to music from their favourite decade. They said, "I saw [Name] rocking along with the music, dancing with their hands. I haven't seen that before."

A member of care staff told us, "[Name] went to a talk at a garden centre with the activity facilitator and they enjoyed it. A couple of ladies went to a garden centre recently." An activities co-ordinator told us they had recently taken two people out to the shops, had a 'baking' week and ran regular exercise sessions. They told us people's physical and emotional wellbeing was improved through socialising and by engaging in activities they enjoyed.

A relative told us they had been asked to complete a list of information about their relation's preferences, likes and dislikes when they first moved into the home. People's care plans included their lifelong cultural values and religious beliefs, where they were known, as well as their current feelings and preferences. Staff told us they encouraged people to make choices whenever possible, such as asking them what they would like to wear by holding up a choice of clothing and by using picture cards of meals to choose what food they would like. A member of staff said, "I ask people about their interests and read their care plans."

The activities co-ordinator told us, if people or their relatives did not, or were not able to, tell them about their interests or hobbies, they used reminiscence cards or a daily newspaper to start a conversation and get to know them. They said, "I have time to say hello to everybody every day, and I know who prefers individual time, such as hand massage, looking at their photos together or listening to music.

A relative told us staff talked to their relation about their life and about the photos on the wall. They told us their relation had been invited to move to their current room, which had a good view across the garden and bordering land, especially because they chose to spend most of their time in their own room and would appreciate and benefit from the view.

Staff told us they had enough time to chat with people and there were enough staff to engage people in planned and spontaneous meaningful activity. During handover between shifts, we heard a member of staff say they had made a folder for one person to look at because they often tried to take a care plan folder when they were updating them. We saw one person drying up some spoons in the middle of the afternoon. They smiled and appeared to be pleased when staff thanked them for their help.

Two people told us staff came when they used the call bell and relatives told us, "They come straight away when [Name] presses the button" and "It's not usually a long time till they come, and there is a call bell in the toilet just in case." Many people were not able to tell us whether staff responded promptly when needed, and many of them were not able to use a call bell to summon staff, because of their complex needs. A relative told us, "[Name] used to have a call bell, but couldn't use it now. [Name] shouts out and they come. The girls know them."

We saw staff knew and understood people's needs and how to support them. For a person who presented behaviour that challenged, staff knew there were 'key words' to use, that would calm the person and distract them from their challenging behaviour. Staff kept a record of when they needed to calm and distract the person. They had shared the information with the commissioners of care, to make sure there would always be enough staff to respond to the person's changing needs.

Staff told us the handover of information between shifts was good. A member of staff said, "I know if a person has been unsettled during the night and what to expect that day." An agency nurse assured us they had all the information they needed to respond to people's needs from the handover meeting at the beginning of their shift and the information about people's needs that was available in the kitchen and in people's daily records and care plans.

The clinical lead nurse told us people's care plans were regularly reviewed and updated when their needs changed. They told us each person was identified as 'resident of the day' in turn, which included reviewing their needs and abilities, checking their room continued to meet their needs and that clothes, bed covers and toiletries were available and in good condition. Records showed their relatives were included at an annual re-assessment of their relation's needs and abilities.

No-one we spoke with could remember making a complaint. A member of staff told us, "If someone wanted to complain I would tell the nurse and help them fill in a complaint form. I would take the form straight to the manager." The provider's complaints policy was explained in reception, with additional forms for people to offer 'suggestions, moans or praise'. The registered manager had not received any written complaints, but explained the actions they had taken when one person had complained to them verbally. The registered manager had investigated the complaint with staff and advised the person of the agreed changes to resolve it. The person had subsequently felt confident enough to have a follow-up conversation with staff, to make sure they understood each other better, without fear of discrimination for making the complaint.

Requires Improvement

Is the service well-led?

Our findings

People told us they saw the registered manager and owner (provider) around the home, but they were not sure which was which. However, their relatives did know. One relative told us, "[Name of owner] came out and assessed [Name] at home. They are very personable and regularly come and speak to me in the lounge." Another relative told us, "They are really great, local people. They care about this community and that makes all the difference."

Relatives told us the service was well-led and all the staff were approachable and helpful. They said they felt well informed about their relations' care. One relative said, "I can't fault the place. I couldn't have chosen a better place. I can tell [Name of the owner] anything and get an instant response."

Staff told us they felt included and empowered by the provider's approach. Staff said, "This is a good place to work" and "The owner and manager are both hands-on and get involved in care." Staff told us there had been changes and improvements in staffing since our previous inspection, which made a difference. They told us, "There's good team working. We now have a good rapport and communication. We are always there to support each other, like a family." Staff told us all staff understood their responsibilities and that the clinical lead and registered manager were, "Constantly walking about to check what's happening and how we are getting on."

Staff told us they felt happy to make suggestions to seniors. For example, when they had noticed one person's mobility had deteriorated, they suggested they might need more support. The person's needs and abilities had been reviewed and their care plan was updated to make sure staff used a hoist to support the person to move around safely. Staff told us, "Information is shared at staff meetings. We all have our say" and "The support is fantastic." A member of staff told us they thought they would ask for longer shifts, to make sure they had time to catch up with the paperwork and could "get more done." The member of staff was confident they would be listened to.

Since our previous inspection, the registered manager had implemented a dependency needs analysis tool to determine staffing levels more accurately. They told us they still listened to feedback from staff and had recruited an additional member of staff to an evening shift in response. The evening shift staff member was employed specifically to support people who liked to stay up late, or who did not sleep well.

During our previous inspection, we judged improvements were required in records relating to people's medicines, fluid and food monitoring charts, and records of the care people needed. At this inspection, we found improvements had been made in people's medicine records through the introduction of standardised medicines administration records (MARs). The pharmacist had conducted a full audit of the medicines in the previous year and nurses had followed their recommendation to use each page of the controlled medicines register consecutively and not to leave any blank pages in between.

However, some other records were still not being filled in accurately or consistently. Food and fluid monitoring charts we looked at did not include a recommended amount of fluid per day, were not filled in

consistently and were not totalled at the end of each 24-hour period. Nurses could not measure how much a person ate or drank in total. A food and fluid monitoring audit in September had not identified that the monitoring charts did not include targets or totals.

During the second day of our inspection, the clinical lead nurse showed us a revised monitoring chart, which included recommended fluid intake targets and totals to ensure consistent recording and enable effective monitoring. They said they would discuss with the nurse team whether the day or night shift nurses would take responsibility for checking and evaluating the charts, to identify any ongoing or worsening risks to people's nutrition and hydration.

We saw other monitoring records, such as re-positioning charts, were not consistently completed or sufficiently detailed to evidence that staff took the necessary actions to minimise risks to people's treatment and care. Although the lack of good records had not caused harm, the nurses had not checked that staff kept effective records to evidence whether people's treatment plans were effective or necessary.

There was no supporting documentation to demonstrate how nurses calculated and monitored the pressure setting for people who used pressure-relieving mattresses to minimise the risks of sore skin. After our inspection, the registered manager sent us additional information, which explained how they planned to calculate and monitor that people's pressure relieving mattresses were set and maintained at a pressure that was appropriate for people's individual needs

Although people's care was regularly reviewed, and their care plans were updated when required, some files contained out of date information that could mislead staff about people's current needs and abilities. The clinical lead nurse told us they would double check that nurses removed all out of date information from people's files to ensure only current guidance was available to staff.

The clinical lead nurse showed us their recently revised audit programme, which was in the middle of being implemented. It included regular checks of medicines management and administration, checks that people's care plans were complete, accurate and regularly reviewed and that monitoring records were maintained for people at risk of sore skin, poor nutrition or of presenting behaviour that challenged. The new audit checklists included the facility to record the percentage rate of adherence to policy found during the audit, which worked as an incentive for staff to improve their rating each month.

The medicines audit included checking that people's medicine records were completed accurately and matched the actual amount of medicines in stock. The most recent audits had identified some mismatches between the recorded and actual amount remaining. This was due to an error in accurately recording the amount still in stock, before the month's delivery. The clinical lead nurse had reminded nurses to double check that the opening figure included both existing and new stock figures, to ensure more accurate recording.

People, relatives and visitors were invited to share their views of the service and suggest improvements. The registered manager showed us the questionnaire they planned to issue to people, relatives and friends in December 2016. The questions invited respondents to rate various aspects of the service on four-point scale between 'excellent' and 'needs improvement' and to comment about their experience. The issues covered in the questionnaire were closely matched to the fundamental standards of care, which demonstrated the provider recognised that quality is measured by the same indicators as the regulations for care home providers.