Bestcare UK Limited

# Saxondale Nursing Home

**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? | Good |
| Is the service well-led? | Good |

## Overall summary

This inspection took place on 26 and 27 January 2015 and was unannounced. We last inspected this service in May 2013 and found that the service was meeting the requirements of the regulations we inspected at that time.

Saxondale nursing home is registered to provide care for up to 36 older people with a diagnosis of dementia or mental health needs. There were 32 people living there at the time of our inspection.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager understood Deprivation of Liberty Safeguards (DoLS) and applied for authorisations as needed which we saw evidence of. She was in the process of making further applications. However, we found that the arrangements in place for obtaining consent for decisions did not always follow the principles

# Summary of findings

of the Mental Capacity Act 2005 (MCA). For example, one person was administered medicines covertly. Although the person's GP and a pharmacist had been consulted and deemed this to be safe, there was no assessment of capacity to show the person could not make the decision themselves to take their required medicines.

We saw clear records in place to ensure people received their medicines in a safe way and only when they needed these. Relevant staff undertook competency assessments to ensure they were safe to administer medicines and apply creams. However, issues with medicine supplies had led to some delays in people receiving prescribed medicines.

We saw that a lot of seating within the home was stained and worn and observed that the environment in communal areas was lacking in stimulation for people. The registered manager had already identified these issues and told us the provider was aware of the condition of the furniture and action was to be taken. Staffing levels were regularly assessed to ensure these met the needs of people. Although most of the time staff were visible and checked on people regularly, there were some periods where there was a lack of staff presence in communal areas.

People's care records were reviewed regularly and in response to any change in needs. They contained current information about people's individual support requirements and preferences and how these were to be met. Staff demonstrated knowledge of people's personalised care preferences. Individual risk assessments were in place in order to minimise and manage risks to people. Staff knew how to identify and report abuse and unsafe practice and received annual safeguarding training.

People at the service were supported to access healthcare and received assistance and treatment for their health needs. People's nutritional preferences were accommodated. Feedback we received from professionals was positive about how staff worked to support people, especially those with complex needs.

An effective recruitment process was in place so that people were assessed as being suitable to work at the service. We looked at three staff files and saw relevant checks had been undertaken about the staff members prior to them commencing employment. Staff told us they felt supported, had training that equipped them for their roles, and received regular supervision. There was opportunity for staff to take on further responsibilities and develop within their roles.

All people and relatives we spoke with were positive about the care they or their family member received and felt they were treated with dignity and respect. The service employed an activities co-ordinator and we saw some activities take place. However, there were periods of time where there was a lack of stimulation for people.

Feedback was sought by the registered manager by way of relatives' meetings. Relatives told us they would feel comfortable in approaching the staff or registered manager about any issues. There was a complaints procedure in place and we saw that complaints were investigated and responded to appropriately.

Staff felt supported by the registered manager and felt part of a team. The registered manager often spent time around the home and helped to support people which staff appreciated. Good practice was highlighted and shared and regular team meetings took place. There was an open culture and all people we spoke with spoke highly of the registered manager and the staff team.

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

# Summary of findings

## 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

Some areas of the service were not safe. Although the service managed most aspects of medicines safely, medicine supplies had led to some delays in people receiving prescribed medicines.

A lot of seating within the home was stained and worn, which besides being visually unappealing also posed a risk to effective infection control. Staffing levels were regularly assessed, but we saw some periods of time where there was a lack of staff presence in communal areas.

Individual risk assessments were in place in order to minimise and manage risks to people. Staff knew how to identify and report abuse and unsafe practice. An effective recruitment process was in place so that people were assessed as being suitable to work at the service.

**Is the service effective?**

Requires improvement

Some areas of the service were not effective. Where it was stated that people lacked capacity for specific decisions, assessments were not always in place to evidence this. Where people were being deprived of their liberty this was identified and relevant authorisations were in place or were being requested.

Some areas of the home were not set out in way which provided stimulation for people. Lounges were sparse with little within the environment to encourage interaction and interest.

Staff received regular supervision and appraisals. Training was monitored to ensure staff had relevant skills and knowledge to support people they cared for. Peoples' nutritional needs were accommodated and people were supported to access healthcare professionals and maintain good health.

**Is the service caring?**

Good

The service was caring. Observations and comments from people and relatives showed that staff were kind, caring and patient in their interactions with people.

Staff offered choice and explanations to people whilst providing support. Care records contained information about people outside of their care needs such as their backgrounds, favourite things and family histories. This helped staff to form positive relationships and engage with people.

People were treated with dignity and respect. There was information in place for people's end of life care needs.

# Summary of findings

**Is the service responsive?**

Good

The service was responsive. People's care records were reviewed regularly. They contained current information about their individual needs and preferences and how these were to be met. Staff demonstrated knowledge of people's personalised care requirements.

The service employed an activities co-ordinator and we saw some activities take place. However, there were periods of time where there was a lack of stimulation available for people.

Feedback was sought by the registered manager by way of relatives' meetings. Relatives said they were kept informed about the service and were able to make staff aware of feedback at any time. There was a complaints procedure in place and we saw that complaints were investigated and responded to appropriately.

**Is the service well-led?**

Good

The service was well led. The registered manager was pro-active in trying to improve the service and knowledgeable about the needs of the people who lived there. There was an open culture within the service with staff speaking highly of the registered manager and feeling confident in her abilities. Comments from stakeholders were positive about the service as a whole.

There was a detailed quality assurance system in place which identified and acted upon areas for improvement and highlighted good practice. Incidents that occurred were routinely monitored and analysed for trends and themes to prevent recurrence.

The registered manager and staff worked pro-actively in partnership with other agencies and professionals.

# Saxondale Nursing Home

**Detailed findings**

## Background to this inspection

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

The inspection took place on 26 and 27 January 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor who was a registered mental health nurse and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service.

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. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted commissioners of the service, the local authority safeguarding team, Healthwatch and other stakeholders for any relevant information they held about Saxondale Nursing Home. We received feedback from two community professionals.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included both formal and informal observation throughout our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with eight people, and six friends and relatives of people, who lived at the home. We spoke with the registered manager, a senior nurse, four care workers, the activities co-ordinator, the cook, two domestic staff and the home's administrator. We reviewed the care records of five people and a range of other documents, including medication records, staff recruitment and training records and records relating to the management of the home

Requires improvement

# Is the service safe?

## Our findings

We asked people if they felt safe living at service and everyone we spoke told us they did. When asked what made them feel safe one person told us, "Having someone there when I need them." Another said, "My life has improved by coming here. The staff come and check on me when I'm in my room." A relative told us, "I live a considerable distance from my [family member]. I worried about him, but when I came I saw his face light up when he saw certain carers. I knew he was safe."

All people were able to come and go to their rooms at any time. Where people were able to manage a key and wanted one, they were provided with one. People told us they had a lockable drawer in their room and we observed these in the rooms of people that we visited. People said they felt that their possessions were safe in the home. We spoke with the administrator who dealt with people's personal finances where this was requested. There was a process in place which provided a clear audit trail of when money had been requested and evidence of this. We checked a random sample of three people's finances which were secured in a safe. All were correct and matched the amounts that were documented which supported that the system in place was effective

All staff received annual training in safeguarding and had knowledge of the different types of abuse. Staff also understood whistleblowing procedures and how to report unsafe practice. Whistleblowing is when a worker reports suspected wrongdoing at work. There were policies and procedures in place for staff to follow if they witnessed or suspected abuse. All said they would report any concerns immediately. We saw that previous incidents or allegations of abuse had been referred to the local authority safeguarding team where required.

Feedback we received from a community professional stated, "Staff engage in a positive way to try and keep residents safe." Individual risk assessments were in place for people and reviewed regularly to determine whether any amendments were required to people's care plans. These were updated following any incidents. The registered manager reviewed all incidents and took action to try to minimise the risk of repeat incidents. For example, we saw where, following incidents, one person was referred to a falls clinic and another person was assessed for and provided with protective equipment.

There were personal emergency evacuation procedures in place for people which gave information about how they were to be supported in the event of an emergency. These, along with other emergency procedures, were also stored in a 'contingency box' in reception which meant they could be accessed from one location in an emergency. During our inspection we saw the maintenance man completing various checks of the premises such as checking water temperatures and window restrictors. We saw records he completed which evidenced regular checks of premises, equipment and fire safety checks.

People told us they saw staff they knew and rarely saw staff unfamiliar to them. Several people could tell us that they had call bells in their rooms. When asked about how well staff responded to these, one person said, "They always seem to be there when you need them." A relative said about staffing levels, "There might be times when they could do with some more, but that's always going to be the case. It hasn't been a problem that I know of." Another relative told us, "There are always staff around."

The registered manager said there was one vacancy at the service for a nurse which was being covered by the use of the service's own bank staff until the role was filled. The registered manager used a computerised tool to calculate staffing levels in the home and to make sure these were appropriate for the needs of the people at the service. She told us if extra resources were required then this would be discussed with her regional manager. One staff member told us staffing levels were "adequate" although there were occasional pressures if people had to be escorted to appointments. Others said, "Always busy here" and "Enough staff most of the time." Staff felt they were still able to meet people's needs despite demands at certain times.

Most of the time we saw that staff were present in, or frequently checked, communal areas. However, there were several noticeable periods where this was not the case. In the afternoon, in one lounge where several people were seated, we did not see any staff for a period of 25 minutes. The next morning at 09.15am we sat in one lounge with two people where no staff were present. At 09.30am one person became restless and asked several times for assistance, but there were still no staff present. A few minutes later, we left the lounge and found a staff member

to assist the person, which they did so promptly. We fed back our observations to the registered manager and suggested they look at ways to ensure that appropriate supervision was provided for all areas of the home.

We asked people about their medication. One person told us, "There's a nurse to look after my medicines. I'd not take them every day if it was left to me." Another said, "They tell me what I'm taking, even though I know." People said if they needed medicine for any pain relief they would be provided with this where appropriate.

With regard to how the service managed medicines, we found there were problems with the supply of medicines. In some cases this impacted on people by causing delays in some prescribed treatments. For example, one person had been prescribed antibiotic treatment three days previously which had been ordered but not delivered by lunchtime on the day of the inspection. A staff member told us they would make alternative arrangements to obtain the medicine that day. Other problems included prescribed medicines being omitted from deliveries, which resulted in home staff having to re-order these. Staff had recorded instances of issues with medication supplies and the registered manager was escalating these. She informed us that the regional manager was in discussion with the supplier to look at how to rectify these issues which had only recently begun due to a change in supplier. We fed back that the service needed to ensure there were suitable contingencies in place to minimise the risk of harm for any further instances of late or omitted medicines.

We looked at the room where medicines were stored and saw items were stored appropriately. Controlled drugs (CDs) were stored in accordance with relevant guidance. Temperatures of the room and drugs fridge were taken daily and we saw that where the room temperature had been in excess of normal range, action had been taken by implementing a fan.

We reviewed medication administration record (MAR) charts for five people and saw these were completed accurately with no gaps. We saw there was a photograph of the person in the medication records to reduce the risk of medicines being given to the wrong person. Body maps were present for people who were prescribed topical preparations, indicating which area these needed to be applied to. There was clear personalised guidance in place for the administration of 'as and when required' (PRN) medicines which detailed the amount and the circumstances in which the medicine could be administered. Such guidance helps to ensure that medicines are administered consistently, safely and as intended for best effect. We observed medication administration at lunch time and saw this was carried out safely by the nurse.

The registered manager told us that staff competency assessments for administration of medicines and administration of topical creams were carried out annually. We saw evidence of the latest competency assessments and saw she was currently in the process of arranging new ones. Comprehensive medication audits were undertaken by the registered manager on a monthly basis. Where actions were identified, we saw that these were followed up for completion at subsequent audits.

We looked at the recruitment files of three members of staff and confirmed that each had relevant documentation in place. We saw that previous employment references and a satisfactory DBS (Disclosure and Barring Service) check had been obtained prior to the staff member commencing employment. The Disclosure and Barring Service helps employers make safer recruitment decisions. One file we looked at was for a registered nurse and we saw evidence of their current registration with the nursing and midwifery council (NMC).This demonstrated that processes were in place to ensure that staff were assessed as being suitable to work at the service.

We saw that people's bedrooms, and bathrooms, and toilet areas were generally clean and well maintained. One visitor told us, "I've never noticed bad smells here and they keep the rooms clean." Two cleaners were working on the day of our inspection and told us they had plenty of supplies and no concerns with managing their duties. They said there should be three cleaners which supported what the registered manager told us about another cleaner awaiting DBS clearance before starting employment.

We were told that some chairs had recently been purchased for one of the three lounges. However, we saw that a lot of seating in the home was worn, heavily soiled and badly stained, particularly in two of the lounges, one of which was malodourous for a period of time in the afternoon. One person said about the chair they were sat in, "Can't get right comfortable, it's hard as rock and a bit worn in places." Attempts to clean the furniture had been made but with little result. The condition of this furniture also posed a risk to effective infection control procedures.

Requires improvement

# Is the service safe?

We fed back our observations to the registered manager. She informed us that the provider was aware of the condition of the furniture and there were plans to address this.

Requires improvement

# Is the service effective?

## Our findings

People told us they felt staff were capable within their roles. One person said, "There's not one that you can point to and say 'they're no good'. Not one." A relative told us "They're not just 'doing a job'. They're all very good." Feedback we received from one community professional said, "The experienced staff lead by example, working hard and creating a positive atmosphere for the clients and younger staff to learn from."

Staff said they received regular supervisions and annual appraisals which enabled them to discuss how they were performing, any support they needed and to set objectives within their roles. We saw a matrix in place which scheduled when supervisions and appraisals were due for each staff member employed by the service. Staff told us they valued these with one saying it was a chance to "put my own ideas across." They said were supported and could go to the registered manager at any time and would not have to wait for a scheduled supervision.

Staff told us they felt they had suitable training for their roles. We saw a training matrix in place which the registered manager used to identify what training staff had and when this required updating. Training was provided in a number of areas which enabled staff to gain skills to support the people they cared for. This included dementia awareness, end of life awareness and behaviour that challenges. The registered manager was also a recognised trainer with the local authority and provided training in dementia and moving and handling within this role. Staff were able to access further training if they wished and said they would be supported in this. The registered manager told us she was in the process of allocating additional responsibilities for staff that they could lead on within their role. For example, one staff member was in charge of nutrition, and keeping menus up to date and another was in charge of weekly weights for people that required this. The manager said these roles were working well and the plan was to roll this out further within the staff team. This showed that staff had opportunities to progress and develop further skills within their roles.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Discussions with the registered manager demonstrated she understood when DoLS authorisations were required and made applications were these were needed. Several DoLS authorisations had been granted for people living at the service and these were present in people's care records with evidence of involvement from professionals and family. More applications were in progress.

Although training was provided to staff about the MCA and DoLS, two staff members we spoke with were unclear about the MCA and were unable to describe what it meant. One staff member believed no-one had a DoLS authorisation in place at the service which meant they may be unclear what restrictions were in place for people.

In one person's care records we saw that they had some medicine administered covertly. There was evidence that this had been discussed in a multi-disciplinary way by involving the G.P and pharmacist who agreed it was suitable for the person to take in this way. However there was no capacity assessment in place, as required by the MCA to evidence that the person did not have capacity to make the decision to take this medicine themselves. Nor was there evidence to show how or what attempts had been made to involve the person themselves or any relatives or advocates in this decision.

We looked at another care record of a person who had bedrails in place. The care plan for these stated, "After a BI (best interest) discussion between staff and family and completion of bedrails assessment it was decided due to [name's] lack of capacity bed rails were needed to prevent falling out of bed." Although the risk assessment was regularly reviewed along with the need for bedrails, there was no accompanying assessment to evidence the person lacked capacity for the decision. The BI discussion referred to did not detail which people had been involved nor did it clearly set out how the decision had been reached. For example, what other options had been considered.

Our findings showed that the arrangements in place for obtaining consent for decisions did not follow the principles of the MCA 2005. As such, it could not be demonstrated that decisions were always being made in

Requires improvement

# Is the service effective?

line with people's best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People described the meals as "nice" and "good". A relative said, "The food always looks very nice." In the afternoon we observed one person tell a member of staff that they wanted some ice-cream. This was brought to the person straightaway. People said that they had regular drinks and could ask for more at any time. We observed several occasions when staff brought drinks to people who asked for them.

We observed lunchtime at the service in the dining room which was where most people ate. Some people chose to eat in their rooms or the lounge. The food looked appetising and portions were generous. Pictures of the meals were on display on a board so people could see what the choices were. The choice for lunch was meat and potato pie or cold meat salad, which meant there was only one hot option available. Staff offered people a choice of the meals and everyone had drinks available which were refilled regularly. Most people ate independently and where people required assistance to eat, this was done in an unhurried way. Staff communicated with people throughout the meal time experience. People were asked if they had finished their meal before their plate was taken away. There was flexibility in the length of time meals were served as we saw that one person had their meal served at 2.30pm when they came into the dining room and it had been kept warm for them. This demonstrated that the service was able to accommodate the needs and preferences of people with regards to their nutritional requirements.

We spoke with the cook who was knowledgeable about people's food preferences. The cook had a diet notification sheet in place for each person. This detailed their type of diet, such as whether they required a soft diet, their fluid requirements, likes and dislikes and any allergies the person had. People were weighed at monthly intervals or more frequently if required and food charts were in place for people who required these. Care plans were in place for nutritional needs and staff knew what support people required. Where anybody's needs changed, for example, if someone experienced significant weight loss, there were guidelines to follow and people were referred to other services where required, such as dieticians and speech and language therapists.

People had access to healthcare professionals to help promote good health and maintain their wellbeing. People said they felt it was easy to see a doctor, dentist or optician whenever they needed to. One person told us "If there's ever a problem they get a doctor straight away." Another said, "There's a dentist that comes. If I wanted some new false teeth I could just go and see him when he comes." Relatives told us that staff kept them updated with any changes to their family member's health. Care records evidenced involvement with a variety of professionals which included G.Ps, community psychiatric nurses, memory clinic team, and occupational therapists. Feedback we received from professionals showed they had trust in the staff to meet people's health needs. One professional told us that, "Staff followed advice and treatments and communicated outcomes and relevant information as required effectively."

People we spoke with did not tell us of any concerns with regards to getting around the building. Bathrooms and toilets had signage on the doors and most people's bedrooms had a large memory box on the wall outside with a high degree of personalisation to them. However, there were other aspects of the home that were not dementia friendly. We observed that the three lounges were sparse and lacking in things for people to engage with. All were laid out in the same design, with a ring of chairs along the walls. There were no arrangements of seating which might facilitate and promote interaction amongst people. Although one lounge was labelled 'reminiscence room' and another as 'pub/cinema room' there was little within them to relate to these descriptions. We also noted there was a lack of tables and surfaces for people to rest personal possessions and drinks on. We saw some people had to keep hold of cups in their laps or on chair arms because of this. The corridors did not contain many places for people walking with purpose to rest or colours, textures and items for them to encounter and interact with.

Good

# Is the service caring?

## Our findings

People we spoke with felt that they were well looked after and had positive relationships with staff members. Comments included, "I've been here a long time and I like it. Everyone is very nice", and "The staff are brilliant with me." Another person pointed out staff as they came in and out of the lounge and said, "She's lovely. And her" and "He's a good one." Someone else commented, "There are some lovely young ladies." Relatives and visitors were happy with the care that people received. One relative commented, "The staff here are lovely. They listen to us, ask us what our [family member] needs." Another said, "It's caring, the staff are lovely."

The comments from professionals we received feedback from included, "Staff are all welcoming, friendly and accommodating", "When I visit, I always receive a warm welcome, from which ever member of staff meets me at the door" and "All staff seem to genuinely care about the people they care for."

We saw that all staff at the service interacted with the people living there. For example, we saw the administrator and the maintenance person speaking with people, addressing them by name and showing familiarity with their likes and dislikes. Explanations and choices were given to people when care staff were supporting them with their care needs. On each occasion the person was supported at their own pace and a staff member checked that they were alright and asked them if they wanted anything before leaving. Staff communicated with people in their preferred manner and provided explanations to people so that they were involved in their care and able to express choice. For example, one person had to be spoken to slowly and at a preferred side due to hearing loss which was documented in their care plan. We saw a staff member do this when speaking with the person and then check that they had heard and understood the information.

The majority of interactions were caring, friendly and professional in approach with staff showing interest in people. On several occasions we observed people's conversations between each other and with staff were humorous and good natured. However, we did witness occasions where staff did not acknowledge people when they came into a room or take opportunity to check whether people were alright or whether they needed anything. For example, we observed one person become restless in their chair and remove one of their slippers. The person remained agitated and started to walk across the room. The member of staff present encouraged the person to take the nearest seat but did not ask whether the person was ok or if they needed anything.

People told us they felt that staff respected them and maintained their dignity. One person said, "They always knock on my door before they come in and treat me with respect." A relative told us, "They treat people as people. My [family member] always gets encouragement to try and maintain as much of his independence as he can. They only intervene when he asks them to." Another relative showed us their family member's clothes in their wardrobe to demonstrate the care with which the staff stored them. They told us, "It shows me that they respect his property and his appearance as much as they respect him."

We observed staff respecting people's privacy by knocking on doors and closing doors on toilets and bathrooms when these were in use. A dignity tree had been painted in the entrance of the home where staff had contributed their views of how to ensure they respected people's dignity. Comments on this included "maintain individuality", "respect", "involving people" and "making sure people look nice." There was a dignity board displayed in reception detailing what this meant and highlighting staff members who acted as dignity champions.

There was an advocacy policy in place at the service and we saw where two people had received support from independent advocates. The home operated a keyworker system and each person had a named nurse. We spoke with one person in their room and saw they had details of their key worker and nurse displayed. This meant that people and relatives had a point of contact to discuss any care needs with and helped to promote relationships between people, relatives and staff.

The registered manager told us about, and we saw, a 'This is my life' document that had been implemented to capture information about people. This included details about the person's background, family, growing up, favourite things, trips, hobbies and emotions. This was designed to provide a holistic view of the person so that staff would have information available which could be used to positively engage with people.

In most care records we saw care plans in place for end of life care. The registered manager had received some new

Good

# Is the service caring?

documentation she was planning to implement to capture further information about people's preferences. We spoke with two relatives about the end of life care being provided for their family member. Both were very complimentary about the performance of the staff and the care that was being delivered. One told us, "We had already had a discussion about his wishes about his funeral and so on; this is all in the care plan, who will arrange it, where it will be. We won't have to do it at the time." They told us that a staff member followed the same religion as their family member and had identified that a religious practice undertaken in that religion would be important to their family member. The staff member had arranged for a religious leader to attend to do this. The person's relatives said, "We thought that was very kind."

The relatives also told us about staff arranging for very small amounts of food for comfort for their family member. One said "My [family member] loves strawberries and they knew that, they gave him a taste of the strawberry mousse that they had made for the evening meal. He doesn't eat now but at least he will have enjoyed that taste."

Good

# Is the service responsive?

## Our findings

People and relatives we spoke with felt that staff knew their, or their family member's, preferences well. One relative gave an example of how the staff had used information from their family member's life to inform how they supported them. They told us, "My [family member] was a fireman and liked to inspect things. The handyman used to take him round with him and ask for his help." This showed that staff were able to act on people's personalised needs and we observed that staff supported people in line with their care and support needs.

Staff we spoke with were able to describe the needs of the people they cared for. They told us they knew most people well and had involvement with families which guided them as to how people liked to be supported. They said that they read care plans for new people to become knowledgeable about their needs. Handovers took place between each shift which all staff were part of which meant they were familiar with people's immediate needs and able to provide continuity of support for these. Two staff members who had previously worked some night shifts both commented that they had found this beneficial as it had given them insight into people's routines and needs during this period. One staff member told us, "You get to know the clients more and you see both sides."

Feedback we received from two professionals involved with the home was positive about how staff responded to people's needs. One commented that staff had "no hesitation" in making referrals where they had any concerns. They went on to say, "They [staff] refer directly, and in a timely manner, by telephone and give a good account of the reason for the referral and previous history of peoples' condition." Some people who lived at the service could display behaviour that challenged others due to their medical conditions. Feedback about how staff dealt with this was also positive and included, "The staff are engaging with the clients and appear to understand their often very complex needs." No restraint was used within the service and we observed that staff managed challenging situations well by distracting or re-directing people.

The registered manager said that care plans were reviewed monthly and in response to any change in needs. She informed us that family members and other relevant professionals were invited to formal reviews every several months. Care records we looked at had evidence of regular reviews. Updates were meaningful, even where there had been no changes, which gave a clear picture of what support the person still required. There was evidence of involvement of relatives. In one care plan we saw the person's relative had been involved in a recent review of care by telephone call with the registered manager. Relatives also told us they were kept updated about their family member's care and welfare. One said, "They keep me in touch with everything, anyone can tell me how my [family member] is." Another relative told us, "Because I live away I've never been to any formal review but my impression is that it's on-going; they know what my [family member] needs and what to do as his condition has changed. The manager is on it straight away when anything changes." Someone else said about their family member, "[The manager] asked us about my [family member] when he was assessed and asked for his likes and dislikes. He seems to be settling in."

We asked people about activities that took place within the home. One person told us, "The worst thing about being here is trying to fill your day." Another said "It's a bit uncomfortable finding things to do." During our observations, we observed some people sat in lounge areas and dining room for long periods with little interaction, other than occasional contact if staff spoke with them in passing. There was also little within the environment to provide any stimulation to people. The registered manager acknowledged there was more work to do around activities and said she was looking at the best way of how to ensure these were meaningful and inclusive.

We did see some activities take place, for example, we saw one person playing table football with a staff member. We saw staff sit with people at times and spend time chatting with them. Another person told us they liked to watch videos in their room and showed us their video collection. In the afternoon we saw three people actively watching a film that was on and commenting about it. On another occasion we observed a member of staff check with a person about the programme that was playing in the lounge. They asked "Are you sure you want to watch this?" There was a discussion with all people present in the room about whether it was what they wanted to see and to ensure all were agreeable.

The registered manager told us she identified that it was late afternoon and early evening when most people

Good

# Is the service responsive?

became restless and lacked stimulation. As a result, an activities worker was employed to work during these periods. We spoke with the activities coordinator about how they planned things for people to do. They told us they tried not to plan too rigidly as if they made a decision in advance, people might not want to join in on the day. They said, "I'd rather find out what people want to do, most things I can set up very quickly. Sometimes we play bingo or skittles, some days I spend time chatting with people one to one. There are plenty of things that I can suggest. Some people are happy if I just sit with them and hold their hand." We asked about activities planned for the afternoon. They said, "I started with painting nails for these two ladies. I started with them because they are often not receptive to things like that, but today they said they really fancied it." We observed one of the people having their nails painted smiled when the activities coordinator sat next to them and said "I've been waiting for you." The activities coordinator showed the person a pot of nail varnish and checked it was the right colour. The person smiled and nodded.

The registered manager told us that relatives meetings regularly took place and there was a good relationship with relatives who attended the home. She told us that minutes of meetings were provided to relatives. We looked at minutes of meetings that had taken place in April and August 2014. These were detailed and talked about a number of areas such as the Deprivation of Liberty Safeguards, frequency of quality assurance surveys, care reviews, any complaints, refurbishment and suggestions put forward by relatives. Not everyone we spoke with was aware of formal meetings but one relative told us "They do have meetings, but I can never get to them. One of the other relatives keeps me in touch with what goes on." We saw there was a 'relatives' information' board at the service which displayed information such as upcoming events. All people and relatives we spoke with said they would feel happy addressing staff or the registered manager if they had any concerns.

No relatives or visitors we spoke with had any complaints to make about the service. When we asked people who they would tell if they felt that they needed to make a complaint they responded, "The staff." The service's complaints procedure was displayed in the reception area of the home. This provided clear details of how to complain, expected response times, along with details of how to escalate complaints. There were no complaints at the time of our inspection. We looked at the latest complaint from January 2014 and saw that the matter had been investigated fully with evidence of learning from the complaint. Full details had been fed back to the complainant with an apology and details of actions taken. This showed that complaints were dealt with in an open transparent manner and used as a way to improve the service.

Good

# Is the service well-led?

## Our findings

The registered manager was a registered mental health nurse who had worked previously at the service in a deputy role and returned in January 2014 as the registered manager. People we spoke with were able to confirm that they knew who the registered manager was and said they regularly saw her about the home. During our visits we observed the manager spend time around the home talking with and supporting people who lived there. Relatives and visitors we spoke with were very complimentary about the registered manager, telling us, "She is very approachable and easy to talk to", "She likes the staff and they like her. You can tell", "[The Manager] is person-centered, she's approachable and respectful" and "Since she [manager] has come back everything is transparent. You know when you visit that you're seeing it how it is. If you tell her that something needs changing then she's straight on it."

Staff also spoke highly of the registered manager. They told us, "She's brilliant. She's a fantastic manager", "We [staff] actually want to be here now. She'll do absolutely anything to help out" and "She has re-energised the home." We saw that the registered manager regularly communicated with staff and responded promptly to assist with any queries they had. The registered manager told us she chose to wear a uniform like the rest of the staff to show that she was an active part of the staff team.

Feedback we received from external professionals was also positive. One professional who had a lot of involvement with the service said, "The manager is very pro-active and spends time on the 'shop floor.' She knows all the residents and leads by example. She has worked hard at making the home a friendly open place. She is willing to discuss clients and take on board any advice."

The registered manager told us that quality assurance surveys were sent out twice a year to relatives, staff and stakeholders. We looked at comments on the latest returned surveys from 2014. These were also very positive about the management and the service. One relative commented, "Now we have a manager who is interested and cares about the residents and their families." A comment on a staff survey stated, "[Name] is a fantastic manager. Having such a hands on manager increases staff morale so much." Stakeholders commented "Best manager by far. Not frightened to be hands on", "All staff professional", "Staff extremely helpful" and "One care home we rely on for complex clients." It was clear from comments we read and received that there were good partnerships in place and confidence in the service. The results of these surveys had been analysed to look for any trends and areas of where the service could improve and to highlight areas of good practice.

From our discussions with the registered manager it was clear that she was knowledgeable about the needs of people at the service. She told us, "I see it as though it's my name above the door and I'm passionate about what we do." She told us how she used staff strengths for the benefit of how the service ran as well as promoting staff confidence by implementing extra roles for staff. There were areas of the service the registered manager planned to work on in future, for example, more work around activities and the environment which demonstrated that she pro-actively sought to make improvements. We found that where requests from staff were made, these were implemented to improve the service. For example, the domestic staff we spoke with told us, "We wanted another trolley and [the manager] got us one straightaway." They said this had helped them to be more effective in their role as it now saved them considerable time spent travelling between floors to access one trolley as they had done previously.

Besides regular audits undertaken by the registered manager, the service received regular quality assurance visits by the provider. We saw details of three which had been undertaken since October 2014. These were comprehensive with a clear level of detail including time limits for any action and who was responsible for completing these. The audits covered a wide range of areas including safeguarding, incidents, care plans, health and safety and environment amongst others. This demonstrated that a holistic view of the service ran was being undertaken in order to identify and make improvements where required. Good practice was identified and highlighted throughout the audits. The registered manager told us she received good support from her manager and other personnel involved with the service.

Staff told us that team meetings took place regularly and we saw minutes of staff meetings that took place between all staff groups, for example kitchen staff, care staff and night staff. This meant that the whole staff team had opportunities to be involved with and receive feedback about the service. We asked how the registered manager

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# Is the service well-led?

ensured that she understood how the service ran at all periods. She told us that she had previously worked some night shifts and said she often stayed over after the day shift ended to ensure that she saw night staff regularly.

Good practice by staff was acknowledged and highlighted as an example to follow. A care worker had recently received a compliment from a member of the public. The member of public had witnessed, and was impressed with, the staff member's care of a person who lived at the home which they had observed during a trip to hospital. The person had sought from the staff member the details of where they worked and had submitted the compliment to the home. A copy of this compliment was on display in reception with recognition to the staff member who had also been awarded a gift voucher for their good practice.

There was a process in place to ensure the registered manager had oversight of all incidents at the service. These were monitored on a regular basis to identify any themes and trends and to look for ways to reduce potential risks. We saw evidence of incidents that were recorded and saw that these were documented and followed up with referrals made where necessary. Statutory notifications in line with the criteria set out in the Health and Social Care Act 2008 had been made accordingly.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>How the regulation was not being met:<br><br>The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them. |