Tameng Care Limited

Shawcross Care Home

Inspection report

Bolton Road
Ashton in Makerfield
Wigan
Greater Manchester
WN4 8TU

Tel: 01942276628
Website: www.fshc.co.uk

Date of inspection visit:
20 March 2017
22 March 2017

Date of publication:
15 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 carried out an unannounced inspection of Shawcross Care Home on 20 and 22 March 2017.

Shawcross Care Home is located in Ashton in Makerfield and provides residential and nursing care. The home is divided into two separate units, one for nursing care and one for people living with a diagnosis of dementia; which the home refer to as the EMI unit, each providing accommodation over two floors. The home provides single occupancy rooms with private toilet facilities and can accommodate up to 50 people. At the time of the inspection there were 43 people living at Shawcross Care Home.

A comprehensive inspection was last carried out at the home on 10 and 11 August 2015, when we rated the service as 'requires improvement' overall with two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing and person centred care.

At this inspection we found the service had made improvements in regards to staffing and person centred care, however identified two breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safe care and treatment and the management of medicines and good governance. You can see what actions we told the provider to take at the back of this report.

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

We saw the home was clean and had appropriate infection control processes in place. Infection control audits were completed regularly and cleaning schedules were in place and up to date. Laundry was collected in different coloured bins to minimise the spread of infection. People told us they were happy with the cleanliness of the home and that their rooms were cleaned daily.

Each person we spoke with told us they felt safe. Relatives expressed no concerns about the safety of their family members and were complementary about the level of care provided. The home had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

We saw the home had systems in place for the safe storage, administration and recording of medicines. Completion of the medication administration record (MAR) was done consistently and the home had effective systems in place for the administering of topical medicines. Staff authorised to administer medicines had completed the necessary training and had their competency assessed on a regular basis. However we identified issues with the management of stock levels and re-ordering of medicines, which

meant people had missed doses of medicine until new supplies arrived. We also identified some issues with the recording of the medication fridge temperature and the monitoring of some medicines which people self-administered; such as inhalers or processes they completed themselves; such as blood glucose monitoring.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We found the home was working within the principles of the MCA and had followed the correct procedures when making DoLS applications. At the time of our inspection there had been 29 applications made to the local authority that were still awaiting assessment.

Staff confirmed that on-going training was provided and they received reminders when refresher training was required to keep their skills and knowledge up to date. Some staff commented on the majority of the training being provided via e-learning and how they would prefer more 'face to face' sessions, which they felt would better suit their learning style. We saw the home did provide practical sessions, many of which were sourced externally through the local authority. Completion of these sessions was monitored on a separate training matrix.

Staff confirmed they received supervision with their line manager, which along with the completion of staff meetings, meant they were supported in their roles. We did note that the frequency of supervisions varied between staff members, with some completing twice as many as others.

Observations of meal times showed these to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal. We saw nutritional assessments were in place and special dietary needs catered for. People told us they received enough to eat and drink and were offered a good choice of meal options, with alternatives available. Food and fluid charts were completed; however we noted inconsistencies in recordings between 17.00 and 22.00 on all the charts we viewed. When this was raised with the registered manager, we saw they had already identified the issue and had taken steps to address this with the staff team.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the quality of the staff and the standard of care received.

We looked at six care files which contained accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and the care that they received was person centred.

The home employed two activity coordinators, who planned and oversaw the activities completed within the home. People we spoke with said they were satisfied with what was on offer, and we observed a range of different activities being completed over both days of the inspection. The home actively documented activities and displayed photographs of the different events that had taken place within the activity room and photo albums.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. We saw evidence of

action plans being implemented to address any issues found, however none of the issues we had found with medicines management had been identified via the auditing process.

Questionnaires were circulated regularly to capture the views of people using the service, their relatives and any visiting professionals, with feedback displayed and accessible for everyone to read.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at Shawcross Care Home.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by staff who had received training and their competency assessed, however we identified issues with the timely re-ordering of some medicines and the monitoring of self-administered medicines and processes.

Is the service effective?

Good

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The service worked closely with other professionals and agencies to ensure people's health needs were being met.

Consideration had been given to ensuring the environment was suitable to people living with dementia, with appropriate décor and a range of aids, adaptations and pictorial signage in place.

Is the service caring?

Good

The service was caring.

Both people living at the home and their relatives were positive about the care and support provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were friendly, kind and respectful and took time to listen to what people had to say.

People were able to make choices about their day such as when to get up, what to eat and how to spend their time. Staff had an understanding of the importance of promoting independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed. People told us they were involved in decisions about their care and asked what they wanted.

The home had an effective complaints procedure in place, with all complaints being investigated and outcomes documented.

The home provided a varied choice of activities. People we spoke with were happy with the activity programme at the home.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, however these did not identify the issues noted with medicines management.

Both the people living at the home, relatives and staff said the home was well-led and managed and they felt supported by management.

Regular meetings were held with staff, people who lived at the home and their relatives, to ensure everyone involved in the home had input and were made aware of all necessary information.

Shawcross Care 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 20 and 22 March 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC) and a specialist adviser (SPA). The specialist advisor was a Pharmacist.

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality assurance team at Wigan Council.

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.

During the course of the inspection we spoke to the registered manager, regional manager and nine staff members, which included three nurses. We also spoke to eight people who lived at the home and two visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included five staff files, six care plans, Medication Administration Record (MAR) charts, meeting minutes, policies and procedures and audit documentation.

Requires Improvement

Is the service safe?

Our findings

Upon arriving at Shawcross Care Home, we noted an outbreak of diarrhoea and vomiting had occurred in the EMI unit and as a result this unit had been closed to visitors. Signs explaining this were clearly displayed both upon entry to the home and the door into the EMI unit. The registered manager explained this had occurred over the weekend and environmental health had been notified. We agreed to continue the inspection, ensuring we remained in the nursing unit which had not been affected and we returned 48 hours later to complete the inspection of the EMI unit.

We looked at medicines management within the home and saw detailed policies and procedures were in place. Each person had a Medicine Administration Record (MAR) chart in place and completion of this documentation for both oral and external medicines had been done consistently. MAR charts had been completed fully with signatures or refusal codes used, with explanations for each code recorded on the reverse of the chart. The home had when required medicines (PRN) protocols in place, which explained what the medicine was, when it should be taken and how staff would know it was required if the person could not tell them. This ensured 'as required' medicines, such as paracetamol, were being administered safely and appropriately.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation, for example morphine. These medicines are called controlled drugs (CD). We checked the controlled drug (CD) cupboard and saw this was locked with the key held safely by the nurse (RGN). We noted that palliative meds were in place for two patients, one of whom had recently passed away. These medicines were being kept for the statutory seven days after death. We checked the stocks of two different medicines for two people and found these tallied with the CD register. The register was well maintained with two signatures recoded for each administration as required.

Medicines were stored safely and securely. Keys for both the store rooms and medicines trolleys were kept with the responsible person allocated to administer medicines at all times and the medicines trolley was locked in between administrations. All creams and ointments had been detailed on separate MAR charts and stock was stored in a separate trolley. On inspection all tubes and tubs had been labelled individually with instructions which matched the MAR charts.

During observation of the medicines round we noted the RGN used a very caring, patient manner with each person allowing for the fact that many of them were still in bed, and some refused to take their medicines until they were up and dressed. We noted the RGN took into account the late administration of morning medicines when administering them at lunchtime.

We saw that one person taking a sleeping tablet had recently had a dose reduction and stock in the CD cabinet reflected this change. The dose reduction had been actioned because of a concern regarding over-sleeping, which impacted on the administration of medicines. This reduction had been initiated by the home and evidenced good care and safe practice.

The home utilised transdermal patch administration sheets, which documented where on the body each patch had been applied. We saw these were not completed consistently which would impact on staff's ability to apply these to a different area each time as required.

When checking the medicines fridge, we noticed that daily monitoring to ensure the temperature was between the normal limits of 2 and 8 degrees had not been completed properly. The temperature gauge had not been reset after each use, as required, which meant the recordings for the last three months were incorrect. This meant it was not possible to guarantee that all stock had been stored safely and correctly. We spoke to the registered manager about this and on the second day of inspection, we saw that a new monitoring form had been introduced which prompted staff to reset the fridge each time which we observed being done.

We noted that stock balance checks and re-ordering of medication processes were not working effectively together. Regular stock checks were being recorded on MAR charts for each person but action was not being taken to order medication in good time. We saw there had been at least four incidents over the current month where medication had either been missing or would be missing within the next 24 hours. For example we saw one person's MAR chart stated that a medicine had been out of stock for the last four days, whilst there would be no serious side effects from missing this medicine, this was not good practice. Another person's anti-coagulant medicine had run out on Sunday 19 March. We asked if more had been ordered and saw this had only been done on Saturday 18 March. The earliest the GP could action this was 20 March, and then the prescription would need to be sent to pharmacy for dispensing. Depending on how long the process took, this could result in the person being without an important medicine for up to 48 hours.

The registered manager told us some of the delays in receiving medicines were due to problems with the GP surgery and pharmacy and how quickly and effectively prescription requests had been dealt with. The registered manager showed us a number of prescription requests that had been faxed to the GP surgery. In most cases these had been sent sufficiently in advance of medicines running out. However we noted that fax confirmation information was not attached or included, which meant we could not confirm the requests had actually been sent on the dates recorded on the forms.

There are certain medicines which are more effective if given before breakfast or on specific days of the week before food. During the inspection we noted the RGN's had knowledge and understanding of this however we saw no consistency in their administration. Some people had these medicines given to them by the night staff, whilst others were given them with the rest of their morning medicines.

We saw that monitoring of self-administered medicines such as inhalers was not in place; with staff only seeking verbal confirmation these had been taken. We also noted that one person who was a type two diabetic was responsible for testing their own blood glucose levels. When asked by the nurse, this person stated they had last tested a few days ago. We saw that no monitoring was in place for staff to document blood glucose readings and ensure daily testing was completed. As this person took a hypo- glycaemic medicine, ensuring regular testing and being aware of the readings was important to ensure they remained safe and well. We discussed this with the registered manager and on the second day of inspection saw new monitoring forms in these areas had been implemented.

This is a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not ensure the proper and safe management of medicines.

We asked people who used the service if they felt safe living at Shawcross Care Home. Everyone we spoke with confirmed they did, with one telling us, "Oh yes, definitely. We have our own keys, so can lock our doors,

this makes me feel very safe." Another said, "I feel safe here. Nothing is ever missing and nobody comes in to my room." A third person told us, "I'm safe. It's great living here."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully. We saw that a review of all incidents had been completed along with analysis to look for potential trends and causation. Lessons learned for each incident were clearly documented, to ensure the service was able to mitigate further risks.

Staff we spoke with were aware of the different ways a person can experience abuse and were clear about what action they would take if they witnessed or suspected any abusive practice. Each member of staff confirmed they had received training in this area and that this was refreshed within required timeframes. One staff member told us, "It's online training, but as it's mandatory it gets refreshed every year." Another said, "Yes, done this via e-learning, we get a reminder when we are due to re-do the course." A third stated, "I would pass on any concerns to the manager, I am confident about what things to look for."

We looked at five staff personnel files to check if safe recruitment procedures were in place. We found robust checks were completed before new staff commenced working at the home. The files included; an application form, full work history, interview notes, proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The bathrooms were well kept and surfaces were clean and clutter free. Personal protective equipment such as gloves and aprons were available throughout the home and there were different coloured bins for collecting different types of laundry depending on their state of cleanliness. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. These ensured staff had information about the safe storage, handling and use of any potentially hazardous substances and what measures to take in case of emergency.

One person told us, "The cleanliness of my room and the home is pretty good. They clean in here daily." A second person said, "It's spot on. The cleaners are in every day."

During the last inspection in August 2015, we found there were not sufficient numbers of staff to meet people's needs at all times. At this inspection we saw this issue had been addressed. The home completed dependency assessments for all people who used the service in order to determine their level of need, and employed a dependency screening tool, the Care Home Equation for Safe Staffing (CHESS) to determine the number of staff needed to meet people's needs. The registered manager told us dependency levels were assessed monthly and staffing organised depending on results. They also told us that the home 'rounded up' the number of staff required, for example if the tool indicated 3.4 staff was needed to meet people's needs, they would assign four staff rather than allocate three. We saw data produced by CHESS for the last three months and noted that both indicative and actual staff numbers were documented. We cross referenced this with staff rotas for the last four weeks and saw the number of staff on shift tallied with the dependency tool.

We asked what arrangements were in place to cover sickness and holidays. We were told the home staffed

at 120% to provide a contingency for any unplanned absences. A bank of staff had also been set up, including three nursing staff to cover any shortfall.

As part of the inspection, we asked people who used the service and their relatives for their views on staffing levels. We received a mixed response with six people telling us there was enough staff, whilst two stated there was not, although both confirmed staff responded to call alarms promptly. One person told us, "There are never enough staff. There are usually two on upstairs and two downstairs with one floater. I personally feel we need three upstairs and three downstairs. I do sometimes have to wait a while for things but they do answer buzzer quickly." The second person told us, ""I don't think there are enough staff but they do come quickly when I press my buzzer." A third person said, "Yes there are, always plenty around." Whilst a fourth stated, "It seems to vary, sometimes there is loads, sometimes not as many but still enough to look after you properly." A relative told us, "I think there are enough staff. They are dotted about the home when we come and we never have to look far."

At the last inspection staff had raised concerns about staffing levels on both the nursing and EMI unit. At this inspection we again asked staff for their views on staffing levels and ability to meet people's needs in a timely manner. One told us, "It has improved. We currently have three carers and one nurse; this is based on the dependency levels of the people on this floor. There is enough to meet needs at the moment." Another said, "When we are full we have three staff on each floor plus a nurse, currently we have two and a nurse due to the number of empty beds. We can meet needs with these levels." A third stated, "My personal view is they are adequate, some people may think we do not have enough, but you have to be realistic. We are busy when on shift but have enough staff to meet people's needs."

We looked at how accidents and incidents were managed at the home. Where accidents occurred, these were investigated and preventative measures were put in place to keep people safe. Accidents and incidents were recorded and the registered manager told us they used 'datix,' which is a web based safety software for healthcare risk management applications. This enabled incidents to be captured and disseminated throughout the organisation. Datix can be used to analyse trends within the care home and to capture trends across the organisation to enable proactive risk management. All accidents and incidents which occurred in the home were recorded and analysed for themes and trends. Action points were recorded as an outcome and we saw evidence that these had been completed. For example; observations commenced or referral to the falls team.

People's care records contained identified areas of risk. Risk assessments were in place for areas such as; falls, moving & handling, use of bed rails, pressure care, choking, safe storage of creams (locked cabinet in rooms). All expected risk assessments were in place and reviewed timely in line with people's care plans. We saw where risks had been identified, there was a detailed care plan identifying what action had been taken to mitigate the risk. For example, people who had been assessed as being at risk of falling out of bed had a bed rails risk assessment completed and bed rails in place. We also saw falls care plans detailed whether a pressure mat transmitter had been put in the person's room for people at risk of falls when mobilising. These mats trigger an alarm if the person starts to get out of bed so staff can offer assistance. This meant staff were identifying risks to individuals and taking action to reduce those risks.

We looked at the home's safety documentation, to ensure the service was appropriately maintained and safe for residents. Gas and electrical safety certificates were in place and up to date, all hoists, lifts and fire equipment were serviced within regulatory timeframes with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers had all been checked regularly to ensure they were in working order.

Good

Is the service effective?

Our findings

People living at the home told us they enjoyed the food and received enough to eat and drink. One said, "Food is good, we get a choice of what to eat." Another told us, "The food is pretty good. I've no complaints against the food. This morning I fancied porridge and that's what I've got. Hot too like I asked." A third person said, "Some of the meals are very good. There are something's that I don't like but personal tastes are accommodated and they'll always get you something else." A fourth person told us, "The food is good. If there is ever something that you don't like then you can request something else."

We observed the meal time experience on both days of the inspection and saw that it was positive for people using the service. Each floor had its own lounge/dining room, where people were supported to sit, however we noted that people had the option to eat wherever they chose including their room. We saw dining tables had been set properly prior to meal times, with each containing napkins, cutlery, side plates, condiments and a vase of flowers. The daily menu was located on each table and there was a large menu board on each dining area wall, where pictures of each meal option were displayed. We saw this had not been completed on either day of the inspection to inform people of the meal options that day.

Upon arriving in the dining room, people were supported to sit at the table of their choice and asked if they would like a drink, with a jug of cordial placed on each table and other drinks available by request. We saw that everyone was served in a timely manner and dishes were emptied and removed promptly. People's care files contained information about people's favourite foods and we cross referenced this information with people's daily food charts to determine that people's food preferences were being catered for.

Each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated timely to reflect people's changing needs. We saw people's weights were closely monitored. People's weights were recorded weekly and the records we viewed showed staff had been responsive to people's changing needs. We saw people had been referred to the community dieticians and commenced on fortified foods, milkshakes and high calorie snacks as per dietician recommendations. A relative told us, "[Person's] weight loss has stabilised since coming in to this home. It's well communicated as staff inform us what [person] weighs."

The home had monitoring charts in place to document what people had eaten and drank throughout the day as well as specific fluid monitoring charts for people who were identified as being at risk of dehydration or requiring support to access fluids. We noted not all of the fluid charts contained the daily amount of fluid which needed to be consumed, which would act as a guide to staff. We also noted that whilst fluid provision and monitoring was consistent for most of the day, we noted gaps in each of the seven charts we looked at between 17.00 and 22.00. We spoke to the registered manager and district manager about this, who told us they had identified this issue through internal audits and had been addressing the importance of fluid provision and monitoring through staff meetings and supervisions. We were shown minutes of a staff meeting which evidenced this discussion.

Everyone we spoke with told us they got enough to drink. One person told us, "My water jug is topped up and they come round with hot drinks regularly." Another said, "I get a drink whenever I want one, no problems with this." A relative told us, "There is always a jug of juice on the table and I check the charts to make sure [person] receives enough to eat and drink. I've no concerns."

We looked to see how the service managed people's pressure care. We saw Waterlow scores were consistently monitored. When people had been identified at risk, we saw they had the required equipment to provide a reduction in pressure on vulnerable areas such as heels and the sacrum, for example; air flow mattresses and pressure relieving chairs. Referrals had been made to the tissue viability nurse (TVN) as required, with TVN guidance clearly documented in the care file. Records showed that positional changes were completed as per each person's care plan. The registered manager maintained an overview of pressure areas through datix.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses, mental health services (CPN's) and speech and language therapists (SaLT).

The people who lived at the home and their relatives told us staff had the right knowledge and skills to provide effective care. One person said, "They are good you know. They are well trained and know what they are doing." A second person said "On the whole they know what they are doing. They are kind when using the hoist and they don't mind me swearing which is good."

We looked at the homes staff training documentation. The home had a training file in place which contained information about each session along with signed training registers and certificates awarded to staff upon completion. The training matrix showed that staff had received training in a number of areas relevant to their role, including dementia, moving and handling, infection control, health and safety and first aid. Training completion was monitored and reminders provided to staff when any training was due to expire. Upon commencing employment each staff member completed an induction programme, before they could work with people living at the home. This included completion of mandatory training sessions as well as an introduction to the home. We saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

We asked staff for their opinions on the training provided by the home. One member of staff said, "We tend to do mainly online training. We can ask for more training if we want to." Another said, "There is enough provided, the e-learning is very in depth." A third said, "I completed all mandatory sessions when I started, had to do this over three week period. They offer what they can after this, and you can ask to do more. I have just started an NVQ." However a fourth said, "No, I don't think there's enough, based on my experiences in the past." A fifth stated, "There's not enough courses run in the home, most is e-learning and I prefer face to face."

Staff told us they received supervision and found this useful. One said, "Supervision is done by [name], I had my last one about three months ago, I find them really useful. [Registered manager] does our appraisals yearly." Another stated, "We have these, I have had quite a few in the last year." Whilst a third told us, "I have had supervisions, although I thought they'd be more often than they have been, I think I have had two or three in last year."

The home had a supervision matrix in place to monitor completion. We noted there was a discrepancy in the frequency with which meetings had been completed, and whilst all staff had been provided supervision

quarterly in the last year, some people had been provided bi-monthly supervision. We spoke to the registered manager who stated that some staff did not attend planned meetings due to sickness or absence and that at times group supervisions were completed, which increased the amount people had completed. The registered manager agreed that supervision meetings should have been re-arranged for staff that had been off-sick or on holiday and said they would be looking at the way meetings were scheduled.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One staff member told us, "Mental capacity is about assessing a person's level of understanding and ability to make decisions." Another said, "I have done e-learning and been on an external course. I know all about mental capacity and DoLS."

At the time of the inspection, 32 DoLS applications had been submitted to the local authority, however only three assessments had been carried out and authorised. We saw evidence that action had been taken to chase up the outstanding applications. We saw the registered manager completed a DoLS matrix, which detailed each person in the home, whether an application had been made, what type of application, date authorised and date of renewal. This ensured the home had a detailed overview of DoLS management.

Within people's care files we saw that potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention utilised. For example a person who was getting out of bed without support and putting themselves at risk of falls due to impaired mobility, had had bed rails fitted following a best interest meeting. When it became apparent these were not working as the person was climbing over the rails, the home had met with the person's relative to discuss alternative options and had purchased a low profiling bed, removed the bed rails and installed a crash mat to maintain their safety and an alert mat to enable staff to respond and provide support when mobilising.

We looked at how the home sought consent from people. Care plans contained consent forms, which had been signed by either the person themselves or their representative. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer. Each person we spoke with told us staff sought their consent, with one saying, "Staff always knock on my door and ask my permission before helping me."

Observations during the inspection showed that consideration had been given to ensuring the environment was dementia friendly, especially the EMI unit, where substantial investment had been made. LED lighting had been installed throughout, to ensure the home was properly illuminated. Corridors were light and airy with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. Large pictorial signage was in place on all bathrooms and toilets, many of which had been decorated in a nautical theme. Information boards were in situ which included the day, date, time and weather, in easy to read format.

Good

Is the service caring?

Our findings

The people we spoke with said they liked the staff and found them to be caring. One told us, "The staff are very kind." Another said, "I love all the carers on the days, I really do." A third person stated, "The care staff are wonderful." Whilst a fourth told us, "The care is good. Staff are nice." We asked visiting relatives for their opinion, one told us, "The staff are fantastic." Whilst a second said, "I can't fault them at all. The care has been brilliant."

People said they were treated with dignity, respect and were given privacy at the times they needed it. One person told us, "They treat me with respect and maintain my dignity. They make sure I'm covered up when supporting personal care." Another said, "I've no issues. They make me feel very comfortable." A relative told us, "I am here all afternoon and it feels like this is our family room. Staff always knock and wait to be invited in."

We asked the staff how they maintained people's dignity and respect. One said, "Ensure you knock on the door, cover up when providing personal care, ask people what they want and let them know what you are going to do before you do it." Another told us, "We take this very seriously, we respect the residents, ensure they are covered, doors are closed and communicate what we are doing."

Whilst speaking to staff we asked them how well they knew the people they cared for and how they knew what they wanted. One told us, "We sit down with them, have a chat, ask them what they would like." Another said, "We take time to get to know them. One of the things I love about working here is you are encouraged to sit and chat to people, develop relationships. As long as no-one else needs assistance, you can spend as much time as you like doing this."

Over the course of the inspection we spent time observing the care provided in all areas of the home. People looked clean, appropriately dressed and well groomed. We saw staff interaction with people was warm and friendly. For example staff members were observed ensuring they were at eye level with people when engaging in conversation, even if this involved kneeling down or pulling up a chair before engaging people in conversation. Appropriate physical contact by the staff was observed, such as hand holding or placing their arm around someone whilst speaking discreetly with them. Throughout the inspection people responded positively to the interactions with staff and care being given.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "I let people do whatever they can manage." Another told us, "I provide support, assistance and encouragement to let people do things for themselves." A third stated, "I ask and encourage people to do things for themselves, such as washing whatever part of themselves they can manage, before helping do the rest. It's important people remain involved."

People's religious beliefs were clearly documented in their care plan and the home arranged for a vicar to visit weekly and communion was provided to those who chose this.

People's end of life care was dealt with in a sensitive way. When appropriate, people had documentation in place to ensure their end of life wishes were considered. This included decisions around resuscitation. One person whose file we looked at had stated they did not wish to be hospitalised. A best interest meeting had been held with their relatives and GP in order to legally honour their wishes.

Good

Is the service responsive?

Our findings

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and their relative(s). The makeup of the assessment mirrored the layout of the care file, which ensured information relative to each section was captured. We saw that each care plan was comprehensive and captured people's support needs and wishes so that staff knew exactly how each person wanted to be cared for.

Each person had two files in use, a main care file, which contained comprehensive assessments and care plans and a file which was kept in people's rooms containing daily notes and monitoring charts. Each bedroom had a rack on the wall in which this file was stored. A copy of each person's 'my preferences' document from their care file was displayed above the rack, which reinforced to staff what the person liked and how they wanted to be cared for. This document included areas such as favourite food and drink, how they liked to dress, whether they preferred a bath or shower and how frequently.

We asked people living at the home and their relatives if staff were responsive to their needs. One person told us, "I'm not told when I have to go to bed or get up but I do sometimes have to wait. It can depend on what staff have got on, however they do explain why a bit later." A second person said, "I get a full body wash daily and oral care." A third person stated, "They respect that I like it quiet and to do my own thing. I go to bed and get up when I want." A fourth told us, "I like my door propped open so they ask me every morning and then do it for me. I like seeing and hearing what's happening." A relative said, "They check on [person] ever hour even when we are here."

We saw evidence of a person centred approach within the main care files. Assessments had been completed in a range of areas including communication, medication, mobility, nutritional needs, hygiene and personal care, which detailed people's needs in each area and how they wished to be supported. Each file also contained a life history and people's aspirations. The quality and extent of information differed but this was attributable to the person's cognitive ability and level of family involvement.

People we spoke with told us they were asked about their care and whether they were happy with what was being provided. One person told us, "Yes, they ask me if I am happy with things. I can tell them if I want something to change." Another said, "Yes, they have asked me about my care. I feel involved." We saw care plans had been reviewed every four weeks, sooner if an issue had arisen. The registered manager told us they actively encouraged relatives to be involved in this process, but so far few had taken up the offer. We noted a sign displayed in reception in regards to this, along with references in the minutes of resident meetings.

As part of the inspection we looked at the activity programme provided by the home. We asked people for their views on what was available. One told us, "There are things going on. They're not always my thing but I have a choice. I enjoyed zoo safari with all the unusual animals." A second person said, "I don't tend to go in the lounges much but staff come and have a chat with me in my room." Other comments included, "I'm happy with what's provided" and "There's plenty going on, I'm happy with what's offered."

Each floor had a large activity board on display, which detailed the activities for that week. We noted that two activities were offered Monday to Friday, one in the morning and one in the afternoon, along with one activity per day at the weekend. The home also had an activity room which tended to be utilised more by those residing in the EMI unit. This contained a range materials and equipment, including a large wall mounted television, with the walls decorated with photographs documenting recent activities and outings. Each person had a journal in place which documented what activities they had engaged in.

The home employed two activities co-ordinators who both worked 20 hours per week. The registered manager told us they had taken on board feedback from the previous inspection and doubled this provision from 20 hours per week to 40 hours per week. During the inspection we noted that the co-ordinators tended to work together and asked the registered manager whether there were any plans for them to split between the two units, so that activities could be provided in both places at the same time. We were told this had already been discussed. We also saw that activity completion varied between the two units, with more being facilitated in the EMI unit compared to the nursing unit. The registered manager told us that due to many people being cared for in bed within the nursing unit, more 1:1 activities were completed in rooms. People in this unit were also less interested in engaging in the planned sessions. During the inspection we did observe people refusing to engage in activities when offered to do so by the staff.

During the second day of the inspection we spent time observing activities in the EMI unit. We observed a floor game of snakes and ladders being completed in the downstairs lounge, with seven people taking part and others watching. Upstairs people were engaged in a range of individual activities including reading old newspapers, completing art and craft tasks, watching music videos on a portable device and playing with nuts and bolts, screwing the nuts onto the bolts and sorting into piles, which helped the person with dexterity and hand eye coordination.

We looked at how complaints were handled. The home had effective systems in place for people to use if they had a concern or were not happy with the service provided to them. We saw for any complaints received the registered manager maintained a complaint record detailing actions taken to resolve the issue. We saw complaints had been resolved within the specified timeframe and the actions clearly listed. There was a complaints process flow chart in place to support the complaint system.

People we spoke with said they knew who to speak to if they had any concerns, but had not needed to. One person told us, "I've never made a complaint. I'd have no hesitation to speak with the manager though if I had a concern." Another said, "I would speak to the person in charge, but I've never had to."

The registered manager held copies of any compliment cards, letters or emails, as well as reviews and feedback left on the home's feedback system or care home review websites. We saw that feedback provided on the home was largely positive, complimenting both the staff and the quality of care. From one person's feedback we discovered the home had invited people's spouses into the home on Valentine's Day, to participate in a valentine's meal. This person was very complimentary, thanking the home for the opportunity to share a 'special meal' with their loved one, which was perfectly cooked and presented.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 home used a range of systems to assess the quality of the service, this included the inclusion of people using the service, their relatives and visiting professional through completion of questionnaires and quality audits. An electronic device for providing feedback was located in the reception area, with people actively encouraged to record their thoughts after each visit. The registered manager told us the provider's expectation was for the home to gather feedback from at least seven professionals each month. Feedback received was anonymised and then displayed on a notice board for all visiting the home to read, along with what actions had been taken to address any issues. People using the service were provided with questionnaires in order to rate the service, and were also asked for their views as part of the auditing systems the home completed to assess the quality of service provision. We saw that feedback provided was positive and complimentary about the service being provided.

We also saw a manager's coffee morning was advertised for each Wednesday between 10.00am and 11.00am where relatives could catch up with the registered manger and discuss any concerns they may have or just have a general chat about the home and their thoughts or suggestions.

Both resident and relative meetings were held every four to six weeks, with minutes taken and displayed on the notice boards throughout the home. One person told us, "We have a residents meeting every month. We can occasionally influence change." Another said, "Yes, we have meetings, we get asked to comment on any changes or suggestions for the home." Whilst a third said, "They have regular meetings; however I've not been to them as I choose not to."

Internally the home completed a wide range of audits covering all aspects of service provision. A large proportion of these were done via the Thematic Resident Care Audit (TRaCA), which is a system designed by the provider. TRaCA's were carried out in a number of areas including the admissions process; to ensure everything was in place, pressure care, nutrition, use of bed rails, resident care; which was an initial 82 point questionnaire which expanded to over a 100 points depending on the feedback provided. We were told that six of these questionnaires were completed on a weekly basis, to ensure that everyone was reviewed via this process every three to four months. Part of the process involved asking people about their care, their experiences and views on things such as the food and environment. All TRaCA's were reviewed by the registered manager who provided action points and ensured these were followed through.

Other auditing systems included a daily walk round, which looked at whether the home was clean and tidy, the quality of care, staff engagement with people and spot checks of documentation and practices. The registered manager also had to provide twice monthly reports to the provider, which were called 12th and 25th reports, based on the dates for submission. These covered a range of areas such a wound care and

analysis, training completion, hoist and sling register, bed checks, staff file checks and night visit feedback, which involved unannounced visits during the night to check on practice.

Despite the comprehensive auditing systems in place, we saw none of the issues noted with medicines management, such as temperature recording or stock control and ordering had been identified as part of these processes.

This is a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not effectively assess, monitor and improve the quality of the service as systems and processes did not identify where quality and/or safety were being compromised and respond appropriately.

The home had a clear management structure in place. A deputy manager was in position, who supported the registered manager. A unit manager was also employed and was responsible for the day to day running of the EMI unit. The regional manager for the provider was based at the home, and therefore had regular involvement.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One told us, "Yes, I love it here." Another said, "I enjoy working here. I am having some issues at the minute, but I couldn't have asked for any more support, they've been really good."

A person living at the home said, "The registered manager is visible in the home. They also attend the resident meetings. On the whole, I would say the home is well-led." A second person said, "I think it's well led. We all know the manager and they come round to see us." A relative said, "The manager is always about and they make time for you."

We asked people living at the home and their relatives if they would recommend the home to other people requiring the level of care provided. One person told us, "Yes, I'd recommend this home." A second person said, "It's very good. I'd recommend this home. I've been in a few and this is definitely the best of them." A third person said, "I've no complaint so I'd recommend here to others." A relative told us, "Its home from home."

We saw that team meetings had been completed both as a staff group and also with each designation of staff including ancillary staff; such as housekeepers and maintenance team, kitchen staff and nurses. We were told due to care staff not turning up for scheduled team meetings, the registered manager had introduced completion of flash meetings, which ensured that staff were made aware of information relating to the home and their roles or changes to practice. These occurred on a regular basis. The home also facilitated clinical governance meetings on a three monthly basis, which involved a differing selection of staff and reviewed all areas of the home and their effectiveness.

We asked staff about the completion of meetings. One told us, "Yes we have meetings, we actually have one arranged for this Thursday, the frequency depends on what we need to discuss." Another said, "We have flash meetings, they are maybe once a week or so." A third stated, "We have not really had a staff meeting for a while as no one turned up to last one, we have been having flash meetings instead, which are useful.|"

The home's policies and procedures were stored electronically, with key policies printed off and stored in an information file. We saw the service had all key policies in place including ones for medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at corporate level and the home notified of any changes; this meant that the most up to date copy was always available and staff

made aware of any changes to practice.

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file.