Delphine Homecare Limited

St George's Nursing Home

Inspection report

1 Court Close, Pastures Avenue
St Georges, Weston-Super-Mare, BS22 7AA
Tel: 01934 524 598
Website:

Date of inspection visit: 15 April, 20 April, 22 April and 23 April 2015
Date of publication: 01/07/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place over four days on 15 April, 20 April, 22 April and 23 April 2015.

St George's Nursing Home is registered to provide personal and nursing care for up to 60 people. The home specialises in the care of older people with dementia. At the time of this inspection there were 31 people living in the home.

The manager had been in post since 23 February 2015; however they were not registered with the Care Quality Commission (CQC) They told us they were preparing the documentation to apply to be registered. 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.

This inspection was scheduled following concerns received regarding staff shortages, end of life care, infection control and the management of risk specific to falls.

Throughout the inspection there was a relaxed and cheerful atmosphere; people living in the home, relatives and staff were happy and at ease when they spoke with us.

Summary of findings

The manager responded to concerns and complaints in line with the provider's policy and procedure. We looked at one complaint in detail. The complaint was received by the provider at the beginning of April and at the time of our inspection had not been concluded. By the end of our inspection the manager had responded to the complaint but the response was defensive and did not address all the issues raised. We discussed the outcome of their investigation and they agreed there had been a breakdown in communication but this was not identified in the response and no apology had been made.

Medicines were not always handled safely. Nursing staff were assisted by care workers to administer medicines. They had not checked the practice of the care workers to ensure it was safe for them to assist them. The medicines charts for some as required medicines such as pain relief did not include information for ensuring they were given in a consistent way. This was addressed during the pharmacist's inspection and guidance was in place for staff to follow. Medicines prescribed for end of life did not include what checks the nurse should carry out before administering. This had been addressed by the end of the inspection and very clear guidance and protocols were in place.

There were systems in place to monitor the care provided and people's experiences. However they had failed to identify specific issues until they were bought to the manager's attention either through a complaint or our discussions during the inspection. Some shortfalls had been identified and where this happened action plans were put in place to address the issues found.

A regular survey was carried out asking people and their relatives about the service provided by the home. Suggestions for change were listened to and actions taken to improve the service provided. All incidents and accidents were monitored, trends identified and learning shared with staff to put into practice.

During the inspection we saw there was adequate staff on duty to meet the needs of people during the day. However people who could comment, relatives and staff all told us there was not enough staff at night. We saw for 31 people, five of whom were residential not nursing, 11 people required two staff to support them; there was one qualified nurse and two care workers. The manager confirmed a twilight shift had been introduced about a year ago. This meant an extra care worker supported the night staff until 11.30 at night. However this did not provide adequate support during the early hours of the morning when some people liked to get up early. The manager agreed to look at ways of also providing extra support for people early morning.

The manager had looked at innovative ways of reducing staff shortages at the weekend. They rostered on more staff than was necessary. This meant if a staff member rang in sick people did not experience poor care due to lack of staff.

The home was in the process of introducing new electronic care plans. We saw one care plan contained conflicting information about the person's wishes. Records showed people were involved in their care plans and consented to the care they received as far as possible. Family members were involved when necessary. We saw the lack of communication between qualified staff had resulted in one family's wishes not being recorded. This meant they were not contacted when their relative's health declined. We recommended the service explored guidance on ways to ensure all staff were kept aware of relatives wishes.

During the inspection we observed and monitored infection control. We found the home was clean, tidy and free from bad odours. We did not observe any dirty laundry or equipment left in the wrong place. However we did observe staff did not wear aprons when serving lunch. We bought this to the manager's attention who said they would talk with staff about the importance of wearing aprons.

We asked the manager how they managed the risks to people who had been identified as at high risk of falls. They confirmed they carried out an audit of falls and incidents which helped identify trends such as time of day or the part of the home. They would assess the need for any equipment that would help prevent injury occurring from falls. People had risk assessments in place and where equipment had been identified this was in place. This included the use of crash mats, and pressure mats to inform staff when a person was moving and one to one support for one person with very high risk of falls due to their illness. The home did not restrain people from moving about which meant falls would happen. However they did attempt to minimise the risk of injury, although injuries did sometimes occur.

Summary of findings

Staff had received training in identifying and reporting abuse. Staff were able to explain to us the signs of abuse and how they would report any concerns they had. They stated they were confident any concerns brought to the manager would be dealt with appropriately. There was a robust recruitment procedure in place which minimised the risks of abuse to people. People who could comment told us they felt safe in the home and they all knew who to talk to if they wanted to raise a concern or complaint.

People saw healthcare professionals such as the GP, district nurse, chiropodist and dentist. Staff supported people to attend appointments with specialist healthcare professionals in hospitals and clinics. Staff made sure when there were changes to people's physical well-being, such as changes in weight or mobility, effective measures were put in place to address any issues.

Everybody spoken with told us they enjoyed the food, they all said the food was good. People were offered choices and the food was nutritious and well presented. People who needed assistance with eating were supported in a dignified and unhurried manner. Some people chose to eat in their room.

We found a 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 this report.

This inspection was unannounced and took place over four days on 15 April, 20 April, 22 April and 23 April 2015.

St George's Nursing Home is registered to provide personal and nursing care for up to 60 people. The home specialises in the care of older people with dementia. At the time of this inspection there were 31 people living in the home.

The manager had been in post since 23 February 2015; however they were not registered with the Care Quality Commission (CQC) They told us they were preparing the documentation to apply to be registered. 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.

This inspection was scheduled following concerns received regarding staff shortages, end of life care, infection control and the management of risk specific to falls.

Throughout the inspection there was a relaxed and cheerful atmosphere; people living in the home, relatives and staff were happy and at ease when they spoke with us.

The manager responded to concerns and complaints in line with the provider's policy and procedure. We looked at one complaint in detail. The complaint was received by the provider at the beginning of April and at the time of our inspection had not been concluded. By the end of our inspection the manager had responded to the complaint but the response was defensive and did not address all the issues raised. We discussed the outcome of their investigation and they agreed there had been a breakdown in communication but this was not identified in the response and no apology had been made.

Medicines were not always handled safely. Nursing staff were assisted by care workers to administer medicines. They had not checked the practice of the care workers to ensure it was safe for them to assist them. The medicines charts for some as required medicines such as pain relief did not include information for ensuring they were given in a consistent way. This was addressed during the pharmacist's inspection and guidance was in place for staff to follow. Medicines prescribed for end of life did not include what checks the nurse should carry out before administering. This had been addressed by the end of the inspection and very clear guidance and protocols were in place.

There were systems in place to monitor the care provided and people's experiences. However they had failed to identify specific issues until they were bought to the manager's attention either through a complaint or our discussions during the inspection. Some shortfalls had been identified and where this happened action plans were put in place to address the issues found.

A regular survey was carried out asking people and their relatives about the service provided by the home. Suggestions for change were listened to and actions taken to improve the service provided. All incidents and accidents were monitored, trends identified and learning shared with staff to put into practice.

Summary of findings

During the inspection we saw there was adequate staff on duty to meet the needs of people during the day. However people who could comment, relatives and staff all told us there was not enough staff at night. We saw for 31 people, five of whom were residential not nursing, 11 people required two staff to support them; there was one qualified nurse and two care workers. The manager confirmed a twilight shift had been introduced about a year ago. This meant an extra care worker supported the night staff until 11.30 at night. However this did not provide adequate support during the early hours of the morning when some people liked to get up early. The manager agreed to look at ways of also providing extra support for people early morning.

The manager had looked at innovative ways of reducing staff shortages at the weekend. They rostered on more staff than was necessary. This meant if a staff member rang in sick people did not experience poor care due to lack of staff.

The home was in the process of introducing new electronic care plans. We saw one care plan contained conflicting information about the person's wishes. Records showed people were involved in their care plans and consented to the care they received as far as possible. Family members were involved when necessary. We saw the lack of communication between qualified staff had resulted in one family's wishes not being recorded. This meant they were not contacted when their relative's health declined. We recommended the service explored guidance on ways to ensure all staff were kept aware of relatives wishes.

During the inspection we observed and monitored infection control. We found the home was clean, tidy and free from bad odours. We did not observe any dirty laundry or equipment left in the wrong place. However we did observe staff did not wear aprons when serving lunch. We bought this to the manager's attention who said they would talk with staff about the importance of wearing aprons.

We asked the manager how they managed the risks to people who had been identified as at high risk of falls. They confirmed they carried out an audit of falls and incidents which helped identify trends such as time of day or the part of the home. They would assess the need for any equipment that would help prevent injury occurring from falls. People had risk assessments in place and where equipment had been identified this was in place. This included the use of crash mats, and pressure mats to inform staff when a person was moving and one to one support for one person with very high risk of falls due to their illness. The home did not restrain people from moving about which meant falls would happen. However they did attempt to minimise the risk of injury, although injuries did sometimes occur.

Staff had received training in identifying and reporting abuse. Staff were able to explain to us the signs of abuse and how they would report any concerns they had. They stated they were confident any concerns brought to the manager would be dealt with appropriately. There was a robust recruitment procedure in place which minimised the risks of abuse to people. People who could comment told us they felt safe in the home and they all knew who to talk to if they wanted to raise a concern or complaint.

People saw healthcare professionals such as the GP, district nurse, chiropodist and dentist. Staff supported people to attend appointments with specialist healthcare professionals in hospitals and clinics. Staff made sure when there were changes to people's physical well-being, such as changes in weight or mobility, effective measures were put in place to address any issues.

Everybody spoken with told us they enjoyed the food, they all said the food was good. People were offered choices and the food was nutritious and well presented. People who needed assistance with eating were supported in a dignified and unhurried manner. Some people chose to eat in their room.

We found a 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 this 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

The service was not always safe.

There was not always enough staff to safely meet the needs of people in the home. This was specifically relevant to the staffing levels at night.

Medicines were not always handled safely.

People were protected from harm because staff had received training in recognising and reporting abuse.

Risks to people were minimised because relevant checks had been completed before staff started to work at the home.

Is the service effective?

Requires improvement

The service was not always effective.

People's wishes were not always effectively communicated between staff.

People who lived at the home received effective care and support because staff had a good understanding of their individual needs.

Staff received ongoing training and supervision to enable them to provide effective care and support.

People's health needs were met and they could see health and social care professional when needed.

People's rights were protected because staff followed the appropriate guidance and processes.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respected people's diverse needs recognising their cultural and social differences.

People's privacy and dignity was respected and they were able to make choices about how their care was provided.

Is the service responsive?

Requires improvement

The service was not always responsive.

Complaints were responded to however the response to one complaint received was defensive and did not take into account the duty of candour in respect of complaints about care and treatment.

Care plans had been reviewed however some information was contradictory providing confusing guidance for staff.

Summary of findings

Care plans had been updated to contain specific information regarding people's end of life care. However this was only completed just prior to the inspection so could not be judged as consistently maintained.

People were offered activities relevant to their interests. However the activities could be cancelled if the activities person was removed to cover care shifts.

Is the service well-led?

Requires improvement

The service was not always well led.

The manager was not registered with the Care Quality Commission, however this was in progress.

The quality of the service provided was monitored; however some issues had not been picked up until mentioned in a complaint or discussed at the inspection.

There was a management team in place who were open and approachable.

The management team listened to any suggestions for the continued development of the service provided.

St George's 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.

This inspection took place over four days on 15 April, 20 April, 22 April and 23 April 2015 and was unannounced.

The inspection team consisted of one adult social care inspector, a pharmacist inspector, a specialist adviser in end of life care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had not completed a provider information return (PIR) as we had not requested one. This document enables the provider to give key information about the service, what the service does well and improvements they plan to make. We had not requested the PIR as this inspection was brought forward following concerns received regarding staff shortages, end of life care, infection control and the management of risk specific to falls.

We looked at information held about the service before the inspection date. At our last inspection of the service in August 2014 we did not identify any concerns with the care provided to people.

At the time of the inspection there were 31 people living in the home. We spoke with seven people, four visitors, six members of staff and one visiting health care professional. We also spoke with the registered manager the two clinical managers and the in-house trainer.

We also looked at records which related to people's individual care and the running of the home. Records included five current care and support plans, five care plans for people who had passed away to review the records for end of life care, four staff recruitment files, quality assurance records and medication records.

Requires improvement

Is the service safe?

Our findings

Medicines were not always handled safely. Medicines were administered by the nursing staff however in the mornings they were assisted by care workers. The nursing staff would dispense the medicines and hand them to a care worker to take to the person. The nursing staff would then sign that the medicines had been given once the care worker had confirmed it. Staff explained that only care workers who had received medicines training were able to do this. However nursing staff had not checked the competency of care workers to make sure this practice was safe for people using the service. Having two members of staff involved in giving people their medicines could increase the risk that someone was given another person's medicine by mistake.

Some people were prescribed medicines to be given 'when required', for example medicines for pain relief. There was no additional information available with people's medicines charts to make sure these medicines were given in a consistent and appropriate way. Staff took action to address this during our inspection.

Suitable arrangements were in place for the safe storage of medicines. People's medicines were available for them although one person recently arrived in the home was without two of their medicines for four days. Staff told us they had ordered the medicine but there had been a delay in the supply.

Some people had been prescribed medicines for end of life care. This was to make sure that suitable medicines were available for people at the time they needed them. However it was not clear from the records or medicines policy what checks were needed before staff should administer these medicines; to make sure they were given at an appropriate time. Staff told us they would be taking action to address this. By the last day of our inspection the qualified staff had developed a clear protocol and guidance for the administration of end of life medicines.

Before this inspection we had received concerns that there was insufficient staff to support people in the home. Most people told us they felt there was usually enough staff however some people said they felt more staff were needed. One person said, "The activities keep being cancelled because the activities organiser gets pulled off to cover when they are short of staff." The manager confirmed they did use the activities organiser if they were short of staff but said they felt meeting people's physical needs were important on those occasions. However the activities organiser was also supported by a volunteer worker who could provide activities on her behalf. One relative said, "It would be good if staff could spend more time with the residents. There have been times when the work has been rather more tasks orientated and the staff have been rushed." During the inspection we observed staff were able to spend time with people and were not rushing to get tasks done.

On the first day of our inspection there were two qualified nurses, six care workers and the activities organiser, one person also had one to one support. The duty rosters for the previous month showed this was consistently maintained during the day time shifts. The manager confirmed they calculated the numbers of staff by the needs of people in the home. At the time of our inspection this was one care worker to five people, however this could be flexible as people's needs changed. One staff member said the night shifts were not well staffed. They said there was only one qualified nurse and two care workers for the whole night. They explained most of the people in the home required two staff to assist them. This meant whilst the qualified nurse was doing their duties two care workers would be assisting people. The staff member said if anything happens such as a fall or someone calls for assistance, they have to decide on the most urgent need.

The staffing rota showed for 31 people, 11 of which required two staff members to support them, there was one qualified nurse and two care workers through the night with one extra care worker working a twilight shift until 11.30pm. We discussed this with the manager who said they had recognised the need for extra support and had introduced the twilight shift. This meant the manager had recognised the need for night staff to have extra support for assisting people to bed and when the qualified nurse was doing medication. However this did not provide cover for early mornings when some people wanted to get up earlier. The manager said they would look into ways of providing extra staff earlier.

The manager explained how they had approached solving issues around staff shortages. They had recognised that weekends were times when staff where more likely to ring in sick. The staff rota for weekends showed they put extra staff on duty so if someone rang in sick they would not be short staffed.

Requires improvement

Is the service safe?

The manager also confirmed the numbers of staff on each shift could be flexible dependent on the needs of people in the home. They said they would assess the needs of people using a dependency tool to show how much support individuals needed. They also confirmed extra staff would attend if they had activities outside the home which required more staff. One person said, "I can go out when I want to and they do organise trips when we can go shopping or see the sights."

People told us they felt safe living in the home. One person said, ""I am comfortable with all the staff and don't have any safety worries." A relative said they felt their relative was safe living in the home.

People were protected from harm because staff had received training in recognising and reporting abuse. Staff told us they had attended training in safeguarding people. They also confirmed they had access to the organisation's policies on safeguarding people and whistle blowing. Staff were able to tell us about the signs that might indicate someone was being abused. They also told us they knew who to report to if they had concerns. Visitors and relatives had access to information on how to report abuse; as the contact details for the local authority safeguarding team were displayed in the reception area of the home. However the information was not available for people who lived in the home. We spoke with the manager about how they made this information available to people living in the home. They said they would make sure the information was also displayed on the noticeboard within the unit.

Risks had been identified and where possible discussed with people or someone acting on their behalf. For example one person was identified as a high risk of falling. The home had arranged one to one support for this person during the day. Their care plan was clear about the strategies in place to reduce this risk. This meant the person was able to continue to mobilise around the home independently with the support of a staff member. Staff demonstrated they were aware of the risk and the way to enable the person to mobilise safely. People were unable to comment on the way risks had been assessed. One visitor said they had been consulted on the use of a pressure mat to help keep their relative safe when mobilising around their room.

Other people who had been identified as having a high risk of falls also had equipment in place to prevent injury whilst not restricting them from moving around the home. For example they used low beds, crash mats and pressure mats which alerted staff when a person started to walk around. These had been discussed and where necessary a best interest decision made, in consultation with relevant people. Where a person had been identified as at risk of falls the local falls team had been involved in assessing the best strategy to put in place to protect the person from harm. However one relative had told us that although the equipment was in place, their relatives pressure mat was on occasion pushed under the bed so not of much use to them. This had been identified by staff and regular checks were recorded. Other risk assessments included the risk of developing pressure ulcers and the risk of choking. People at risk of developing pressure ulcers had been assessed and the protective equipment was put in place to reduce the risk. For example people used pressure relieving mattresses and cushions. Care workers demonstrated an understanding of the risks in place and showed us how they carried out regular checks to ensure a person was repositioned or had sufficient to drink.

Risks of possible abuse to people were minimised because relevant checks had been completed before staff started to work at the home. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were of good character. The DBS checks people's criminal history and their suitability to work with vulnerable people.

Before the inspection we had received concerns from one complainant about the management of infection control in the home. We had been told that false teeth had been left to go mouldy, dirty dressings had been left on tables in people's rooms and rooms were dirty. During our inspection we toured the premises on more than one occasion to monitor the levels of cleanliness in the home. There were no bad odours throughout the home, all the rooms were clean and tidy and dirty laundry had been removed to the laundry room. We spoke with the manager who said they were made aware of the complaint when the incidents occurred and carried out their own investigation and dealt with through discussions at staff meeting. We observed staff wore appropriate protective clothing when providing care and hand washing procedures were followed. However during lunch it was observed that staff did not wear aprons. We bought this to the attention of the manager Who said that aprons should and were normally worn and she would remind staff of the reasons and importance of this; this was done on the same day.

Requires improvement

Is the service safe?

We recommend that the service consider the Nursing and Midwifery Council (NMC) guidance for medicines administration and take action to update their practice and policies accordingly.

Medicines were not always handled safely. Medicines were administered by the nursing staff however in the mornings they were assisted by care workers. The nursing staff would dispense the medicines and hand them to a care worker to take to the person. The nursing staff would then sign that the medicines had been given once the care worker had confirmed it. Staff explained that only care workers who had received medicines training were able to do this. However nursing staff had not checked the competency of care workers to make sure this practice was safe for people using the service. Having two members of staff involved in giving people their medicines could increase the risk that someone was given another person's medicine by mistake.

Some people were prescribed medicines to be given 'when required', for example medicines for pain relief. There was no additional information available with people's medicines charts to make sure these medicines were given in a consistent and appropriate way. Staff took action to address this during our inspection.

Suitable arrangements were in place for the safe storage of medicines. People's medicines were available for them although one person recently arrived in the home was without two of their medicines for four days. Staff told us they had ordered the medicine but there had been a delay in the supply.

Some people had been prescribed medicines for end of life care. This was to make sure that suitable medicines were available for people at the time they needed them. However it was not clear from the records or medicines policy what checks were needed before staff should administer these medicines; to make sure they were given at an appropriate time. Staff told us they would be taking action to address this. By the last day of our inspection the qualified staff had developed a clear protocol and guidance for the administration of end of life medicines.

Before this inspection we had received concerns that there was insufficient staff to support people in the home. Most people told us they felt there was usually enough staff however some people said they felt more staff were needed. One person said, "The activities keep being cancelled because the activities organiser gets pulled off to cover when they are short of staff." The manager confirmed they did use the activities organiser if they were short of staff but said they felt meeting people's physical needs were important on those occasions. However the activities organiser was also supported by a volunteer worker who could provide activities on her behalf. One relative said, "It would be good if staff could spend more time with the residents. There have been times when the work has been rather more tasks orientated and the staff have been rushed." During the inspection we observed staff were able to spend time with people and were not rushing to get tasks done.

On the first day of our inspection there were two qualified nurses, six care workers and the activities organiser, one person also had one to one support. The duty rosters for the previous month showed this was consistently maintained during the day time shifts. The manager confirmed they calculated the numbers of staff by the needs of people in the home. At the time of our inspection this was one care worker to five people, however this could be flexible as people's needs changed. One staff member said the night shifts were not well staffed. They said there was only one qualified nurse and two care workers for the whole night. They explained most of the people in the home required two staff to assist them. This meant whilst the qualified nurse was doing their duties two care workers would be assisting people. The staff member said if anything happens such as a fall or someone calls for assistance, they have to decide on the most urgent need.

The staffing rota showed for 31 people, 11 of which required two staff members to support them, there was one qualified nurse and two care workers through the night with one extra care worker working a twilight shift until 11.30pm. We discussed this with the manager who said they had recognised the need for extra support and had introduced the twilight shift. This meant the manager had recognised the need for night staff to have extra support for assisting people to bed and when the qualified nurse was doing medication. However this did not provide cover for early mornings when some people wanted to get up earlier. The manager said they would look into ways of providing extra staff earlier.

The manager explained how they had approached solving issues around staff shortages. They had recognised that

Is the service safe?

weekends were times when staff where more likely to ring in sick. The staff rota for weekends showed they put extra staff on duty so if someone rang in sick they would not be short staffed.

The manager also confirmed the numbers of staff on each shift could be flexible dependent on the needs of people in the home. They said they would assess the needs of people using a dependency tool to show how much support individuals needed. They also confirmed extra staff would attend if they had activities outside the home which required more staff. One person said, "I can go out when I want to and they do organise trips when we can go shopping or see the sights."

People told us they felt safe living in the home. One person said, ""I am comfortable with all the staff and don't have any safety worries." A relative said they felt their relative was safe living in the home.

People were protected from harm because staff had received training in recognising and reporting abuse. Staff told us they had attended training in safeguarding people. They also confirmed they had access to the organisation's policies on safeguarding people and whistle blowing. Staff were able to tell us about the signs that might indicate someone was being abused. They also told us they knew who to report to if they had concerns. Visitors and relatives had access to information on how to report abuse; as the contact details for the local authority safeguarding team were displayed in the reception area of the home. However the information was not available for people who lived in the home. We spoke with the manager about how they made this information available to people living in the home. They said they would make sure the information was also displayed on the noticeboard within the unit.

Risks had been identified and where possible discussed with people or someone acting on their behalf. For example one person was identified as a high risk of falling. The home had arranged one to one support for this person during the day. Their care plan was clear about the strategies in place to reduce this risk. This meant the person was able to continue to mobilise around the home independently with the support of a staff member. Staff demonstrated they were aware of the risk and the way to enable the person to mobilise safely. People were unable to comment on the way risks had been assessed. One visitor said they had been consulted on the use of a pressure mat to help keep their relative safe when mobilising around their room.

Other people who had been identified as having a high risk of falls also had equipment in place to prevent injury whilst not restricting them from moving around the home. For example they used low beds, crash mats and pressure mats which alerted staff when a person started to walk around. These had been discussed and where necessary a best interest decision made, in consultation with relevant people. Where a person had been identified as at risk of falls the local falls team had been involved in assessing the best strategy to put in place to protect the person from harm. However one relative had told us that although the equipment was in place, their relatives pressure mat was on occasion pushed under the bed so not of much use to them. This had been identified by staff and regular checks were recorded. Other risk assessments included the risk of developing pressure ulcers and the risk of choking. People at risk of developing pressure ulcers had been assessed and the protective equipment was put in place to reduce the risk. For example people used pressure relieving mattresses and cushions. Care workers demonstrated an understanding of the risks in place and showed us how they carried out regular checks to ensure a person was repositioned or had sufficient to drink.

Risks of possible abuse to people were minimised because relevant checks had been completed before staff started to work at the home. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were of good character. The DBS checks people's criminal history and their suitability to work with vulnerable people.

Before the inspection we had received concerns from one complainant about the management of infection control in the home. We had been told that false teeth had been left to go mouldy, dirty dressings had been left on tables in people's rooms and rooms were dirty. During our inspection we toured the premises on more than one occasion to monitor the levels of cleanliness in the home. There were no bad odours throughout the home, all the rooms were clean and tidy and dirty laundry had been removed to the laundry room. We spoke with the manager who said they were made aware of the complaint when the incidents occurred and carried out their own investigation

Requires improvement

Is the service safe?

and dealt with through discussions at staff meeting. We observed staff wore appropriate protective clothing when providing care and hand washing procedures were followed. However during lunch it was observed that staff did not wear aprons. We bought this to the attention of the manager Who said that aprons should and were normally worn and she would remind staff of the reasons and importance of this; this was done on the same day.

We recommend that the service consider the Nursing and Midwifery Council (NMC) guidance for medicines administration and take action to update their practice and policies accordingly.

Requires improvement

Is the service effective?

Our findings

We found one person had not always received effective care and support as important information had not been documented and was not communicated between staff efficiently.

We looked at the records for one person who had passed away. The records showed that following a discussion about the person's end of life needs the family had requested they be contacted and consulted before an injection was given. The clinical manager who took this message failed to pass it onto the night staff and the family were not contacted so were unable to be present to make the decision themselves. The clinical manager confirmed they had passed the information on verbally to one night nurse but had not recorded the request in the person's care plan, or in their handover record. This meant the following night the night nurse was not aware of the request. The manager confirmed that following the incident care plans included detailed advance care planning where a record of the person's and relative's wishes would be recorded.

Records showed people were involved in their care plans and consented to the care they received as far as possible. Where people lacked capacity to consent relevant representatives or relatives were involved. The manager confirmed before a friend or relative was allowed to make decisions on a person's behalf they requested a copy of the Lasting power of Attorney (LPA). An LPA gives a person the legal right to make decisions on another person's behalf. A care plan which had been signed by a relative included a copy of the LPA. One relative said, "They are really good they have involved me from the start and I am kept informed of everything." However another relative told us following best interest discussions they had requested to be informed when a specific decision needed to be made. They said the home had not contacted them as agreed and they had not been able to be involved.

The manager and staff had a clear understanding of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People's care plans showed best interest meetings had been carried out and the relevant people had been involved in the decision making. Staff were aware people's capacity could vary from day to day. One staff member said, "The training said you can't assume the person does not have the capacity to make decisions. That was so right I really appreciate that no one day is the same as another."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was familiar with this legislation and had carried out appropriate assessments to ensure people were not deprived of their liberty and had their legal rights protected. The registered manager had carried out assessments for some people and the appropriate DoLs applications had been sent to the local authority who were in the process of considering the documentation.

People were confident staff were able to meet their needs. One person said, they thought staff were well trained to meet their needs. One person said, "When you need the support it seems to be there." A relative said, "The staff they have now all appear to be well trained and know my (relatives) needs."

The staff team consisted of a mix of long standing and new staff. Staff were able to tell us how they would care for each individual effectively. Staff told us they had very good handovers when they could talk about people's changing needs. There was a handover sheet for both care workers and qualified staff. They recorded any changes and important issues the staff should know about. The manager told us they had introduced the records as they had previously realised some new staff and agency staff did not have a clear understanding of important needs such as risks identified around mealtimes such as choking or needing encouragement to eat. The manager confirmed that following the introduction of the records all staff were aware of people's needs and any changes were communicated immediately. One care worker confirmed they used the records during hand over meetings to record any changes.

We spoke with staff and reviewed training records. Staff said there were opportunities for on-going training and for obtaining additional qualifications. This included annual updates of the organisation's statutory subjects such as, manual handling including use of hoists, safeguarding

Requires improvement

Is the service effective?

vulnerable adults, infection control, health and safety, health and hygiene, first aid and nutrition. Records showed most of the staff had attended all the statutory training and dates were advertised for 'mop up' sessions to ensure all staff had attended. Staff confirmed they could also request training specific to people's needs such as dementia care or diabetes care. For example one staff member said the dementia awareness training had given them confidence to talk with people in the home and understand why they might be doing or saying something that might seem out of place.

Of the six qualified staff employed by the service three had attended end of life training. Two of the three staff had received training in implementing the gold standards framework which they were in the process of introducing in the home. The gold standards framework is a nationally recognised approach to enable 'frontline staff to provide a gold standard of care for people nearing the end of life'. The manager said they planned to ensure all qualified staff had attended end of life care training and then to role this out to care workers. They were also supported by the local hospice community team who could provide advice, guidance and support training when required.

All new staff attended thorough induction training. The manager said they had introduced a twelve week induction programme in line with the new care certificate. The new Care Certificate is training provided before new staff should practice without supervision. New care staff confirmed they had been given induction training and had worked alongside experienced staff before they were able to work unsupervised. Before the new care certificate the induction training had followed the Skills for Care common induction standards. These were nationally recognised standards for people to achieve during induction.

Care records showed people saw health care professionals if they needed to. The records showed regular appointments had been made with a chiropodist, optician and a dentist. One relative confirmed staff would arrange for a doctor to visit if they felt it was necessary. One person told us how they had seen the optician. They said they could go out to see the dentist if they wanted to and staff were always available to support them.

Everybody spoken with said the food was really good, one person said, "I enjoy the food here it is always good and there's a choice." Another person said there's always plenty on my plate and I really enjoy it." One relative said, "The food is lovely. It smells and looks wonderful and is pureed too for the residents if they need that." We observed dinner was relaxed and a social occasion. The tables were nicely laid and there was music playing in the background. However we did notice that only one table had salt and pepper and staff did not give people napkins. The manager said they had ordered more salt and pepper sets and would ensure they were used in future. They also confirmed they had napkins for people to use and did not know why staff had not used them. We observed some people struggled with keeping their food on their plate. No aids had been considered to help people be independent, for example plate guards. We raised this with the manager who said they would look into the use of plate guards for people who required them.

People who were being supported by staff to eat were treated in a dignified and respectful way. Staff spoke with people and informed them what they were doing and what they were eating. The menu for the day was a roast dinner. On roast dinner days there is not a choice as most people ask for the roast however the cook was able to confirm that if a person did not want the roast dinner on offer they could have an alternative. The cook was also able to demonstrate an awareness of people's likes and dislikes and any dietary or culture preferences. One person told us they had discussed meals they liked at a resident meeting.

Appropriate professionals had been involved where people had been identified as at risk of weight loss and malnutrition. Care plans had been put in place to ensure staff were aware of dietary needs such as food supplements and the risk of choking. Records showed staff monitored how much people ate and drank and entries made, showed staff were aware of people's individual needs. Staff demonstrated they were aware they needed to provide more support to some people to maintain a healthy diet. One staff member mentioned how they would make sure one person who liked to get up later in the day had breakfast as soon as they were up so they did not miss a meal. We also observed people were offered drinks and snacks throughout the day.

The building was well designed to meet the needs of people living with dementia. Corridors were straight and wide to aid visibility and accessibility. Walls, carpets and lavatory doors were in contrasting colours to help people recognise where they were. Staff room doors were painted the same colour as the walls this meant people were not

prompted to walk through these doors as they did not stand out. In many of the living areas there were tactile objects for people to look at, feel and pick up if necessary. For example there was an old fashioned pram and hoover in one of the corridors, an old fashioned radio in one of the sitting rooms; Easter bonnets and games were left in appropriate places around the home for people to use. Library books were available in a library for reading purposes and the manager informed us one of the people in the home was involved in running it. One person said they enjoyed reading and spent a good part of their day with a book from the library. They said the books were changed regularly so they had a good choice.

All rooms had large letters on the doors, describing the room. The door of the library was kept locked as we were told that some books 'disappeared' on occasion, The books belonged to the local library so needed to be accounted for. There was a large sign on the door advising people to ask a member of staff to open the room for them if they wished to go in. There was a 'pretend' kitchen area with pots, pans, kettles and boxes of cereals, no plugs were visible, so it was a safe area for people living with dementia to be in. We observed one person tidying away boxes of cereals and dusting the counter. They appeared to be happily occupied. Bedrooms were well-furnished and light with seating for visitors. A hearing loop had been installed in the home. For ease of vision there were large clocks in the corridors, main living and dining rooms. There were pictures of people on their bedroom doors, along with large numbers to assist people to find their way around. One visitor commented on the way the home supported people to get about independently. They said it was good that there was enough information for people to be able to find their own room. They said "I have been in other homes and people get lost and keep asking where to go but here people seem to be able to find their way about."

Good

Is the service caring?

Our findings

Everybody spoken with told us they felt staff were caring and respectful. During the inspection we observed staff were kind, compassionate and treated people with dignity and respect. The atmosphere in the home was cheerful and people appeared relaxed and comfortable with the staff that supported them. One person told us, "They are all very kind and caring never a cross word." A visiting relative said, "Most of the staff are caring, kind and compassionate and give person-centred care. The privacy and dignity of residents has certainly improved and someone will quickly come to the rescue if residents need any help." However we did note that the failure to use aids to promote independence at mealtimes placed people in an undignified position when they were unable to stop their food falling off the plate.

People who could comment said they thought staff responded appropriately to their requests. Two relatives said, staff treated people well and they were all really friendly, caring and compassionate.

We observed very caring conversations with people for example we observed a volunteer with seven people doing an activities session on reminiscence. The session was cheerful with plenty of laughter and discussion.

People who were able to comment told us they could see their friends and relatives whenever they wanted. Visitors came and went throughout the day, one visitor told us they felt they were welcomed and enjoyed seeing their friend. People told us they could maintain contact with friends and family in the community and go out if they wanted to. Staff and relatives told us the local school children visited to talk with people or sing for them on special occasions.

People who could comment said staff respected their privacy. All rooms at the home were used for single occupancy. Relatives told us people could spend time in the privacy of their own room if they wanted to. A staff member said two people liked to stay in bed late some days. We observed one person was becoming upset. A staff member immediately asked them what they would like to do. They said sit in the corridor. The staff member assisted them to the corridor and made them comfortable. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people feel at home. Staff always knocked on doors and waited for a response before entering. We noted staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality.

We saw people were treated with respect for their dignity. For example one person required the assistance of a member of staff when walking around the home. We observed a caring and supportive interaction with the support being more of a stroll and a chat than physical assistance. On another occasion we observed a person required assistance with personal care. The care worker approached them gently and whispered in their ear. They smiled and went with the care worker. At no time was anyone in the room made aware that the person needed assistance.

People were able to make choices about their day to day care. They told us they could choose when they got up or went to bed and whether they took part in an activity or not. Some life histories had been recorded in care plans so staff knew what the person liked to talk about, their hobbies and likes and dislikes.

One visitor told us they found the support their relative was receiving towards the end of their life was compassionate and caring. They said staff understood the need for privacy and support in a way the person and the relative preferred. They said they had been asked what their relative would like and staff understood their wishes. They also said they could not ask for better care and commented on how well their relative was looking that day.

Requires improvement

Is the service responsive?

Our findings

People who could comment and relatives said they felt the home was responsive to their needs; however this was not what we found during our inspection. We found the managers response to complaints were defensive and did not take responsibility for the shortfalls found.

We looked at how people's views, concerns or complaints were acted upon. There was clear documentation to show a complaint or concern had been received and how it had been managed. Complaints had been dealt with promptly and included outcomes for the person as well as a record of what could be learnt. One relative said they had raised an issue and the manager had arranged a meeting with the provider. They had discussed their concerns and they were happy with the way it had been managed.

Before our inspection the manager had received a complaint from family members about the way they managed a person's end of life care. We read the response the manager and provider had sent to the family. We discussed the complaint with the manager. They agreed the clinical manager had not recorded the family's wishes following a meeting with the family in which they made their wishes clear. The clinical manager had verbally informed the night nurse but not recorded the request in writing. This meant the following night the night nurse was not aware of the request. The response to the family was defensive and did not apologise for the shortfalls the manager and clinical manager agreed had happened.

This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager's response did tell the complainant what they had learnt from the incident and said they had put in place advanced care planning for all people; "So we are able to clearly document in advance the wishes of residents and relatives."

Staff spoken with demonstrated a clear knowledge of the needs of the people in the home. This meant they were able to provide care that was responsive to individual needs. Staff were able to give us detailed information of how they would care for each person as an individual. However care plans did not always provide clear guidance for staff to follow. One care worker told us, "Communication is really good we have handovers to discuss how a person's needs have changed since we were last in the home." Another staff member said, ""The information we have is clear and easy to read so we know the people we are looking after."

Before a person moved into the home their needs were assessed to ensure the home could meet them. The manager confirmed they would only take a person into the home if they felt they could meet their needs. They confirmed the assessment would include the person as far as was possible, healthcare professionals and relatives involved in their care.

Following the initial assessment each person had a personalised care plan which reflected their individual needs. The clinical manager explained they were in the process of updating their care plans onto an electronic system We looked at a selection of care plans both in the old written format and the new electronic format.

Most of the care records we looked at were up to date and included regular reviews and changes made when people's needs changed. Each care plan included a 'hospital passport' so key issues were immediately available for health professionals if a hospital admission was needed. However in one old style care plan there was conflicting information. At the front of the file under planning for the future it said the person wished to be resuscitated in the event of a cardiac arrest. At the back of the file the person had said they no longer wished to be resuscitated if this occurred. We asked how staff would be aware of people's wishes in respect of whether they wished to be resuscitated or not and we were shown the information was clearly recorded in the front of other people's care plans, in the office and on the daily handover sheets for the qualified staff.

Care plans included regular reviews and showed people and their relatives had been involved. However one hand written care plan said last reviewed 15 Jan 2015. When we asked about this we were shown the new electronic care plan which showed the review had been carried out in March and documented. Staff confirmed that care plans were reviewed monthly or when people's needs changed. The clinical manager said they had just not printed a copy at the time we were reviewing the records. Daily records showed that the needs identified in care plans had been met, for example people were monitored for falls or weight loss in line with their care plan.

Requires improvement

Is the service responsive?

We also looked at the end of life care plans for five people who had passed away. Prior to our inspection people had not had specific comprehensive end of life care plans. They had not recorded the wishes and requests of the family for one person. This meant the families wishes had not been met when their relative's health declined and they passed away. The manager and clinical manager had picked up on this shortfall following a complaint received before our inspection and had formulated new end of life care plans that were, itemised, straight forward and comprehensive. They included a record of conversations with relatives and their specific wishes. One relative confirmed they had discussed their wishes with the qualified nurses and staff had acknowledged and followed their requests. One clinical manager explained they were introducing the Gold Standards Framework to the home. They also showed how they were researching better ways of providing end of life care by obtaining the information called "One Chance to get it right". This guidance is published by the Leadership Alliance for the Care of Dying People.

Each person was allocated a keyworker. This is a staff member who understands one person's specific needs and likes and dislikes. They were responsible for ensuring all staff were kept informed of any changes in this person's care. One person who was able to comment said they knew who to go to if they wanted to discuss any changes and liked having a named person as it was more personal.

The service encouraged and responded to people's views and suggestions. People who could comment said they felt they could discuss their care and living in the home at any time. One person told us about the resident meetings. They said they had no problem discussing anything at the meetings. One example they gave was they had mentioned the use of the activities organiser to cover nursing shifts. The manager had advertised for a part time activities organiser to support them. One relative said they had raised their concern about staff not wearing uniforms at the last resident meeting. The manager had explained they did not wear uniforms as this was the guidance they were following for providing care to people living with dementia.

On the first day of our inspection we observed people joined in a reminiscence session with a volunteer. They all appeared to enjoy learning how to use the iPad. During the afternoon there was a religious service when people could join in singing well known hymns. One person told us this happened every month and they enjoyed attending. We were told the home had three rabbits that people enjoyed looking after and one garden had raised bedding areas so people could grow their own vegetables. We observed people being helped to sit in the garden so they could enjoy the spring sunshine. The activities organiser had completed life histories for people which included information on their likes and dislikes, hobbies and interests. One person enjoyed organising the library. They said they had always been interested in reading and liked being involved. One person who could comment said they enjoyed being in the garden and they were looking forward to, "getting the vegetables in."

Requires improvement

Is the service well-led?

Our findings

The service was not always well led. The manager was not registered with the Care Quality Commission and we found that although audits were being carried out some issues had been overlooked and only dealt with when we commented on them during the inspection

The manager had been in post since February 2015. They had not completed their application to register with the Care Quality Commission (CQC). We asked about their registration, they confirmed they had sent for the DBS check and would forward the documentation to CQC as soon as it arrived.

There were quality assurance systems in place to monitor care and plans for ongoing improvements. However they had failed to identify the lack of specific end of life care plans, conflicting information in one care plan and the lack of guidance for staff on the administration of end of life medicines. These issues had only been dealt with when raised as part of a complaint and when we discussed them during the inspection.

There were audits and checks in place to monitor safety and quality of care. Some shortfalls had been identified and action had been taken to improve practice. For example in response to issues identified around care workers knowledge of people's specific needs a hand over sheet had been introduced so all care workers had a clear summary of people's needs. Also following an audit of the way the care plans were managed the manager had introduced a new electronic care planning system.

Audits for all areas of the service were completed by the manager then reviewed by the provider. The organisation had a system that meant a full audit of the home was carried out as well as the audits untaken by the manager. An annual survey of people, relatives, staff and service commissioners was carried out so people could be assured that improvements were driven by their comments and experiences. following these surveys action plans were put in place to address any issues raised for example an item would be included on the agenda for the resident meeting. for example, seasonal menus and activities had been discussed.

People who could comment said the manager was open and approachable. We observed the manager talking with people and they all appeared to know her and responded in a relaxed and cheerful way. Relatives said they could talk to the manager and they were always available. Staff all said they felt they could talk with the manager and that issues would be dealt with appropriately. However the manager's approach to handling the complaint from one family was defensive and failed to take responsibility for shortfalls identified.

The manager was supported by two clinical managers who were qualified nurses. They had also developed a role for an in-house trainer who organised training and managed supervision for care staff. Staff members had job descriptions which identified their role and who they were responsible to. Staff rotas showed there was a senior member of staff on each shift for staff to go to for guidance. This meant people could be reassured that staff were able to ask for support to provide appropriate care.

The manager had a clear vision that people living with dementia would be supported in an environment that enabled them to remain independent as long as possible. This vision was evident in the approach staff took with people during the inspection. One care worker said they felt the induction had reflected the philosophy of the home as it included he Dementia Care Matters training to make sure they understood the needs of people living with dementia from the start.

All accidents and incidents which occurred in the home were recorded and analysed. The time and place of any accident was recorded to establish patterns and monitor if changes to practice needed to be made. Where concerns with an individual were raised by the analysis appropriate additional support was provided.

The manager and senior staff kept their skills and knowledge up to date by on-going training and reading. They also joined other managers within the wider care home community to discuss current trends and share training. They shared the knowledge they gained with staff at staff meetings, and cascaded training to other staff. For example the house keeping staff had completed their COSHH training; this is training regarding the control of substances hazardous to health, such as bleach and cleaning products. They were arranging to provide this training for the care staff.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 20 HSCA (RA) Regulations 2014 Duty of candour **The registered person did not act in accordance with Duty of Candour in respect of a complaint about care and treatment.**