A Spellman Steeton Court Nursing Home

Inspection report

Steeton Hall Gardens
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Ratings

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

Overall summary

Steeton Court Nursing Home provides accommodation and nursing care for up to 71 older people at any one time. On the date of the inspection, 14 May 2015, 68 people were living in the service.

A registered manager was in place. 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 and associated Regulations about how the service is run.

We found medicines were safely managed. Arrangements were in place to ensure people received their medicines at the time that they required them and this was documented by staff.

The premises was safely managed. There were a number of nicely decorated communal areas where people could

Summary of findings

spend time. Bedrooms were homely and well maintained. The dementia unit was well laid out with a sensory garden which was used in a therapeutic way to help meet people's needs.

Risks to people's health, safety and welfare were assessed and a range of relevant risk assessments were in place which covered specific risks such as falls, bed rails and nutrition. This helped to keep people safe.

We found staffing levels were sufficient to ensure people received safe care.

People said they received good quality care from staff who had the appropriate skills and knowledge to undertake their role. We found staff demonstrated a good knowledge of those they were caring for, for example nursing staff were able to confidently describe how to meet people's nutritional and emotional needs. Staff knowledge is some subjects such as mental capacity act and safeguarding was inconsistent and training updates were overdue in these areas.

Appetising meals were provided by the home and feedback from people about the quality of the food was positive. People's nutritional intake was monitored and where risks to people were identified, detailed plans of care put in place.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and the service was acting within the requirements of the Mental Capacity Act (MCA).

People told us staff were kind and treated them with dignity and respect. Most of the interactions we observed during the inspection were positive. Staff had developed good relationships with the people they were caring for and demonstrated they knew about their individual needs. This helped staff to provide effective care.

A range of suitable activities were provided by the home. These were delivered by three activities co-ordinators and were well received by people in the home. Specific activities were provided for people living with dementia and we saw the staff delivering activities were dedicated to providing friendly companionship.

We found people's care needs were assessed and appropriate plans of care were put in place, although two care records we reviewed were missing key assessments.

Prior to the inspection, we received concerns that some people were being bed-bathed as early as 4.30am. We identified that this was occurring in one area of the home. Staff told us that they felt pressured into getting people up early by day staff. Following the inspection the manager told us they had taken immediate action to address this.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

People spoke positively about the overall quality of the care in the home. We found some systems were in place to assess and monitor the quality of the service which included audits of medication, infection control and finances. However no care plan audits had been carried out since January 2015 despite records stating three would be carried out a month. The service had also not ensured through an appropriate management plan that staff training was provided before it become out-of-date.

There was evidence that best practice guidance such as the National Institute for Health and Care Excellence (NICE) Guidelines were used to inform and improve care practice. This helped ensure the service worked to national standards.

Some staff told us they did not feel well supported by the service and there had not been a care worker staff meeting since May 2014.

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?

Good

The service was safe. Medicines were appropriately managed; people received their medicines at the times they needed them and this was clearly documented..

Safe recruitment procedures were in place. Although we concluded staffing levels were overall sufficient, some staff raised concerns about staffing levels on the 1st floor at certain times of the day. We asked the manager to investigate in consultation with staff.

People told us they felt safe in the home and did not raise any concerns over their safety. Risks to people's health, safety and welfare were appropriately managed. Safeguarding procedures were in place and we saw evidence they were followed. The premises was homely and well maintained.

Is the service effective?

Good

The service was effective. People said that they received good quality care from staff with the right skills and knowledge. Care was appropriately planned from staff with a good level of expertise and we saw that best practice guidance had been used to help create effective plans of care. Good care practices were in place on the dementia unit to create a therapeutic environment for the care of people living with dementia.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the requirements of the Mental Capacity Act (MCA).

People told us the food was good and we saw that a well thought out and varied menu was provided, overseen by staff with a good level of professional expertise.

Is the service caring?

Good

People and their relatives said staff were kind and compassionate and treated them well. We saw procedures were in place to promote dignified care. We observed care in several areas of the home and saw on the whole people were treated well. We did observe some negative interactions between two staff and people who used the service, but we concluded these were isolated cases and not representative of the home as a whole.

Sensitive and dignified end of life plans were in place to ensure people were treated well in the latter stages of their lives.

Is the service responsive?

Requires improvement

The service was not consistently responsive. People's needs had been assessed and plans of care put in place, although we did find two people were missing key care plans.

Summary of findings

We found care was not consistently delivered to meet people's individual needs and preferences. Although no issues were found on the ground floor, some people on the 1st floor were receiving bed baths as early as 4.30am, some staff said this was to take the pressure off day staff. This was not a personalised approach to care.

A varied and well received programme of activities was available delivered by three activities co-ordinators. Bespoke activities were provided on the dementia unit to help meet people's individual needs.

Is the service well-led?

Requires improvement

The service was not consistently well led. People and their relatives told us the home provided a good quality care experience and there was evidence that best practice guidance and research had been used to inform care decisions and help deliver a high quality service.

However the service had not notified us of all required notifiable incidents, as we had not been notified of four Deprivation of Liberty Safeguards (DoLS) authorisations.

Although systems were in place to monitor and assess the quality of the service these were not sufficiently robust as they had not identified some of the issues we identified during the inspection. For example, the manager was unaware of some the working practices going on in the home.

Steeton Court 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 on 14 May 2015 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection we spoke with eight people who used the service, five relatives the registered manager, the deputy manager, four registered nurses, 10 care workers, the catering manager, and an activities co-ordinator. We reviewed nine people's care records relating to specific areas of care and support.

We did not ask the provider to complete 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. Before the inspection, we reviewed all the information held about the provider. As part of the inspection we also spoke with a health care professional who visited the service.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe and secure in the home and nobody raised any concerns with us over the manner in which they were treated by staff. Staff also told us they thought people were safe and did not raise any concerns about people's safety.

The manager demonstrated a good awareness of safeguarding matters. Safeguarding procedures were in place, we saw these were followed, for example investigations had been undertaken where concerns regarding staff practice were identified. Any injuries to people such as skin tears and bruising were documented and investigations undertaken to determine the cause. Overall we concluded safeguarding was appropriately managed by the home; however we did find inconsistencies in staff knowledge on the subject. Most staff we spoke with had a good understanding of safeguarding and all staff knew how to escalate concerns internally. However one staff member we spoke with was not aware of how to report to external agencies and did not fully understand whistleblowing. The training matrix showed most staff were overdue training updates in safeguarding. The manager showed us the training plan which had highlighted this as a priority to address over the coming month.

We observed safe handling practices. For example, we observed one person was moved with a hoist from their wheelchair into an easy chair in the lounge. The two staff operated the equipment competently and safely and explained to the person what they were doing and offered reassurance. The person told us they felt safe and comfortable during the process. Two other people we spoke with told us they were always safely transferred using hoists. We found staff were all up-to-date with safe handling training.

Prior to the inspection, we received two concerns that staffing levels were not always sufficient. We spoke with the manager, examined care plans and staffing rotas and observed staff responsiveness to people's needs to check if there were sufficient numbers of staff with the right mix of skills available to deliver care. The home divided its staffing resource into units which reflected people's care needs and served to ensure staff with the right skills and knowledge were allocated to meet people's needs. For instance, one unit of 17 beds catered for people living with dementia and was led by a registered mental health nurse. Another two units caring for people with a broader range of physical needs were led by registered general nurses. The clinical leadership in the four areas of the home was, at all times, provided by registered nurses. A senior member of staff provided on-call support. This ensured staff had access to an experienced member of staff who could provide advice or attend the home if necessary.

Most people told us that there were enough staff, for example one person said, "[I] don't have to wait long for the toilet." Another person said, "They are on the ball" and a third person said, "There's always someone there if you need them." One person did however complain about staff sometimes taking breaks at the same time, we raised this with the manager who said they would investigate.

While observing care we found that although staff were busy there were enough staff to ensure that people were responded to promptly and provided with adequate supervision. The provision of a dedicated activities co-ordinators meant staff were available to support people to meet their social needs. We saw staff were responsive and able to provide assistance when required, for example one person spilt their drink and staff noticed quickly and cleaned it up. We saw nursing staff were also involved in the delivery of care which showed all the staff worked as a team to help ensure people's needs were met. Care records such as the daily care notes and food and fluid charts were well completing, indicating staff had time to attend to people's regular care needs.

Staff on the dementia unit told us there enough staff throughout the day and night although it could be busy at times. Some staff raised concerns about staffing levels on the 1st floor particularly during pressure points for example in the evening. In addition, the Branwell unit on the ground floor was allocated one member of staff at night. The unit catered for eight people some of whom needed two staff to deliver some elements of their care although we recognised that staff assistance could be summoned from elsewhere to assist. Although we did not find any direct evidence that staffing was insufficient we asked the manager to investigate these matters in consultation with staff as it was obviously a cause for concern for some staff. The staffing rotas we looked at showed some reliance on staff overtime but this was not excessive and was sustainable.

Good

Is the service safe?

Safe recruitment procedures were in place to ensure staff were of appropriate character to work with vulnerable people. This included completing an application form, attending an interview, proving their identity, providing two references, and ensuring a Disclosure and Baring Service (DBS check) was in place. Staff we spoke with confirmed they had to wait for these checks to be completed before they started work.

Medicines were administered to people by trained nursing staff. People were assessed as to their capability to self-medicate. Whilst no people had been found capable of self-medication the process demonstrated the provider was attempting to maximise people's independence. We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were completed demonstrating medicines were given as prescribed. Staff maintained records for medication which were not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted a sample audit of medicines to check their quantity. We found on all occasions the medicines could be accounted for. We found people's medicines were available at the home to administer when they needed them. Our examination of the MAR's and our observations of the administration of medicines demonstrated medicines to be administered before food were given as prescribed. We looked at two people's medicine administration records (MAR) who had been prescribed warfarin. This was administered appropriately dependent on the outcome of a monthly blood clotting test. We saw the manager had instituted a specific protocol for all to follow to ensure the blood results were accurately recorded and the correct dose of warfarin dispensed. This meant the provider was taking appropriate action to protect people from receiving unsafe care.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. The registered nurse demonstrated a good understanding of the protocols in place. We looked at prescription sheets and care records to ascertain the frequency of use of PRN antipsychotic medication to control distress behaviour. We were assured from our discussions with staff and our examination of the MAR sheets that non-pharmacological interventions were the preferred method of addressing behaviours that challenged

Appropriate and secure storage arrangements were in place. Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all medicines accurately recorded and accounted for.

Safety incidents were routinely recorded and evidence recorded of action taken to protect people and try and prevent a re-occurrence. We looked at a number of incidents which included falls. Documentation showed that following falls people were examined by nursing staff to ensure they were okay and observations such as blood pressure and pulse were taken. Where incidents had occurred care plans were updated, for example one person had a specific care plan in place to help protect them when using the hoist following an incident. This helped to keep people safe.

Risk assessments were in place for areas of key risk including skin integrity, falls, and nutrition. Where risks were identified plans of care were put in place to help keep people safe. For example someone who was at risk of poor nutrition had a 24 point care plan instructing staff on how to reduce this risk. Plans were in place where people had wheelchairs, profiling beds and bed rails to ensure they were suitable. We found the provider had a robust system of bed-rail evaluation and assessment. We saw there was compatibility between the bed, mattress and bed-rail to prevent serious injuries from ill-fitting appliances.

The premises were adequately maintained and suitable for its purpose. There were a number of communal lounges and dining areas where people could spend time dependant on their preferences. Bedrooms were homely and nicely decorated. Adequate bathroom facilities were present although we did note some ingrained dirt on some of the floors. The home was situated in large grounds

Good

Is the service safe?

where people could spend time. We examined service and maintenance records to ensure the premises were a safe environment in which to care for vulnerable people. We saw failures of equipment were speedily attended to and where potential failure was highlighted through routine maintenance programmes, remedial action was taken. We saw evidence of water flushing regimes to prevent stagnation of water which may encourage the growth of legionella. The home had in place up-to-date certification for gas compliance, emergency lighting, electrical hard wiring and installation, water safety, fire appliances and installations, passenger lifts and hoists.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the MCA and specifically Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Our observations of the environment and people's care plans suggested the provider utilised a number of methods which may constitute a deprivation of liberty. Four people at the home were subject to DoLS with one of the authorisations containing conditions. We found the care plans reflected the conditions and the daily activity record demonstrated they were delivered consistently. Discussion with the manager demonstrated a good understanding of the legal framework in which the home had to operate to secure a valid DoLS authorisation. In addition to the four authorised DoLS a further 15 applications had been made by the managing authority and were awaiting an outcome from the supervisory body. We did identify that further applications were probable for some people in the home, the manager told us they would relook at some people's care plans and outcomes of mental capacity assessments and make further applications for DoLS as necessary.

The manager was aware of people who had Court of Protection and Lasting Power of Attorneys to manage people's affairs and demonstrated a good understanding of the legal implications and their responsibilities. We spoke with the manager about the role of Independent Mental Capacity Advocates (IMCA) as defined in the Mental Capacity Act 2005 (MCA) and advocacy in general. The answers we received demonstrated a good understanding.

Information about people's capacity was documented in their care plans. For example in one person's care plan it had been recognised that it would a risk if the person left the building and a DOLS application had been submitted. The records showed a best interest approach had been conducted with family involvement as to how to care appropriately for the person. Best interest decisions in line with MCA were in place for example in making decisions over whether bed rails were appropriate. We saw staff asked people's consent before assisting with tasks, for example the nurse asked people if they wanted their medication and the approach to promoting choice was demonstrated through care planning.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital.

A catering manager was in place who had responsibilities for the provision of suitable food within the home and undertaking quality checks on this aspect of the service. They demonstrated to us they kept up-to-date with best practice guidance and new legislative requirements for example around Salmonella. They demonstrated to us a commitment to continually improve the quality of the service, and gave examples of a number of initiatives they had put in place to since they joined the home. For example pureed food was now presented separately so people could enjoy the individual flavours and colours. Menus were appropriately planned to ensure people had a variety of different food. The menus offered a choice of a cooked breakfast in the morning and options for lunch and teatime. A high calorie menu was promoted to help reduce the risk of malnutrition. Each person was asked for their daily preferences which was then sent to the kitchen to ensure they were provided with food that they liked.

We asked people what they thought about the food, everybody said it was either good or okay. One person commented that the food had improved of late because there was a new cook. "When I first came here [18 months ago] the food was not that good but we now have a new cook and the foods a lot better. We choose from a menu and can have cooked breakfast if we want." People told us if they did not want what was on offer the staff would make them something else. For example one person told us he felt like egg and chips at teatime and the cook provided this for them.

The lunch served on the day looked nutritious and appetising with meat and fresh vegetables and a dessert. We observed in the morning that the breakfast was late with some people still waiting at 9.30 and two people confirmed to us that breakfast was sometimes late. One person told us they thought the meals could be better spaced out as no sooner was breakfast out of the way than it was lunch at around 12pm and that people weren't ready for it. We raised this with the manager who agreed to look

into it immediately. We observed the lunchtime meal. We found people were provided with appropriate support as specified in their care plans. For example one person required support with the knife and fork and a pureed diet and we saw this was provided.

People's weights were regularly monitored. Where weight loss was identified we saw this was recorded and changes made to the plan of care. People's food and fluid input was monitored where they were at risk. Where people were at risk, nutritional supplements were given by nursing staff to help meet people's individual needs. We looked at one person in particularly who was at risk on admission and saw their weight had increased significantly, this provided evidence that staff were providing effective nutritional care. We saw people were encouraged to eat snacks between meals as part of the activity programme and saw one person who had been identified as underweight being particularly encouraged in this respect. We saw that one person was given someone else's prescribed food suppliment. We also found that some care staff were not clear about the use of thickening agents which are used to thicken fluids when people have swallowing difficulties. One of the care staff we spoke with said they would "Add one or two scoops and see what it looks like." There was no clear instruction in this person's care plan as to exactly how to prepare thickened fluids. .

We saw evidence people had access to health professionals which included tissue viability nurses, general practitioners and audiologists and speech and language therapists. Care plans provided evidence people's healthcare needs were fully assessed to help staff deliver appropriate care. For example on the dementia unit care plans considered therapeutic measures to meet peoples individual needs such as activities and going out into the garden if they became distressed. Health care plans included references to published sources such as National Institute for Health and Care Excellence (NICE) and published journal articles to provide rationale as to why care was planned and delivered in a particular way, for example regarding behaviour and weight loss. This helped to ensure care was effective. Nursing staff we spoke with displayed a high level of understanding of people's individual needs, for example how to effectively calm people when they became distressed. People reported staff were able to meet their healthcare needs for example one person said, "If I am in pain or poorly they will get me a tablet or send for the doctor." We spoke with a visiting health professional who told us that the service always kept nutritional risk assessments and weights up to date, that staff knew people's needs and the manager acted on any problems or concerns.

The dementia unit was adapted to providing a therapeutic environment for people with dementia. Reminisce material, clear signage and a secure sensory garden area were present. Activities tailored to the people living on the unit were provided to help meet their individual needs. Where people displayed behaviours that challenged we saw care plans were in place to guide staff. Care plans focused on providing a therapeutic atmosphere to help reduce distress, for example utilising the calming influence of the garden.

Training was delivered as a mixture of face to face and DVD based. Staff reported training was good and provided them with the necessary skills they needed to undertake their role. Previous induction training was based on the Skills for Care Standards, and new training to match the care certificate had been introduced. Induction covered whistleblowing, safeguarding, fire and manual handling. Mandatory training updates were provided in a range of areas such as safeguarding (including MCA/DOLS), fire, manual handling, infection control, dementia and end of life. Some staff were overdue training updates particularly safeguarding and dementia. Staff confirmed this was the case for example one carer on the dementia unit told us they had not completed dementia training and other staff said they had not received training in the MCA. The manager showed us evidence this had been highlighted and was to be addressed as a matter of priority through the training schedule. Staff we spoke with demonstrated a good understanding of people we asked them about and senior staff understood DOLS/MCA. However, the care staff we spoke with demonstrated a poor understanding of MCA/DOLS indicating that training updates were required in these areas as a matter of priority. Checks were undertake on nursing staff to ensure they were still registered. Staff were subject to periodic supervision and appraisal and we saw staff were supported to access additional training that interested them.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about staff in the home. For example one person told us "Staff are good if I want something they get me it" and "I chat with her [nurse] she has a lot of patience." Another person told us "Staff are good, they ask if any problems and sort them out, no serious ones but they help me fasten buttons, put more sugar in my tea, call me be my first name. Same ones come to see to me, I know them all and they know me and what I like and don't like." Another person said, "Very content here, I have a hug and a kiss. The staff are absolutely marvellous, very kind" and another person said, "I came here from another home, staff are very kind." Another person said "The nurses are good, some of the younger ones don't stop to chat but I was having a laugh with the girls last night. If I want something there's no problem in getting it." People told us they had a choice as to when they got up and went to bed and staff respected this. A relative told us "Staff excellent, no concerns about care."

Most of the staff interactions we observed throughout the home were positive. For example, we noted on all areas the nurses were very kind and friendly with people and seemed to have a good rapport with them. Nurses also assisted with care tasks such as supporting people to eat and offering companionship, which led to a nice friendly atmosphere in the home. Staff were conscious of people's dignity, for example adjusting their clothing as appropriate. Where people became distressed we saw staff quickly intervened offering support and guidance and in one case they got a magazine for a person.

We saw nursing and care staff engaged people in conversations as well as carrying out care tasks. The two activities co-ordinators working within the home had a kind and compassionate approach and we observed them meeting people's social needs, in an inclusive environment trying to involve as many people as possible. People were assisted with food in a patient manner and encouraged to take their time.

Although the vast majority of the interactions we saw were positive and people told us staff were kind and considerate, we did see some poor interactions caused by two staff at lunchtime on the dementia unit. Staff voices were sharp and raised, for example we heard one care worker instructing a person to "Come on" and observed another not taking proper care in transferring a person to the dining room table. One person was was reading a magazine and a care worker ordered loudly 'Give me that.' The person handed it over and it was swiftly taken off her and put away. Another carer then came to assist and their manner was much better. We also found examples of staff speaking about people in a way which did not promote their dignity. For example, one of the nursing staff described a person as "Attention seeking" when we asked a question about their care and another referred to people who required help to eat as, "The feeds." We concluded these were not representative of the home as a whole but were clearly concerning examples of poor dignity and respect which we asked the manager to investigate.

Research into promoting dignity and respect had been consulted in the creation of care plans, for example specific guidance from the Alzheimer's society had been used to instruct staff on how to maintain dignity during personal care. This showed the provider was utilising effective guidance to ensure it maintained standards in this area. Values and standards of care were in place which staff were expected to work to. For example on the dementia unit, posters were displayed showing the homes philosophies around person centred care, care planning, and staff values.

We saw compassionate end of life care was in place. End of life care plans were in place which promoted wellbeing, privacy and dignity. Pain assessments were also in place which considered any pain people may be experiencing and how to assist them in being more comfortable. End of life care was reflected for each individual after their death to determine whether the experience could be improved.

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us they were happy with the care provided and that home kept them up-to-date. For example one relative told us "They always keep us updated with any issues."

Care plans showed people were subject to a full admissions assessment on admission, this assessed people's needs in a range of areas such as behaviour, eating, drinking, communication and social needs. This helped staff deliver appropriate care as soon as the person arrived in the home. Care plans were clear and identified any problems/needs and had well defined goals/and objectives. They were detailed and contained clear guidelines to help meet people's needs for example around reducing distress, delivering personal care or safe handling.

People's needs were regularly re-assessed to help provide responsive care. For example we found that one person had been subject to a number of falls and arrangements had been made in the persons best interests to move them to the dementia unit where they could receive a higher level of supervision. Care records showed that people had received care in line with their plans of care such as regular weight checks and position changes. Records were in place which showed people had received showers/baths and residents looked clean and tidy which indicated their personal hygiene needs were being met.

We did note some inconsistencies in care plan documentation. Although most people had appropriate plans of care in place, we looked at the records of two people which records showed became anxious and had displayed behaviours that challenge. They were missing care plans assessing their needs in these areas and instructing staff how to provide appropriate care. One record also had a life history section missing and personal possessions inventory blank and another had a blank mental capacity assessment. We raised this with the manager who agreed to immediately address to ensure personalised care plans were put in place to enable all staff to know how to meet these people's individual needs.

We generally observed healthcare delivered in line with care plans. For example charts showed people were subject to regular reposition checks and checks on their health and welfare throughout the day and night. Pressure relieving equipment was in place; however we noted four mattresses were on the incorrect setting which increased the risk that pressure area care was not effective. This was immediately rectified by staff during the inspection

Prior to the inspection, we received a whistleblowing concern which suggested night staff were being asked to bed bath people from 4am without gaining valid consent. Throughout the ground floor we did not identify any concerns and records saw people were offered care at appropriate times. However on the 1st floor, we identified that four people were receiving bed baths early in the morning such as between 4.30am and 6.00am without giving valid consent. For example on 14 May 2015, one person had a bed bath at 04:45 and another at 04:55am. There was nothing recorded within the care plans about their preferred time for personal care to be delivered Some staff said that there was a pressure to get as many people as possible "done" before the day staff came on duty. This was not a person centred approach to care and was not in line with their individual preferences. We identified this instruction had come from the night management on the unit. The manager told us they were unaware of this and following the inspection they informed us they had taken immediate action to stop the practice.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed three activities coordinators and offered a wide range of activities for people which ran seven days a week. The programme included concerts, games and crafts and regular trips out. From the comments we received these were much enjoyed and appreciated by people. For example one person said, "I like the cards and skittles, which I am good at, I play with other residents and the staff." Another person said the activities were "extremely good". A relative said, "They [activities] are excellent and that's one of the reasons why we chose this place for dad."

People had detailed activities plans in place designed to provide therapeutic benefits and we saw evidence these were followed. For example one person's highlighted that they like to read magazines and we saw staff provided them with papers and magazines throughout the day. A range of therapeutic activities such as flower arranging ,

Requires improvement

Is the service responsive?

trips out, sensory activities were provided. Bespoke activities were provided on the dementia care unit, which included sensory activities and encouraging people to recall memories.

People told us they were generally happy and did not have any cause for complaint. One person told us they had raised a concern regarding poor communication from a member of night staff and said this had been rectified showing the management team listened to and acted on complaints. We saw a system was in place to record and investigate complaints. This included verbal and more formal complaints. Clear actions were put in place as a result which demonstrated the provider was committed to continuous improvement of the service.

Requires improvement

Is the service well-led?

Our findings

We found the provider had correctly reported some notifications such as notification of deaths. However although four deprivations of liberty safeguards (DoLS) had been authorised by the supervisory body, the Commission had not been notified. We have warned the provider of the need to submit all required notifications in the future.

We found systems of quality assurance were in place and some of these were highly effective. However we discovered a number of inconsistencies and examples of sub optimal care which should have been identified and rectified by the provider in order to demonstrate a consistently high quality service.

We noted four airflow mattresses designed to reduce the risk of pressure sores were on the incorrect weight setting. We raised this with the provider who immediately ensured all mattresses were put on the correct setting by the end of our inspection. Although a daily mattress audit was in place this had failed to consider whether the weight setting was correct. The manager told us they would add this to the audit in future. One staff member raised concerns that an appropriate skill mix of staff was not always present on the dementia unit to care for people living with dementia. Mandatory training was not up-to-date in safeguarding and dementia and the Mental Capacity Act. We found inconsistencies in staff knowledge for example around safeguarding and the Mental Capacity Act. Although this had been identified by the provider as a training priority, appropriate action had not been taken to plan and schedule training to ensure it was provided before training was out-of-date.

When we informed the managers that some people on the 1st floor were being bed bathed from 4.30am, they were unaware of this. This demonstrated that the registered manager was not fully aware of how the home was operating. This should have been identified and rectified through the providers own quality assurance system and demonstrated that the home was not providing a consistent service throughout the four units.

Care plan audits were periodically undertaken but had been completed since January 2015 despite the audit file stating that three would be done a month. Although we found the quality of most care files to be good, we found two care plans were missing some documents and this should have been identified through audits.

A range of robust audits were undertaken in other areas. Medication, general management and provider audits were undertaken and checks on health and safety, environment and catering were undertaken and regular monitoring of the environment for defects was undertaken. These audits provided evidence that issues were identified and robustly dealt with in these areas. End of Life care was regularly evaluated, with a reflection taking place after people had died involving the people's relatives. This was a requirement of the Gold Standards Framework for end of life care. This helped to improve the end of life experience constantly through reflective practice. The provider had scored 96% in an Infection Control audit undertaken by the local authority in January 2015. Where improvements were advised we saw evidence these had been made.

People were regularly asked about the quality and variety of food through questionnaires and there was evidence their views were taken on board and menus changed. Feedback suggested most people were very happy with the quality of food. Activities were constantly reviewed, people were regularly asked for their preferences. We saw a variety of well received activities were provided showing this system worked well. People and their relatives told us quarterly "residents" meetings took place. They said they were provided with copies of the minutes and said the home was good at acting on any problems raised. We looked at the minutes which confirmed this was the case. The minutes were detailed and showed trips/outings, catering and communication was discussed.

An annual satisfaction questionnaire was sent to people who used the service and their relatives which looked at a range of areas. Most responses were very positive . Where negative comments were identified it was evident that actions had been taken to address the issues raised.

Care plans contained a level of expertise and evidence from a range of source including scientific papers and National Institute of Care Excellence (NICE) had been consulted for example in planning appropriate behavioural care and nutritional care plans. There was evidence the provider was working to best practice by working to the Department of Health's "Dementia Challenge". This evaluated topics such as quality of life, environmental stimulation, reminiscence

Requires improvement

Is the service well-led?

and activities. The service had undertaken a piece of work evaluating itself against these standards. This demonstrated that relevant research and best practice had been consulted in order to help provide high quality care.

We looked at the way the service assessed and recorded people's dependency. The service utilised a recognised dependency rating scale which gave a broad indication of people's needs in such matters of mobility, eating and drinking , continence and personal care and hygiene. The rating also gave an indication as to how many staff were required to deliver certain elements of care. However it was unclear how this was linked to the current staffing levels. Staff sickness and absenteeism's was monitored and disciplinary procedures were in place. Incidents such as violence towards staff were fully investigated with clear actions put in place. The number of incidents was analysed every month to look for any trends.

People told us they had a high level of satisfaction with the service and said it delivered good quality care. However, most of the people who used the service and relatives we spoke with did not know who managed the home. Some staff also raised concerns with us that the registered manager was not very visible and that they didn't feel well supported. We found a carer staff meeting had not taken place since May 2014 which meant there was not a regular group opportunity for care workers to have a say about the running of the home or to raise and discuss any concerns. A number of staff raised concerns about staffing levels, said they did not feel supported by management and that communication could be improved. The lack of a regular staff meeting to air views could be responsible for some of the sentiment.

Meetings were undertaken by activities staff to plan a high quality programme of varied activities. Nursing staff meeting also took place and there was evidence they discussed care practices to ensure continuous improvement of the standard of care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred Care The care and treatment delivered was not always designed to achieve service users preferences and ensure their needs were met.