St Dominic's Limited

St Dominic's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected St Dominic's Nursing Home on the 26 February and 2 March 2018. The inspection was unannounced. At the previous inspection of this service in April 2017 the overall rating was requires improvement. The history of the service had demonstrated they had not been able to sustain improvements in the past and we needed to see that as more people come to live at the service, the improvements were continued and sustained.
Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key questions safe, effective, caring, responsive and well led to at least good. This inspection found that improvements had been sustained and the overall rating was 'Good'. We will review the overall rating of good at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been sustained.

St Dominic's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Dominic's Nursing Home provides accommodation and nursing care for up to 91 people, who have nursing needs, including poor mobility, diabetes, as well as those living with various stages of dementia.

St Dominic's Nursing Home is registered to provide care to people with nursing needs, such as Parkinson's, diabetes, and heart failure, many of whom were also living with dementia. The home was divided into six units, over three floors, Fern, Crocus, Dahlia, Aster, Bluebell and Elderflower. Fern unit was on the lower ground floor and was home to people living with complex dementia needs. Elderflower unit remained closed. There were 53 people living at the home on the days of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

This inspection found that the provider had continued to progress quality assurance systems to review the support and care provided. This included undertaking root core analysis on events that affect people at the service and reflective learning from safeguardings, incident and complaints. Root cause analysisis a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems. Audits included those for accidents and incidents, care plans, medicines and health and safety.

The overall rating for St Dominic's Nursing Home has been changed to good. We will review the overall rating of good at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been sustained.

People were safe at the service. Staff knew how to identify abuse and understood the safeguarding

procedures to follow to protect people from abuse. Risks to people's health and well-being were assessed and managed. There were appropriate risk management systems which ensured staff delivered safe care. People's needs were met in a safe and timely manner by a sufficient number of staff. The provider followed appropriate recruitment procedures to ensure they employed staff who were suitable to provide care. People received their medicines when needed. Medicines were administered and managed safely by staff who were trained to perform that role.

Staff received the training necessary to provide safe and effective care. People were supported to eat a healthy and nutritious diet. Food and fluid charts were completed when risk of poor eating and drinking had been identified. These showed people were supported to eat and drink. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Health and social care professionals were involved in the planning and reviewing of people's care to ensure support provided met best practice guidance and legislation. Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them.

Staff provided care that was responsive to people's needs. Lessons were learnt from incidents and accidents to minimise a recurrence. A range of activities were available for people to participate in if they wished and plans to develop activities were in progress. Staff had received training in end of life care supported by the local Hospice team. Visits from healthcare professionals were recorded in people's care plans, together with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with external health professionals.

Staff said the management team was fair, care meetings were held every morning to discuss people's changing needs and inform staff. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions.

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

St Dominic's Nursing Home remains Good.

There were systems to make sure risks were assessed. Measures were put in place where possible to reduce or eliminate risks.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it.

Is the service effective?

Good

St Dominic's Nursing Home was effective.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements of the Mental Capacity act (2005)

Staff received training which was appropriate to their job role. They had regular supervisions with their manager, and formal personal development plans, such as annual appraisals.

Is the service caring?

Good

St Dominic's was caring.

People were enabled and supported to access the community and maintain relationships with families and friends.

People's dignity was protected and staff offered assistance discretely when it was needed.

Staff provided the support people wanted, by respecting their

choices and enabling people to make decisions about their care.

Is the service responsive?

Good

St Dominic's Nursing Home was responsive.

People's preferences and choices were respected and support was planned and delivered with these in mind.

Group and individual activities were decided by people living in the home and regularly reviewed by them.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint, but also said they had no reason to.

Is the service well-led?

Good

St Dominic's Nursing Home was well-led.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

A quality assurance and monitoring system was in place. The registered manager used this to identify areas that could improve.

Feedback was sought from people through regular meetings and from relatives, friends and health and social care professionals through satisfaction questionnaires.

St Dominic'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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 26 February and 2 March 2018. This was an unannounced inspection. The inspection was prompted in part by some concerning information received. The inspection team consisted of five inspectors.

During the inspection, we spoke with 27 people who lived at the home, four visiting relatives, the registered manager, eight care staff, three registered nurses (RN), the cook, an activity co-ordinator, maintenance person and the area manager. We also contacted external health professionals, such as the tissue viability nurse, GP and speech and language therapists to gain their views of the service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. The inspection was brought forward by four weeks due to concerns which meant that the provider information form (PIR) was not received until after the inspection. 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. We used the completed PIR during our analysis of the evidence gathered during the inspection process.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used when we spoke with them.

During the inspection we reviewed records. These included staff training records and policies and procedures. We looked at ten care plans from the nursing floor, and three care plans from the dementia unit. We also looked at risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' eight people living at St Dominic's Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection, this key question was judged to be good. This inspection found that it remained good.

People told us they felt safe living at St Dominic's Nursing Home. Comments included, "Very safe, no worries at all," and "The place is kept clean and staff make sure I'm safe." A visitor said, "I'm confident that my relative is safe, the staff know what they are doing, plenty of staff about and they seem knowledgeable."

There were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to keep people safe. A needs assessment tool for assessing staffing levels was undertaken for each individual and for the size and layout of the building. This was then used to calculate a staffing ratio that was appropriate to meet peoples' collective needs.

Comments from people, visitors and staff in respect of staffing levels were mostly positive. People told us, "I ring my bell and staff always come quickly, I think they get busy but I've never been left waiting. Another person said, "Of course they are always busy, so hard working, they have asked me on occasion if I mind waiting for a few minutes but that's understandable, I've never been ignored." Visitors said that "staffing seems okay, I have noticed a few times staffing levels have seemed low but I don't know the reason and they could be in with a resident, on the whole I have no concerns." Another visitor said "I think staffing is correct, when I visit I see staff with people, there's always someone on reception." We spoke with a RN who said, "We help care staff and answer bells if we need to, no day is the same and some days it's quiet and there are days it is busy, but we manage. If staff are sick we have agency staff who come to help." Another staff member said, "We have good staffing levels, wouldn't say no to more staff at meal times because it's always busy at those times." There was additional staff in the home to respond to domestic, catering, entertainment, administration, and receptionist duties. The manager confirmed staffing arrangements were flexible and extra staffing was available to respond to any changes in people's needs. We reviewed audits for falls, accidents and looked at response times to call bells. There were no trends or specific times of accidents/falls that indicated staffing numbers impacted negatively on the health and safety of people at this time. We found the staffing arrangements ensured people had their individual needs attended to.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults. Interviews were undertaken and two staff completed these using an interview proforma. There were systems to ensure staff working as registered nurses had a current registration with the nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. One staff member said, "If I saw or

heard something that I was concerned about, I would report to the manager and follow the procedure." Another staff member said, "We have had training and I know to contact the local authority." Staff told us they had read the whistleblowing policy and it was displayed in the home. People, relatives and staff said they had not seen or heard anything they were concerned about.

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "Everyone is treated the same, and everyone is treated with dignity and respect." Staff received training in equality and diversity and were made aware of racism and sexism and of the need to respect people's differences. One staff member said "We as a team come from different countries and we ensure we do not talk in front of people in a language they do not understand. We respect diversity and if we saw that someone was discriminating someone, we would report it."

Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. Risk assessments for health related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. There were detailed plans that told staff how to meet people's needs in a safe way. For example, care plans contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure damage. One person's care plan directed staff to offer a change of position every two hours as they were at high risk from pressure damage. Another care plan directed staff on how to position the person for maximum comfort when siting in their recliner chair in the lounge. Pressure relieving mattresses and seat cushions were used for people identified at risk and were set according to the manufacturer's instructions. Settings for the pressure relieving equipment were checked by staff on a daily basis. The settings were correct on the two days. Risks associated with the use of bedrails were assessed in line with the guidance set by the Health and Safety Executive. All bedrails were checked by the maintenance person on a monthly basis.

All accidents, falls, incidents and unexplained bruising or skin tears had been documented. There was a clear follow up of immediate actions taken and of how staff had mitigated risk to people of further harm. For people who had unwitnessed falls a record of an investigation or a plan to prevent further falls had been completed. These actions meant the provider had put preventative measures in place to prevent a re-occurrence and protect the person from harm. Following an unexplained incident where a person had sustained a fractured hip, the service had provided a full investigative report to the local authority. Due to some irregularities found by the quality lead of the service, the staff involved had been asked to reflect on the incident and complete a document that incorporated lessons learnt from the incident. Staff told us that this had been very helpful and insightful.

People received their medicines as prescribed in a safe way. The improvements seen at the last inspection had been sustained and systems of medicine auditing had improved medicine management within the service. People's medicines were securely stored in locked clinical rooms on each floor and medicines were given by registered nurses. We observed medicines were given safely and that staff signed the medicines administration record (MAR) once taken by people. The clinical room was well organised and all medicines were stored correctly and at the correct temperature. Medicine audits were being undertaken weekly at the present time to drive improvement in medicine management. There was a clear audit trail that defined what action was taken following audits such as medicine retraining and competency tests. RNs took responsibility on their shift to ensure medicines prescribed were given as prescribed and the stock left was correct. Medicine records showed that each person had an individualised MAR, which included a photograph of the person with a list of their known allergies. Records confirmed medicines were received, disposed of, and administered correctly. There was clear advice on how to support people to take their

medicines including 'as required' (PRN) medicines, such as paracetamol. Records had been completed with details of why they had been given and if it was effective in relieving the pain. Topical creams were signed as being applied following personal care.

The equipment for use in a medical emergency such as suction machines (used to assist in removing excess saliva and mucus to aide breathing and swallowing) were checked regularly and ready to use in an emergency. Personal emergency evacuation plans (PEEPs) were in place with the necessary information for staff to follow in the event of an emergency. People's ability to evacuate the building in the event of a fire had been considered and where required each person had a PEEP

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was evidence of legionella testing. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. .
The provider had ensured people were cared and supported for in a clean, safe and well maintained environment. The cleaning and care team followed best practice guidelines in infection control prevention. Staff used gloves and aprons appropriately and ensured laundry and waste products were dealt with appropriately.

People also commented positively on the general standards of cleanliness across the service. One person told us, "My room is kept clean, every day," another said, "I've no issues about the laundry, all seems very efficient," "My room is clean enough." We looked at difficult to reach areas like the undersides of bath hoists. They were all clean. The laundry worker told us all staff were very good at separating different categories of laundry, and they received all potentially infected laundry in appropriately colour-coded laundry bags. They confirmed one of the washing machines had a sluice wash programme.

Good

Is the service effective?

Our findings

At our last inspection in April 2017 we found improvements had been made in respect of meeting people's nutritional needs and people's capacity to consent, but there were still areas that had required further time to be embedded and structured. This inspection found that improvements had been made and sustained.

People told us they received effective care and their individual needs were met. One person told us, "The staff know their stuff, they are really very good." Another person said, "I think they are pretty good, certainly look at my health and keep me well." A visitor said, "If my relative is poorly they pick up on it and phone the GP and also tell us." The organisation had ensured that staff training had continued to progress. The training provided was both face to face and DVD training. The training included health and safety, infection control, food hygiene, safe moving and handling, and safeguarding. Training in equality and diversity and person centred care had also been provided.

People's needs and choices had been assessed in line with current legislation and good practice guidance. The registered manager or senior staff met with people before they moved to the service to discuss their needs. The assessments were clearly recorded and incorporated information about their preferences and wishes. The provider used a series of standard assessments to establish people's needs with regards to health, skin integrity, nutritional needs, assisted moving and mental capacity. These helped determine people's base line care needs. The assessments were enhanced with personalised information which had been provided by the person themselves and their representatives. The staff used these assessments and additional initial observations to create care plans so people received the care and support which was right for them. Assessments were reviewed each month and following any changes in people's needs.

Staff training was closely monitored to ensure staff had completed required training. Staff whose first language was not English were supported by the organisation to have English classes and given support with training. Staff and training records confirmed that a programme of training had been established and staff had undertaken essential training throughout the year. We observed good practice in moving and handling people and in staff assisting people with their food. Staff received specialist training to meet the needs of the people they supported. For example, diabetic care, catheter care and wound care. Additional training was also provided to support staff with developing roles, specific interests and meeting the changing needs of people living in the service. For example, a dignity champion.

Staff told us the training provided them with the skills they needed and included practical sessions, along with time to discuss specific areas of care. Senior staff reviewed staff training at supervision and supported them to complete the required programme. Staff received regular and on-going supervision. It was also an opportunity for staff to feedback any concerns they may have. RNs confirmed they had opportunities to support their professional development as part of their evidence for re-validation to remain registered with the Nursing and Midwifery Council. There was also specific training for RNs to maintain skills and competencies. Staff told us they had received all the training they felt they needed and that they were aware that further training and updates were planned, to ensure they could continue to carry out their roles effectively. RNs told us they felt supported to maintain the skills needed to meet people's nursing needs. The

provider had worked with RNs when they were required to complete revalidation to maintain their nursing registration. There was evidence of clinical training completed by nurses. All staff felt that appropriate training was in place and one said "If you identified an area of learning you could discuss this at your supervision or appraisal."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. We saw that people's capacity was recorded and reflected in care documentation. For example, when alcohol consumption had affected a person's capacity this had been recorded. Staff told us that they understood that people's capacity to make choices and decisions can change and fluctuate and they felt that they had the training and understanding to support people. Within the documentation there was evidence of best interest meetings being held to support people to make decisions. These were well documented.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. The registered manager understood when an application should be made and there was a folder that showed applications made, those that had been granted and those still waiting to be processed. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. For example, we saw that a condition of someone's DoLS was that their medication should be reviewed frequently by the GP and this had been done. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information. Risk assessments had considered if people were able to consent to restrictive measures used to keep them safe, such as bed rails and whether a less restrictive practice could be used, for example pressure mats.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GPs, community nurses and social workers. Access was also provided to more specialist services, such as opticians and physiotherapists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "They make sure I see the doctor when I need to, I have also been to the hospital for appointments which they never forget." Staff told us they knew people well and were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured that when people were referred for treatment that they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them.

People's individual needs were met by the adaptation of the premises. The service was purpose built, with safe accessible gardens and plenty of communal areas. All communal areas of the service were accessible via a lift. There were adapted bathrooms and toilets and hand rails to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment. One person told us, "The garden is nice and I like to sit there in good weather." The management team and staff had continued to improve the décor and environment

for the people who lived there and shared their plans for further development. All lounges and communal areas had been rearranged and brightened with pictures to reflect people's interests. The reception area was welcoming and inviting for visitors

People told us that the food was usually "Very good," "Plenty of it," and, "Not bad grub." We also received some negative comments which were fed back to the registered manager and chef. There was a new chef that was currently reviewing menus, meeting with people to discuss their preferences and to discuss any concerns they had.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required and to establish preferences around food. There was a varied menu and people were offered alternative food choices depending on their preference.

Specific diets were catered for to support people's health needs. For example, vegetarian, diabetes, pureed and soft. An individual diet plan had been discussed, developed and agreed with the people who needed special meals. Nobody at the service required a culturally appropriate diet at this time but the cook confirmed that this would be sourced when required.

People said they could have something to eat or drink at any time. One person told us, "If I go out, they will make me a sandwich when I get back." Cold drinks were available in the lounge, dining room and people's bedrooms and, hot drinks were offered throughout the day when people wanted them, in addition to the usual mid-morning and afternoon drinks. Fresh fruit was available in communal areas.

Staff weighed people monthly and more often if there were any concerns. One member of staff said, "We know how much residents eat and drink and that means we know immediately if they are not eating as much as usual and we do something about this straight away." GPs were contacted if staff had any concerns and referrals had been made to the dietician with advice to support people with high calorie meals or supplements.

Good

Is the service caring?

Our findings

At the last inspection in April 2017, improvements were needed to ensure that people were consistently treated with respect and dignity. This inspection found that people were treated with dignity and respect.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones if they wished to. Lounge areas were welcoming and people were enjoying spending time in these areas with visitors during the day. Newspapers and books were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's preferences were recorded in their care plans and staff knew people well. Care staff gave us insight into people's personalities and how they wished to spend their time. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. These were being further developed and updated by the new activity team.

Peoples' dignity was promoted. People were dressed appropriately in suitable clothing of their choice. People wore clean clothes and looked well cared for. They told us they could have showers or a wash when they wanted. They explained they were able to rise and retire at a time of their choosing. During our visit we saw that people were able to spend time in bed, in their rooms or in communal areas and were not restricted. When one person asked to be escorted to their room for a rest they were supported to do this. Each person had a single room which was fitted with appropriate locks and people told us they could spend time alone if they wished. Some people had made their room their own by bringing in their own furniture, paintings, and other precious belongings. We saw some rooms which were very personalised. One person we spoke with said, "I have all my own bits and pieces, makes it feel like home." There were policies and procedures for staff about caring for people in a dignified way. There were also a designated Dignity Champion on the staff team who was able to provide staff with advice, training and support in this area. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting.

People's equality and diversity was recognised and respected. People were encouraged to maintain their independence and live a life they wanted. People who lived with dementia were treated in the same way as people who didn't live with dementia. They were offered the same opportunities to join activities in other lounges and were able to have their meals in a dining room of their choice. We noted that two people who lived on Fern unit preferred to eat on Bluebell unit as Fern unit was too noisy for them. This showed their choices were respected. One staff member said, "Everybody is treated the same way, we offer them choices and listen to them, we don't differentiate." Some people chose to remain in their room and not socialise. One person told us, "There's usually something to do every morning and afternoon, but I chose to stay here (in their room), no one forces us to attend." Another person told us they used a mobile phone, had their own

radio, fridge and television and this was sufficient for their needs and staff respected this. One staff member said, "We remind people when activities are on, so they can make their own decision."

We saw some really nice interactions when staff supported people to mobilise. One staff member was supporting a person with a walking aid. They were quietly encouraging, with a gentle manner. They had one hand on the person's back, praising, telling them where the chair was and that if they stepped back, they would feel it on the back of their knees. They appeared unhurried and told the person to take their time. They spoke with the person in a friendly manner and were continually smiling. We also saw staff supporting a person from using a walking frame to sitting in a wheelchair. Both staff were very patient, praising the person, putting brakes on wheelchair and using equipment appropriately, therefore encouraging independence.

People were able to express their views and were involved in making decisions about their care and support, and the running of the home as much as possible. People who lived with dementia were supported to share their views by staff, for people who couldn't, family members were involved. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

At the last inspection in April 2017 improvements were needed to ensure people received person centred care. This inspection found that improvements had been made and were on-going.

People commented they were well looked after by care staff and that staff listened to them. One person said, "They look after me, if I am off-colour, they check me out and call the doctor." Another person said, "I was unwell and the staff really looked after me well." We were also told, " Because I have health problems they take my blood regularly and make sure my medicine is right."

People's health and social needs were recorded in care plans. We saw that people, if they were able, were involved in the development and review of these and their wishes and preferences were recorded. The staff reviewed these regularly and changes in people's needs were recorded clearly. For example, changes to people's mobility and skin health. Staff completed records each day to show how the person had been cared for and recorded any changes in their condition. One person who lived with diabetes had guidance in their care plan for staff to follow to maintain their health. The care plan told staff what their normal blood sugar reading should be and what action staff should take if it was higher or lower than their norm. It also had guidance for staff in respect of signs and symptoms of high and low blood sugars to be aware of, such as unusual thirst. This meant that care delivery was responsive to people's individual needs. Some of the records were unclear about people's changing emotional and social needs. The registered manager was aware of this and was working with the staff to improve this part of record keeping. Staff demonstrated a good understanding about individual people's needs and how they liked to be cared for. Where people required additional assistance or supervision, records were in place to monitor this and make sure they received this support.

People's families told us they were involved in planning and reviewing care needs. They said the staff were good at communicating with them and let them know straight away if their relative was unwell or had an accident.

Activities were an area the provider was still continuously trying to improve. They were aware there was still work to do, to ensure the activity team had the right support and skills to provide meaningful activities for the people who lived at St Dominic's Nursing Home. The provider had employed two new activity coordinators since the last inspection. We saw they had planned and facilitated a number of group and individual social activities. This included one to one activities, which included hand massage and manicures. The programme of activities was displayed in areas around the home. There was discussion about the plans for a sensory room on Aster unit which people throughout the home could use. Ideas from people, visitors and staff were being taken forward and implemented. For example trips out in to the community. The home continues to encourage visitors to become 'friends of St Dominic's Nursing Home'.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We looked at what arrangements the service had taken to identify record and meet communication and support needs of

people with an impairment, disability or sensory loss. Support plans seen confirmed the management team's assessment procedures identified information about whether a person had communication needs. These included whether the person required for example, large print to read. This was to ensure people who lived at the home had access to information in different formats, such as large print. To help communication with a person whose first language was not English staff had created helpful sentences for staff to use. These were in the person's care plan and laminated in their room. This person experienced behaviours that challenge at certain times and the only thing that reduced their anxiety was listening to music via ear phones. We saw all staff were aware of this and the music was available for this person.

The home encouraged people to maintain relationships with their friends and families. One visitor said, "I am always welcomed with a smile, staff greet us all and come and chat and tell us how our relative has been." Another visitor said, "I come most days to see dad, staff are great." One person told us, "My family come at different times because of their job, and staff don't mind at all." Another person told us, "I go out every day, staff are supportive."

Records continued to demonstrate comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning were recorded. The procedure for raising and investigating complaints was available for people. We looked at the complaints file and saw complaints were managed in accordance with the provider's policy. We read the details of a recent complaint and the actions required had been checked and followed up by the registered provider. The people we spoke with had not had a reason to make a complaint, but felt confident they could do so if needed. Comments included, "I would ask to the see the person in charge, I have no complaints." A visitor said, "We would see the manageress or get the number of the owner if we were worried."

People being cared for at the end of their lives were kept comfortable and pain free. Care plans included information about people's wishes and preferences for care at this time. The staff worked closely with palliative care teams to make sure each person had the individual support they needed. They were able to request a visit from palliative care professionals if they needed any advice or people required changes to their care plan. There was clear guidance regarding management of pain and the staff had access to additional support and medicines for people who had been assessed as potentially needing these in the last few days of their lives. In a card received at the home from a relative of a person who had died, confirmed that the staff had given lovely care and maintained their dignity and shown real empathy.

Good

Is the service well-led?

Our findings

At the last inspection we found that the quality assurance systems further time to ensure that they could sustain improvements. This was an area that requires sustained improvement. This inspection found that they had sustained the improvements.

People told us they liked living at St Dominic's Nursing Home. Visitors said that although there had been a lot of changes they were satisfied that the home was being well managed now. One relative said, "Lots of change, but that's a good thing." Another visitor said, "Yes I know who is in charge, very visible and approachable." Comments reflected on the approachability of the managers and senior staff working in the home and the belief that they listened to their feedback.

St Dominic's Nursing Home had management structures in place that staff were now familiar with. This included an area manager, registered manager, registered nurses and senior care staff. The staff were complimentary about the changes and the leadership within the home. One staff member said, "She has worked so hard, totally committed to improving, and she's fair and honest." Another said, "It really has improved here, we work together and we are listened to."

Organisational audits were now being completed routinely. Quality monitoring systems had been developed. These included audits for care plans, which had identified that additional training and support was required to ensure care staff updated the care records when people's needs changed. Medicine audits looked at record keeping and administration of medicines and the registered manager said action would be taken through the supervision process if issues were identified. Feedback from a visiting pharmacist confirmed that the audits had driven improvement and the staff now audited each other on a daily basis and medicine errors had significantly decreased. Staffing levels had been reviewed, although a recognised tool was not used, and an active recruitment programme was in place. Audits for accidents, incidents, falls and skin tears were undertaken monthly and had led to a decrease in repeated falls and accidents.

The provider and area manager had been working with the registered manager to develop the support and care provided at the home. The organisation had also received additional support from the Local authority and the Clinical Commissioning Group and they continue to work closely with the registered manager. From their reports we saw a record of some of the improvements we identified, such as the care plans and staff recruitment as well as areas for further improvements, with action plans to address them.

Relatives felt they were able to talk to the registered manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are really encouraged to be involved in developing ideas for people, to ensure they are."

The registered manager said she used the notification system to inform CQC of any accidents, incidents and issues raised under safeguarding and we were able to check this on our system. We found information had been sent to CQC within an appropriate timescale.

Staff told us that they were clear on who they reported to and had access to the manager if needed. They felt there had been a lack of leadership in the past but was more confident with the current management arrangements. They told us that the changes in the management structure had been a positive development and that they were more supported. Three staff members when asked if they felt supported said, "It's better, we know we will be listened to." Staff were aware of the whistle blowing procedure and said they would use it if they needed to.

The management structure had responded positively to a number of concerns raised by local authority. Staff had been supported through the resulting investigation process and told us they had learnt a great deal from this. The management and staff had been open and honest where problems had arisen and were looking for ways of improving the service further. This proactive response to information was also evident throughout the inspection process where improvements were progressed immediately following identification. For example, reassessing a person who had been on continuous bed rest and showing us the next day that the person was up and socialising with others in a really positive way. The staff were really enthusiastic about this change. Staff were involved in the decision making as a team.

St Dominic's Nursing Home had clear values and principles established at an organisational level. All new staff had a thorough induction programme that covered the organisation's history and underlying principles, aims and objectives. These were reviewed and discussed within supervision sessions with staff.

The provider sought feedback from people and those who mattered to them in order to improve their service. Meetings were used to update people and families on events and works completed in the home and any changes including those of staff. People also used these meetings to talk about the quality of the food and activities in the home. Meetings were minuted and available to view.

Staff meetings were now regularly held to provide a forum for open communication. Staff said meetings were an important part of communication as they could raise ideas, concerns issues and feel supported by the staff team.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.