HC-One Oval Limited

Shaw Side Care Home

Inspection report

77 Oldham Road
Shaw
Oldham
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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

Shaw Side Care Home is a care home that provides 24-hour residential and nursing care for up to 150 service users. The home provides accommodation in five separate units or 'houses'. Shaw Side is situated on the outskirts of Shaw and is approximately three miles from Oldham town centre.

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

We saw that staff received an induction when they commenced work. Sufficient training was provided and staff were supported and supervised.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and did not contain any offensive odours. The environment was maintained at a good level and homely in character.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were encouraged to eat and drink to ensure they were hydrated and well fed.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager and clinical lead nurse were aware of their responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Supervision sessions gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

Activities were provided which were suitable to the age and gender of people who used the service.

Audits, quality assurance surveys and meetings helped the service analyse performance to help improve the service.

There was a suitable complaints procedure for people to raise any concerns.

Staff, relatives and people who used the service said the home was well-led and the manager was approachable.

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.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was not always effective.

There were insufficient amounts of staff who received more than the basic training for people who had a dementia.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were offered a choice of food and drink to help meet their nutritional needs.

Is the service caring?

Good

The service was caring.

We observed and were told staff were kind and caring.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

Staff had completed or were taking six steps end of life care at

the local hospice to help support people who used the service and their relatives at the end of their lives

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns. The manager of the home responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was not always well-led.

The training of staff was not always sufficient to meet the needs of the people accommodated at the home.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Shaw Side Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection and was conducted by one adult social care inspector and an Expert by Experience on the 24 October 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia. Two adult social care inspectors returned on the 25 October 2017 and the inspection was concluded by one adult social care inspector on the 26 October 2017.

We requested and received a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help plan the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also attended a meeting with the local authority where some information of concern was passed to us mainly around Oldham unit. This included a shortage of staff and safeguarding concerns.

We spoke with eleven people who used the service, eight visitors/relatives, the registered manager, the clinical services manager, area manager, the cook and sixteen care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for six people and medicines administration records for ten people who used the service. We also looked at the recruitment, training and supervision records of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at Shaw Side. Comments included, "I am happy and safe in this home"; "Oh, I am very safe here"; "I feel safe. I've lived here for about two years and I like it"; "I feel safe and happy here" and "'I feel safe here." One person made a One person made a negative comment, "Agency staff don't understand my needs and I feel that it affects my safety. They don't have time to read all the notes when they arrive and can give inappropriate support, which can be very painful for me." Visitors/relatives said, "My relative is safe and seems to be happy here"; "My relative has settled well here. It's a safe environment and her room is pleasant"; "It's a relief that our relative is in a home like this. It's clean. She is safe here and receiving a good standard of care" and "In general the care that my relative receives here is safe."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and to report any incidents to. There was a whistle blowing policy available for staff to follow good practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations. We saw that safeguarding incidents were recorded and reported to the local authority safeguarding team. We saw the service liaised with the local authority to investigate and respond to any incidents to try to minimise them.

All the staff we spoke with understood what was unsafe practice. Staff told us, "I have completed safeguarding training. I am aware of the speak up (whistle blowing) policy. I have reported a safeguarding issue in the past. The managers dealt with it"; "I have completed my safeguarding training. I am aware of the whistle blowing policy. I would be prepared to use the policy to report poor practice" and "I have had my safeguarding training and feel confident I know what to look for. I am aware of the whistle blowing policy and would be prepared to use it."

We looked at the numbers of staff on duty on each unit. The off duty rotas were separately produced for each unit. For the two weeks commencing 13th October 2017. For Oldham unit (nursing dementia) there was an average of two registered nurses and seven care staff. On Miller unit (general nursing) there was one or two registered nurses, an average of six or seven care staff and a hostess who helped serve meals and assist people to take their diet. On Beech unit (residential dementia) there were six care staff in the morning and five in the afternoon. On Shaw unit (residential) there were five care staff and Royton (residential) there were also an average of five care staff on each shift. Each unit had a manager and all units were supported by one clinical lead registered nurse. There were domestic staff who cleaned the units and worked in the laundry. There was also a cook and supporting kitchen staff, a maintenance person, the registered manager, up to five activities staff each day and administration staff.

Some people thought there were times when they felt short staffed but also said staff responded quickly to call bells. Relatives told us, "We have had concerns about my mother being rushed to bed in evening because of the staffing issues. My sister raised these concerns with the staff and it's been OK since then" and

"They are sometimes short staffed here and that can cause problems." Staff said, "We are well staffed. We have had difficulties recruiting nursing staff for nights. We have increased the numbers on Oldham due to dependency levels. We tend to get the same agency staff who know the unit"; "In general we have enough staff. If we think we need more staff because of dependency we are listened to and the managers provide cover"; "We can meet the needs of the people who live here and the managers will send us extra staff if we need it"; "I think there are enough staff to meet people's needs. We occasionally get time to have a chat with people" and "There are enough staff and we cover for each other and work together. It would be nice if we had more time to sit and talk to people although people's needs are being met." A dependency tool was used to determine the numbers of staff required. We saw there was a drive to recruit more staff and some new staff were completing their induction which would help to replace agency staff. On the second say of the inspection we stayed for some time on Oldham unit where in the past most safeguarding referrals had been made. We saw staff were attentive and appeared to have time to meet people's needs but were very busy. We saw that staffing levels were adequate to meet people's needs.

We looked at four staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that checks were undertaken on qualified nursing staff to ensure they remained registered with their professional body, the Nursing and Midwifery Council.

We saw that the electrical and gas installation and equipment had been serviced. There were certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), hoists, the nurse call and fire alarm system. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. Radiators had a control valve to minimise the risks of burns. There was a person employed to repair or replace any faulty equipment and to decorate the home. The maintenance of the building and equipment helped protect the health and welfare of people who used the service and staff.

The fire alarm system had been serviced. Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the procedures. Each person who used the service had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in a folder near the front of each unit so staff could get hold of them in an emergency to present to the fire brigade. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a power failure.

We looked at six plans of care during the inspection. We took a selection from each of the five units. Each care record contained a risk assessment for falls, moving and handling, tissue viability and nutrition. The risk assessments had been reviewed and provided staff with up to date information to help protect the health and welfare of people who used the service. There were also environmental audits to check for possible hazards such as fire escapes being blocked or slips, trips and falls.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

Visitors/relatives told us, "It is clean enough here and warm"; "It's a relief that my relative is in a home like this. It's clean" and "It is very clean. All the washing is done on a one-day turnaround or less. My relative is incontinent but the room never smells and is always in clean clothes when I arrive."

At the last inspection the service was not always clean and equipment kept in a good state of repair. We saw improvements had been made at this inspection and the home was clean and equipment in good order. There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy. Management conducted a daily 'walk around' and checked cleanliness as part of the process.

There was a laundry sited away from any food preparation areas. There were three industrial type washing machines and three dryers to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to.

We looked at the systems for the administration of medicines. People who used the service told us staff gave their medicines at the times they expected to take them. We observed a member of staff administering medicines and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. There was also a copy of the national institute of clinical excellence (NICE) medicines guidelines for staff to refer to. This is considered to be best practice guidance for the administration of medicines. All staff who supported people to take their medicines had been trained to do so and had their competency checked to ensure they continued to safely administer medicines.

We looked at ten medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home which helped staff check the numbers of medicines people had. There was a photograph on each MAR to help staff identify the correct person.

Medicines were stored in locked trolleys chained to the wall within a locked room. Medicines were stored separately from other clinical supplies and supplements. The temperature of the medicines room was checked daily as was the medicines fridge to ensure medicines were stored to manufacturer's guidelines. We saw from the records the temperatures were within the recommended range.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

We saw that topical medicines such as ointments were recorded in the MAR. The service used body maps to show staff where to apply the medicines.

Food supplements were given by trained staff and recorded in the MAR charts. We saw the medicines system

was fully audited monthly with random checks in between to check for any errors. Staff retained patient information leaflets for medicines and also a copy of the British National Formulary to check for information such as side effects.

Good

Is the service effective?

Our findings

Relatives told us, "'I do think that the staff have the necessary knowledge and skills to provide the right care"; "The staff here seem to understand my relative and her needs are being met", My family member has been here for two years and you would think by now that they would have acquired the necessary knowledge and skills to provide the care that she needs, but sadly sometimes things can go wrong. It's generally good though and they do contact us if necessary";
"The staff have got the necessary skills and they do make the right referrals when needed" and "The staff seemed to understand my relatives care needs."

Training and support for nurses to validate their registration was provided at this care home. This included clinical training for the use of equipment, for example, syringe drivers, support with medicines administration and liaising with professionals from other organisations such as the local hospice. Two members of staff said, "I think the extra dementia training would be beneficial." and I have completed all my basic training. It's been a long time since I had any dementia training."

From looking at the training matrix (which is a document which shows what training all staff have completed) , staff files and talking to members of staff, we found basic training had been undertaken. We saw that staff were trained in moving and handling, safe food hygiene, infection control, health and safety, first aid, fire safety, medicines administration, mental capacity and DoLS. Some staff had undertaken palliative care training at the local hospice. Behaviours that may challenge others training was also completed for some staff by an external organisation. The training for person first dementia second training, which is more advanced training for people who had a dementia, had been completed by 30% of staff at the home. We were told that most of the staff who received this training worked on the dementia units (60%). We were told the trainer who provided the training for person first dementia second no longer worked at the organisation. The registered manager told us she had approached BUPA management about the shortfall in training but there had been no initial response to provide a new trainer. However, we were sent evidence the training was still going to be provided with the dates and names of staff, which were all from Oldham unit (the nursing dementia unit). This meant there would be sufficient amounts of staff trained in the care of people who had a dementia.

We asked people who used the service what they thought about the meals served at the home. People who used the service told us, "The food is very good. I've eaten everything today"; "The food is OK. At least we're all being fed, so that's good"; "Mealtimes are a chance to talk to others and the food is OK"; "The meals are not good at the moment. They're often lukewarm, not cooked properly, or we're getting the same meals or on two or three consecutive days" and "The food is very good." Families/visitors views ranged from 'It's a bit like school dinners' to ''Food is more than adequate'. One relative told us, "What's good is that my relative can use a spoon now to eat. Do you know that a year ago they had given up eating, so this is really good progress."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. During the inspection we observed mealtimes on different units. On most

of the units staff were good at providing people with choices at mealtimes they could understand. Staff explained what the choices were or showed people pictures of what was on offer. Although people on another unit were also asked what they wanted it depended on the person's ability to understand what it was they were being asked. For example a choice of four different types of sandwiches proved difficult. However, people were offered choice and did appear to get what they wanted. We talked to the cook and registered manager about meals and mealtimes. The cook said they never produced the same meals on consecutive days and we saw that the menu's supported this. The registered manager said they tried to obtain people's preferences and staff would quite often know what people liked. The manager thought it was possible for people to be shown the actual choices of meals which would help ensure people had what they wanted.

We did see some good practice of staff assisting people to take their meals. One example was a staff member asking a person if they would like their meal chopped and another example was a table being pushed closer to enable the person to reach their drink.

There was a menu on display which was supported by pictures of the food so people knew what they were ordering. Not all staff used the menu People were shown the choices of meal so they could point to their choice or asked what they wanted. We observed a meal and saw that staff engaged with people who used the service, although some staff communicated better than others.

Tables were set on the units where it was safe to do so. This included tablecloths, napkins, cutlery and condiments to flavour this food. Where this was not readily available we saw staff could bring it from the kitchenette. There was a kitchenette on each unit for staff to make drinks or prepare snacks.

There was a four weekly menu cycle. There were three meals a day with a hot option provided each time. People could have any of the usual breakfast foods, for example cereals toast or eggs. Lunch was a smaller option with the main meal served in the evening. Supper was provided and drinks were offered at intervals during the day. People were able to have a 'night bite' from the kitchenettes, such as toast or biscuits.

We visited the kitchen and saw there were sufficient supplies of fresh, frozen, canned and dried foods including fruit. The chefs were given information around allergens from their head office. There was a board in the kitchen which showed people who were on specialised diets and the service provided pureed, mashed, diabetic and soft diets if people required them. The service had access to a specialist provider who they could contact should a person require food for a specific cultural or ethnic need such as Halal. At this inspection we did not see any person who required this type of food.

Food supplements were kept on the units and care staff were responsible for ensuring people received them. Some foods were fortified with milk and cream by kitchen staff to provide more calories. We saw that people had a nutritional risk assessment and where required had access to dieticians and speech and language therapists (SALT). We saw that people's weight was recorded regularly so that staff could monitor any weight gain or loss.

People and their families told us they had access to healthcare professionals. For example relatives said, "Our relative had to be admitted three times into hospital last week with low blood pressure. Everyone was fantastic. Referrals are made to the Parkinson's nurse, the district nurses, GP and consultants. Staff have contacted me if my relatives needs have changed" and "They have referred my relative for new hearing aids and call in the GP when needed." A person who used the service said, "The staff know if I'm not well. For example, last week, they sent for my GP as my chest was bad." From looking at the plans of care we saw that people who used the service had access to healthcare professionals, for example hospital consultants,

community nurse specialists and district nurses. Arrangements were made for people to attend routine appointments to podiatrists, opticians and dentists. Each person had their own GP.

During the tour of the building we noted that the home was warm, clean and fresh smelling, except one unit we visited in the morning which had an offensive odour. When we visited later in the day this had gone. 50 new mattresses had been purchased to replace any defective or soiled mattresses and they were now audited to ensure they were in good order.

Bedrooms we visited had been personalised to people's tastes, some with furniture, photographs and ornaments. Communal areas contained a variety of seating and were homely in style. There was sufficient seating for all people accommodated at the home, although we saw that people could sit in their rooms if they wished. The corridors were wide to allow wheelchair access and had hand rails for people to steady themselves if they needed to.

Bathrooms and toilets had aids to assist people with their mobility to help them attend to their personal hygiene. There was a choice of bath or shower and we saw people's preferences were recorded in their plan of care. There were accessible gardens with seating for people to use in good weather. The garden for people who had a dementia was secure and safe for people to use. There was a person employed to keep the gardens in good order.

There was signage to help direct people around the home although this could be improved to help people familiarise themselves around the home. There were memory boxes available outside of people's room although not all had anything in them. We did see a staff meeting record where improving the signage had been discussed. This meant the service were aware that the signage was not consistent throughout the home.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005) and DoLS. The clinical lead nurse was responsible for ensuring all mental capacity assessments, best interest meetings and DoLS applications were made and recorded. This ensured the service was up to date with people's mental health needs.

We saw evidence in the plans of care that people who did not have mental capacity had an assessment and were referred to the local authority using the current guidance. This meant people were assessed independently and a DoLS authorised if needed. There were 47 people accommodated at the home who required a DoLS authorisation, which had been reported as required to the Care Quality Commission. People's mental capacity was regularly assessed to ensure any previous assessment remained valid.

People signed their consent to care and treatment if they could. Some family members signed for their care

and treatment if their relative was on a DoLS or they had power of attorney for health and welfare. We also saw many examples of staff asking people who used the service for their consent before undertaking any tasks.

Staff received a five day induction. Part of the induction included being shown around the home to familiarise themselves with the building and fire procedures. New staff were supported by more experienced members of staff until they were confident to work with people who used the service. We could see that staff received training in topics relevant to the needs of people who used the service. This included all relevant topics, for example moving and handling, infection control and safeguarding. There was a short time spent on the care of people with dementia and behaviours that challenge. We saw several files which showed staff had completed the training and were aware that some new staff members were on the induction course during the inspection. Staff were then offered a course on health and social care such as a diploma.

At the last inspection records showed and staff told us they had not had supervision regularly. At this inspection we saw supervision and support was ongoing. Staff told us, "I get regular supervision. They are one to ones and we get chance to have our say"; "I have had supervision. I feel supported"; "I have supervision. It is a two way process. They are quite good like that" and "I do my utmost to support staff. I am also supported and can bring up any topics at supervision." Staff felt supported and were able to discuss training and support during one to one conversations which we saw were recorded.

Good

Is the service caring?

Our findings

People who used the service said, "The staff are all nice. They are kind and show respect"; "All the staff are kind and they treat us with respect. They do listen to me. I listen to them too and do what they tell me"; "All the staff are very kind. They do seem to listen and respect what I say. I'm not sure how independence is supported, as we can't get about like we used to"; "The staff here are kind and they do listen to us. I suppose that, as far as possible, independence is supported" and "The staff are very nice and they show respect." People we spoke with thought staff were kind.

Relatives/visitors said, "The regular staff are kind and they listen. I don't think the staff are paid enough for this job. It could be so much better if it was made a more professional service and staff paid accordingly. There is too much turnover of staff"; "Staff are generally kind and caring. They seem to be friendly and approachable. They treat my wife with dignity and respect her privacy. I feel that my wife is supported to be independent here. Obviously, she must be supervised, but she manages a lot of daily activities independently. I would give the staff 10 out of 10 here", "From the caring perspective, everything seems to be fine. The staff are kind and they listen to us. My relative is mobile and takes part in different activities, which helps to maintain independence"; "The staff are generally kind and caring. And they do seem to listen" and "The full-time staff are good here, but there are a lot of agency staff especially at the weekends, when the care isn't always up to standard." Most relatives we spoke with thought staff were kind, listened to them and promoted independence.

Staff told us, "I love it here it's fabulous"; "It's going ok working here. It was the best thing I ever did getting the unit managers job. I worked my way up. It like the extra responsibility and making a difference to people's lives. I hope I am improving the standards. I am happy working here and would not still be here if I was not"; "I know the people who live here well. It makes a lot of difference if you know what people want. I like working here" and "I think the job is rewarding. I like being there for people and supporting them at the end of their life." Staff were happy working at the service. All the staff we spoke with thought it would be all right for a relative to use the service.

In the plans of care we saw there was a good background history of each person. This included people's likes and dislikes, hobbies and interests. In the plans of care we saw that it was recorded what a person could do for themselves, for example if a person could take their own diet or choose their own meals. The information enabled staff to treat people as individuals. One person who used the service told us, "Both the staff and I are trying to maintain independence. It's important that we try to do for ourselves whatever possible, whenever possible and within reason."

We saw that staff knew people by their preferred names which showed staff knew them well. We also saw that people went out independently of staff, usually with a family member for a meal or shopping. We observed staff had a kind yet professional attitude and we did not see any breaches of privacy when staff were supporting people with their personal care needs. A person who used the service told us, "Privacy and dignity are respected, for example they will always ask my permission before giving care. I am lucky in that my family visit me and by working together we try to retain as much independence as possible."

People were able to choose what they wanted to do such as join in activities, the times they got up or went to bed and where they preferred to sit during the day. Some people chose the lounges while others remained in their rooms. We observed staff offering people choice in what they did or, for example, what drink or meal they wanted.

We saw that staff were taught about confidentiality topics, had confidentiality policies to support their practice and that records were stored securely so only people who needed access to the documents were able to do so.

We did not see anyone being treated disrespectfully. We were told that staff members who had been rude and disrespectful to people in the recent past had been dismissed or suspended. This ensured only caring staff remained looking after vulnerable adults although this could cause a shortfall in staff until new people were employed.

Family members we spoke with said, "I visit every day in the mornings. Visiting was unrestricted and people could take visitors in the communal areas or quiet areas or their rooms if they wished privacy. People who used the service were encouraged to remain in contact with their family and friends.

Some staff had completed the six steps end of life training with the local hospice which is considered to be best practice in this area. This training equips staff with the skills to care for people and their families at the end of their lives. Where people could tell staff what their last wishes were we saw that this was recorded in the plans of care. If a person did not have capacity we saw that the person responsible for any end of life decisions was also recorded.

People were able to attend a religious service and take communion if this was their preferred way of following their religion. The registered manager said specific clergy attended at request for people with specific religious needs such as for last rites.

Good

Is the service responsive?

Our findings

There was a suitable complaints procedure accessible to people who used the service and their relatives. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission. We saw the registered manager recorded any complaints and the outcome of any investigation. This included a financial concern for a person which was resolved to the satisfaction of the person and their family and one around staff attitude was dealt with using the homes disciplinary policy. This showed the registered manager responded to any concerns raised.

A person who used the service said, "I would speak to my family if I had any complaints." A family member said, "We have had concerns about my relative being rushed to bed in the evening because of the staffing issues. Another family member raised these concerns with the staff and it's been OK since then." Other people told us staff listened to them and family members said regular staff were responsive to them but this was not always so if there were agency staff who did not know them as well.

We looked at six plans of care during the inspection. Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. We saw that the assessments in the plans of care we looked at had been fully completed for each person. This process helped to ensure that people's individual needs could be met at the home.

The family members we spoke with said staff kept them up to date with the changing needs of their relatives. The plans of care showed what level of support people needed and how staff should support them. Each heading, for example personal care, tissue viability, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. The plans were reviewed regularly to keep staff up to date with people's needs. The quality of care plans was regularly audited by management. There was a daily record of what people who used the service had done or how they had been to keep staff up to date with information.

At the beginning of each shift there was a staff handover. One family member did not think information was always passed between the day and night shift. Each day the managers of each unit and departments held a take ten meeting to discuss the care of people on their unit or if there were any problems with the running of the service to keep the manager up to date. Staff told us they attended handovers on each unit.

People who used the service told us, "Sometimes I join in with the card games and dominoes, which I like"; "The staff do take us out which is brilliant. For example, we go out for walks and down to the shops"; "I really enjoy drawing, reading and I love music. They volunteer to take me out, but I choose to stay in here because it's too much toil and bother. I do attend residents' meetings, or if I'm feeling unwell, they visit me here and

have a chat about things. I get holy communion from Saint Mark's"; "I don't really get too much involved with the activities here, but staff sometimes comes along to do things on a 1 to 1 basis with me. For example, [staff member] called in earlier today with a ball and we played armchair netball. I used to love aerobics and playing darts, but I suppose that would be very difficult now. I haven't attended any of the residents' meetings here, but my daughter has been involved. I get plenty of visitors, thankfully"
and "I like the environment generally, and wonderful [staff members name] makes sure that there are nuts but out for the birds. The staff member was the one who moved the bird table to the position just outside my window."

Family members we spoke with told us, "My relative is lucky in that she is taken out regularly. We're going out today together to have lunch in Royton and do a bit of shopping. In this way we can help support and maintain independence skills. They could possibly do a lot more to support daily living skills in this home" and "My relative is mobile and takes part in different activities, which helps to maintain her independence."

There was a series of planned activities at the care home. There was an activity coordinator who worked on each of the units. During our tour of the building and observations during the inspection we saw that people were engaged in various activities with staff, the activity coordinators and family members. Where service users did not want to engage in activities we saw that staff usually engaged them in conversation separately. We saw people playing dominoes and card games, going out with family members, exercising using a ball, listening to appropriate music and reading.

We were told other activities on offer included arts and crafts, you to me (one to one engagement), music and movement, gardening, karaoke, a knitting club, video club, board games, bingo and pamper sessions. Entertainers came in every couple of months. There is a coffee house in the grounds people can attend with or without their family, some people go shopping or for a coffee morning at other organisations and events are held such as a summer fair.

Besides pet therapy there is a cat and a bird for people to help look after if they wish. Children from a local school come into the home to provide entertainment and the Rotary club take people out to lunch. Each unit had their own funds which have been raised to help provide activities. Birthdays and special days were celebrated, sometimes with a special menu or entertainment.

We saw each unit held meetings with people who used the service and families. We saw records of meetings and also spoke to family members who had attended meetings. The responses were different with one family member saying she had brought up a specific problem which had not been completely rectified (regarding losing a person's wheelchair footplates) to another person who said the ban on attending at mealtimes had been lifted following a meeting which was important to them because their relative was not eating well. It would be good practice to record what the service had done to respond to comments made during meetings.

Good

Is the service well-led?

Our findings

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

We asked people who used the service, relatives and staff what they thought about the management of the home. People who used the service told us, "I don't know who the manager is, but I'd certainly tell them if something wasn't right"; "I can talk to the managers. They are approachable and they listen to me. [Staff member's name] is very good"; "There are two managers on the unit here and I find them both approachable. I feel that they usually listen to me" and "I do feel that I can speak with any of the managers here and I think the regular staff are approachable and know me quite well." People thought managers were approachable and available to talk to.

Relatives we spoke with said, "I find that [staff members name] is very approachable and I feel that I can talk to her about mother's care"; "I can talk with the managers here. They are all approachable, which helps to allay concerns"; "If I didn't get any results from the managers on this house, I would go to the registered manager to raise concerns. I think that [staff member's name] is particularly good at the moment. She seems to listen and respond appropriately"; "They are both very approachable"; "I definitely can talk to the managers and often do. They are all so good here! Staff know you very well" and "The staff here are approachable and they listen. Both managers on this house are good and if they weren't here, I could speak with the general manager." Relatives thought they could talk to staff on the units or go to the registered manager if they wanted to.

Staff we spoke with said, "I can go to the manager with everything. I can also speak to the area manager if I need to, "I am really well supported. I would not be where I am today if it was not for the managers. The managers come on the unit. The registered manager's door is always open"; "There is a good staff team. We all work together" and "The support is really brilliant and they have supported me with work and personal issues." Staff felt supported by management.

A statement of purpose was available to inform professionals of the registration details of the service, key staff and their contact details, the range of staff and qualifications, the organisational structure, aims and objectives, the facilities and services offered and the complaints procedure. There was also a service user guide which also informed people who used the service the full range of what the service provided, how to complain if people wished, the facilities on offer, service user involvement, meals and mealtimes and what was included in the fees or people had to pay for. These documents helped people make an informed to choice to stay at Shaw Side Care Home.

We looked at some policies and procedures which included key ones, for example, confidentiality, health and safety, infection prevention and control, safeguarding, speak up (whistle blowing), medicines administration and complaints. We saw the policies and procedures were updated and available for staff to

follow good practice.

We saw the registered manager and area manager conducted many audits to help maintain and improve standards at the home. The audits included health and safety, infection control, medicines administration, equipment and the environment, training and supervision, best interest meetings and DoLS, plans of care, cleanliness, people's finances and clinical issues, for example, pressure sores. We saw that action was taken when any problems was spotted. A plan was developed with the person responsible for achieving the target specified. Audits helped to ensure that the service maintained or improved standards and we saw examples following audits where the décor was improved in an area, new flooring fitted, items added to staff meeting agendas and equipment repaired or replaced.

Staff meetings were held regularly. Managers met daily. At the last meeting of 17 October 2017. Items on the agenda included reminding staff of the sleeping on duty policy, the uniform policy, dignity and respect, making new admissions welcome, the rota and agency cover, flu vaccination, mattress checks, signage in the care home and staffing.

Every three months staff completed a survey to see how satisfied they were with Shaw Side. The last survey responses were reviewed and summarised but at this stage we did not see what action the service intended to take to improve on the responses. This care home is part of the restructuring of BUPA and the home will change to another organisation. Staff we spoke with were worried about their jobs and the changes that were about to happen which did not help morale.

Quality assurance surveys had been sent out to people who used the service and so far eight had been returned. Questions were asked around the cleanliness of the home, staff attitude, are people involved in their care, are people's rights such as voting respected and communication. The results were mostly positive. The registered manager was auditing the surveys and when sufficient were returned would produce a summary and what actions needed to be taken to make any improvements.