Care Quality Commission

Sonesta Nursing Home Limited

Sonesta Nursing Home Limited

Inspection report

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Ratings

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

Overall summary

We inspected this service on 5 November 2015. It was an unannounced inspection. We last inspected the home on 23 July 2014 and no concerns were identified.

Sonesta Nursing Limited is registered to provide accommodation with nursing and personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for up to 32 people. The people living at the service are older people, many with dementia and physical health needs. There were 24 people living at the service at the time of the inspection.

The service had a registered manager who had run the home for over 16 years, and was also the owner. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The service was held in high esteem by people using the service and their relatives and they said the service was caring, although we saw that dignity and respect were not always upheld by all staff.

Medicines were safely administered and staff knew how to identify and respond to abuse. Care and treatment was delivered in a way that met people's individual needs but records were not always accurate. This increased the risk that people could receive inappropriate care.

There were enough staff to meet the needs of people and people had a named key worker and nurse so that they would get consistent care and support. People were happy with the food and drink on offer and it was prepared in a way that met nutrition and hydration needs.

We saw that some people stayed in their rooms all day, in some cases this was due to an expressed preference but for some people the decision had been taken out of their hands and they were at risk of isolation.

During the inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe and medicines were safely administered.

Staff knew about safeguarding and how to report it

Recruitment processes were in place to ensure appropriate staff were employed.

There were enough staff to meet the needs of people

Risk assessments were not robust and did not give an overview of risks to people

Requires improvement

Is the service effective?
The service was effective.

Fluid and food charts were up to date and people said they were happy with the food.

There was regular supervision and internal staff training taking place.

There were Deprivation of Liberty Safeguards in place for people

Good

Is the service caring?
The service was not consistently caring.

People said they found staff caring and we observed some caring interactions.

Dignity and respect were not consistently upheld.

Cultural needs were respected and different faiths catered for.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

Care plans were not person centred and did not record personal preferences.

Complaints were logged and responded to.

Activities were planned for every day and were flexible

Some people were in their rooms for large periods of the day or stayed in their room all the time and were at risk of isolation

Requires improvement

Summary of findings

Is the service well-led?

The manager had a hands on approach and was involved in the day to day lives of people.

Audits were not effective at capturing issues with quality.

Partnership working was taking place

Requires improvement

Sonesta Nursing Home Limited

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 tocheck whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 November 2015 and was unannounced.

The inspection team consisted of one inspector, one specialist nurse adviser and one expert-by -experience.An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.Before the inspection we looked at information we already held about the service. We reviewed previous inspection reports for this service and reviewed notifications made to the CQC.

We spoke with six people using the service, five relatives and friends, and seven staff members. We spoke with three health and social care professionals, looked at care documents of five people, observed mealtimes and interactions between the staff, registered manager and people using the service. We reviewed records for fire and complaints and looked at four staff files. After the visit we asked the manager to send us further information on record keeping and quality audits for the service which were sent over in a timely manner.

Requires improvement

Is the service safe?

Our findings

People using the service said they felt safe. One person we spoke with said "I feel safe, very safe". A relative that we spoke with said "as a family we have no concerns…I don't believe his needs could be better met".

Risk assessments that we looked at did not have a good overview of risks and did not contain enough detail about how to support people to manage risks. For each risk and need there was a separate sheet that gave a general description but actions were not specific. For example for one person identified as at risk of pressure sores their action plan was "regular repositioning and maintain a chart" but it did not state how often to reposition or any other details that would help to prevent pressure sores and maintain good skin integrity. The review process for risks was on a separate sheet and for each month a one line comment was added such as "care plan same" or "no change". The service used the Morse Fall Scale (MFS) which is a rapid and simple method of assessing a patient's likelihood of falling. For one person the risk of falls was assessed at high with a MFS scale of 70 but there was not an action plan in place for this person with detail of how to manage the risk and what equipment was to be used in the event of a fall. There were risk assessments in place for the use of a bedrail but this was a tick sheet document and it was not clear who was checking and signing these. This did not provide a detailed risk assessment or review plan for people which may put them at risk of inappropriate care or treatment as it was not clear what specific actions needed to take place to manage the risk.

The above evidence demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff that we spoke with were aware of the different kinds of abuse, what they might look like and how to report any concerns they had. Staff said that they knew where to get information about safeguarding and the staff files that we looked at showed training records for safeguarding within the last 12 months. When we asked to look at the safeguarding records which were incorporated into the complaints file, the registered manager said that there had not been a safeguarding incident since 2011. When we met with the registered manager later in the day she showed an understanding of when to report safeguarding issues and what kinds of incidents would require a notification to be sent to the CQC and the local safeguarding authority.

When we arrived on inspection the clinical room door in the entrance hallway was open and there were no staff in the vicinity. This was locked when the registered nurse (RN) returned. There was a sign on the door alerting people that oxygen was located in the clinical room. In the clinical room were three freestanding oxygen cylinders which were not attached to the wall which could put people at risk if they fell over. We saw on two further occasions that the clinical room was left open, and in one instance a person who was wandering around the hallways went in to the clinical room with no staff present. We fed this back to a nurse who then locked the door and informed the registered manager when we fed back later in the day.

Medicines were stored securely in a locked trolley in the home's clinical room We observed that a senior nurse held the key to the medicines trolley. Medicines that needed to be kept cool were stored appropriately in a refrigerator in the clinical room. These medicines were in date and stored correctly. The temperature in the refrigerator and the clinical room was being checked and recorded on a daily basis by the nurse in charge, records did not indicate the minimum and maximum for the fridge temperature but the nurses were aware of the safe temperature range. This was raised with the nurse manager who said they would adjust the recording sheet.

We saw that sharps bins were dated on opening and medicines were disposed of safely. An external company collected any unwanted medicines and disposed of them. We looked at records for returned medicines, these were recorded and witnessed by two staff, and the person collecting the returned items signed the records. There were safe systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use. These were recorded in a register and stored in a secure controlled drugs cupboard.

We observed a medicines round and saw that medicines were administered safely during this inspection. The RN used a non-touch technique and checked the Medication Administration Record (MAR) prior to administering the medicine, and signed after it was taken. The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacy. We spoke

with a nurse and the registered manager about how medicines were managed; they confirmed that only trained nurses administered medicines for people using the service.

We found that there were some gaps with records regarding medicines. The home had medicines policies, procedures and guidance in place for staff to refer to. The medicines policy was undated, although there was an attached sheet regarding disposal of medicines in a different type font and this was dated January 2015 .The medicines policy did not contain information regarding the storage or use of oxygen. However later in the day we were given by an RN a sheet of paper with some information about oxygen and handling it safely. In the front of the medicines file was a sheet for staff to sign and initial to confirm they had understood and read the medicines policy. This was a recommendation from a pharmacy visit in January 2015; however there were only three out of five nurse signatures on the list. The nurse manager said she was aware that the other two nurses needed to sign to say they had understood the policy.

We looked at a medicines folder. The folder was easy to follow and included individual medicine administration records (MAR) for each person using the service. In addition there was a front sheet containing the person's photograph and information about their allergies. In some files some allergies were omitted or abbreviations were used on the front sheets and on some of the other MAR charts. On MAR charts some medicines were listed yet not recorded as given. For example where Procyclidene was recorded as a prescribed medication this had not been recorded as administered, staff told us that these had been discontinued but not updated on the MAR chart. MAR charts were up to date for medicines that still needed to be administered and no gaps were evident in the recording of them being given. We did see that creams and supplements such as Thick and Easy were not on the MAR charts and creams that we saw were without dates of opening/expiry and in some cases the name of the person it was prescribed for. This was fed back to nurses at the time of the medicines being observed and the nurse in charge said that this would be changed.

We saw that the outside, entrance and bedrooms were clean and well maintained. The carpets in the hallways and on the stairs were heavily stained and worn in places. On the lower ground floor the lino flooring was torn in places and held together by tape. The lino was peeling away from the walls in places and there was a tear in the lino causing a trip hazard coming out of the lift on the lower ground floor. We noted that the bathroom on the lower ground floor had damaged flooring around the base of the toilet and looked stained and soiled and poorly fitted. When we asked the manager about this she said that some refurbishment work had been organised and the priority was to refurbish the top floor bathroom which was out of use and then replace the flooring on the lower ground floor. We were later sent copies of quotes and consultations that had taken place and the manager confirmed during the inspection that work would commence in November.

The service had an infection control policy in place. We saw gloves and aprons being used by staff and they confirmed there were supplies of these readily available. We saw that there were bins in communal areas and in the clinical room which did not have lids which could have posed an infection control risk. The registered manager told us the service had two full time domestic staff that clean the service daily. The domestic staff that we spoke with had a good working knowledge of infection control and maintaining standards of hygiene.

We looked at staffing levels in the service on the day of our inspection and were told by the registered manager during the day there were always two nurses, eight care and domestic staff, and the registered manager. We were told that at night there was one nurse and two carers. We saw that these staffing levels were reflected on the four weeks of rota we looked at and in the amount of staff that were available on the day we inspected. A person that we spoke with said "there's always someone around to help." When we spoke with staff they felt there were enough staff on duty at any one time. The registered manager and staff said they were proud that they never used agency staff and that all staff knew people well and if there was ever a shortage that a permanent staff member would step in and cover so that consistent care was provided.

There was a call bell system in operation when we visited the service. We saw at first that the bells were responded to quickly but did see two staff members cancel the bell without first checking that the person who had made the call had been responded to by a staff member. At 2pm in the lounge we saw the alarm ringing as someone had called for help, a staff member cancelled the alarm. When we asked if they knew it had been answered they said that

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Is the service safe?

they thought someone had gone up. We asked who that person was but they did not know. We asked them to check that the person who had activated the alarm was ok and did not need assistance. We spoke to the registered manager and nurse manager about this and they said they would look into if they can have the system adapted so it can only be answered inside the room where the call has been made. Fire signage was located throughout the home indicating fire doors and fire exits and an assembly point of where to meet in the event of a fire. There was an undated fire policy in place and an undated basic fire risk assessment. We requested details of when the last fire drill took place and were sent after the inspection a record of one having taken place on the morning of our inspection before we arrived. We were sent weekly breakpoint testing records and certificates to show that the building had been checked for emergency lights, fire extinguishers, and fire alarm function and no issues were identified. The gas safety record showed it had been inspected with no concerns.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. There was a folder in the service which held mental capacity assessments for people, these were not filled out as per the instructions on the form and in many cases contained only the name of a person and date of assessment. The forms were not issue specific and did not detail reasoning for the decisions made.

When we spoke with staff about MCA and DoLS they did have a basic understanding of best interests decisions and when a DoLS application might need to be made. The service was making DoLS applications when needed and care notes reflected recommendations by visiting DoLS professionals which showed they had had a part in decisions made regarding people. A professional that we spoke with said that they felt that all best interests, mental capacity and DoLS paperwork was in place for the file they had looked at and demonstrated that the home knew what they were doing through the MCA process. In care files some consent forms were in place for some aspects of care where someone had been assessed as not having capacity, but these were not consistent for all aspects of care. When we fed back to the registered manager and nursing manager we discussed gaps in the paperwork, in particular around covert medication and were told these would be addressed and each person's MCA paperwork would be gone through.

Staff said that they received regular in-house training, when we looked at staff files we saw records to show that they had been on recent training. Individual training records showed recent training taking place for equality and diversity, safeguarding, and whistleblowing within September. When we spoke with staff we were told that there was not often external training booked but that most topics were covered in internal training. The activity co-ordinator had been linked in with other activity co-ordinators in the area and the manager had been on dementia specific training put on by the local authority. We were sent a training record for the whole staff team which showed that every staff member had done internal training on fire safety, infection control all care staff had attended moving and handling and health and safety. With the exception of two staff all had completed equality and diversity training and with the exception of six all staff had attended dementia awareness training. We saw a certificate for the nurse manager showing that she was Qualifications and Credit Framework certified to provide training for the lifelong learning sector, and were told by staff and the manager that she ran a lot of the in-house training sessions.

When we spoke with staff they said they had regular supervision and appraisals and these were helpful. The supervision policy stated that supervision should take place at least every two months and last at least 50 minutes. The appraisal policy stated that appraisals were annual. We requested dates of last supervisions and appraisals whilst on inspection and these were sent to us after the inspection. We saw notes for clinical supervision and appraisal, all of which kept within the policy recommended time frame and had review dates on them. The notes were brief but did identify areas for improvement and were signed by each staff member and their supervisor.

We sat with people whilst they ate their lunch and saw that they ate in their chairs in the lounge rather than at the dining table. There were no menus on display in communal areas to remind people what was on offer for their next meal; this was commented on by a relative in a feedback form to say they had not ever seen a menu. We did not see any adapted cutlery or plateware to enable easier feeding and self-feeding. Where people were being supported to eat we saw that staff sat with them and one person was left to take their time over their meal and feed themselves. We did notice that mealtimes were disorganised and fed this back to the manager, for example one person who was feeding themselves and was spilling their food only had a napkin provided towards the end of their meal rather than at the beginning. We looked at food and fluid charts and saw that these were filled out regularly with no gaps and fluid intake was being totalled at the end of a 24 hour period so that staff could check people were hydrated according to the records. In communal areas there were jugs of juice and squash in one corner and people had fluids within reach of them but we did not see in every person's bedroom that they had fluid to hand if they were thirsty.

Good

Is the service effective?

We spoke with the chef who showed a good understanding of the varying needs of people in the service, and who was flexible about what he was cooking and would adapt the meals to preferences. In the kitchen there was on clear display a chart with allergies, swallowing needs, and personal and cultural preferences so that each meal could be checked before it went out. Food temperature checks were being completed and there were no gaps in the records. The food was all in date and stored in sealed tubs and labelled. The kitchen was clean and well organised and a food hygiene rating of very good had been awarded on 18 August 2015 by the Food Standards Agency.. A food survey had been completed by five people and their relatives in the last six months and all had positive comments on them about the food with some suggestions such as “more vegetables please”. When we spoke with staff and people using the service they told us that the menu was taken round in the morning and people could choose whether they wanted to have the meal listed on the menu or choose something different from an alternative list. We saw that there was a good choice of food available for people to choose from with halal and kosher options, and that nutrition needs were being met.

The building is an adapted house spread over four floors with one lift which travels to each floor. We found the building difficult to navigate as each floor and corridor was not distinguishable. There was no signposting in communal areas to show people where the lounge or bathrooms were and this may have made it hard for people with dementia to locate themselves and did not contribute to a homely atmosphere. Peoples’ doors had their names on them and room numbers in very small print but no personal effects or pictures to identify the rooms as belonging to individuals from the outside. A notice with the date and day on it was in the corridor, visible to people only as they were taken from the lift into the lounge. We fed back to the registered manager that the premises could be adapted easily with putting clear signposting up for where rooms were and labelling cupboards and everyday objects.

Requires improvement

Is the service caring?

Our findings

People and relatives that we spoke with, without exception said they found the staff caring, one person said "I like the staff, they do look after us." One person who we spoke with described how they had arrived after a long hospital stay and looked up from their stretcher and saw three smiling faces. They said "I can't tell you how welcoming they all were…it was such a relief". People and their relatives said that visitors were made to feel welcome and staff were accommodating. For example one person told us of a relative visiting from abroad who had come very early in the morning and was welcomed by staff.

Staff were not always respectful of people's dignity and privacy. When asked whether staff knock before entering a bedroom for example, one person laughed and said, "Most of them. One or two don't." Staff were observed knocking on bedroom doors but rarely waiting for an answer before entering and were not seen to announce themselves by name or ask if they could enter.

After lunch in the lounge, a staff member was observed approaching a person and asking loudly and in a manner that could be heard by the whole room, "do you want to go to the toilet?" We observed that when using the hoist to raise a person in their chair, staff members left the person's stomach exposed throughout. No effort was made to cover them up until the procedure had been finished.

We observed that the use of the hoist was efficient but that people were given little reassurance or encouragement. People were not requested to make movements but instructed in a tone that though polite, was delivered as a command. They were given no opportunity to have any control or say over what was going on. This was observed on three occasions. The first shortly before lunch at 12.45pm when a person returned from the toilet and was hoisted back to their armchair. There was no conversation with the resident, who had good communication skills, just a series of instructions including, "feet up please" and, "going down." After eating, (approximately 1.30pm) another person was taken to the toilet and was moved from armchair to wheelchair without a hoist but with the help of a walking frame. The person was given a string of commands as follows, "Stand up please." "Put your feet straight." "Move forward." "Sit back - Sit back please." Their feet were then placed on the wheelchair footplates without any communication at all. Shortly afterwards, at 1.45pm staff assisted a person with no verbal communication and very limited mobility who had to be hoisted up as he had slid down in his armchair. Nothing was said to the person during the entire procedure. At one point, while they were hanging in the sling, the staff member stopped to discuss with a second staff member what they were doing, referring to the person in the third person before lowering them into the chair. They were then pulled forward by their sweater at the shoulder in order to remove the sling. There was no interaction with the person, no announcing of what was about to happen at each stage and no comfort or reassurance offered throughout.

During lunch two staff were observed having a whispered conversation while one of them was assisting a person with eating. The conversation was in the care workers' native language. At several points during a game of bingo staff members slipped into their own languages in front of people when addressing other staff. We heard on several occasions throughout the day staff members whispering to each other in communal areas and corridors and then stopped when we approached or walked past. This may have made people feel uncomfortable as staff were not being open about what they were communicating, both in the language they were using and in their whispering.

The above evidence demonstrates a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were observed to be kind and friendly in their approach to people in most interactions. However, with the exception of the organised activities, all interactions observed were task based such as supporting to feed, or repositioning. We observed positive social care from the manager who spoke warmly with each person in the lounge during the morning and appeared to know everybody well. Other staff were largely absent from the lounge until the late morning. While there, they were mostly working on charts and notes. One staff sat with a person before lunch but made no effort to communicate with them beyond occasionally showing them a stuffed toy. During a 15-minute period before lunch, there was silence in the lounge except for the television on low in the background. Signs of wellbeing were visible in the communal lounge with people smiling, engaging with one another making choices and generally spending time as they wished, others were sleeping or quiet. Some people in their bedrooms showed less signs of wellbeing. In one

Requires improvement

Is the service caring?

bedroom the room was darkened and the television and radio were not on on three occasions when we entered the room, we asked staff about this and they opened the curtains and put the radio on.

When we spoke with staff we were told that that there were no people on end of life care currently. Staff said they received good support from the local hospice and were addressing the Gold Standards Framework in end of life care. In care plans that we looked at there was some information about end of life and this referred to people's wishes for end of life care. In one person's file the do not attempt resuscitation (DNAR) form was located in the middle of care plans, which would be difficult to access in the event of a resuscitation situation occurring.

Requires improvement

Is the service responsive?

Our findings

We saw that care files were not person centred and did not always reflect the preference of people, they used several of the same phrases and sentences, with many general and nonspecific interventions such as "discuss with multidisciplinary team, "ensure privacy".

One file we looked at had a personal information sheet which recorded how many children people had, previous occupation and interests and basic medical information. In three other files that we looked at this information regarding social and physical history was missing. In each file was a record of a pre-assessment visit so that needs could be assessed before moving into the service. There was also a nursing assessment which we were told provides the basis for the care plan, and these assessments were conducted by the clinical lead nurse.

Reviews were very limited and did not provide an overview of what had happened in the preceding month since the last review. These documents lacked details about what actions could be taken and specifics of how care was to be delivered. For example for one person's lifting assessment it said "nursed in bed" with no further explanation. A continence assessment and plan we looked at did not give guidance on what continence wear was to be used or frequency of changes needed. The records were handwritten and difficult to read in places which would have made it hard for staff to understand the needs of this person and how they were to be met through care.

Some of the information in care plans was contradictory. For example one person's care plan referred to cleaning the catheter and then on the bottom of the page it had a handwritten addition that the catheter had been removed, showing the care document to be out of date and needing rewriting. One person's continence assessment dated 15 November 2013, referred to a catheter with an additional entry stating it had been pulled out. The same care file noted an infection but no guidance or timeframe around how this was to be managed or reviewed. In another care file on the nursing assessment, it referred to the person as on a soft diet. The care plan regarding nutrition referred to diabetes and the possibility of hypo or hyperglycaemic attack, but did not make reference to the soft diet required.

Personal preferences such as what times people liked to go to bed, if they preferred a bath or shower, or male or female care staff were not recorded on care documents and people were not consulted on them on an ongoing basis. We asked people if they went to bed when they chose to and were told by one relative they had been surprised on visiting the home at 6pm to find their relative already being taken back to their room from the lounge. The relative said to a member of staff that it seemed a bit early but the staff member said that was what the person had wanted. The person had reported to his relative that was not the case, and "they just moved me." The relative then returned to the lounge before leaving the home at 7pm and found it deserted. All the people had been taken to their rooms. One relative said "I'm not sure there's enough "what do you want to do"'. When we spoke to a person using the service about choice and control over their care they said they have an occasional shower and referring to speaking to staff about it said "I don't ask. I think it's when they want to…they can't do everyone at once."

We saw that in one person's care documents it was repeated that they stay in bed and cannot partake in any activities and are bathed and toileted in their bed. No justification was given for thison care records other than "medical conditions" and when we asked a nurse and care staff they responded with "he slips out of his chair" and "he has a PEG feed". A Percutaneous endoscopic gastrostomy (PEG) is where a tube is passed into someone's stomach through their skin to help them feed. We went to this person's room three times to see them and found that on the first two occasions the curtains were partially drawn and there was no television or radio on. When we spoke to them about something from their life that was noted in their care file they moved their legs and eyes and responded. When we asked a nurse about this and why they were left alone they said that he does not understand anything that is said and cannot respond. We fed back to the manager that it was unclear why this person was isolated in their room. The manager and nurse manager said that they had poor sitting balance and therefore were at risk out of bed. It was also not clear what stimulation was provided for those people who remained in their rooms or those who were only brought to the lounge later in the day and were not included in any activities. We saw ten people that had used the lounge throughout the duration of our inspection. One person that we spoke with said they stayed in their room out of choice and found the lounge "too noisy and there's no one to have a

Requires improvement

Is the service responsive?

conversation with". Some people who were unable to vocalise their wishes appeared to spend the majority of the day alone in their rooms which may have put them at risk of isolation.

The above evidence contributes to a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A list of activities was posted in the entrance of the home and outside the lift for people to see. We saw activities taking place in the lounge in the morning and afternoon. In the morning there were eight people present, three of whom took part in a memory word game. The registered manager who ran the activity also spent time sitting with other, less communicative people, and talking to them. In the afternoon more people took part in a popular bingo game by request. Care staff assisted the less able people and the atmosphere was lively and engaging. There were ten people in the lounge at this time.

People were supported to go into the community when possible. One person we spoke with told us they were encouraged to go out with friends and relatives and that care home staff regularly suggested they try going shopping with a care worker. A plan had been made to do this in the near future. The manager and nursing staff told us that they regularly had the faith needs of individuals met and that they had good relationships with the local imam, priest, rabbi and Buddhist monk who were invited into the home to provide one to one pastoral support for those people who identified with those faiths so they could maintain their religious practices.

We were told by people that they had regular meetings with the registered manager and fed back into the running of the service. One person said "Nothing's missed. If I mention something it's passed up and made a note of. Someone comes to see me to talk about it even if it's just a slight comment I've made". When we spoke with the manager she said that she spends most mornings interacting with people in the lounge and going into their rooms and finds that is a good opportunity to gather feedback on a daily basis about care but that also there was a complaints and compliments process in place. We saw the complaints procedure on display in the entrance hallway and a policy was in place with complaints recorded and notes made of when and how they had been actioned. Feedback on documents completed by relatives that we looked at was that messages were always passed on acted upon.

Requires improvement

Is the service well-led?

Our findings

The service was held in high esteem by people using the service, relatives and staff. The feedback we had was that people were happy in the service and that relatives and other professionals felt the service offered good care and support. From our observations we saw the registered manager interacting with people in a caring way but did not see this with all interactions taking place between junior staff and people. This showed that there was a training need for some care staff in how to talk to people when completing a care task and the caring attitude that the registered manager had did not come across in the work of some of the care staff.

The registered manager had some audits in place to assess, monitor and improve the quality of the service. However, these audits had not identified the issues we found in relation to assessing and managing risks to people, monitoring of communication and dignity and respect and having up to date accurate records in respect of people's care planning. We saw records for auditing care plans that had a date of last review and were ticked "Yes" but with no actions or further comments. This showed that there was not an insight into or acknowledgement that the care plans needed updating fully and the style of them reviewing so that they showed all needs in one place with specific person centred actions to guide how care is delivered. Some records that were sent over after the inspection showed that checks were being done by staff, but did not show that any learning or improvement were being taken from them or that there was a general overview from the registered manager.

Some management tasks, such as ensuring audits and record reviews, had not been thoroughly undertaken. Care records and risk assessments were not consistently reviewed and updated. These concerns were not reflected in the experience of people and relatives during this inspection but they raised potential risks of unsafe and inappropriate care and treatment if not rectified and highlighted gaps in the governance of the service.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Leadership was visible within the home with the registered manager interacting with people using the service and staff throughout the day. The registered manager was supported by a nurse manager who we also observed supporting staff. A clinical lead was also in post to improve clinical practice and conducted clinical audits and shared nursing clinical supervision with the nurse manager. Our observations and discussions with staff showed they were clear about their roles and responsibilities and what was expected of them during their shift.

We saw evidence of partnership working taking place, visiting professionals that we spoke with said that they had found the service accommodating and their communication was good. The manager told us the GP visited the home once a week or when required to attend to a person's needs. We saw records and care notes that there had been visits from local GP, opticians, chiropodist and social workers and feedback had been gathered from these using a questionnaire, the answers to which were positive about the service.

The registered manager told us that about how staff were attending more external training and how the service could reflect on its practice more by getting a fresh perspective on best practice in care, particularly in the area of dementia care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to the health and safety of people receiving care or treatment were not assessed. Regulation 12 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect and their privacy was not always ensured.People were at risk of isolation and not always involved in the community. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not well established to assess, monitor and improve quality and safety of care received by people or mitigate the risks, or maintain an accurate, contemporaneous record in respect of each person. Regulation 17 (1) (2) (a) (b) (c) (f)