Lister House Limited

Sherrington House Nursing Home

Inspection report

13 Heaton Road
Heaton
Bradford
West Yorkshire
BD8 8RA

Tel: 01274494911
Website: www.lhnh.co.uk

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Sherrington House is a purpose built care home offering care for up to 39 people over three floors. There is a lounge and dining area on each floor and disabled toilet and bath facilities. The home is situated in the Heaton area of Bradford with good access to local amenities and public transport.

At the previous inspection on 30 and 31 March 2016 we rated the service 'Requires Improvement' and identified a breach of regulation relating to the way records and documentation was managed. As part of this inspection, we checked whether improvements had been made.

This was an unannounced inspection which took place on 25 January 2017. On the date of the inspection there were 39 people living in the home.

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

Feedback about the service from people and relatives was positive. People said they felt safe in the company of staff and that they had no concerns over the way care and support was provided.

Overall most medicines were managed safely, although as at the previous inspection, the recording of the application of topical medicines such as creams required improvement.

Safeguarding procedures were in place and we saw safeguarding incidents were thoroughly investigated and action had been taken to help prevent a re-occurrence. Incidents and accidents were logged, investigated and analysed for any themes or trends.

Risk assessments were undertaken and these were subject to regular review. However risk assessments did not always contain the required level of detail about people's care or the equipment they had in place to keep them safe. People were encouraged to maintain freedom and take positive risks.

Overall, we found sufficient staff were deployed to keep people safe. People told us they thought there were enough staff deployed to ensure safe care. We found the staff team were busy and some staff said they could do with an extra pair of hands at times. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

The premises was safely managed and there was adequate amounts of communal space for people to spend time. The home was clean and hygienic with no offensive odours.

People spoke positively about the food provided by the home. We saw there was sufficient choice and

action was taken to support people who were at risk of malnutrition.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. People were asked for their consent before care and support and their opinions and views respected.

People said staff were kind and caring and treated them well. Staff demonstrated a good knowledge of the people they were caring for and we saw a personalised approach to care and support.

People's care needs were assessed and plans of care put in place. Although some care plans contained good person centred detail, others lacked the necessary detail required. The recording of care and support interventions on the electronic care recording system was not consistently undertaken. Although this shortfall had been identified by the registered manager it had not yet been fully resolved.

People told us they had access to a range of suitable activities and social opportunities.

People and staff spoke positively about the registered manager and said there was a positive and supportive atmosphere within the home. They said they felt able to raise issues with management and these were usually resolved.

A range of audits and checks were undertaken by the registered manager, who demonstrated a commitment to continuous improvement of the service. Whilst checks were effective in identifying issues, persistent problems relating to the completion of documentation, had yet to be fully resolved.

We found one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People provided positive feedback about the safety of the service and said they felt secure and safe from abuse. Action was taken to investigate any concerns raised about the service or staff.

Most people's medicines were managed safely, although there was a lack of evidence people were receiving their topical medicines such as creams as prescribed.

Risks to people's health and safety were assessed and plans of care put in place. Some of these needed to be updated to reflect people's current needs.

Overall we concluded staffing levels were suitable although staff reported they were very busy.

Is the service effective?

Good

The service was effective.

People told us staff had the right skills to care for them. Staff received regular relevant training. Staff told us they felt well supported in their role.

People spoke positively about the food provided. People had access to a choice of suitable nutritious food.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were assessed and the service worked in partnership with other agencies to help meet people's individual healthcare needs.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and said they treated them

well and with dignity and respect. We saw good positive relationships had developed between staff and people.

People felt listened to and we saw people's comments were acted on by the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People spoke positively about the service and said care and support met their individual needs.

Care plans were in place, however these did not always contain the necessary detail relevant to people's care and support. Care and support interventions were not always robustly documented on the electronic care system in line with people's plans of care.

The service made reasonable adjustments to deliver care and support in line with people's individual needs and beliefs.

A system was in place to log, investigate and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A registered manager was in place. We found a positive culture within the home with the registered manager committed to further improving the service.

A range of audits and checks were undertaken and these were successful in identifying issues such as inconsistent completion of documentation. However although identified, these long standing issues with the completion of documentation had yet to be fully resolved.

Sherrington House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 January 2017 and was unannounced.

The inspection team consisted of two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned to us in a prompt manner.

On the day of our inspection we spoke with ten people who lived at Sherrington House Nursing Home, five relatives or visitors, four care workers, two registered nurses, the cook, the registered manager, another manager and the provider. We spent time observing care in the lounge and dining room. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; four people's care records, staff recruitment files and records relating to the management of the service.

We also spoke with four health or social care professionals who regularly liaise with the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure living in Sherrington House Nursing Home. One person told us, "I feel safe, there's nothing unsafe about the home." Nobody we spoke with reported any incidents of poor behaviour on the part of the staff. One person told us, "I have never seen anything or any behaviour that concerned me." Another person told us, "From what I have seen they treat everybody properly." Staff we spoke with demonstrated a good understanding of safeguarding and how to identify and act on allegations of abuse. They told us they had never witnessed anything of concern whilst working in the home. People and staff were encouraged to raise concerns in a number of ways through one to one discussions with management and safeguarding had been on the agenda of recent staff and service user meetings. Where safeguarding allegations had been made, we saw detailed and thorough investigations were undertaken to help ensure people were kept safe. This included producing an action plan to work through to further improve safe working practices. Where the home identified possible safeguarding concerns, appropriate referral took place to the local authority safeguarding team, although we noted two incidents which were not referred to the Commission in line with the provider's statutory responsibilities.

Risk assessments were in place for areas of risk which included nutrition, pressure ulcers, falls and other areas of risk specific to individuals such as bed rails. Risk assessments were subject to regular review. We found when people were assessed as being at risk of developing pressure ulcers there was equipment in place to reduce the risk. However, the risk assessments and care plans we looked at did not always have information about the type of equipment being used. For example, one person's records stated they had an air mattress and cushion however we found they actually had a foam mattress and cushion. Another person's records stated they should be nursed on an 'appropriate mattress and pressure relief cushion' but did not specify what this was. We raised this with the registered manager about the importance of ensuring risk assessments reflected the current care and support people were receiving.

Incidents were recorded on the electronic care management system. We saw these were reviewed by the manager and preventative measures put in place to prevent a re-occurrence for example around falls management. Where appropriate, people were given the freedom to maintain their own risks for example in accessing the community and making their own daily life choices. People and relatives felt that staff managed risks well while encouraging individuals to be as independent as possible. One relative said, "They manage the risks well and keep them as independent as possible." They went on to say, "They explain minor injuries like scrapes straight away."

We undertook a tour of the premises. The building was kept in a clean and hygienic condition and was safely managed. The building had adequate communal areas for people to spend time in, which included a large lounge/dining room and several smaller lounges. We found the building to be appropriately maintained and suitable for its purpose. Rooms had been personalised by people to make them more homely and individualised.

We found most aspects of the medicine management system were safely managed. At the last inspection we identified issues with documentation of the medicine management system. Improvements had been

made in a number of areas, however issues remained in the recording and management of topical medicines such as creams. Medicines were administered by nursing staff who had received training in medicines management and had their competency to safely administer medicines observed on a periodic basis.

Topical medicines such as creams and lotions were not always managed safely. Following the last inspection, where shortfalls had been identified in the way topical medicines were recorded, the registered manager had set up a new system whereby staff were required to record details of people's prescribed creams and their application electronically. However this had not been fully successful and we found the information held electronically did not always correspond with the information in people's Medicine Administration Records (MAR), and care plans. Records indicated that three people had not received their prescribed creams at the frequency noted on their prescription. In addition, for one person, we identified the creams in their room did not match the creams stated on their MAR which meant we could not be assured they were receiving the correct creams.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We looked at the MARs for other medicines and found they were consistently completed indicating people had received their medicines as prescribed. Most medicines were provided in pre-packaged dosette boxes from the pharmacy and MARs were printed from the pharmacy which reduced the risk of errors. Where hand written MARs were in place we saw these were checked by a second staff member to reduce the risk of errors. Arrangements were in place to give medicines to people at the right times. For example, night staff administered medicines which had to be given at a certain time before meals. Appropriate arrangements were in place to store medicines securely and at the right temperature.

Where people were administered boxed medicines, we saw stock balances were routinely recorded on the MAR to provide full accountability for the medicines in stock. We checked the stock of medicines compared to what should have been present if people had received their medicines as prescribed. Stock balances tallied which indicated people had received their medicines as prescribed. However in one case, we found the stock balance had not been correctly carried forward from the previous month making it difficult to establish how many tablets should be in stock.

Some people were prescribed "as required" medicines. We saw protocols were in place for these medicines and when they were given the reason for administering was recorded on the back of the MAR chart.

Regular audits were undertaken by the management team which looked at medicine management. We saw these had been effective in identifying issues such as missing signatures and lack of recording stock balances. This gave us assurance that any further discrepancies of this nature would be identified and rectified within a prompt timescale.

Safe recruitment procedures were in place. We looked at three newly recruited staff files. There was evidence of an application form, interview notes, identity checks, disclosure and barring service checks and at least two references provided. This demonstrated appropriate checks on new staff were undertaken. We saw records of nurses personal identification number (PIN) were recorded in their recruitment files to provide assurance that nurses were correctly registered. Staff we spoke with confirmed they had been subject to the required recruitment checks.

Overall we concluded staffing levels were sufficient for the needs of the people living in the service. At

previous inspections we found recruitment had been challenging and agency staff were regularly used. At the time of this inspection, the service was close to being fully staffed and as a result no agency staff were being used. We found a more stable staff team who were more familiar with people and their needs. Staffing levels were calculated using a dependency tool which looked at people's needs and the care and support they required. People and relatives we spoke with all felt staffing levels were sufficient although two people commented that at times staff were very stretched and did not always have time for much of a chat. One person told us, "Sometimes they are really busy but there are usually enough." Nobody reported that there was an unacceptable delay in responding to the buzzer. One person said, "They come for the buzzer straight away or pretty quick" and another person said, "The buzzer response is a couple of minutes." Staff provided mixed feedback about staffing levels. Staff said they were constantly busy but managed to respond to people's needs within an appropriate timeframe. One member of staff said they felt they needed an additional member of staff, to ensure documentation was consistently completed and to reduce stress and pressure on the staff team.

Good

Is the service effective?

Our findings

We found staff had the right skills and knowledge to care for people. Everybody we spoke with responded positively about the skills and knowledge of staff. One person told us, "They are well trained they have to look after all types of people's illnesses" and another person told us, "They are well trained and know what they are doing."

New staff without previous care experience were required to complete the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards.New staff also received a local induction to the service. This included a tour of the premises, the aims and objectives of the service and familiarisation with the service's policies and procedures. New staff undertook a period of shadowing for up to five days to become familiar with the home, the people that lived there and the ways of working. A care worker told us they had shadowed for five days when they started work despite the fact they had many years of experience in care work which showed the provider was keen to ensure staff understood people's needs before working alone.

Staff received regular training in subjects such as safeguarding, moving and handling, health and safety. This had previously been delivered by the registered manager but an external training provider had been enlisted to provide the majority of this training going forward. We saw training was mostly up-to-date, with a plan in place to address any training that had recently expired. A training programme was in place for 2017 to provide a structured approach to future delivery.

Staff received specialist training relevant to their role. 93% of staff had received skin integrity training in 2016. In addition, two members of staff had recently received updated 'React to Red' Pressure Ulcer Prevention training delivered by local health professionals aimed at raising awareness over skin health, with the aim of helping to prevent pressure ulcers. These two staff were identified as champions within the service and had trained up a number of other staff, with further training of the workforce planned. We spoke with an external health professional about this who stated the home had made good progress with regards to this training.

Staff said they felt well supported by the management team. Staff received unscheduled supervisions which were held with staff to address specific quality issues picked up through the registered manager's audits and checks. However, staff did not always receive regular supervision unless specific quality issues were identified. This is important to provide a support mechanism for staff. The registered manager recognised this shortfall and said they would take action to address this matter. Annual appraisals took place. An appraisal plan was in place for 2017 to ensure all staff continued to receive timely appraisal. Appraisals asked staff to reflect on what worked well and in which areas their practice could be improved.

People we spoke with praised the food provided. They all said it was generally good with plenty to eat and drink. One person said, "Food is absolutely fantastic, too much really, well cooked and hot." People were happy with the variety of meals and with the care taken to ensure they had the correct diet, one person told us, "I am on a special diet but they know about it." During observations of care we saw people were

supported patiently and appropriately with meals. People confirmed this was always the case, for example one person told us, "They are good at helping at mealtimes."

Menus were displayed in the home in pictures and words and showed the different options available at each mealtime. People were involved in the creation of the menu with their choices and preferences used to formulate a suitably varied and nutritious menu. People had access to a range of options at each mealtime, including at breakfast, a cooked option, cereals and toasts. At lunch there were two hot options available plus alternatives if people did not like what was on offer. In the evening, a range of snacks and lighter meals was available. The chef told us all meals were home-made and we saw they made home baked cakes each day as well as providing other snacks such as fruit. We spoke with the chef about people's dietary needs and preferences. They showed us how information on people's dietary needs was held by the kitchen to ensure they met people's individual needs. Food was fortified and milkshakes were made for people who required a high calorie diet. The kitchen kept a list of people's birthdays and provided them with a cake on their birthday to help make their birthday special.

During observations of care, we saw people had access to a range of food and drink throughout the day. This included tea, coffee and juices as well as cakes and fruit. We found the lunchtime dining experience to be pleasant. Staff were involved in interacting with the diners encouraging people to eat and asking them if they were happy with the food. The food looked good and was served in a large portion size. People were offered drinks with their meals and throughout the day. We saw people could choose where to have their meals with some people preferring to eat in their rooms while others went to the dining room. Care staff said they thought the food people received was 'excellent'. They said there was no shortage of food and drinks for people.

We saw people's nutritional status was assessed using the MUST (Malnutrition Universal Screening Tool) which is a nationally recognised assessment tool. The registered manager told us people's weights were checked at the beginning of the month and they reviewed the records. They said they would ask for people's weights to be checked again if there was a significant difference from the previous month. The records showed the majority of people who used the service were not at risk of malnutrition as their weight was within the healthy range or they were overweight. We found a small number of people had been assessed at being nutritionally at risk. These were people with complex care needs and in most cases they had long standing issues with nutrition. We found action was being taken to manage the risk; however, this was not always clearly evidenced in people's care records. This was discussed with the registered manager.

People's food and fluid intake was recorded in the electronic care records. The registered manager told us they checked the records, in particular the fluid intake records, and sent reminders to staff if they found people were not receiving enough fluids. They registered manager told us they were monitoring one person's fluid intake to check if there was a link between a low fluid intake and the number of falls the person had. This demonstrated the information was monitored and used to improve people's care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

The manager had made appropriate DoLS referrals for some people who lived at the home that lacked capacity to consent to their care and treatment and were subject to a high level of supervision and control by staff. At the time of the inspection there was one DoLS in place, with further authorisations applied for which were with the local authority awaiting assessment. The registered manager demonstrated a good understanding of the correct process to follow, which provided assurance that the service would continue to act appropriately within the legal framework and make further referrals where appropriate. However we found some staff did not have a full understanding of DoLS and who had one in place, although staff had a good understanding of how to ensure consent was gained. Staff were able to give examples of consent from their day to day work. This included examples of people's right to refuse care and treatment. They explained their approach when people did not have capacity. For example, judging by people's body language whether or not they were happy with the support being provided. We observed staff offered consent and promoted choices with people before providing care and support.

Mental capacity assessments were in place within people's care and support plans. Although these were improved since the last inspection, further work was needed to integrate mental capacity into each care and support plan as these were of variable quality. We saw evidence of best interest processes being followed when people lacked capacity. The registered manager was able to give us an example of one ongoing best interest process and we saw the process for giving medicines covertly was managed correctly.

People we spoke with felt that there was good access to other health care professionals. One person said, "They will always sort out the GP or opticians or anybody." The service worked in partnership with others to make sure they trained staff to follow best practice guidance. This included the tissue viability service. In addition, the home had recently entered into a contract with a local health professional team to provide an enhanced package of training and support. This focused on weekly visits by the team to help support staff with nutrition and swallowing. The home was only the second provider within the Bradford area to enter into this enhanced programme of support and showed the provider was committed to using external expertise to improve the effectiveness of the service. External health professionals we spoke with told us they believed the service provided good quality care.

Good

Is the service caring?

Our findings

Everyone we spoke with told us the staff were kind and caring and treated them well. One person told us, "They are nice and caring and kind." Another person told us, "You can have a good laugh with them." A third person told us, "They are friendly, kind and mostly caring." although they did say, "The night staff are not as good as they could be." A fourth person said, "Staff are absolutely outstanding, they will spend time if they see you are upset." A relative told us, "They are very friendly to visitors and everybody" and another relative told us, "The staff are nice and caring and talk to her properly."

Staff we spoke with demonstrated good, caring values and a dedication to providing personalised care and support to people. We observed care and support and saw staff interacted with people warmly. Staff were busy but constantly assisting and engaging with people in a friendly manner.
Staff engaged people in conversation and shared jokes with them as well as undertaking care based tasks. It was evident from observing care and speaking with staff that staff and people knew each other well and had developed positive caring relationships. Information on people's preferences, and life history was present within their care and support records. This demonstrated staff had learnt about people to aid in the provision of personalised care.

Everybody felt that they were treated with respect and dignity. One person said, "They treat me with respect and look after my dignity" and "They make sure I understand things if they have to tell me something." A relative told us, "They always respect [relatives] privacy and dignity." We observed care and saw personal care was undertaken behind closed doors, and staff knocked on doors before entering. People looked clean, were dressed in appropriate clothes and looked well cared for, indicating their personal care needs were met by the service.

People told us that staff promoted independence by allowing them to make decisions regarding their daily routine. One person said, "They let me be as independent as possible." We saw measures such as adaptive cutlery and plate guards were in place to help promote independence. People were able to take positive risks for example in accessing the community and developing their independence. One person told us how the service had helped them to rehabilitate and develop their mobility and they were now much more independent. During the inspection, we saw staff assisted the person to further improve their mobility by taking the time to support them to mobilise around the building.

People told us they felt listened to, that the staff chatted to them and they felt their opinions mattered. One person told us, "They listen to me and make me feel important." We saw people had been supported to access Independent Mental Capacity Advocates (IMCAs) where appropriate. People were encouraged to air their views through review meetings, service user meetings and more informal discussions with staff. However, the electronic recording system operated by the home was not fully conductive to recording people's opinions and views regarding their care.

Relatives reported they were able to visit the home when they wanted and nobody reported any restrictions on visiting.

There was evidence end of life care planning in place where appropriate and care records showed whether people had a Do Not Resuscitate form in place. The forms we looked at had been completed correctly.

Requires Improvement

Is the service responsive?

Our findings

Everyone we spoke with was happy with the quality of the care provided by the home. One person told us, "I have a good standard of care" and another person said, "The care is absolutely brilliant compared to other homes." A third person told us, "If I hadn't arrived when I had, I would be dead, this place has saved my life." During observations of care and support we saw staff were responsive to people's individual needs. For example, one person had difficulty in swallowing towards the end of their main course, the care staff noticed and responded quickly and in a kindly fashion helped the person clean themselves whilst maintaining their dignity. Staff were attentive to people's responses for assistance with toileting, and in dealing with any anxieties or distress. People told us staff "checked up on them lots" during the day to ensure they were okay.

Reasonable adjustments were made for people to ensure their individual needs were met. This included the provision of adaptive equipment and food which met people's individual needs. Religious services were held at the service to help meet people's spiritual needs.

At previous inspections we found risks associated with care plan documentation and care interventions not being fully completed. We found whilst in some cases, care plans were better populated with information, variable quality of care documentation was still an issue at this inspection. People's needs were assessed and there were care plans in place. However, the care plans did not always accurately reflect people's current needs. In addition, daily care notes did not always show care was being delivered in line with the care plans. For example, in one person's records the care plan about dietary needs referred to dietary supplements which the person was no longer receiving. In the same person's records the instructions for care staff stated they should carry out checks every half hour because of the high risk of falls but the daily care notes showed staff were doing hourly checks. In the same person's records the mobility care plan contained no clear instructions about how staff should support the person to move. Staff told us the person was able to transfer using a zimmer frame, although the zimmer frame was referenced in the evaluation it was not mentioned in the actual care plan. In another person's records we saw they sometimes presented with behaviour which challenged. There was a care plan in place but it did not provide clear guidance for staff. For example, the care plan stated staff should be aware of 'triggers' (things likely to cause behaviour) but did not state what they were. Similarly, the care plan stated staff should use 'diversionary techniques' but provided no detail. When we spoke with care staff they were able to tell us about the person's interests and how they used this information to engage with the person and encourage them to accept care and support.

Although staff told us that they performed daily skin checks on people who were at elevated risk of pressure ulcers this was not always recorded in a consistent manner. Staff were recording daily skin checks both on paper and electronically, however neither was completed in a consistent manner in line with local health professional advice. However staff we spoke with demonstrated a good awareness of pressure area care and we saw appropriate equipment was put in place where people were at risk which was subject to regular review.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw examples of care plans being followed and staff we spoke with were aware of people's care regimes, for example how much thickening agent was required in their drinks and the required pressure area care they required. This gave us assurances that overall people were receiving care and support that met their individual needs.

People and relatives reported they were involved in the care plan creation and review. One relative said, "I am not involved in the care plan as she does it herself" and another told us, "I do discuss the care plan with the staff." Although we saw this was the case, the electronic care recording system made it challenging to record people and relative's involvement.

Overall people praised the activities provided at the home. One person told us, "There are enough activities for me I can choose to take part if I want to." Another person told us, "I do some activities but I am involved in other things at that time." A third person told us, "It's my choice not to attend the activities, they encourage you but respect your choice." Overall relatives thought there were sufficient activities. One relative told us, "There are enough activities for her" and another said, "I suppose there could be a few more activities it's getting better lately." Although a dedicated activities co-ordinator was not employed, we saw numerous external visitors came in to provide events such as exercise, music sessions. Staff also engaged people in activities and a weekly activities schedule was on display.

People told us they were satisfied with the care and did not have any reason to complain. One person told us, "I have never wanted to complain but I think I know how." A second person said, "I have no complaints but I have an idea of how I could make one" and a third person told us, "I don't want to complain but I know the management and everybody would be happy to do something if I did." Where people had complained about things previously they said their complaints had been resolved. For example, one person told us, "I did complain about putting me to bed too late, it's sorted out now and I am now going when I want." Another person said, "I have complained about minor things, always obliging and dealt with straight away."

We saw a low number of complaints had been received about the service. A complaints log was maintained to monitor the number of complaints and the action taken. We saw the registered manager investigated any concerns and complaints in a thorough manner. People told us that they were satisfied with the service and had no cause for concerns. A person told us, "If you have any issues they are attended to straight away."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place. Whilst we found the majority of incidents were notified to us, we found two safeguarding incidents which should have been reported to the Commission. Although these incidents had been handled appropriately by the service, we raised this with the registered manager and reminded them of their legal duty to report these types of incidents.

All the people and relatives we spoke with told us they were happy with the care experience provided by Sherrington House Nursing Home. One person told us, "It runs like a well-oiled machine, amazing when you think how complicated it is." People and relatives said they would be happy to recommend the service to others. One visitor told us, "I would be happy to come here myself and have already recommended it to several people." Health professionals we contacted spoke positively about the service.

People knew who the registered manager was and spoke positively about them. One person said "I do speak to the manager she is very approachable." A second person said, "I speak to the manager every day she comes around each morning to check up" and many people said it was a well-run and managed home. Relatives were also complimentary about the way the service was run.

Staff told us morale was good within the home and that they felt well supported by the management team. We observed an open and inclusive culture with staff getting on well with people living there.

Although we identified further discrepancies with documentation as at previous inspections, we felt assured that the registered manager was leading the home in the right direction, slowly improving working practices, organisation, staff skill and the overall quality of service provided. A number of initiatives were planned to improve the quality of care further including more extensive training and support for staff and more productive ties with local health professionals to help share their expertise and knowledge. The staff team was relatively stable with less agency use and recruitment challenges previously had been addressed. A care worker told us there had been lots of recent improvements and the staff team had improved as they became more stable and experienced.

Systems were in place to assess, monitor and improve the quality of the service. The registered manager regularly undertook audits and checks on care records which could be done quickly and effectively through use of the electronic care record system. They regularly monitored people's fluid intake and where this raised questions about whether people had received regular fluids this was flagged up with the staff concerned. Care and support plans and entries in daily records were regularly checked by the registered manager and emails sent to nursing staff to ensure any deficiencies were addressed. Whilst we found these checks were effective in identifying issues, quality assurance systems were not fully effective in ensuring the necessary improvement with regards to the consistent documentation of skin checks, position changes and regular checks. We asked the registered manager to review in depth the underlying reasons why staff were unable to consistently complete documentation despite it being raised previously by ourselves and by the registered manager on an on-going basis.

Audits were undertaken in other areas such as people's weights, and pressure area care. Mealtime experience audits were undertaken and we saw these had been used to help improve people's experience. Hospital admissions were monitored to establish the cause and determine whether they could have been prevented.

Medicine management audits were undertaken. We saw evidence these were regularly identifying issues which were flagged up with nursing staff. Whilst this was positive, the audits had not identified all the issues we identified during the inspection, demonstrating more in depth audits and checks on topical medicines were required.

Where shortfalls in staff practice were identified we saw action was taken to address. This included supervisory meetings and disciplinary meetings where appropriate. There was evidence of learning from complaints, accidents and incidents to further improve the service.

Periodic management, nursing staff and care staff meetings were held. We saw these were an opportunity to discuss issues found during audits such as the quality of care plans, medicine discrepancies and documentation of care and support interventions.

People told us they felt involved in life within the home and felt listened to. People's comments and suggestions were obtained through a variety of mechanisms including informal contact with management, annual surveys and regular meetings. People we spoke with confirmed these mechanisms existed. We looked at the most recent meetings and saw food activities were discussed. We saw people were asked about whether they were happy in the home and they said they were.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance A complete, accurate record of each person's care was not consistently maintained.

The enforcement action we took:

(1) (2)(a)(c)(e)(f)

We issued a warning notice requesting the provider to be compliant with this regulation by 3 July 2017.