Pegmar Limited

St Annes Nursing Home

Inspection report

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Date of inspection visit:
25 April 2017
02 May 2017

Date of publication:
14 June 2017

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 25 April and 2 May 2017and was unannounced. St Annes Nursing Home provides accommodation and personal care for up to 58 older people with nursing care needs. There were 34 people living at the home when we visited.

There was a registered manager at the home. 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.

People said they would like more activities and relatives identified that people would benefit from additional mental and physical stimulation. We have made a recommendation about this.

There was an open and transparent culture within the home. The management team were approachable. People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the registered manager and director with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. At the end of their life, people received appropriate care to have a comfortable, dignified and pain free death.

There were enough staff to meet people's needs. Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and external health professionals were positive about the service people received. People were positive about meals and the support they received to ensure they had a nutritious diet. Procedures were in place to ensure medicines were managed safely. Individual and environmental risks were managed appropriately.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

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

People felt safe. Staff had completed safeguarding training and knew how to report abuse. All staff were aware of how to respond in an emergency situation.

Procedures were in place to ensure medicines were managed safely. Individual and environmental risks were managed appropriately.

There were enough staff to meet people's needs. The process used to recruit staff helped ensure staff were suitable for their role.

Is the service effective?

Good

The service was effective

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision and staff meetings.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs. They had access to healthcare services when needed and the environment was suitable for the people living there.

Is the service caring?

Good

The service was caring.

Most people were mainly positive about the way staff treated them.

Independence and choice was promoted. People's privacy was protected and confidential information was kept securely.

At the end of their life people received appropriate care to have a

comfortable, dignified and pain free death.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People identified that they would like more activities.

Some people had concerns about staff responding to call bells.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

People and visitors knew how to make complaints and they were dealt with promptly in accordance with the provider's policy.

The registered manager sought feedback from relevant people about the service provided.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The management team were approachable.

People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the registered manager and director with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

St Annes 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 April and 2 May 2017and was unannounced. The inspection was undertaken by one inspector, a specialist nurse advisor in the care of older people 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 information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered manager completed 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.

We spoke with 14 people living at the home and seven visitors. We spoke with the provider, the registered manager, two nursing staff members, eight care staff and ancillary staff including the receptionist, administrator, activities staff, the chef and housekeeping staff. We also spoke with two visiting health professionals and one other health professional by telephone. We looked at care plans and associated records for seven people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected in March 2016 when we identified some areas for improvement.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes I feel safe". Another person told us "I feel safe. Nothing worries me really." A visitor told us "[Name person] wasn't safe at home. Here? Most definitely. They look after her and her medication is given at the right time". Another visitor said "There's an alarm and they put her bed rails up and check her every hour". They and other visitors told us that when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns.

The provider had appropriate policies in place to protect people from abuse. Staff had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that the registered manager would take appropriate action. Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. One staff member said, "If I had any safeguarding concerns, I would report them to the nurse or the registered manager." Another staff member told us, "I would go to the registered manager first, or [name of administrator]. I know I'd get a good response from either." The registered manager took their safeguarding responsibilities seriously and worked closely with the local safeguarding authority to protect people from harm. Information about safeguarding was available to all staff in the home's policy file and copies of the safeguarding policy were provided to all new staff. This meant staff would be able to refresh their knowledge if needed and had access to contact numbers for external organisations should they need these.

There were appropriate arrangements in place for the safe management of medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. Registered nurses told us they had received training in medicines management and administration at the home in addition to that completed during their nurse training. Senior care staff had also completed medicines training to enable them to support qualified nurses at night when two staff were required for the administration of some medicines. We observed nursing staff administering medicines to people in a patient manner, and informing people what the medicine was for. They did not hurry the medicines rounds and we found the Medicines Administration Records (MAR) were fully completed.

There was a procedure for the covert administration of medicines, although nobody was receiving their medicines in this way at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedure would protect people's legal rights. It would ensure that all relevant people, including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used 'as and when necessary' (prn) protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people.

Regular audits of medicines management were completed by the home, and an external pharmacist had

undertaken a medicines audit in January 2017. This had not identified any areas requiring improvement in the management of medicines at the home.

Where individual risks to people were identified action was taken to reduce the risk. These included, the risks to people of falls, choking, nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Systems were in place to monitor the use of pressure relief mattresses and we found these were being used correctly according to the person's weight. People were assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments set out the way staff should support each person to move or reposition in bed. Staff had been trained to support people to move safely and we observed equipment, such as hoists and standaids being used in accordance with best practice guidance. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk.

Risk assessments were completed for all aspects of the environment and measures identified to reduce the likelihood of harm. For example, the temperature of hot water was regulated to prevent scalding and arrangements were in place to check that gas and electric systems were maintained in good condition. Equipment, such as hoists and lifts, were serviced regularly to help ensure they were in good working order and safe to use. Where remedial action was needed, this was completed promptly.

There were plans in place to deal with foreseeable emergencies. Weekly checks of the fire safety equipment were conducted, together with regular fire drills. Staff knew what action to take in the event of a fire or other emergency. Personal evacuation plans had been developed and included details of the support people would need if they had to be evacuated from the building in an emergency. Nurses had access to an 'emergency folder'. This contained relevant information and procedures for managing a variety of potential emergency situations such as severe weather, loss of power to the home or a missing person.

People told us there were enough staff although they identified that at some times of the day staff could take longer to respond to call bells. One person said, "When you ring the bell it sometimes takes a little time, but they've got a lot to see to. It's not too bad." Another person said, "Depends on what's happening on the day". We were also told by a person, "There are times when the staff are stretched and this makes difficulties. But they are very polite and willing". Whilst a visitor said, "They are short staffed. It's not fair on the staff who are here."

Staff told us their workload was "achievable" and we saw they responded promptly and compassionately to people's requests for support. However, care staff also told us they often felt under pressure meaning they were not able to deliver any more than essential care due to staffing levels and the high dependency of people. We saw staff worked continuously, however they did not rush people and were able to spend time clarifying information for people and explaining what they were about to do before providing care. The registered manager told us staffing levels were based on the needs of people using the service. When setting the staffing rotas, they took account of the skill mix to help make sure staff with the necessary qualifications and experience were available throughout the day. Absence and sickness were usually covered by permanent staff working additional hours, when necessary agency staff were used. Systems were in place that when agency staff were working at the home they were paired with an existing staff member which meant that people were cared for by staff who they knew and who knew their needs.

There was a suitable and robust recruitment procedure in place to help ensure staff were suitable for their role. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting

decisions. Files for recently recruited staff showed all necessary checks had been completed.

Good

Is the service effective?

Our findings

People received the personal and nursing care they required. One person said, "I had sores on my heels when I came here. I've had treatment here and they've cleared up nicely. They put a pillow in place so they're not rubbing and change my position in bed." A visitor told us they were happy with the way their relative's personal care needs were met. They said, "When they use the hoist, it's always two staff. They use the slider on the bed to move her". The relative confirmed that health professionals were contacted when required. This was also the view of all people and relatives we spoke with. An external professional told us the registered manager was "Very clear about the level of needs the home could meet" and did not accept people whose initial assessment indicated that it would be inappropriate for them to move to St Annes.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required and people were seen regularly by doctors, opticians and chiropodists. One person told us, "The dentist, the doctor and the hairdresser comes to me. Oh, and a hearing person is coming, I'm going deaf". Whilst a relative said, "They are going to check his pacemaker. He was going to have to go to the hospital, but there would be long wait to get him back so they arranged to have the check here". Where necessary people's specific nursing care needs were met. For example, wound care was managed effectively. We saw nurses used the correct procedures to assess and manage wounds. Where necessary contact was made with external tissue viability nurses who had visited the home to provide advice and guidance on specific wound care concerns. An external health professional told us they were consulted appropriately and staff followed their recommendations

Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. Care staff told us they had been provided with information about new people prior to them being admitted. They said this helped them to understand the person's needs and how they should be met. St Annes had equipment suited to the needs of people living there and the registered manager said they would only admit people for whom all necessary equipment was available.

Most people told us they liked the food and were able to make choices about what they ate. One person said, "They told me I could have a cooked breakfast, a full English, every day so I have. I enjoy that". Other people said, "Very good" and "I have nicely made dinners". A few people were less positive and said, "It's alright, not marvellous. They [meals] could be warmer" and "Mediocre. It sounds alright when they tell you what it is, but when it comes it's a bit doubtful. I asked for cheese and biscuits, I've got my own biscuits, but they said no, because the chef's not on. For cheese and biscuits?" Catering staff were aware of people's special dietary needs and described how they would meet these. Snacks were available for people at any time with staff having full access to the kitchen and food stocks to prepare these when a chef was not on duty.

Drinks were available throughout the day and staff prompted people to drink often. Staff monitored the fluid intake of people although the individual amount each person had drunk was not always added up each day. Therefore staff may not be aware if people were drinking inadequate amounts. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight

loss and nutritional risk assessments were in place.

People received the support they required to meet their nutritional needs. Discussions with staff showed they were aware of the specific needs of individual people. For example, a staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Where necessary and as identified in nutritional care plans and prescribed by medical practitioners, people were receiving supplement drinks or fortified food.

Care staff told us how they offered choices and sought consent before providing care. One said, "If they said no, we try later, or someone else [staff] would try. If that didn't work we would tell the nurse." Another staff member told us, "If people decline care, I would try to encourage them and then see if there was any other way care could be provided such as a wash if they did not want a bath". Care plans contained information as to who had the legal right to make other decisions on behalf of the person. When in place, copies of the legal documents confirming this were held.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people living at St Annes had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Care plans contained information and assessments about the decisions people could make for themselves. Where these showed people were unable to make decisions about their health or personal care best interest decisions had been recorded. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. We saw that where necessary restrictions to ensure people's safety had been put in place these were the minimum necessary to ensure safety. For example, one person's care plan detail how bed rails were necessary to prevent the person rolling out of bed but that this was only needed for the top half of the bed therefore the foot end bedrails should be left down.

People can only be deprived of their liberty 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 found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met.

People were cared for by staff who had received appropriate training. One person said, "They [staff] know their job, whoever you have, they go through the same routine, so it's obvious they are trained in the same way". Another person said, "They [staff] know what they're doing. Sometimes they have beginners, but they usually have someone else with them". Staff had completed a wide range of training relevant to their roles and responsibilities. All staff regardless of their role, had undertaken essential training in areas such as dementia, safeguarding, MCA and health and safety. Most care staff had a recognised qualification in care and the registered manager was aware of how to access care qualifications for staff new to care work. Staff were positive about the quality of the training and told us they were supported to complete any additional training they requested. The registered manager had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as,

medication, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focused on the specific needs of people using the service, such as, end of life care. The registered manager and several other nursing staff were undertaking end of life care training run by the nearby hospice.

There were arrangements in place to ensure staff received an effective induction into their role. New staff completed the Care Certificate while being supported by an experienced staff member acting as their mentor. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Each new member of staff spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. We observed staff put training into practice when providing care for people. For example, we saw staff using equipment such as hoists and standaids correctly.

Staff were supported appropriately in their role. Staff received formal supervisions on a regular basis. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at subsequent supervision meetings. Staff meetings provided opportunities for group supervision. Staff said they felt supported, and the registered manager had an open door policy and they could raise any concerns straight away.

The environment was appropriate for the care of people accommodated. Many people living at St Annes required a high level of support to meet their physical care needs. The home was suitable to meet the physical care needs of people as it had wider corridors and doorways and bedrooms were large enough for the use of any specialist equipment required. All bedrooms were for single occupancy and had ensuite facilities of at least a toilet and wash hand basin. Individual bedrooms had been personalised to meet the preferences of the person living there. People were able to bring in items of their own including furniture to make their rooms feel homely and familiar. This would help people to settle in and feel at home. Good quality lighting and hand rails in a contrasting colour to the walls were available in corridors which would make them readily identifiable by people moving around on their own. Some people were living with dementia. Additional signs were in place such as on toilet and bathroom doors to help people identify these. There was a passenger lift connecting the three floors of the home with a bathroom and assisted shower room on each floor. People had access to an enclosed garden which we were told was popular in the warmer months.

Good

Is the service caring?

Our findings

People gave us mixed views about how caring staff were but most were happy with the way they were cared for and felt staff were caring. A person told us, "They [staff] are happy to do what you want and go out of their way to do extra if need be, but they are under time pressure. They have to do things more quickly at some times than others. Then you get pushed about a bit". We asked this person if they felt staff were rough and they replied, "No, not rough". Another person said, "Some are a bit rough. Agency nurses are the worse, some are a bit gung ho". The registered manager told us agency staff were now allocated to always work with a permanent member of care staff and we saw this occurred during the inspection. Relatives felt staff were caring. One said, "Mum loves the staff. She's very happy. They pop in and say hello. They call her by her nick name, which is a nice touch". Another relative said, "The staff are friendly to mum and courteous to me".

People were supported to maintain relationships with family members or others who were important to them. Where appropriate, relatives were supported to continue to provide some care for their loved one. We saw a visitor supporting a person with their lunch showing that they were enabled to maintain their relationship and feel that they were involved in the care of their relative. The registered manager told us how they had invited a relative to stay at Christmas as they knew they would be on their own. St Annes also cared for the family members of people receiving end of life care including providing them with the opportunity to stay at the home and providing them with a place they could rest or have some quiet time if required. We saw in a thankyou card that a relative had written "The staff were kind and welcoming to us all".

We observed staff over the course of our inspection and found that most interactions were positive and staff were caring and kind. For example, one person was unwell and had no appetite. A staff member brought some soup to their room, which was refused. They were offered other flavours of soup, a sandwich or fruit. The staff member tried to ascertain whether the person would like to eat something else, finally saying, "I'll send someone in in an hour with a sandwich, just to keep me happy!" The encounter was caring, patient and good humoured, with the staff member doing their best to tempt the person to eat. However, we observed one occasion when a person was not treated as nicely. The person was being supported with their lunch and was eating very slowly. The care staff member often bought up another spoonful of food to her mouth to find she had resumed chewing. They then held the spoon by the woman's mouth while waiting. The care staff member was interrupted during the task, having to get up to speak to other staff and leaving the room briefly. They did this without apology to the person and also wiped the person's face a few times without explanation. When another member of staff took over supporting the person to eat, they did so slowly and in a more appropriate manner.

Staff protected people's privacy and dignity at all times. People confirmed their privacy was maintained by care staff when they were receiving personal care. A visitor said, "[Staff] always pull the curtains and shut the door when they do something, for privacy". From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said, "We

make sure people are covered and promote independence for them to do as much as they can". Staff knocked, sought permission before entering people's rooms and then introduced themselves before providing care. St Annes had a dignity champion. This was a senior care staff member with an interest and responsibility for promoting dignity within the home. Their role included attending local authority meetings with other dignity champions, talking to care staff and observations of staff to ensure people were cared for in a way that promoted their dignity. Confidential care records were kept securely and only accessed by staff authorised to view them.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed. Care staff told us which people preferred care from staff of a specific gender. They told us this was always met. Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. Each month a Christian minister visited the home and the registered manager was aware of how to contact other religious leaders if required. Cultural needs were also met. For example, a staff member had been on holiday in the birth country of one person. They had thought about the person and brought back some magazines in the person's first language. The registered manager was aware of how other cultural needs should be met and described how they would seek any specific information during the preadmission assessment. This would help ensure individual cultural needs would be known and met.

People were supported without restricting their independence and staff enabled them to continue to do things for themselves. People were provided with specialist crockery and drinking cups to maximise independence. Where possible, and in the person's agreement, people were supported to move to the dining room for their main meal. This meant they could enjoy both a social occasion and sit at dining tables which promoted a better posture and position for independence. Care plans contained information about what each person could do for themselves and what they needed help with. This would help ensure people received consistent support and promote people to continue to undertake aspects of their care they could complete.

People were supported to express their views and were involved in making decisions about their care, treatment and support. Staff described how they involved people in choices. One said, "We ask them, or we pick some bits from their wardrobe and show them". Staff were skilled at communicating with people. Many people living at St Annes had some level of communication difficulty. Care plans contained a section relating to communication and gave staff guidance as to how they should communicate with people. Care plans included information about aspects of life where the person was able to make choice. For example, one care plan stated: 'Promote choices. Able to choose food, drinks and clothes'. People who wanted to leave their bedrooms were able to use the communal rooms as the home had suitable seating for everyone's needs.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. A thankyou letter had been received which stated staff had 'gone the extra mile' and thanked staff for having time to talk with the relatives. They had added, "It was a comfort to know she was so well looked after during her last days". Records showed staff acted to administered pain relief and symptom management medicine when this was required. The registered manager and nursing staff had attended training to enable them to better manager symptoms people may have at the end of their life. They were aware of how to obtain and administer symptom management medicines should these be required. The registered manager was aware of who they could contact for additional support if required. Information about people's preferences for their end of life care were included within care files.

Requires Improvement

Is the service responsive?

Our findings

People told us they would like more activities to be provided. One person said, "I wish there was more activity in the lounge. Like quizzes. I'd like crafts like making cards or doing keep fit, if possible". Another person told us, "A relative was here before and there were more activities then. There were things most weeks, but they don't seem so frequent now". Whilst a third said "Activities? No, that's a drawback, they don't do them here ". One person told us, "One [staff member] is good because she paints my nails, it's a silly thing, but it makes me feel better".

An activities coordinator was employed three days each week who provided various activities both in groups and individually, adapting these according to the likes and preferences of people on a day to day basis. However, the activities staff member also supported other staff when required. For example, on the first morning of the inspection the activities staff member was supporting care staff as a care staff member had reported as unavailable for work at short notice. Care staff said that whilst they would like to provide activities they rarely had time to do this. There were also some visiting entertainments. For example, musicians each week, quizzes alternate weeks and visits by animals, such as therapy dogs. A volunteer worked at the home four days each week and we saw they were involved with assisting people to play board games throughout the day. The interests, hobbies and backgrounds of people were recorded in their care plans. The activities coordinator said that they would complete these with people where family members were unable to do so, however, this took at least two hours out of the time allocated for activities that day further reducing activity provision. At the previous inspection the registered manager identified a need to increase the provision of activities and a need for activities staff to be provided over five days each week. They told us this was still their plan which would be enacted once the home was more fully occupied and a suitable staff member could be recruited.

We recommend the provider reviews the provision of activities staff and arrangements for the use of activities staff for other tasks and takes action to ensure all people have the opportunity for adequate mental and physical stimulation. We will monitor this and check at the next inspection.

Systems had not been in place which ensured that changes were made to practises within the home when guidance and information required this. For example, the risk to people from a fluid thickening powder had not been assessed. We saw tins of the powder located in bedrooms and although not in reach of people these posed a risk should people eat the thickening powder. The registered manager was unaware of the dangers this powder could pose to people. As soon as we identified the risk they took immediate action arranging for the powder to be stored safely and to inform staff of the risk. The registered manager told us they would undertake risk assessments for the thickening powder.

People were unable to confirm that their call bells were answered promptly by staff when they were pressed. One person told us "Sometimes they take about an hour. If I was seriously ill and needed something quickly, it would be terrible. They are short staffed. Sometimes when they are helping, they sling the buzzer out of the way, over the back of the bed and then I can't reach it. I've called out and they've said 'Use your buzzer', but I can't reach it". We checked that people had access to their call bells throughout the inspection. We

found that most people had access to their call bell, however for one person there was no call bell located in their bedroom. The provider was informed and immediately arranged for a substitute bell for the person. We were unable to clarify why the bell system was missing from this person's room. The provider told us they frequently undertook checks to make sure people had access to their call bells and this was not usually an issue.

People were happy with the times staff provided care. One person said, "Some [care staff] are slower than others, it depends of them. It doesn't bother me. But if you have to get up for something, they remember and they get you up. Another person was asked if they could request care at different times and said, "I think they would, it's not arisen for me". Care staff said they were able to be responsive to people's needs. For example, staff said that if a person told them they did not want care at a particular time they would return later. They also said that if people expressed a wish not to have a bath or shower an alternative time would be offered or care provided in a different way such as a full wash.

Nursing and care staff were able to describe the care and support required by individual people. For example, how they supported people who required assistance with repositioning and equipment used for specific people. They were also able to describe the support people required to meet nutritional needs. Within each room there was a short version of the person's care plan which detailed essential information for care staff. Staff were kept up to date about people's needs through a formal handover meeting at the start of each shift. During this meeting relevant information about new admissions or concerns about specific people was shared. All oncoming staff were present and there were opportunities for any staff member to ask questions or clarify information. Care staff stated that they felt able to ask questions during handovers if required. The senior care staff member on each shift was responsible for allocating care staff to specific areas of the home. Care staff also told us that if they compelted all their work they would then offer support to other staff. We saw this happened on the second day of the inspection when a care staff member allocated to the top floor was supporting staff on the second floor as they had completed their morning routine work.

People, and when appropriate relatives, were involved in care planning and reviews of care. One relative told us they had been involved in a review of the care plan. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said, "[Staff] tell us of any changes; I'm in most days and the staff always tell me how [my relative] has been." Another visitor said of the staff, "They [staff] or [name of registered manager] tell me or call me if there is anything I need to know".

Care plans were centred on the individual, considered aspects of their individual circumstances and reflected their needs and preferences. Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised and the guidance and information for staff within them was individualised and detailed. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, a care plan contained specific guidance as to how often a person should be repositioned. The care people were receiving corresponded to information in care plans.

Care plans and related risk assessments had been reviewed monthly and amended when required to ensure the information continued to reflect people's needs. The registered manager told us a nurse was employed one day per week to write and update care plans. Care staff told us they were consulted about care plans and that the reviewing nurse spoke with them to clarify specific information. This helped ensure care plans reflected how people were being cared for.

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints, if they were dissatisfied with the service provided at St Annes. One person said they would speak to the registered manager or senior staff member. Another person said they would talk to the nurse and "if she didn't do anything, ask to see the supervisor". Another person said, "I'd call one of the nurses and have a chat, but there's been no need". A relative said, "[name of registered manager] It depends on what it was". The home arranged 'residents meetings' to give people an opportunity to express their views about the service. These were attended by both the provider and the registered manager. We looked at the minutes of the last meeting where people were asked whether they were happy at the home, suggestions about activities, menus and whether the staff were helpful. A suggestions box was provided in the entrance hall meaning people, staff or visitors could provide anonymous suggestions or comments should they wish to do so. We saw the box was empty and the registered manage told us this was usually the case and few suggestions had been made. However, it did provide an opportunity for anyone to comment on the service at any time.

The registered manager asked people and their relatives to complete satisfaction surveys yearly. The registered manager analysed the responses to each survey and told us that if issues were identified they would use the information to help develop an improvement plan for the home. These showed that people had been happy with the service provided. We saw cards from relatives thanking staff for the care provided to their relatives and were told these were also shared with staff.

There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. We received mixed views from relatives about the way complaints were handled. One visitor said, "My complaint was handled OK. Her room [loved ones] was a bit untidy, but that's because she's in it a lot". Another visitor said, "Well, it's not really a criticism, but things need repairing, drawers and curtains need putting right". We saw action was occurring to repair these minor environment issues. The registered manager told us they recorded any concerns raised by people, even minor issues, as a complaint. The complaints file showed there had been five complaints over the previous year, all of a minor nature. We reviewed these and saw that they had been investigated and the result of that investigation fed back to the person concerned.

Good

Is the service well-led?

Our findings

People and relatives said they would recommend St Annes. One person said, "Yes, I suppose I would [recommend the home]". Another person said, "Certainly I'd recommend it. Compared with many places you hear about, I think we're very well off here". Relatives were also positive. One said, "I thank the social worker who suggested this place [St Annes]; I could not expect a better place".

There was an open culture at the home. Relatives said they could visit at any time and were made welcome. People and relatives knew who the provider and registered manager were and were able to name them as people they would approach if they had any questions or concerns about the care provided. Records showed that notifications about significant events were reported to CQC as required. There was a duty of candour policy in place which required staff to act in an open way when people came to harm and we saw this was followed appropriately. A poster showing the outcome and rating following our previous inspection was displayed in the entrance hall. The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally.

Although a limited company St Annes Nursing Home was family owned with the owners (provider and registered manager) taking a very active role in the service. The provider told us their vision was to provide a high quality service which met people's needs. They said, "We need to continually look at what we are doing and see if there are ways we can improve". They added that when positive comments were received from people or relatives they made sure relevant staff were aware of these. The provider was at the home when we arrived on the day first day of the unannounced inspection. The registered manager explained their vision and values for the home as "Providing a home from home, a friendly and environment where people receive an excellent standard of care and are happy". Staff were aware of the service's vision and values and how they related to their work. One staff member said the goal of the home was to be "Home from home, all part of one large family". They said they tried to achieve this by, "Being open and welcoming" to people and visitors. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service.

The registered manager completed the Provider Information Return when this was requested. The PIR 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 completed to a good standard and identified areas they planned to improve. For example, the home had champions (staff with specific interests and responsibilities for a given aspect of care) for dignity, falls and infection control. The registered manager planned to appoint and train additional champions for safeguarding, pressure area care, nutrition and end of life care.

There was a clear management structure with the provider, the registered manager, a clinical nursing lead, head of housekeeping, a head chef, nursing staff and senior care staff. People benefitted from staff who understood their roles, were motivated, and worked well as a team. Comments from staff included: "I love my job, I really love working here". Another staff member said, "Management are very supportive, if I went to management with a concern it would get sorted". Other staff also commented on the providers saying they

were able to talk to them. Care staff said they felt able to ask the provider or registered manager to help them should the need arise. We were told the provider was at the home most weekends and would make themselves available if required to collect prescriptions or items from shops at any time including evenings. Observations of the provider and registered manager showed they knew people's names and those of visitors.

The provider and registered manager sought feedback from staff, including through staff meetings and individual supervision. Staff were encouraged to make suggestions about how the service could be improved and these were acted upon. The provider told us they visited the home on a daily basis. They reviewed the results of all of the audits, maintained oversight of the health and safety management, staff training and monitored concerns and issues through attendance at staff meetings.

The provider understood the need for clinical governance and quality assurance systems which involved staff and other stakeholders. There were systems in place to monitor the quality and safety of the service provided on a regular and planned basis. Whilst many audits were completed by the provider or registered manager other staff were also involved. For example, housekeeping and nursing staff were involved with some infection control and cleaning audits. There were regular audits of medicines management, including the use of homely remedies, people accommodated under the deprivation of liberties safeguards, infection control, the environment and care records. Where issues or concerns were identified remedial action was taken. The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. We were told policies were reviewed by the registered manager yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run.