Barchester Healthcare Homes Limited

Overslade House

Inspection report

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Date of inspection visit: 8 July 2014
Date of publication: 29/01/2015

Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. The inspection was unannounced.

Overslade House provides accommodation with nursing and personal care for up to 89 older people who may have dementia. Seventy-eight people were living at the home on the day of our inspection. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found people's health needs were assessed and care plans were written to minimise the identified risks. However, people's emotional and psychological needs, which related to their dementia, were not planned for in the same detail as their health needs. Staff levels were decided according to people's health needs, which did not always take into account people's emotional and psychological dependencies related to their dementia.

During our inspection we saw there were not enough staff to ensure everyone's needs were met in a timely manner.

Summary of findings

Relatives we spoke with confirmed that people regularly had to wait for assistance to eat. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The provider had a robust recruitment process. The registered manager checked staff were suitably qualified to work with people before they started working at the home. All the staff we spoke with told us they received regular training and supervision to enable them to deliver care and support effectively. Staff understood their responsibilities for protecting people from abuse and knew how to respond to any concerns appropriately.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people who were assessed as not having capacity, records showed that their families were involved in discussions about who should make decisions in their relation's best interests. The registered manager told us they checked with the local authority that the way they cared for people did not amount to a deprivation of their liberty. No one was under a DoLS at the time of our inspection.

People told us staff were good and knew them well. Records we reviewed showed staff were mentored and supervised by experienced staff. Staff told us they received training that helped them to understand and meet the needs of people who lived at the home. At the time of our inspection there was an ongoing programme for all staff from the Alzheimer's Society's training in dementia awareness.

People told us the food was good and they always had a choice. We saw records of menu planning meetings, which included information from people's care profiles about their dietary requirements and preferences.

Relatives we spoke with were satisfied their relation had access to other health professionals, such as doctors, dentists and opticians, when they needed it. People and their relatives told us they were able to discuss their ongoing needs for care and support with the nurses. They told us they were invited to attend group meetings to discuss things of interest to them.

The service had a good reputation for delivering effective end of life and palliative care, but we found improvements were needed in recording people's preferences for the care and treatment they would like in the future. The registered manager assured us they would check people's understanding of advanced decisions they had already made at their regular care plan review meetings. They told us the provider planned to implement written end of life care plans for those people who would like them.

We observed staff were thoughtful and caring with people. We saw from people's response to staff's actions that staff knew people well and anticipated their needs. We saw that staff encouraged people to maintain their independence. Staff encouraged people to be involved in physical and community events according to their interests. Relatives told us they always felt welcome and were involved in decisions about their relation's care. Meetings for people and their relatives were recorded and we could see how suggestions were acted on.

Everyone we spoke with told us they respected the registered manager. The registered manager made sure that people who lived at the home were confident to approach her about any aspect of the home or their personal care needs. Staff told us the registered manager was approachable and they respected her judgement and expertise.

We saw that the registered manager attended staff handover meetings so they kept up to date with changes in people's care needs. Staff meetings were arranged to ensure all staff could attend at a suitable time of day. Staff were encouraged to champion, or take a lead role, in a specific aspect of care, which improved the quality of care and supported staff in their personal development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe for people with complex care needs.

The number of staff on duty was not related to an analysis of people's complex psychological needs resulting from their dementia and there were not enough staff on duty to support everyone effectively.

People's care plans included risk assessments and the actions staff should take to minimise the identified risks.

People were protected from the risks of abuse because staff understood their responsibilities for protecting people from abuse and knew how to respond to any concerns appropriately.

The registered manager understood their responsibilities under the Mental Capacity Act 2005. They had recently checked with the local authority to make sure they did not need a Deprivation Of Liberty Safeguards (DoLS) order for two people who lived at the home.

Is the service effective?

Good

The service was effective.

People were supported by staff who knew them well and understood their needs.

Staff received appropriate training and were supervised by experienced staff, which enabled them to support people effectively.

People's nutritional needs were known and understood. Menus were planned to meet people's dietary requirements and preferences.

People were referred to other health professionals appropriately and staff supported people to follow the professionals' advice.

Is the service caring?

Requires Improvement

The service was caring.

People's care plans for their, "Hopes and Concerns" for the future did not explain their preferences for future treatments or for their care at the end of their life.

Where people or their relatives had expressed the desire not to be resuscitated in the event of a cardiac arrest, the decision was not recorded in a format accepted by the local emergency services.

We observed staff were thoughtful and caring with people and anticipated their needs. People and their relatives were involved in discussing how they wanted to be cared for and supported.

Summary of findings

People were supported to maintain their independence and interests and relatives were welcome to visit whenever they wanted to.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in discussions about how they were cared for and treated.

People told us they were encouraged and supported to maintain their interests and involvement in the community.

People were confident that if they raised any issues, they would be listened to and action would be taken.

Is the service well-led?

Good

The service was well led.

Visitors were welcome to visit at any time and the registered manager made sure they took time to speak with people and their relatives every day.

The registered manager led by example and regularly worked alongside care staff and nurses. Staff told us they respected the manager's experience and expertise.

Staff were encouraged to contribute to improvements in the quality of care and had opportunities to study and to develop their area of interest.

The registered manager monitored accidents, incidents and falls and took action were to minimise the risks of a reoccurrence.

Overslade House

Detailed findings

Background to this inspection

The inspection team included two inspectors, a specialist dementia nurse and an expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

During our previous inspection in July 2013, we found the service met the requirements of the regulations.

Before the inspection we reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send us by law.

We reviewed the information that the local authority commissioners shared with us and the provider's information return. This is information we have asked the provider to send us to explain how they are meeting the requirements of the five key questions.

Before our inspection had noted the service had a high number of deaths compared to similar size services. We decided to check how people were supported at the end of their life to have a private, comfortable and pain free death.

During our inspection we spoke with 10 people who use the service and seven relatives. We spoke with the registered manager, three nurses and three care staff. Many of the people living at the home were not able to tell us in detail about how they were cared for and supported because of their complex needs.

However, we used the short observational framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed care being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed eight care plans and checked the records of how people were cared for and supported. We reviewed four staff files to check how staff were recruited, trained and supported to deliver care and support appropriate to each person's needs. We reviewed management records of the checks the registered manager made to assure themselves people received a quality service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

One person we spoke with told us, "Staff are co-operative and helpful. Unfortunately, sometimes you have to wait for members of staff to help you, especially in the mornings."

We asked the manager how they decided how many staff were rostered on each shift. The manager told us the number of staff on each shift was decided by the provider and depended on the number of people who lived at the home and their health care needs. This meant the number of staff on duty was not related to an assessment of people's individual needs nor an aggregated dependency needs analysis that included people's emotional and psychological needs.

All the relatives we spoke with felt there was a lack of staff to meet people's needs. One relative told us, "The staff seem a bit pushed. They seem a bit over-stretched at times. I worry sometimes that there is no one to talk to my relative because they are all busy doing." Another relative said, "I don't think there are sufficient staff. They do undertake some activities, but really he could do with someone to maybe sit with him now and again, helping with the crossword or something. That never seems to happen." Nurses we spoke with told us more staff would allow staff to spend more time engaging in one to one support with individual people.

We saw that staff did their best to make sure people were encouraged to follow their own interests throughout the day, but there were not enough staff to ensure people spent their day in the way they wanted to. For example, during the morning we heard a member of care staff say to one person, "There aren't enough staff to take you out today. Would you like to do some cooking instead?"

Throughout the day of our inspection we saw there were not enough staff on duty to meet people's needs. At lunch time in the elderly frail unit we saw there were not enough staff to support everyone to eat at the same time. There were 11 people who needed assistance to eat, but only two staff available to assist them. This meant people had to wait to eat their lunch, which was kept hot for them in the trolley. All the people who needed assistance were sat in a row, facing the dining tables where they could see other people eating. We were not able to ask the eleven people how they felt about this arrangement because they were unable to communicate verbally.

In the dementia unit at lunch time, we observed several people who needed assistance or prompting with their meal had to wait for staff to support them. One relative told us, "[Name] needs extra time with food but they just haven't got enough workers to cope with his wanderings." Another relative told us, "The staff are always pleasant and kind to [Name] but I think, at teatime and breakfast, like now, look." The relative pointed out untouched food on plates in front of other people. "I think the food is placed in front of [Name], but she needs encouragement to eat, but I just don't think they have the staff." We saw the registered manager worked alongside staff and assisted people to eat at lunch time, because there were not enough staff.

The registered manager told us their recent audit recognised that more staff were needed for lunch time due to high levels of dependency for eating and the number of people receiving end of life care, but the provider's methods for assessing staff ratios did not include a dependency needs analysis. The provider did not ensure there were sufficient numbers of staff to meet the health and welfare needs of all the people who lived at the home. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The manager told they had recently met with the local authority and discussed those people who might need a DoLS. The local authority had confirmed that a DoLS was not needed because their freedom was not restricted

In the eight care plans we looked at, we saw staff assessed people's capacity to make decisions. For those people assessed as not able to make decisions we saw that people's relatives had signed to say staff should make decisions in people's best interests for their health, personal hygiene and nutrition, for example.

We observed people with dementia walking independently around the dementia unit. People were protected from the risk of leaving the building unaccompanied by key coded doors. The key code number was disguised within a picture so staff and visitors could leave the unit when they needed

Requires Improvement

Is the service safe?

to. The garden and patio were safe because they were enclosed with shaded areas and a summerhouse. We saw the garden was accessible for wheelchairs and there were rails to enable people to walk around safely.

We saw care staff knew people's individual risks and supported them accordingly. For example, staff told us that one person needed one-to-one support at all times. We observed that this person was supported by a member of care staff throughout our inspection. For another person who was at risk of poor nutrition, we saw their care plan included use of a specialised chair. We saw a detailed monthly audit that confirmed that staff monitored the condition of the person's skin effectively. We observed the person was wearing special socks, as detailed in their care plan, to prevent pressure sores from developing. This meant staff understood the actions they needed to take to minimise risks to people's wellbeing.

One person we spoke with told us they always felt safe. They told us they enjoyed living at the home. They said, "The staff are really nice and it's the cleanest place ever."

In the four staff files we looked at, we saw the manager had checked they were suitably qualified to deliver personal care to people before they started working at the home. The manager checked two references from previous employers, identification documents, proof of staff's right to work in the United Kingdom and whether the Disclosure and Barring Service (DBS) had any information about the staff. The DBS is a national agency that keeps records of criminal convictions.

The manager's records showed that 80% of staff had up to date safeguarding training. We saw reminders in the staff room for staff to enrol for the next safeguarding training session.

Staff told us they were confident in the safeguarding and whistleblowing procedures in place at the home. One staff member told us the organisation had a special helpline that they could ring if they were concerned about anything at the home. Staff explained the types of events or incidents that they would refer to the local authority safeguarding team.

We saw the record of a safeguarding referral that had been made when one person who lived at the home was at risk of harm from another person who lived at the home. We saw that the local safeguarding team had assessed that the registered manager had taken appropriate action to minimise the risk of a reoccurrence. The safeguarding team had not taken any further action.

Good

Is the service effective?

Our findings

People told us the staff were all, "Good" and understood their needs. One relative said, "I honestly don't think there is a bad one amongst them!"

A member of care staff told us when they started working at the home their induction programme included training and shadowing experienced staff. All the staff we spoke with told us they received regular training to enable them to deliver care and support effectively. Staff told us they received annual training in moving and handling, fire awareness and health and safety.

The registered manager's records showed 68% of staff were up to date with their health and safety training and 80% or more staff were up to date with infection prevention and control, food safety and safeguarding adults. We saw a poster in the staff room reminding staff that e-learning training for these subjects must be completed by a specific date in July.

Two care staff told us they had completed, or were currently undertaking, national vocational qualifications in health and social care. Both care staff told us they had regular up-date training and felt supported by the manager. One member of care staff told us they had been supported to gain a dementia specific qualification. The manager told us 37 of the 78 people who lived at the home had a diagnosis of dementia and 50% of the staff had training in dementia awareness. They told us they were in the middle of delivering an ongoing programme of training produced by the Alzheimer's Society, "Tomorrow's another day". This meant staff were suitably trained to meet people's needs effectively.

Staff told us they had regular supervision meetings and annual appraisals and discussed the supervisor's observations of their practice. Where issues were identified, a learning action plan was agreed between the staff and supervisor. This meant staff were supervised effectively and understood how to improve their practice.

The registered manager told us, "I attended a nutrition training conference last week" and "The permanent chef has left and we have a new team in place. One chef is supporting a team of reliefs. They use butter, cream, cheese and lots of it. Everyone has put on weight in the last two months, including the staff. The pureed meals are the same as the main menu, just pureed."

We saw the minutes of a recent nutrition meeting involving the head chef, head of care, head of units and senior carer, who was the nutrition champion. We saw nutrition and menus were considered for each individual. We saw people's food likes, dislikes and preferences were recorded in their care plans. During lunchtime we saw staff offered people a choice of meal. People who needed support were assisted to eat in a calm and unhurried manner.

In one care plan we saw the person was at risk of choking. There were detailed risk assessments in place to minimise their risk of choking. Their care plans included their food preferences to help staff tempt them to eat, a weight management plan, which included checking the person's weight every fortnight, and a nutrition profile. We observed care staff helping the person to eat during our visit. Care staff were patient and encouraged them to eat at their own pace. Staff encouraged the person to eat food on several occasions during our visit, outside of mealtimes. This meant people were supported to minimise risks to their nutrition.

All the care plans we looked at contained risk assessments for people's nutrition. Where risks were identified, a care plan was written to minimise the risks. For example, one person who was identified as at risk of poor nutrition was referred to the speech and language team (SALT) for specialist advice. Daily records showed staff followed the advice of the SALT and gave the person thickened food and drink.

Staff kept detailed observation records for people who were at high risk of poor health. For example, we were able to calculate how much people ate and drank, how much time they spent in bed or in the communal areas and how often they were supported to change position. This meant staff knew when people's needs changed and when to ask other health professionals for advice.

The registered manager told us any changes in a person's behaviour would prompt a request for re-assessment by their GP. They said changes included an unusual degree of confusion or the person withdrawing from their preferred routines.

All the relatives we spoke with told us their relation had access to community and hospital services when they needed them.

In all the care plans we looked at we saw communication logs recorded when other health professionals, such as

Good

Is the service effective?

opticians, dentists and general practitioners (GPs) had visited the person to review their care. We saw specialists, such as community mental health team and speech and language therapists, were asked to visit and assess people when they exhibited unusual or changed abilities. Care records showed nurses followed the advice of other health professionals. This meant people received appropriate healthcare support, according to their needs.

Requires Improvement

Is the service caring?

Our findings

We decided to check how people were supported at the end of their life because we had noted the service had a high number of expected deaths compared to similar sized nursing homes in the local area. The manager told us they expected to have a higher number of deaths because they had acquired a good reputation with the local authority and were regularly commissioned to deliver end of life and palliative care.

A member of care staff told us that end of life care included respecting the person's and family's wishes at the time. They told us families were welcome to stay and sit with a person at the end of their life. Another member of care staff told us that when a person died, there was no counselling or formal bereavement support in place for families or staff. They told us, "It would be really good to have some kind of specialist training in bereavement to support families."

There were no written end of life care plans in place at the time of our inspection. The manager told us the provider planned to implement end of life care plans across the group of homes, but the target completion date was not known to the manager.

We saw there were care plans entitled, "Hopes and concerns for the future", which recorded people's preferences for funeral arrangements, where they were expressed, but did not always explain whether the person would prefer to receive or refuse particular treatments, either at home or in hospital. This meant there was a risk that people's preferences and choices for their end of life care might not be adhered to or known by staff.

Relatives told us they were involved in discussions about whether staff and emergency services should attempt cardiopulmonary resuscitation if their relation experienced a cardiac arrest. In one care plan we saw relatives had signed to say they would like their relation to be allowed a natural death and "Do not attempt resuscitation" (DNAR). The decision was recorded and signed on the provider's standard, in-house documentation. However, the local Coventry and Warwickshire emergency services have recently declared they were only authorised to comply with the decision not to attempt resuscitation if the decision was recorded on a specified, red-edged document issued by the local health services. This meant there was a risk that people's decisions to be resuscitated or not might not be respected. We discussed this with the registered manager who assured us they would take action to make sure they used documents acceptable to the local emergency services to record people's decisions.

In another care plan we saw a red-edged DNAR issued by the local health services. It had been signed by a health professional while the person was in hospital and before they moved into the home. The DNAR was marked, "No capacity and welfare attorney appointed" and "Family not available at present, staff to inform family". In the person's care plan we saw an instruction for staff to, "Talk to family about DNAR seen in care plan", but there was no record of the relevant discussion since the person moved into the home. Records were not sufficiently detailed to confirm that this person's next of kin was aware of the health professional's decision.

This meant improvements were needed to ensure people's preferences were known and regularly reviewed for their end of life care and treatment.

People and their relatives told us staff were kind and caring. One person said, "The girls treat me very well, they are very polite."

Relatives told us, "The staff are always kind – giving just that bit of TLC which costs nothing. They treat him well" and "The staff here are lovely and they are very nice to me too. I can come at any time and they make me feel so welcome."

We saw many instances of staff's thoughtfulness and compassion during our inspection. In the elderly frail unit we saw one person, who was not able to communicate verbally, resisted the support of two staff to use a hoist to move from their armchair to the dining table. We saw a third member of care staff knelt down by the chair and asked the person if they felt unsafe using the hoist. The person did not answer, but looked directly into the care staff's eyes. We saw the person did stand up independently and smiled as they walked away using the walking frame supported by two staff. This meant staff were observant and understood people's unspoken anxieties. People were encouraged to express their views and make their own decisions.

We saw staff worked hard to help people maintain their independence. In the new unit we saw one person, who was not able to communicate verbally, declined to eat their meal. We saw two care staff at different times of the day

Requires Improvement

Is the service caring?

continue to encourage the person to eat. One care staff sat with the person and stroked their hand while encouraging them to eat. The care staff patiently explained why they were asking them to eat their food. The person did not answer, but smiled at the member of care staff.

People told us they made their own decisions about their day to day lives. One person assured us they understood the risks involved in some of their choices, because staff had explained the risks to them, but they were still free to exercise their right to choose.

Five relatives we spoke with told us they were consulted before their relation moved into the home. One relative, whose relation had been at the home for over two years, said they had been involved in a review of their relation's care and support needs. All the relatives we spoke with told us their relation had been present at and encouraged to participate in the care plan meetings. This meant people were encouraged to make their views known about the care and treatment.

Relatives we spoke with told us they were encouraged to be involved in their relation's care. One person was supported by their relative with their personal hygiene, instead of care staff. This was because the person preferred to be supported by their relative.

Relatives told us they could visit at any time. We saw relatives were encouraged to join their relations for meals. There was a poster advising that visitors were welcome to join their relations for lunch at a minimal cost. We saw that families brought young children to visit their relatives.

Care plans we looked at included a 'cultural, spiritual and social' care plan. We saw these plans included people's religion, preferred radio stations, newspapers and topics of conversation. This meant staff were informed about people's beliefs and values. Relatives told us the staff were always respectful to their their loved one.

Good

Is the service responsive?

Our findings

People told us they received the care and support they needed. They told us staff listened to them and they could, “Change things” if they wanted to. One person told us, “I am waiting for a re-assessment. I just want to know if there is any chance I can go home.”

One member of care staff told us they reported any significant changes in people’s health to the nurse so they could check for the cause of the change. They said nurses were responsible for monitoring and reviewing people’s care needs. One care plan we looked at included the outcome of a recent review of the care plans. We saw the review involved a nurse, the person and their relative, because the person was assessed as ‘lacking capacity to make decisions’ about their care. The relative had commented, “I am happy with things as they are.”

All the relatives we spoke with told us their relation had been present at and encouraged to participate in the care plan meetings. The care plans we looked at had been reviewed monthly and were signed by the nurse and people’s relatives. This meant that people and their relatives were supported to express their opinion about their care and treatment

People told us they could choose how they wanted to spend their time. The service was accredited by the National Association for Providers of Activities for Older People. The accreditation recognised staff’s ability and success in supporting and encouraging people to engage in appropriate physical and sensory activities, if they were unable to express their preferences. During the morning of our inspection, a visitor arrived with a Pets as Therapy (PAT) dog. We saw some people who were unable to communicate verbally became animated and were affectionate towards the dog, which showed they enjoyed the visit.

We saw information on display about regular and planned events which people could choose to attend. Regular events included one-to-one reading, watching movies, music sessions and painting classes. Community events included walking and strawberry picking.

A nurse told us there were quarterly meetings for people who lived at the home, for relatives, for the relatives’ support group and a relatives’ evening meeting. We saw the minutes of meetings held in June and July. The records showed examples of the areas people discussed, such as, the food, one to one and group activities.

One person told us, “I’m not happy with the food here, there is little flavour in the meals. I would like more vegetables and healthy choices.” We spoke with the person’s relatives, who told us they were happy with the care that was provided to their relative, but the food could be improved.

We found the registered manager had responded to dissatisfaction about the food, which had been discussed at residents’ and relatives’ meetings. A new cook had been employed and new menus had been implemented. A relative we spoke with after the inspection told us there had, “Definitely been some improvements in the food.”

People and their relatives told us they knew who to go to if they had a complaint. Relatives told us they were able to talk to any of the staff about any issue relating to their relation. We saw the provider’s complaints policy and procedure was explained in the ‘Welcome to Overslade House’ booklet that was provided to everyone who moved into the home. The registered manager told us, "I think of complaints as an opportunity to get things right.”

Good

Is the service well-led?

Our findings

The registered manager told us, "I check people are happy with the service by one-to-one chats with them after the office closes at 5pm. I go and wander round and talk to staff, people and relatives. They know they can always knock on the door." Relatives we spoke with told us they had every confidence in the management. We saw the registered manager spent time out of their office in the communal areas on the floor and was known to visiting relatives.

After our inspection the manager sent us the results of the provider's most recent survey of people who lived at the home and their relatives. We found most people had reported they were satisfied with the home and the staff. We saw the manager had highlighted areas of dissatisfaction in a memo to staff and asked for their suggestions for how to improve satisfaction.

The registered manager was a registered nurse and we saw their uniform was hung on the back of the office door. The registered manager told us, "I don the uniform and work as an extra with care staff. They see me differently. I am able to observe and mentor them. I can discuss their practice straight away, without waiting until their next supervision." We saw the registered manager supported care staff with day to day care activities too, such as supporting people to eat at lunch time. We observed from care staff's behaviour during the meal that this was a regular, not occasional practice.

The nurses we spoke with said they felt supported by the registered manager. We found the manager attended the daily handover meeting when staff changed shifts. During the meeting it was clear there was a good rapport and shared understanding between staff and the registered manager. The registered manager was knowledgeable about all areas and issues in the home. . We saw notes were taken during the meeting and shared with all staff to make sure they knew and understood any changes in people's care. Nurses told us the handover meetings were useful for updating and sharing information about people's needs, staffing issues and for peer support.

Nurses made decisions about people's nursing care and the registered manager used their own clinical knowledge and experience to mentor the nurses. The manager was able to question, debate and support the nurses' reasoning and decisions. The registered manager had previously written a programme for a nationally recognised qualification at level two, for a government accredited training body. The registered manager told us the provider checked they maintained their continuing professional development during the monthly provider visit.

Care staff we spoke with told us they felt supported by the registered manager and her team. They said they felt they could turn to them if required for advice and guidance. Staff team meetings were held at four different times in one week to make sure that all staff could attend at a time that was appropriate for their normal working hours. We saw the minutes of staff team meetings and copies of memos to staff. We saw the meeting agenda recognised the importance of encouraging and valuing staff as well as the importance of enabling people who lived at the home to maintain their dignity and self respect.

We saw staff were reminded that the focus of their day should be on the needs of people who lived at the home, not the needs of staff. Staff were encouraged to spend time with people and make every interaction meaningful for people. The registered manager had asked for 10 staff to become 'dignity champions' to make sure that people's dignity and choice were promoted in every action. Four staff had volunteered within two weeks of the registered manager's request.

All the staff we spoke with demonstrated a good understanding of their role and responsibilities. We observed that people responded positively to the care and support offered by staff.

We saw the registered manager regularly monitored the quality of the service through a programme of audits. For example, we saw records of the monthly audits for infection control and medicines. We saw where issues had been identified, action plans had been drawn up to improve the service. We saw action plans were monitored and reported to the provider to make sure that actions were completed in a timely way.

Records we looked at showed that staff recorded every time an accident or incident occurred. We saw they analysed the incidents to identify patterns or trends and put plans in place to minimise the risks of a reoccurrence. We saw one person had suffered a series of falls. No injuries were sustained and frequent falls were a known effect of their disease. However, the person had nonetheless been

Good

Is the service well-led?

referred to a falls clinic to obtain external advice on how best to support them. We saw their care plan had been updated to reflect the advice given. We saw the external health professional had said the increasing frequency of falls suggested they might be eligible for additional one-to-one support. This meant the person would be safely supported to maintain their independence, despite their increasing need for support.

The registered manager kept a record of complaints and the actions they had taken as a result of complaints. We saw copies of letters in response to complaints made. The letters of response addressed all the issues that had been raised and explained the actions that had been taken to minimise the risk of the same issue arising again. We saw one complaint was marked, “Family do not wish to go beyond informal comment, not formal complaint.” The manager had made notes of the conversation they had with the complainant, which meant their response and action was recorded effectively.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there were a sufficient number of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.**

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.