HC-One Limited

Snapethorpe Hall

Inspection report

Snapethorpe Gate
Lupset
Wakefield
West Yorkshire
WF2 8YA

Tel: 01924332488
Website: www.hc-one.co.uk/homes/snapethorpe-hall/

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection of Snapethorpe Hall took place on 5 April 2016 and was unannounced. We had previously inspected the home in September 2015 and found it to be requiring improvement in all areas apart from responsive which was rated good. At the previous inspection, there were breaches of regulations in regards to dignity and respect displayed by staff, medication errors and a lack of staff. We brought forward this inspection following receipt of concerns around poor staff conduct and unsafe moving and handling practices. During this inspection we checked whether there had been any improvement in the service following receipt of an action plan which detailed how such changes were to be made.

Snapethorpe Hall provides personal care and nursing care for up to 62 older people, some of whom are living with dementia. Accommodation is provided on two floors with lift access between floors. Communal lounge and dining areas are provided on both floors. On the day we inspected there were 48 people living at the home; 12 were in the specialist dementia unit, 14 in the residential area and 22 in the nursing section upstairs in the home. The home had recently changed the nursing unit to upstairs to create a more secure and cosy dementia unit downstairs.

The home had recently appointed a new manager who was undergoing the required checks before being registered. They had been in post since 8 March. 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 living in the home felt safe and had confidence in the staff caring for them. Staff were able to explain what action they would take if they were concerned about someone and knew the procedure to report such concerns.

Some people living in the home did not feel there were enough staff and this was also reflected by some staff comments. We did not witness any major impact on people in the home but were aware that staff were working in a pressured situation for much of the time we were there, and that in the dementia unit some people required one-to-one care which restricted the flexibility of the staff team to respond at times.

Medicines were administered safely although we found issues with the lack of fridge temperature monitoring in the treatment room and for some people, a lack of specific instructions in how they took their medication. There were no specific capacity assessments or best interest decisions detailing how to support someone who was resistant to taking medicines.

Risk assessments were in place for factors such as choking, skin integrity and falls but not all of the risk assessments were detailed and some contained conflicting information. We could not find any reference to safe moving and handling instructions for staff when using equipment such as a hoist. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not have

access to written instructions for the safe moving and handling of people.

People in the dementia unit were supported well with their nutrition and hydration needs but this was not reflected in all areas of the home. Food and fluid charts were kept but not always used to their full potential. However, the new manager had implemented further training and detailed care plans in relation to supporting people with weight loss. People had timely access to health and social care services.

Staff had received supervision from the new manager since they had started but there were gaps in the training schedule for some staff. The manager was aware of this and addressing these gaps. It was evident from conversations with staff that understanding around the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards was limited. We spoke with the manager about this and they agreed to look at this issue promptly. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as there was no consistent recording or understanding about people's ability to consent to care.

People were supported by staff who were kind, caring and friendly. We observed people being acknowledged throughout the day which was an improvement from our previous inspection. Staff were discreet in offering support and worked well with colleagues to ensure people's needs were met in a timely manner.

People had access to a wide range of activities, especially in the dementia unit. These were varied according to people's needs and interests.

The home focused on person-centred care giving people as much choice as possible, such as when to get up, and most records were reflective of individual needs. However, not all the information was current and some records needed further scrutiny. We were concerned as some staff told us they did not have time to read the records which could have meant incorrect care was delivered.

We saw a detailed complaints log with in-depth investigations, apologies where required and learning from situations which was shared with staff at team meetings.

People and staff all said they liked working at the home but for staff there had been a long period of instability due to the lack of a registered manager. The home had been supported by relief and turnaround managers in the interim. The new manager had been pro-active since starting only one month previously and had already implemented some changes which were taking effect. Communication was a key area and staff had access to detailed information through meetings and supervisions.

The home had a quality assurance process in place and we saw the audits were in detail with action points completed. However, the lack of effective care plan auditing over the past six months meant there were issues in people's records and the lack of evaluation about staff's training had resulted in problems with the understanding of mental capacity.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe and staff knew how to report any safeguarding concerns.

Staff ensured people had their needs met. However, this was not always in a timely manner as reflected in comments we received.

Medicines were administered safely but there were minor issues with detail in records and storage.

Although the home had risk assessments in place these were not always accurate or detailed to effectively reduce risks.

Is the service effective?

Requires Improvement

The service was not always effective.

People in some areas of the home were supported with their nutritional and hydration needs well but not all staff enabled people to make decisions.

Staff had received supervision and training and an ongoing programme was being developed. However, it was clear that not all the training was effective as staff did not understand the principles of mental capacity or DoLS requirements.

Access to health and social care was timely and the environment was vastly improved from our previous inspection.

Is the service caring?

Good

The service was caring.

We observed people being supported by friendly, caring and kind staff.

We saw people being acknowledged and their privacy being respected as staff were discreet in asking if people needed help.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had access to a wide range of activities, and there was good links with the local community.

Records were person-centred but some information was out of date.

Complaints were handled thoroughly and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The lack of a permanent manager had resulted in a loss of consistent leadership for the home but we saw that the new manager had already implemented some changes.

People and staff were happy at the home.

The quality assurance processes were used effectively but needed further development to ensure they addressed the areas of concern we identified.

Snapethorpe Hall

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 5 April 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

We had received information of concern prior to the inspection regarding staff conduct and poor moving and handling practice. We had checked information we had received about the service through information sent to the Care Quality Commission and other agencies.

We spoke with nine people living in the home and one of their relatives. We also spoke with twelve staff including four carers, one senior carer, two nurses, the activities co-ordinator, the deputy manager, supporting manager, the new manager and the assistant director.

We looked at six care records including risk assessments, three staff records, minutes of staff and resident meetings, complaints records, safeguarding records, accident logs, audits and medicine administration records, and other relevant documentation.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said "I know I'm safe here" and another told us "I feel safe. Everything is secure and there are people around."

We asked staff about their understanding of what may be a safeguarding concern. One staff member advised us "It could be an injury or accident that needs reporting that may not have been dealt with properly. I would always speak to the manager about any concerns about staff. I have been here three years and never had to." A different staff member said "I am always aware of the signs to note for possible abuse or neglect and would always report this to the manager or go to CQC (Care Quality Commission). I would not leave it. I would say if a person was bruised or said anything or made an accusation. I am confident to report." This demonstrated staff knew how to recognise and respond to any concerns in a timely manner.

The home had kept records of any safeguarding concerns along with notifications to the CQC. However, the details of the concerns were only on the notification along with a record of a call to the local safeguarding authority. There was no further documentation unless the local authority had taken further action. This meant it was not clear that the home used such incidents as a learning point for staff.

One person we spoke with advised us that "I don't see the same staff. If the girls come in I wouldn't know them as I don't get the same faces. We spoke with a relative who told us "The staff are just rushed off their feet, there's not enough of them." This relative visited regularly and found their relation often had to wait for continence care as "staff are dealing with other people."

A staff member we spoke with told us "I do not think there are enough staff. This is mostly in the morning as people choose when to get up but this makes it hard for staff." We noted mid-morning that in the residential unit there were no staff visible. We found this was because staff were assisting someone to have a bath. This person needed two staff members to support safely but it meant the unit was left unattended for this duration. Another staff member told us "We struggle to get breaks, rarely able to have a drink or a meal break as there is no cover for this. We just have to manage. If something happened they would try to call for help but the expectation is to just manage."

A further staff member said things had improved since the home had relocated its dementia unit. They said "It's been a positive change as people get more attention now." They told us "We have staff at the moment but this hasn't always been the case. Some people need closer observation and we're not always able to do this. Our numbers (in the unit) are lower at the moment so that means we can manage. However, if this increases it will get more difficult." This staff member said they had advised managers of the need to keep this staffing ratio but they felt they were not always listened to.

We spent some time in the dementia unit lounge during the morning and noted one person kept trying to get out of their chair. They edged themselves to the edge of their chair every 30 seconds or so despite regular input from the activities co-ordinator to ensure they remained safe. The person was unable to walk unaided and thus posed a significant risk of placing themselves on the floor by trying to move. Staff were

busy attending to other people in the unit during this time and so the burden of care fell to the activities co-ordinator during this time. This meant they were limited as to what they could do. After a period of around 30 minutes the inspector sought a staff member to assist with this person as the activities co-ordinator did not feel they could leave the room. If they had not been there it would have been highly likely this person would have fallen. We discussed this person's care needs with the manager who advised us they were aware of the difficulties and were in liaison with the local authority social work team. The manager also advised us they were beginning to use a dependency tool to determine necessary staffing levels based on people's specific needs.

On the day we inspected there were five carers and a bank nurse on duty in the nursing unit, an agency nurse and three carers in the dementia unit and a further two carers, one of whom was senior in the residential unit. The staffing ratio was the same at weekends as during the week. The deputy manager was also in the home but was supernumerary that day as they were completing other tasks. They advised us they spent three days as the nurse-in-charge being the clinical lead to ensure they were aware of what was happening in the home. We saw from minutes of resident and relatives meetings held in November 2015 that the home had tried to lessen the risk of a lack of regular nurses by block-booking agency nurses to ensure consistency for people in the home.

We asked the manager about staffing at night and were advised there were six staff comprising two nurses and four carers. In the short time they had been in post the manager had not identified any particular issues with night care as most people settled well. This was based partly on their own observations as they had recently completed a night shift. They also told us that one staff member was a qualified nursing assistant and another person was about to be which meant an increased skill base for the team. They reassured us these staff members would not be replacing registered nurses.

We checked staff recruitment files and found that all appropriate pre-employment checks had been carried out including identity and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. All agency staff were subject to the same checks prior to the commencement of their employment and consistency was sought wherever possible to minimise disruption to people in the home.

We spent time observing the medication rounds on each of the three units. In the dementia unit the agency nurse was able to explain and show the medication procedure and practice in detail. They checked each person's stock levels prior to removing any medication from the packets to ensure they tallied with the person's records. They explained what each medication was for such as one tablet was to help a person manage their anxiety levels and another to promote bowel movements as this person was prone to infections otherwise. We observed staff ask people if they required any painkillers in line with the PRN (as required medication) protocols for that individual.

People's medication records contained their photograph, details of any allergies, their admission date to the home and GP contact. We also saw notes recorded as to how a person may need assistance with receiving their medication. However, on one record this was not accurate as it was recorded the person took them with supervision but we observed they were very resistant.

Medication was boxed and checks were made prior to administration to ensure the dosage and person was correct. Medicines in the fridge were dated from the date of opening to ensure they were not used past their expiry date. Controlled drugs were stored in line with the required guidelines of the Misuse of Drugs Act 1971. The deputy manager advised that controlled drugs were only administered in conjunction with another member of staff from a different unit to ensure this was done appropriately.

The nurse on the nursing unit encouraged people to take their medication in a sensitive and patient manner. We saw one person spit out their medication and this was recorded correctly as 'refused' on the Medication Administration Record sheet (MARs) and that a further attempt was to be made later to try and give the person their eye drops. We noted this had been done later that morning. People had the option to take their medication with fresh orange juice as the nurse was aware that many disliked taking their medication with water.

We found the treatment room unlocked on the nursing unit. It was also quite untidy and we asked the nurse about the finished medication containers which were in the room. They advised us "If I've time today I will put them into the right containers to be returned." We were later advised this was partly due to the recent move around the home of all the units. There were significant gaps in the recording of the fridge temperature which meant that medicines may not be stored safely. We noticed that temperature checks had not taken place between 12-15 March and 26-27 March 2016.

We spoke with the nurse on the nursing unit about how people received PRN (as required) medication. There was a protocol in one person's file which said paracetamol was to be given four times daily as needed. It was recorded this person was able to make their need for this medication known but didn't specify how they did this. However, we observed the nurse administer this medication to this person without asking them if they needed it. When we asked why they had done this, they said "[Name] will say no. They say no to everything." However, we could not see any mental capacity or best interest assessment to evidence this. We also noted thickener was added to this person's liquid medication as directed but when we asked the nurse what 'as directed' meant they could find no instructions to direct the person administering this medication.
This could have meant this medicine was not administered correctly due to the lack of instructions which could have posed a heightened risk of choking.

Through our observations, we found the nurse had put all one person's medication ready but then when checking the administration sheet found that it was recorded the person had already received their medication. We asked who would have done this and they replied "It must have been the night nurse." They were unable to check who had done this as there was no record of signatures in the medication records and they were uncertain whether the medication had been administered or incorrectly recorded as given on the record. However, on checking with the deputy manager, the nurse counted the medication and found number of medicines indicated the person had received their medication.

We spoke with the deputy manager who was the clinical lead for the home and asked them how staff's medication competency was checked. They advised us "I trust the agency has up to date records and bank staff are done by me. Refresher training is done every 12 months on Touchstone which is all online. Staff can access this here and at home." We asked if anyone was given covert medication but were advised not. We asked if someone had refused their medication what would staff do. The deputy manager said "We would tell them what we are doing and try and convince them." They advised us that one person who had initially refused their eye drops had now had them.

We considered how the home managed risk. We found people had risk assessments for choking, nutrition, skin integrity, dependency and falls. There were bed rails risk assessments in place which were reviewed monthly. However, not all of the risk assessments were reviewed monthly as stated in people's care records and there were some discrepancies in the details held.

In one care record it said the person used a stand aid and needed the assistance of one member of staff. However, later in the care record it said the person needed two staff and this was confirmed by the staff on

duty in the unit. There was a lack of detail about the method of safe transfer for this person referring only to the equipment such as 'wheelchair' or 'hoist'. The information was not person-specific.

We could not find any record of the method of transfer for people who needed the use of a hoist or other equipment to move safely. Staff did not have access to any written procedure as to how to use a hoist safely and we observed a person remaining seated on a sling without an appropriate risk assessment to say this was safe. We asked the deputy manager for the guidance from the manufacturer indicating this sling could remain in situ throughout the day but this could not be found. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not able to refer to the correct procedure for the safe moving and handling of a person.

We saw the home logged accidents and incidents in detail. The time, location and nature of any injury was recorded. These were reported to the Care Quality Commission (CQC) as required. One person who had had an unwitnessed fall had been seen promptly by the GP, had medication for an infection prescribed, and was observed half hourly. The home completed investigations for more serious injuries and considered whether different practice needed to result. We saw that accidents were considered at health and safety meetings held between the manager and senior staff in the home.

Requires Improvement

Is the service effective?

Our findings

One person told us "The food is good. There's always two choices at meal times and I've never had a problem. Portion sizes are always right."

We observed people receiving their lunch in the dining room in both the residential and dementia units but we found contrasting dining experiences. In the residential unit, one person said "The food is really nice." Another person said "I'm not eating that with all those bloomin' bits in it. What is it anyway?" one staff member replied "It's beef and barley soup [name]." The person replied "Well, I've never heard of it. If I don't want it will you get me something else? I don't think I shall have any." Staff did not respond but took the food away and carried on serving other people. They later provided the person with an alternative. One person we saw did not understand the options and no attempt was made to support them with decision-making through visual choices. Staff did offer people a choice of jacket potato or sandwiches and we saw that one person who had asked for cheese on toast was given this option.

When we arrived we observed people in the dementia unit dining room having their breakfast. One person was eating a bacon sandwich and four other people were being supported to eat porridge and drink their fruit juice. People had a choice of apple or orange juice. We noted the dining rooms in the residential and nursing unit were laid with tablecloths, napkins, condiments and full fruit bowls. However, we did not observe the dining room in the nursing unit being used during the day. When we asked a staff member we were told that one person had used the dining room and others had not as "they are all bed bound up here."

In the dementia unit, people were able to choose where they sat and were offered a choice of juice or tea. If they were unable to make a decision they were given both to promote choice. There was a good level of interaction and all three care staff were assisting in preparing meals for people. Meals were presented on contrasting plates to enable people to identify their food clearly. Once everyone had their food staff took time to sit with people encouraging them to eat or offering the alternatives if they did not appear to like their first choice. One person finished their soup quickly and was offered a further portion.

We looked at food and fluid records. We found these were completed in relation to what had been eaten and the quantity. We asked one staff member if any people were nutritionally at risk and they said "A few people are on fortisips and pureed diets. The SALT (Speech and Language Therapy) service are involved. I assist people to eat and in nearly every room is a food and fluid chart. I record exactly what they've drunk." However, totals were not always completed and cross-referenced to people's specific needs showing that monitoring was not as effective as it could be. The manager had actioned further training in relation to fortifying food as they had noted in their short time at the home that weight loss was evident for some people. They had compiled a detailed care plan outlining all the actions that needed to be taken and this was in care files. This showed that the manager had taken action to immediately rectify a possible problem and ensure all staff were aware what needed to be done.

We spoke with staff about their induction, supervision and training needs. One staff member said they

thought supervision was every 6-12 months. They said "I haven't had any since changing the unit I work on." A different staff member said "Is it supposed to be every six months? I haven't had one recently." Neither staff member had any recollection of an appraisal. They referred to group supervisions where particular topics were discussed such as safeguarding, however they could not remember when the last one of these had taken place.

One staff member who had worked at the home for over three years said they had not received an induction at a specific time but had received training since. However, they were aware some of this needed updating. In a different staff member's file we saw evidence of a planned induction in regards to shadowing shifts, training requirements and the completion of an induction workbook to evidence their learning. This had been followed up to ensure they were meeting these targets.

The home had a folder containing details of all staff's supervision records since the end of 2015. The home had commenced a timetable outlining the frequency of supervisions and appraisals for staff. It was evident that most staff had received a supervision and appraisal within the past two months. Topics were recorded generically but did focus on very specific requirements in regards to safer people handling, DoLS and MCA, the role of dignity champion and keyworker. Each session outlined the expectations for the conduct of the worker which was discussed with them and then signed by both employee and manager. Staff had personal training need targets set for completion. We saw evidence of supervision sessions which dealt with specific staff members' issues completed during the past two months, whether personal or performance –related.

We noted that some staff had received an appraisal and this was an ongoing programme. In one staff member's record there was information about the person's knowledge of their role and demonstration of the service values such as kindness and trustworthiness and how they performed. There was also discussion around a staff member's level of initiative and their contribution to the working of the team. Where improvement was needed this was recorded and a plan put in place to tackle any shortfalls.

Training records showed that most staff had completed mandatory training. However, there was a shortfall in safer people handling where 12 out of 43 staff needed to renew their training and also in medicine competency for both nurses and senior carers. Both of these areas were identified as concerns by the inspection. One staff member told us "I can keep on doing the tests at the end until I get through them." This staff member had particular learning needs and did not find the online training very accessible. They did advise us that "moving and handling is done in a practical way." Another staff member advised us they had received training in moving and handling which included wheelchair and all equipment that was used. They had also received training in treating people with dignity.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the home, under the direction of the new manager, was submitting applications for DoLS as they had identified people who were in need of them. They had also applied for an extension of one that was due to expire. This showed the manager was aware of their responsibilities under the MCA.

During the late afternoon we saw one person trying to attract attention by banging on the door of the dementia unit. The home administrator was aware this person often did this and said "Oh that's [name]. They try to get out but they can't come out." We checked whether this person had a DoLS in place and found that one had been applied for. We asked a different member of staff how they would support someone who may present with more challenging behaviour. They said "We've had residents here that have been challenging and we don't know what we are able to do to protect ourselves and them." This meant that the home had not ensured all its staff were confident in supporting people presenting with more challenging behaviour.

We asked staff about their understanding of DoLS. One staff member said "We would not let any resident anywhere in the home out alone." We asked what staff would do if the person asked to leave and the staff member said "It's for the safety of the residents. It wouldn't be allowed. Staff would run to the shop if a resident wanted shopping but otherwise we would ask family." This demonstrated the staff member did not understand the law in regards to people having capacity and the need for safeguards if people would be at risk if they left the home.

Only one staff member was able to tell us what DoLS related to and that if a person lacked capacity then a decision could be made on their behalf. However, knowledge was limited as to the purpose and effects of a DoLS authorisation as the staff member said "It's to keep a person safe." We asked a further member of staff what they understood about DoLS and they said "Another one slipping my mind. It's so they can make their own… Sorry I can't remember." We checked the training records and found that most staff had received online training in regards to mental capacity and DoLS but we did not find they had understood this.

One staff member acknowledged "I don't have any understanding about capacity. I don't know how they do it. It would be fascinating to see how it's done." We asked this staff member how they would support someone who was unable to make a choice. They replied "If they couldn't make a decision I would ask the nurse. I can't make a decision for someone I don't know very well." This showed not all staff had a good understanding as to how to support someone with limited capacity. A different staff member did not know of anyone who had a capacity assessment and replied when prompted if someone was able to agree to care "I would ask them. It would be in their best interests to wash them. You wouldn't want them smelling." They were aware they were able to re-do any training they felt they needed.

There was some evidence in care records of mental capacity assessments and best interest decisions where it had been determined that someone did not have capacity to make a specific decision. We saw this in relation to a bed rails assessment. However, there was no DoLS authorisation for this person and no capacity assessment in relation to the administering of medication. In another care record a bed rails assessment had been signed by a relative despite the assessment saying the person had capacity. This did not follow the principle of the MCA and it was not clear whether the relation had the authority to make such a decision. This is a breach of Regulation 11Helath and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as the home did not have capacity or best interest assessments in place to ensure they were complying with the requirements of the MCA where a person lacked capacity to make a specific decision.

People had access to external health and social care agencies as required. There was active involvement from the GP as the manager had requested reviews of people's medication to ensure this was not adversely impacting on their wellbeing. We noted one person who had been due to have assistance with a bath did not as the district nurse had advised they needed to keep a dressing dry. This showed the home was aware of people's health needs.

We looked at pressure care records. In one record we saw that positional changes were recorded. In another record we saw that bed rails were checked at regular intervals at the same time as providing pressure care relief. One staff member said "A lot of people are turned every two hours and sometimes it's every hour. It tells you on the position chart." Another staff member was able to describe who had pressure relieving equipment such as a mattress or cushion. This meant that staff had the knowledge to offer people appropriate and necessary pressure care.

We spoke with staff about handovers between shifts. One staff member said "We always ensure there is cover on the unit during a handover to keep people safe." Another staff member also said "We are unable to do the handover on the unit as this would not be confidential." The manager said the nurse or senior, depending on which unit, takes the lead prior to the start of the shift. We saw that notes were kept, some more detailed than others about key events in that person's life that day. Where external support had been obtained such as the district nurse or a GP then this was recorded and any subsequent actions noted. Vital information was highlighted in red to direct staff quicker.

The environment was much improved from our previous inspection as the home had undergone a significant refurbishment and the communal areas were much brighter and tastefully decorated. The bathrooms were painted in calming colours and accessible with appropriate equipment. There was a very smart hairdressing salon.

Staff had access to necessary personal protective equipment when supporting someone with personal care. This meant that the home was aware of its responsibilities to prevent and control the spread of infection.

Good

Is the service caring?

Our findings

One person living in the home told us "I like my girls" and another person said "They're marvellous" when we asked them about the staff. A further person was keen to say "The girls are so friendly. They are very kind to me and very nice." One relative we spoke with said "I can't fault the staff. They're all lovely."

We asked staff how they responded to someone who may be resistant to receiving care. One staff member said "I would do nothing. It's part of the role. We have to care for them. If I was shaving a gentleman, I would try and go back later, and if they still refused would mention it to the nurse. If someone needs personal care you can't leave them like that. You've got to reassure the person that you're not hurting them. You try as best you can."

Staff were kind and patient when supporting people with medication or offering assistance to people. This was a significant improvement from our previous inspection where some staff had been dismissive and shouted across people. We observed staff acknowledging people even if they were involved in another task. We saw a carer noticed someone had got up from their chair to go into their en-suite bathroom and discreetly asked if the person was fine. This recognition is important for people's general wellbeing. The person who was continually trying to move from their chair was treated with the utmost respect and patience all day by many different staff. No staff displayed any signs of irritation even though it meant they were limited as to what other tasks they could perform as the person needed such close monitoring. The staff supported each other by taking it in turns to offer support.

During the morning one person came out of their room only dressed in a pyjama top. The inspector alerted a staff member who responded promptly and kindly, encouraging the person to return to their room which they did. We observed some staff supporting people with eating, supporting them to hold cutlery to promote their independence as far as possible. One staff member said "Would you like cornflakes [name]? You looked tired today – do you just want to go back to bed?" This was offered after breakfast had been completed. Another staff member said to a person in their room "I'll help you with a shave later [name] if you would like it."

Staff demonstrated knowledge of people they were caring for. One staff member was able to tell us about a person's abilities as much as what they struggled with, saying "When you've known a resident a while, it's an instinct. You know what they want." Another member of staff was aware of how someone's needs had changed since admission to the home. A further staff member spoke with us about people who had had special dietary requirements due to their religion but were not aware of anyone they currently cared for where this applied. They also told us that someone had an advocate who supported the person with making decisions. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

One staff member said "When someone first comes to us we ask them their likes, dislikes, what time they want to get up, go to bed and whether they prefer to have a shower or bath." They said this information helps us to care for that person as they preferred.

Staff were aware of supporting people in making their choices. One staff member said "It's their choice to get up when they want. Some people like to stay in their pyjamas all day. They can if they want, it's their choice." Another staff member told us "We keep asking people as they can change their mind. Information needs updating. It's the nurse or senior who writes the care plans."

We observed staff knocking on people's doors and seeking permission before entering someone's room. This included domestic staff who held conversations with people about the weather. One staff member told us they respected people's privacy by "shutting doors and closing curtains when someone is getting dressed. If giving a bed bath we wrap people in a towel. We treat people with dignity." The manager was keen to stress how this aspect of care was important to them and told us "I will prompt staff if I see things I'm not happy with. I may say 'Let me close this door for you' in the hope it reminds staff of appropriate conduct." We observed staff moving a person from a wheelchair into a more comfortable chair. During the whole procedure they spoke with the person checking they were happy and reassuring them.

The manager said the home had been caring for some people who were at the end of their life recently. They explained that each person had a special care plan and staff were allocated time to spend with people. People had DNACPR (do not attempt cardiopulmonary resuscitation) forms in their file which detailed whether they wished to be resuscitated. The home had had a death the night prior to the inspection and as staff came on shift they were informed and allowed a few minutes to collect their thoughts before going to work. This consideration from the manager meant the values of respect were embedded in the culture of the home.

Requires Improvement

Is the service responsive?

Our findings

One person living in the home told us "There are very thoughtful staff." Another told us "They look after me. I get up for breakfast and can choose when to get dressed. I have a bath once a week which is my choice. There's always someone around."

The activities co-ordinator showed us some artwork which people had completed the previous day in preparation for the Care Home Open Day in June. We saw people had been involved in making lanterns during February. Activities were planned on a monthly basis and included visits from outside agencies. On the afternoon of the inspection there was a visit from a local shoe shop which had proved popular. There was a vintage tea party arranged for 7 April. There was a display in the entrance foyer of previous events and activities the home had been involved in, and also a display about the Queen's forthcoming 90th birthday. We saw a newsletter in the reception area for March/April 2016 which outlined forthcoming activities and news about the home. It also included a competition entry form for the naming of the new hair salon.

During the morning people in the residential unit were in their own rooms watching TV or reading as most indicated to us this was their preference. Drinks were available for each person in their room. The activities co-ordinator spent much of their time during the morning in the dementia unit. We observed them talking with one person about a book which contained photographs of the local area. The conversation focused on the person's memories of the area and which things they had liked to do when they were younger. This showed the home recognised the importance of reminiscence to establish positive relationships with people. The agency nurse was talking to a different person and began to sing with them.

The activities progressed in the unit to three people throwing bean bags into a hoop on the floor. This was later changed when one person struggled with this to skittles as it was easier for them to roll the ball. There was a high level of engagement until the activities co-ordinator had to divert their attention to the person who kept trying to get off their chair but was unsafe to do so.

We asked staff if they felt people had enough to do. One staff member said "There is enough. They colour, they make things, the ones that can get out of bed. The activities co-ordinator will do things individually with people. A lot of people just like to watch TV. They will tell you if they want TV or music." Another member of staff said "We don't have time to do activities. If we have time we will. I think people need more outdoor trips. There is only a veranda for safe outdoor space. We're on a busy road so it's difficult to go outside."

We looked at care records and found them to contain the person's photograph and a personal evacuation plan in the event of a fire. Some pre-admission information was in care plans but it was not always dated. People's likes and dislikes were noted as well as things that were important to people such as 'family' and 'past achievements in sport'. However, again not all of this information was current. Daily notes were completed regularly in people's care plans which showed how a person had been both physically and emotionally.

Specific care plans were in place for routines on waking, skin integrity, personal hygiene, continence care,

nutrition, mobility, evening routine, sleeping, general physical health, medication and psychological health. Most of these reflected people's individual needs. In one care record we read "to wake naturally, offer a drink and let them come round before offering any assistance." In another person's care record it had been noted they needed supervision while eating due to a risk of choking. There was also mention of a referral to the dietician as the person's condition had deteriorated. The person's dietary preferences were also recorded and weight monitored. The person whom we had observed leave their room and asking to return to bed had it logged in their care plan this was their frequent choice.

However, in other care records there was conflicting information. In one person's plan, it stated, "[name] unable to use buzzer" but then "[name] knows how to use buzzer." We spoke with a relative of this person who advised us their relation had a diagnosis of dementia and was unable to understand some information. However, we did not find a capacity assessment in the file and the relative said they had not been invited to contribute to any care plan review. We could not find any evidence of relative involvement in care plan reviews in any file we looked at. In another file it was noted that "[name] will take their medication with encouragement from the nurse" but this person had spat out their medication when we had observed the medication round earlier that day. There was no capacity assessment in place to manage this situation.

Two members of staff told us they did not always read people's care plans as they did not have time. One relied on their own knowledge of the person "You get to know them. You get feedback from the family. You can look in the care plan to see what they like or don't like."

We found the home to have a comprehensive complaints log detailing complaints that had been received by the service, the key issues, the ensuing investigation and the reply sent to relatives and other concerned people. It was evident that previous managers had taken any concerns very seriously and conducted in-depth investigations collating information from care records and their own observations of practice. Where necessary referrals had been made to the local authority safeguarding team and the CQC, and action taken to discipline and dismiss staff where conduct fell below the required standards.

Requires Improvement

Is the service well-led?

Our findings

One person living in the home told us "On the whole, it's not too bad really. If I was living on my own I'd be all those hours on my own, so it's better from that point of view. It's a very nice home." Another person said "It's a lovely place. I like being here you know." A further person said "Nothing could be done better."

In a recent survey about care in the home we saw comments from relatives which included "They are safe, well looked after and happy" and "Want to acknowledge the friendliness and professionalism of the staff." Other comments said "Staff are wonderful, kind and helpful" and "Care has been first class." A staff member told us "I think people get good enough care here. I would be happy for my relative to live here."

We asked staff if they felt supported. One staff member told us "I do not feel there is enough support for staff as there have been so many managers. I am aware there are staff meetings but have not attended one yet" as they clashed with this staff member's days off. However, they were aware there were minutes for them to read if they were unable to attend. Another staff member also commented on the frequent manager changes in a short space of time. They told us "I sometimes feel supported. Sometimes we don't seem to be doing anything right and we don't get any appreciation. It's only the bad things that get mentioned, not the good things. You know you are working your hardest and get no thanks."

This staff member spoke positively of the changes to the location of the units in the home as they felt this was much more manageable. They said people with dementia had much more attention now as it had been too difficult to provide effective care when they had been upstairs as the unit had been so much larger. This helped provide more focused care and we were told, "it's a positive change". The staff member said "Team members are very supportive. I wasn't sure I would like the change but it's lovely."

One staff member said "There is good leadership with a good team. The senior carer is in charge of us. If we are worried about anything we would go to them. If there was a complaint that could not be sorted I would go to the nurse, and if not happy then to the manager." They said they felt listened to. They'd recently had to request some leave and this was accommodated.

We asked staff if they enjoyed working at Snapethorpe Hall. One staff member said "I do. It's a happy place if you have the staff. You can have a laugh with the residents. There's always someone to go to if you have a problem. I wouldn't change anything apart from perhaps more staff." Another said "It has its moments. If I could change anything I would have sufficient staff but I know that's not always possible due to sickness."

Staff meetings were held frequently. The previous inspection report had been shared with staff and the action plan that had been created as a result. We saw minutes of a staff meeting from March 2016 which introduced the new manager, discussed staff attendance and general initial impressions by the new manager. They had shared with staff "All residents look cared for and all seem happy." The meeting had also discussed practice issues such as medicine competency, how to support someone nutritionally at risk and how staffing levels were being reviewed in light of the development of a dependency tool. This showed that the home were aware of the difficulties and that staff needed further guidance and support to operate

effectively.

The new manager told us they completed a daily walk-around and visual monitoring but "I'll be honest, I don't always write it down." We observed them doing this during the day and talking to both people in the home and staff as they did. They advised us they had completed a night and weekend shift and always checked at handover whether there have been any significant issues such as safeguarding concerns. The manager said they felt supported in their role with easy access to other senior managers and a clear management structure.

We also spoke with the assistant director who told us they offered support to both the temporary manager and the new manager in post. They advised us they made regular visits as well as completing additional visits if a home had a change of managers such as in Snapethorpe's case. Part of their role included a walk-around to check that standards were being met in the home.

We asked the new manager what they felt the risks were to the home. They advised it was the two main aspects which they had already actioned, that is, people nutritionally at risk and the application of DoLS which was an ongoing programme. We also asked them what was positive and they said "I've seen some good care in all units, and families have given me positive feedback." They also advised us they were keen to develop relationships with external partners as "care has to be good. Any of these people could be my mum or dad. I need to be happy they could come here."

The home had held frequent relatives and resident meetings. In one held in November 2015 the major changes to the location of the units in the home had been discussed followed by an update in January 2016. In another we saw evidence of discussion around mealtimes as people were asked if they wished to have their main meal at lunchtime, evidence of activities such as a Pulse exercise class and other events such as church services and entertainment. People were offered the opportunity to attend a lunch club at a local church using the home's minibus. One person mentioned this to us when we were speaking with them. More recent meetings had included an introduction to the new manager and discussion about the gardens outside the home.

There was a 'Kindness in Care Award' on display in the reception area which had been given to the nursing unit in January 2016 for 'great kindness and good teamwork to all residents, staff members and families.'

We looked at the home's quality assurance processes including audits they had completed. We found audits for medicines, infection control, health and safety, weight management and housekeeping. The weight management had been completed up to February 2016 and evidenced where people had needed a referral to the dietician and/or were being prescribed food supplements. The housekeeping audit was also completed with monthly audits being maintained and we saw in our own observations how these standards were being applied.

There was also a care plan audit file which showed in February 2016 nine care plan audits had been completed in the residential unit, one in the nursing unit and three in the dementia unit. We saw that actions had been taken in three of these but it was not always clear whether any further follow up action had taken place.

We saw the home had completed all necessary premises and equipment checks such as gas and electric services, slings and lifting equipment and fire risk assessments.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The home did not have capacity or best interest assessments in place to ensure they were complying with the requirements of the MCA where a person lacked capacity to make a specific decision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not able to refer to the correct procedure for the safe moving and handling of someone as there was no record in people's files.