S.E.S Care Homes Ltd

Crossways Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection was unannounced and took place on the 5 and 6 June 2017.

Crossways Nursing Home (to be referred to as 'the home' throughout this report) is a home which provides nursing and residential care for up to 18 people who have a range of needs, including those living with dementia, epilepsy and diabetes and those receiving end of life care. At the time of our inspection 14 people were living in the home.

Crossways is a two storey building set in secure grounds in a village on the outskirts of Basingstoke. The home comprises of 10 single rooms and 4 double rooms for residents, some with ensuite bathroom facilities. There is a communal lounge and dining room on the ground floor with a lift that offers people access to both floors. There is a secure garden to the rear of the home which houses a marquee allowing people to enjoy sitting in the garden in all weather conditions. However this was being used to store equipment such as wheelchairs at the time of this inspection.

At our last inspection on 28 and 29 June 2016 we made a recommendation that the provider sought guidance on the environmental factors in the home to ensure they could be adapted to meet the needs of those living with dementia. Additional work was also planned to ensure the home's environment was developed further in order to continue to meet people's needs. At our last inspection we also made a recommendation that the provider actively promoted activities identified as appropriate for those living with dementia.

At this inspection we saw improvements had been made to ensure the environment met the needs of those living with dementia. However more work was required to fully engage people in personalised activities enabling them to live a socially active and enjoyable life.

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

People were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 (MCA) when supporting people to make decisions. However the provider had not always completed mental capacity assessments and best interest decisions where required, to ensure those requirements of the MCA were met at all times.

People's needs were assessed and care plans were in place to address their needs. However care plans were not always person centred ensuring each person's individual needs were met appropriately.

People, relatives and staff were not always encouraged to provide feedback on the quality of the service

they received. Quality assurance processes were not in place to enable people to provide feedback identifying where improvements in service provision could be made.

The provider had not effectively implemented quality assurance systems to assess, monitor and improve the quality of the service people experienced.

People using the service told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people. People's safety was promoted because risks that may cause them harm had been identified and guidance provided to staff to help manage these appropriately.

People told us they there were sufficient numbers of staff deployed in order to meet their needs. The provider was able to adapt their staffing levels appropriately when required, in order to meet changes in people's needs.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely. Nurses received the appropriate training and guidance to enable them to complete their role in relation to medicines safely. Medicines were stored, administered, disposed of and documented appropriately.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire or flood. These were easily accessible to staff and emergency personnel such as the fire service, if required. This ensured people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable. These plans were updated monthly to ensure the information contained within remained current and met people's changing needs.

People were supported to eat and drink safely whilst maintaining their dignity and independence. We saw that people were able to choose their meals and were offered alternative meal choices where required. People's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

Staff promptly engaged with healthcare professionals to ensure people's identified healthcare needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which apply to care homes. The registered manager showed an understanding of what constituted a deprivation of a person's liberty and was able to discuss the processes required in order to ensure people were not deprived of their liberty without legal authority.

People told us that care was delivered by caring staff who sought to meet their needs. We saw that people had friendly and relaxed relationships with staff.

People knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way.

The provider's values and philosophy of care were available to people and staff. Staff understood these and people and relatives told us these standards were evident in the way that care was delivered.

The registered manager and staff promoted a culture which focused on high quality care in a warm and welcoming homely environment. The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

Risks to people had been identified and recorded; and detailed guidance provided for staff to manage these safely.

Medicines were administered safely by nurses whose competence was assessed by appropriately trained senior staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not ensured that appropriate MCA and best interest processes had always been followed.

People were supported by staff who completed a nationally recognised induction process to ensure they had the skills and knowledge required to meet people's needs in an effective way.

People were encouraged to participate fully in mealtimes to ensure they ate and drank sufficiently to maintain their health and wellbeing.

People were supported to seek healthcare professional advice where required in order to monitor, manage and treat their changing health needs.

Is the service caring?

Good

The service was caring.

Staff were caring in their approach with people, supporting them in a kind and sensitive manner.

Staff had a well-developed understanding of people and had developed companionable and friendly relationships with them.

People were encouraged to assist in creating their own personal care plans to ensure their individual needs and preferences were known and provided by staff.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always sufficient opportunities to ensure people received personalised interaction to meet their social wellbeing needs.

People's care plans were not accurately created to reflect people were receiving individualised and personalised care.

People were enabled to raise concerns which were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes were not always effective in identifying shortfalls in the quality of the service provided so that continual improvements could be made.

The registered manager promoted a culture which placed the emphasis on people receiving care from staff in a homely and welcoming environment.

Staff were aware of their role and felt supported by the registered manager and told us they provided good leadership.

Crossways Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory function. This inspection checked whether the provider was 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 the 5 and 6 June 2017 and was unannounced. The inspection was conducted by an adult social care inspector and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, their relatives, observed mealtime sittings and interactions between staff and people living at the home

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We had not requested that the provider complete a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked this information during the inspection.

During the inspection we spoke with four people, two relatives, one nurse, the chef, two care staff and the registered manager. We looked at seven care plans, three staff recruitment files, staff training records and seven medication administration records. We also looked at staff rotas for the period 8 to 21 May 2017, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. During the inspection we spent time observing staff interactions with people including during two lunch time sittings and with two people in their rooms.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us that people living at the home were safe. One person told us, "Yes (feel safe)They (staff) are very good- I have to be hoisted to be moved. I don't like it but they have got the knack now", another person said, "Yes (feel safe) I don't have any concerns". This was a viewed shared by relatives, one relative told us, "Oh yes (family member is safe), they (staff) are very good".

Staff demonstrated their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns. Staff felt confident that the manager would act promptly and effectively in response to any concerns raised. The provider's policy provided guidance for staff on how and where to raise safeguarding concerns which included contacting the CQC and Adult Social Care Hotline. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's overall health and wellbeing were identified and guidance provided to mitigate the risk of harm to them. People's care plans included their assessed areas of risk. These included risks associated with people mobilising, their oral health, and risk of receiving pressure ulcers. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people were at risk of suffering from injury whilst mobilising around the home. Information in people's care plans provided guidance for staff about how to support people safely to move around the home which included when transferring people to and from chairs.

The provider also took positive action to mitigate these risks to people's wellbeing. For example the registered manager and staff identified in order to minimise the risks of people acquiring pressure ulcers new pressure relieving beds would support people's skin integrity. Pressure ulcers can be suffered when a person maintains the same position for a period of time placing pressure on a person's skin. As a result of this request ten new pressure relieving beds had been purchased and supplied for people living at the home. This action ensured people's skin integrity was maintained and minimised the risk of people suffering from a pressure ulcer. Staff understood risks to people's health and wellbeing, followed appropriate guidance and took proactive steps to minimise these risks where possible.

People were protected from the risk of harm because there were contingency plans in place in the event of an untoward event, such as accommodation loss due to fire or flood. This was detailed in the home's Business Interruption Plan (BIP) which was easily accessible in the home's foyer. These plans provided a quick reference for staff and emergency personnel such as the fire service, of the actions to take in the event of evacuation, to ensure continuity of care for people living in the home. Personal Emergency Evacuation Plans (PEEPs) had also been completed for people living at the home. These provided an easy to follow guide for staff and emergency personnel about the support people required in the event of a fire, such as their moving and handling needs. The PEEPs were updated monthly to ensure they contained the most recent guidance to enable people to be supported safely. The BIP and PEEPs allowed for people to continue receiving the care they required at the time it was needed.

There were sufficient staffing levels to meet people's needs, which was confirmed by people and their relatives. One person told us, "Yes I do, (think there's enough staff), there is always someone available to help". Another person told us, "Yes, I think so (enough staff) there is always someone in and about". A relative told us, "Oh yes (enough staff)".

The registered manager identified that the staffing levels across the home consisted of one nurse and two staff during the day, with one nurse and one member of staff working during the night. The registered manager was able to identify when additional staffing numbers were required. When people were receiving end of life care or required additional support as a result of their deteriorating health needs staff told us that additional staff were used appropriately. The registered manager spoke frequently with staff members to ensure that if additional time was needed to support people's needs then staffing levels would be adapted accordingly. Records and observations during the inspection showed the deployment of sufficient numbers of staff to meet people's care needs safely.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services.

People living at the home received their medicines safely and told us they were happy with the level of support they received. People said they received the correct medication at the correct time and staff ensured they took this to maintain their health and wellbeing. This was confirmed by a relative we spoke with.

Nurses were responsible for administering medicines. Medicine administration records were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to annual competency assessments to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance.

A medicines round was observed during which the nurse appropriately supported people to take their medicines as prescribed. Medicines were stored, administered and disposed of correctly which included those which require refrigeration to remain safe. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. There were no controlled drugs being used at the home but processes were in place that should they be required they would be audited to check that records and stock levels were always correct.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the ability of staff to meet their care needs. People said that they felt staff were trained and had sufficient knowledge and skills to deliver care. One person we spoke with told us, "They (staff) seem to be OK, yes, they understand my needs" another person said, "They (staff) seem to be skilled enough" and a relative said, "They (staff) are all very caring and helpful".

At our last inspection of the service in June 2016 we identified the home had not always been decorated or adapted in a way to support those people living with dementia to live as independently as possible. We made a recommendation that the provider sought advice on how to develop a dementia friendly environment which would meet people's needs.

At this inspection we saw action had been taken to increase people's ability to move independently around the home, for example; handrails were painted contrasting colours to the walls to enable people to have a clear focal point allowing them to walk safely within the home. There were also pictorial signs to assist people in identifying the different areas of the home such as communal areas including the dining room, lounge and private areas, such as bathrooms and toilets. Lighting within the home had been updated to ensure that all areas of the home were well lit to aid people's ability to move around the home.

The provider had taken action to ensure people were supported to move around the home safely. The provider was also due to commence additional redecoration works following the inspection which would lead to a replacement of all floor coverings in the home. This work was designed to ensure the further development of a dementia friendly environment for people living at the home.

People were assisted by staff who received a thorough and effective induction into their role at Crossways Nursing Home. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people unsupervised. New staff were required to complete an induction which was based on the Care Certificate. This is a structured induction programme which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support.

Nurses were also supported to undertake training in specific areas which enabled them to maintain their professional registration. This training included specific medical tasks such as, venepuncture (this is the procedure of inserting a needle into the vein), pressure ulcer prevention and treatment and the management of percutaneous endoscopic gastrostomy (a tube placed directly into a person's stomach through which they can receive, food, water and medication).

However professional registration documents for nurses were not always available and updated to show they remained registered with the Nursing and Midwifery Council (NMC) in order to provide nursing care. The registered manager's staffing records did not contain up to date registration documentation for nurses. Records indicated a nurse was no longer able to deliver care in their professional nursing capacity. Records identified their registration had expired in January 2017 and had not been updated to show they had re-

registered and were able to continue to practice nursing care.

The registered manager explained the provider's Operations Manager held this information separately away from the home as they were responsible for completing appraisals of nursing staff. This information was then sought by the registered manager during the inspection who spoke with the individual nurse who was asked to provide evidence of their re-registration. There was a risk that should the Operations Manager not be available this information would not be made available for the registered manager. Whilst nursing staff are responsible for ensuring their registration remains current there was a risk the registered manager would not be aware if this work was not completed. Immediate action was taken by the registered manager during the inspection. The registered searched the NMC for all nurses employed to ensure their registrations were valid and evidenced this within their office. From this it was evidenced that all nurses professional registrations were in date and valid.

The provider did not have effective systems and processes in place to ensure the registered manager was aware of staff's training needs and when any updates to such training would be required.

Records held by the registered manager identified that staff should undertake training in a number of key subjects. These included moving and handling, first aid, health and safety, safeguarding, dementia care and mental capacity. However these records showed that no staff had completed the following training subjects including, first aid, food hygiene, safeguarding, infection control and dementia care for example.

We saw in staff records that training certificates were in place and staff evidenced they had knowledge in these areas. However there were no available records in place to allow the registered manager to identify which staff had completed this training and when this training required additional updating. The registered manager explained the provider's Operations Manager maintained control of this information as they were responsible for organising and delivering training for staff. A request was made on two occasions to receive this information from the Operations Manager during the inspection. However, on both occasions the information received related to training dates for the provider's sister home and did not contain the required and requested information. There was a risk that should the Operations Manager not be available the registered manager would not be aware of who required training in order to keep their skill levels appropriate in order to meet people's needs.

The registered manager had not maintained records necessarily in regards to staff training therefore creating risk that staff would not receive their training as required in order to maintain their skills. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 make 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 any authorisations to deprive a person of their liberty were being met. The registered manager displayed

an understanding of when a DoLS would be required by submitting the correct applications. Staff were able to clearly identify the principles of the MCA and demonstrated that they complied effectively with the MCA by offering people choices with their day to day care.

However, the provider had not ensured that MCA assessments were completed where required and when decisions had been made in people's best interests that relevant persons were involved in these discussions. For example, the provider's care plan documentation stated that where a person was suspected of lacking the capacity to agree to receiving care then appropriate MCA documentation should be completed on their behalf. We found this was not being completed for all people living at the home who did not have the capacity to make all decisions regarding their care.

One person had been deemed as not having the capacity to consent to agree to their care however no best interest meetings or decisions had been recorded. This person did not have a nominated individual who had the legal authority to make decisions on their behalf. Best interest decisions are those which are made for people who are no longer able to agree to a particular aspect of their care. Best interest meetings are held with people close to that person the decision is being made on behalf, ensuring their needs are met fairly and that any action taken is for the benefit of that person. This meant it was not always clear that people were receiving care which was in their best interests.

Whilst decoration was happening at the home a number of residents were currently sharing a room. However the provider had not followed their own 'Shared Room' policy which identified the actions needed to be taken prior to people being moved to a shared room. This meant the provider had not always protected people's right and ensured they had lawfully consented to sharing a room with another person. We saw that for two persons living at the home sharing a room no MCA or best interests' records had been completed. There was no documentation regarding whether or not they could consent to this action or if sharing a room was in their best interests. For one of these people we saw that the family had been asked informally whether or not they agreed to the room share however this had not been completed for the other person. This meant that people were at risk of sharing rooms where it had not been appropriately assessed as being in their best interests and the appropriate consent sought before this action was taken.

Where a person lacked mental capacity to make an informed decision or give consent the provider had not acted in accordance with the requirements of the MCA and associated code of practice. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop their skills and abilities. Supervision and appraisal records were detailed and individualised. During these processes issues of importance to both the supervisor and member of staff were discussed. Most staff told us and records confirmed supervisions occurred approximately every three months and were used as a way to identify if staff required or wanted to complete any additional training to support them in their role. Staff told us they were able to speak to their team leader and registered manager at any time if they required additional support. Processes were in place so that staff received the most relevant and current knowledge and support to enable them to conduct their role effectively.

People and relatives were complimentary about the food provided and told us there were sufficient quantities available for people to enjoy. One person told us about the food, "Food is ok, plenty and good quality yes", another person said, "Food is good, about as good at home". A relative told us, "Food is very good".

People were supported at mealtimes by staff who were attentive to their needs. We saw staff were flexible in their approach when supporting people to ensure they were offered every opportunity to enjoy their meals. We saw one member of staff sat alongside one person supporting them to eat, they were patient and gentle in their approach and gave the person time to eat what was provided. Lunchtimes were a relaxed and unhurried occasion. Where one person did not want their lunch staff approached them on a number of occasions to see if they had changed their mind. People had drinks readily available to them and cakes and biscuits were regularly offered throughout the day to support people who may not always be willing to eat a main meal. Snacks such as sandwiches, fruits and yoghurts were available to people day and night in the event they wished to have something additional to eat.

People were supported to enjoy their meals at the time and pace appropriate to their needs. The registered manager also supported people at lunchtime and provided assistance to staff. When people stated that they did not wish to continue or had not eaten much of their meal staff sought alternatives to try to encourage these peoples to eat. Staff came down to eye level to help the interaction with people to offer support whilst assisting them to eat. Staff reported to the chef when people in their rooms had not eaten well and alternative food and fluids were provided to encourage people to eat and drink. Squashes were available in people's rooms with snacks available with biscuits and tea on frequent offer. Additionally fruit salad and homemade cakes were available in the afternoon to assist people to eat and drink sufficiently to ensure their on-going health and wellbeing.

The chef spoke positively about the role they completed and about the menu provided. The provider identified a seasonal menu however the chef was able to adapt these to suit people's individual's tastes and preferences. The chef was aware of who had a range of specific dietary needs such as those who required a diabetic, pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained a visual appeal and was separated on the plates to allow people to identify what they were eating. The chef took time to understand people, getting to know their likes and dislikes and providing food accordingly. For example when meals identified on the provider's menu were returned uneaten or partially eaten to the kitchen, the chef adapted the food offered so it was a preferred and well received menu.

People were supported to maintain good health and could access healthcare services when needed. Processes were in place to ensure that early detection of illness could be identified. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Records showed that these were being completed showing minimal variations in weight suggesting they were supported to eat and drink sufficient amounts to maintain a healthy weight.

Professional healthcare advice was sought and followed by staff which was evidenced during the interactions with the staff. For example some people living at the home could exhibit behaviour which could challenge others. This placed them, staff and other people at risk of injury or distress. Staff appropriately sought professional support and guidance from other professionals such as the community mental health team to monitor their on-going wellbeing. This was sought to identify whether or not there was any additional action staff could take to meet people's needs. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to enable staff to manage people living with certain conditions, such as asthma, sensory impairments such as hearing loss and diabetes. Care plans and health records showed these conditions were managed safely and regular health checks such as blood glucose testing was completed in order to maintain people's wellbeing.

Good

Is the service caring?

Our findings

People were supported by staff who were motivated to deliver care in a gentle and caring manner. People and relatives confirmed that support was delivered by caring staff. One person we spoke with told us, "Excellent…oh yes very kind and caring." Another person told us about the staff, "They are good people-they look after me well". This view was shared by relatives. One relative told us, " Very (caring) She (family member) likes them and trusts them (staff)".

Positive and caring relationships had been developed by staff with people. This was supported by personal life history information provided in people's care plans. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them in their daily activities. Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families, interests and support they required. Staff took time to engage and listen to people.

For people who were unable to verbally communicate guidance was provided to staff about the changes in body language or facial expressions to identify whether or not people were happy or if they required additional support. This guidance included the importance of engaging and maintaining eye contact and offering physical touch as a way of interacting with people. We observed this guidance being followed by staff during the inspection.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. When people were seen calling out during the inspection staff were quick, patient and caring in their response.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw staff used touch support to interact with people and to engage fully with them. We saw people were comfortable and actively sought this physical contact holding staff members' hands whilst speaking with them. Friendly conversations were held whilst staff and people chatted and held hands.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day. Care plans were agreed with the person's relative or nominated person, such as those with a lasting Power of Attorney (POA) for health and welfare. A POA is appointed to make decisions for people when they are unable to do so for themselves.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in the nurse's station to protect confidentiality.

During the inspection staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity

and treated people with compassion. This included making sure people were suitably clothed and had their modesty protected when they were assisted with their personal care. People were provided with personal care with the doors shut and curtains drawn to protect their privacy. A large moveable fabric screen was also used when people were being assisted in public areas. This provided privacy for people when they were being assisted to transfer to and from wheelchairs and being assisted to stand.

People told us they were treated with respect and had their dignity maintained by staff during care delivery. One person told us, "Yes, certainly, they (staff) keep doors closed when needed". This was a view shared by relatives. One relative said, "Always, she (family member) is treated with great respect ". Staff were seen to ask people before delivering or supporting with the delivery of care.

People were also respected by having their appearance maintained. Attention to appearance was important to people and noted in care plans. Staff assisted people to ensure they were well dressed, clean, wearing matching clothes and jewellery items, with well-groomed hair. We saw staff regularly supported people to maintain their appearance and ensured they were appropriately dressed.

People were supported to maintain relationships with friends and family who were important to them. Friends and relatives were able to visit their loved ones without restrictions and were welcomed to the home by staff whenever they were present. One person told us, "There isn't any problem (seeing friends and family whenever available). People come and go all the time", another person said, "Visitors come in whenever they want". A relative agreed that they were able to visit the home whenever they wished telling us, "I've never found visiting a problem".

Requires Improvement

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. One person told us, "I was totally involved (in writing my care plan) and still am able to make my own decisions".

People provided mixed views on whether they felt there were sufficient activities available in order to maintain their interest. One person told us, "We don't go out ", another said, "Not always. We play skittles and listen to music". Other people told us they enjoyed the activities available, one person told us, "I like the exercise, painting, I like reading" another person said, "I like to listen to music and the sing-a-longs".

At our last inspection of the service in June 2016 we recommended the provider took steps to actively promote activities identified as appropriate for those living with dementia. This was to ensure all people were offered the opportunity to participate in meaningful activities to enrich their daily lives.

At this inspection we saw action had been taken to find alternative activities for people to participate in, this included sourcing 'Elderly Activity Sheets'. These provided activities appropriate for those living with dementia, which included ideas such as creating conversation boxes containing items to help people reminisce and encourage interaction. Despite producing a number of these activity sheets, observations and records did not show these activities were promoted to ensure people led meaningful and interesting lives.

Documentation relating to the activities people completed were not accurately completed to evidence people were encouraged to participate in activities to meet their needs. For a number of people 'Daily Activity at Crossways' records documented friends and family had visited which had provided them with their only interest to their day. However this was not confirmed by the relatives and visitors signing in and out sheet. The registered manager told us staff would complete these activity sheets some days after the actual events which would explain some discrepancies. As a result it could not be accurately evidenced which activities people were offered or had participated in.

During the inspection one person in the lounge slammed their hand repeatedly against their table. This person said they were taking this action "To do something". This person had been sat in their chair since lunchtime and had not been encouraged to participate in any activities. This person had been sat been looking around the room without stimulation and the television was not on to provide any interest. As a result of this exhibited behaviour staff sat with this person and read to them however they did not fully engage with the staff member and no alternatives were offered. Other residents were taking part in insular activities such as completing a word search book, one person was sleeping, another person completed a child's puzzle, whilst two other people sat in their chair not engaged in conversation or activities with staff or each other. During the inspection we saw a number of people would sleep, stare at the floor or wall for periods of time without meaningful staff interaction.

During the inspection no activities were provided for those who were being supported in their rooms. Staff

encouraged activities participation from people in the lounge where the inspector and Expert by Experience were initially sat however staff were not seen engaging with people nursed in their rooms.

Care plans documented people's particular social interaction needs providing guidance for staff on how to meet these needs. One person's care plan stated they needed to keep their body and mind engaged to prevent boredom and isolation and needed to be encouraged to pursue previous hobbies to make them feel part of the Crossways community. However it was not evidenced this action was being taken. A relative told us that their family member, who was nursed in bed, enjoyed watching the television however the placement of their bed in relation to the television made it difficult for them to view this properly. During the inspection we noted this person's bed was in a lowered position so that the television could be viewed clearly however if their bed were raised the television would be difficult for them to view which the relative had witnessed. This person was heard to cry out continually during the inspection, a known behaviour, however we saw people in their rooms did not receive the same level of social and personalised interaction as more mobile people living in the home. People were not receiving care and activities support they needed in order to meet their individual needs.

The provider had not always ensured that people were provided with opportunities to participate in activities which met their individual needs and personal preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's care needs had been assessed and documented by the nursing or managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met. Care plans were being reviewed monthly and people, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care.

Care plans provided detailed guidance for staff on how to manage people's needs however these were not always accurately completed for each individual.

We noted that care plans written for females sometimes used male terminology, such as 'him' to describe the care people required. One person had a care plan in place for maintaining their skin integrity; however this was dated three years before they moved to the home. Another person had a care plan in place detailing guidance staff should take to preserve their dignity whilst receiving care. However this care plan was written in the name of a person who had passed away. People had been receiving the care they required to ensure their health needs were met however care records were not always accurately completed to ensure they reflected people's individual needs.

Another person had a care plan in place which contained information for staff on how to manage their impaired verbal communication skills. This provided guidance for staff to assist them in identifying this person's non-verbal cues which would support their decision making process. However the care plans documented rational and desire outcomes for the work to be undertaken by staff did not relate to this person's communications skills. Each person's care plan contained guidance which was to be followed by staff to meet a specific need. They also documented rationale and desire outcomes which were to be expected from the action taken by staff. One person's care plan rationale and desired outcomes related to this person's British Citizenship care plan not their impaired communication skills. There was a risk that not having desired outcomes or rationale for this person meant the care regarding this person's communication skills could not be measured against any identified outcomes as being effective.

The provider had not ensured that accurate and complete documentation had not been completed for all

people living in the home. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Handovers between all staff were held at the change of shift twice a day. These were held between the nurses and the care staff. The handover contained specific and detailed information in relation to people's needs, such as their moving and handling needs, their emotional wellbeing and if people had eaten and drunk well throughout the day or night. People were supported by staff who knew their health needs and ensured that all members of staff responsible for their care were aware of any changes in their physical or mental wellbeing.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. One person told us, "Nothing to complain about", another said, "No, never (had to complain). Relatives also told us they knew how to complain if required. One relative told us, "No, never (had to complain)…not ever needed to make a complaint".

The provider's complaints policy was available in people's rooms as part of their service user guides and accessible to their visitors and relatives. People's care plans also included information providing guidance to staff on how to support people to make a complaint if they expressed a wish to do so.

Even though no formal complaints had been made since the last inspection processes were in place to ensure if received they would be acknowledged, investigated and responded to appropriately in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The registered manager sought to achieve an open and supportive culture amongst all staff, people and visitors to the home. Most people and relatives recognised and knew who the registered manager was. One relative told us the registered manager was "Very Good". However this was not always a view shared by all. Regarding the leadership and management of the home, one person told us, "It's OK", another person said, "I don't know who the manager is" and another person told us the management of the home was "Fine".

The quality of the service people experienced was not always assessed and monitored through effective feedback processes. Throughout the inspection we observed people and relatives speak freely with the registered manager. However there were no formalised processes to ensure that peoples, relatives, staff and visitors feedback was obtained to identify areas for improvement.

The provider's quality assurance process identified that quarterly residents and relatives meetings should be held in order to gain this feedback. However there was no evidence to show these were being held in accordance with the provider's guidance.

People and relatives could not remember a time when their feedback about the service was sought by the provider. One person said, "Not that I remember" (being asked to provide feedback), another person said, "No", whilst another person said, "No, no, I can't remember any residents meetings, there are only a few of us that would be able to attend". A relative told us, "No, no residents meetings". During the inspection we asked to see evidence that people had been asked to provide their feedback on the quality of the service they received from the home. The registered manager told us the last quality questionnaire had been completed in April 2017 however records did not evidence this had been completed. It was not evidenced that people, relatives, visitors and staff were actively encouraged to participate in providing feedback identifying where improvements could be made to drive the performance of the service.

However people and their relatives spoke positively of the quality of the care provided. One person told us they were "Very happy" with the quality of care provided, another person said, "It's very good care" and another person said, "It's (the home) a good place". Relatives told us they had a good degree of satisfaction with the home. We were provided with written compliments which had been received by the home which evidenced staff were motivated to treat people as individuals and deliver care in the way people requested and required.

The provider completed a number of quality assurance audits to monitor the service provision. The provider's policy identified the frequency and type of these quality assurance processes. These included weekly room and clothing checks, monthly staff training needs, care plan audits, reviews of risk assessments, quarterly checks including confirming nurses PIN numbers, bi-annual quality reviews including reviewing care plans and annual checks such as infection control, medication audits and training, staff file audits. We could see these audits were being completed however they were not always effective in identifying areas for improvement.

The provider's Operations Manager was responsible for completing monthly quality audits to assess the quality of the care provided by reviewing care plans and outcomes and care staff records for example. In January 2017 the Operations Manager completed an audit which identified that all people with mental health needs had a care plan reflecting their capacity and that care was provided in their best interests. However, during this inspection we could not see this was always completed.

Where people lacked the capacity to make informed decisions or give consent regarding their care the principles of the Mental Capacity Act 2005 had not always been followed. In February 2017 the provider completed an audit which viewed care plan documentation. This audit did not identify that care plans were not always accurately completed for each individual and that the information contained within specific to the needs of that person. The provider's audit in April 2017 looked at whether there was an effective quality assurance process in place to receive feedback from staff, residents, relatives and representative. It stated that the relatives meeting needed to be held as soon as possible. However this had not been arranged at the time of this inspection.

The provider had regular quality assurance processes in place however they were not always effective. The provider had not identified that records relating to people's care plans had been accurately completed and the use of the Mental Capacity Act 2005 was fully embedded in the home's working practices.

The provider had not ensured appropriate and effective quality assurance processes were in place to assess, monitor and improve the quality of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager was keen to promote an atmosphere where people felt they were receiving care in a warm, welcoming and homely family environment. People and relatives told us they felt Crossways provided a positive living environment. One person said of the home's atmosphere, "It's friendly, nice" another person said, "It's very good" and a relative told us, "(the home is) Open, friendly and honest".

The provider had a 'Philosophy of Care' which was openly displayed in the home and the provider's 'Charter of Residents Rights.' This included a documented list of rights people had whilst living at the home and receiving care. These included that people live in a secure, relaxed and homely environment in which their care, medical requirements, wellbeing and comfort was of prime importance..

Staff were able to identify the providers philosophy of care and provided evidence of how this supported the care they provided. One member of staff told us, "We're treating people like safely, securely, very securely and not in a negative way, whatever they (people) want we provide on that basis, not what we want, what they want". Another member of staff said of the philosophy, "(it's providing) High quality (care) and safe environment for the residents…it's their home always try to respect dignity and providing care to keep them respected all the time".

The registered manager was a visible presence to relatives and staff. Whilst not all people were able to recognise the registered manager, all felt they were able to speak with them and felt confident they would be act on any issues raised. People and relatives spoke positively of the ease of communication they had when speaking with the registered manager, one person told us, "He comes and speaks to me" and another person said, "No problem ever (speaking with the manager) always willing to talk".

Staff spoke positively about the registered manager's ability to lead the service and all felt supported as a result. They told us the registered manager was available to them if they required support or guidance and were actively involved in the day to day running of the service, which we observed throughout the

inspection. The registered manager was actively involved in the day to do day running of the home and supported staff with care delivery, activities and assisting people to eat at lunchtimes. One member of staff told us, "Yes he's really, really supportive" another member of staff said, "He's very open".

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not always ensured that people were provided with opportunities to participate in activities which met their individual needs and personal preferences. This was a breach of Regulation 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a person lacked mental capacity to make an informed decision or give consent the provider had not acted in accordance with the requirements of the MCA and associated code of practice. This was a breach of Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not maintained records necessarily in regards to staff training therefore creating risk that staff would not receive their training as required in order to maintain their skills. The provider had not ensured that accurate and complete documentation had not been completed for all people living in the home.

The provider had not ensured appropriate and effective quality assurance processes were in place to assess, monitor and improve the quality of the services provided

These were breaches of Regulation 17 (1)(2)(c)(b)(d)(i).