Mr Christopher Chawner

Minshull Court Nursing Home

Inspection report

Minshull New Road, Crewe, Cheshire. CW1 3PP
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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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 28 October 2014 and was unannounced. A second day of inspection took place on 5 November 2014. At the last inspection in December 2013 the home was found to be compliant with all the regulations which were looked at on that occasion.

Minshull Court Nursing Home provides nursing and personal care and is located in a residential area of Crewe. The premises provide purpose built accommodation for 34 people in single bedrooms. It is a two storey building and people live on both floors. Access between floors is via a stair lift or the stairs.

Minshull Court Nursing Home is required to have a registered manager. 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.

When we inspected the home people said that they felt looked after by staff who cared for them. Staff were able to do this was because they had a good relationship with the people who lived in the home as well as their relatives and the other agencies which provided care. There were some activities organised in the home and people could make choices about how they spent their time.

People told us that they felt their concerns and wishes were listened to by the staff. They told us the food in the

Summary of findings

home was good and that they could choose what and where to eat. The staff were well led by the registered manager and received training as well as supervision but the home's policies and procedures were out of date and needed revising.

Some parts of the home require decoration and at present could present a risk to some of the people living there. The heating equipment was not working properly and some of the furnishings were not suitable or required replacement. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe because adequate steps had not been taken to control infection within the home by making sure that bathroom areas were decorated and adequate flooring was in place in toilets. There had been errors in the recording and accounting for certain medicines.

The people who lived in the home and their relatives all felt safe from abuse. There were sufficient staff working in the home and the provider took steps to make sure that the people employed were suitable to work there.

Is the service effective?
The service was not always effective because the some of the furniture was not suitable for the people who lived in the home. Some of the carpets were stained or worn and needed replacement. We found that it was cold in the morning at the home. This was because the heating system to part of the home did not work effectively.

Staff at the home had received training in order to help them to do their jobs. There were good arrangements for handover of information between staff shifts. Everybody we spoke to was complimentary about the food that was served to them at the home and felt that there was a good choice of dishes. People who lived in the home received health and social care services from agencies outside the home.

Is the service caring?
The service was caring. People who lived in the home and their relatives all described the staff as caring. We saw that staff took the time to provide care to people at a pace which was unhurried.

Staff knew the likes and preferences of people and respected these when providing them with care.

Is the service responsive?
The service was responsive because people who lived in the home felt they had choices about their care. Staff asked them before they undertook tasks for them. Activities were planned for each day but people did not have to take part if they did not wish to.

Care in the home was planned around people's individual requirements but further adaptation was required to respond to the needs of people living with dementia.

People felt that they could complain if they needed to. The registered manager listened to people's comments and responded to them.

Is the service well-led?
The home was well led. Staff, the people who lived in the home, relatives and professionals all found the management of the home to be approachable. The registered manager was making sure that staff received supervision and arrangements were in hand to introduce appraisals. The manager had a system of audits in place so that she could monitor performance in the home.

The registered manager took turns on the rota so that she could keep in direct contact with standards of care in the home. However there was an urgent need to provide updated policies and procedures.

Minshull Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 28 October 2014 and was unannounced.

The inspection team was made up of two inspectors, a specialist adviser in mental health, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had expertise in services for people living with dementia. A second day of inspection was undertaken by one inspector on 5 November 2014.

Before the inspection we reviewed all the information we held about the home including any formal notifications they had made and any comments we had received from the public. A notification is information about important events which the service is required to send us by law. We contacted the local authority safeguarding and quality assurance teams and considered any information they provided to us.

During the inspection we spoke with six people who used the service and five of their relatives. We looked at six care files as well as other records related to the management of the home. We walked around the home on several occasions and visited people's bedrooms with their permission. We spent time with people who used the home when they were in the lounge and also during a meal time. We talked with five staff as well as the registered manager and the assistant manager. We also spoke with the local infection prevention and control service of the local NHS Trust and a member of the Clinical Commissioning Group's quality improvement team.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Is the service safe?

Our findings

We were concerned that certain elements of the home required maintenance and in their current state might represent an infection risk. We saw that in two toilets the linoleum had been removed exposing a tiled floor underneath. The surface of the tiles was worn and exposed a porous surface over most of the floor area. This would make it difficult to maintain this area in such a way as to keep it hygienic and clean and to protect people from infection. We also saw a bathroom in which some plastering work had been undertaken but not redecorated. The exposed plaster represented a further infection risk. The seals between the shower basin and the wall were dirty and required replacement. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Minshull Court Nursing Home is an old building and we saw plans for its replacement sometime in the next 18 months. We saw that the registered provider had recently converted a downstairs toilet to provide bathroom facilities for people whose bedrooms were on the ground floor of the home. We saw that there were no en- suite toilet facilities in bedrooms and we were told that commodes were used when people could not reach a toilet at night. In order to empty the commode staff carried them to the only sluice in the building which was on the ground floor. When we checked this sluice just before we left the inspection we saw that it required cleaning. We brought this to the attention of the assistant manager.

People who lived in the home told us they felt safe at the home. They said “I feel very safe here - nothing is too much trouble for the staff” and “I feel safe. Nothing bothers me. If it does I tell the staff but if I take it in general it’s great.” A relative told us “We think (our relative) is very safe here. They were very frightened at home. Now they are very settled and as a family we want them to stay.”

We asked staff if they understood what was meant by safeguarding adults. All the staff we spoke with defined this firstly in terms of keeping adults safe from hazards such as falling or making sure that people living in the home were happy. Staff were clear that they would report anything of concern to the senior nurse or to the manager but did not readily identify issues such as physical or financial abuse when we asked them. Although some of the staff had worked in the home for some years they could not recall safeguarding as every having been a concern within the home.

We saw that the home had retained copies of care concerns which were used to notify the local safeguarding team about any incidents which should be reported. We saw that the manager had taken appropriate action in response to these events. The local safeguarding authority told us there were no current safeguarding concerns relating to the home.

We saw that there was information about safeguarding and whistleblowing clearly displayed on the noticeboard where staff could find the contact details for both the local authority safeguarding team as well as the Care Quality Commission. We saw that there was a copy of the local authority’s safeguarding procedures in a file in the registered manager’s office. However the only policy and procedure published by the home that we could find for safeguarding was dated 2002, had not been reviewed recently and was in the form of a standard document published by a trade association.

We saw that access to the home was controlled through a front door operated by staff. Measures were also in place to ensure that people were free to move anywhere in the home including in the grounds which were secure. One person told us “No complaints about it here but I like to walk best of all. I like to go and walk. I like to go in the garden if the weather is good.” We saw that there were personal emergency evacuation plans for people which identified the particular needs were there to be a need to evacuate the home, for instance in the event of a fire We also saw that clear arrangements were displayed telling staff what to do in an emergency and that an alternative location had been identified in the event that the building had to be evacuated.

When we looked at care plans we saw that each one contained a number of risk assessments relating to such items as pressure ulcer prevention, the use of bed rails and the use of hoists. People’s weights were recorded on a weekly basis so that this information could be used to monitor their well-being. We saw that the home had a system of identifying those people with particular risks. For example we saw that one person had special dietary needs and saw from the care plan that attention was given to

Is the service safe?

monitoring weight as well as any impact this might have for their skin condition. We saw that the registered manager audited records of weight loss and produced a monthly report which identified the action required from staff.

We saw that the number of staff on duty was sufficient to meet the needs of the people living at the home even though on the first day of our inspection the staff were one short because of sickness. Although we saw that staff were busy we did not see people waiting for attention nor did we hear call bells going unanswered. People told us "I think there are enough staff and they are all nice. No problems with any of the staff. Never really have to wait long if you want anything". Relatives and visitors told us "There are always loads of staff on whenever you come. The staff here run about like nobody's business – nothing is too much trouble" and "I accidentally set off the call button in my relative's room. I did not know what it was but staff came from all directions immediately to see what was the matter. I was very impressed". All the staff we spoke with thought there were enough staff.

We saw that people often received attention from two care staff such as when making their way from their bedroom to the dining room or up or down the stairs using the stair lift. We noticed that the staff worked well as a team so that if a carer was not able to attend to a person immediately they would reassure that person and then find another carer to assist. We saw that that the level of staffing at the home meant that there was always at least one member of staff in the lounge and that people were not left unattended.

We looked at the staff files of four people to see if the registered provider took steps to make sure that the people employed in the home were suitable. We found that there were references from former employers, application forms which allowed for a check to be made on employment history and evidence that Disclosure and Barring Service (DBS) checks had been made. Checks were made on registered nurses against the records held by the Nursing and Midwifery Council. On one file we found that the DBS check was very old and on another there was no explanation of a long gap in employment history. We asked the provider to review their arrangements in respect of these checks.

We looked at the arrangements for the administration of medicines in the home. Where possible these were delivered to the home by a pharmacist using a monitored dosage system. Clear procedures were displayed about how deliveries would be managed. We saw that drugs were stored in a medicines trolley which was locked and secured in a medicines room when not in use. Medicines were dispensed by a member of nursing staff and a record made on the person's individual medicines administration record (MAR) which was supplied to the home by the pharmacy. We saw that care was taken to offer people a drink when they were offered their medicines.

We saw that there were instances of people who had been prescribed drugs PRN or "as required". We were told that care staff knew people well and would therefore detect if someone was in pain or discomfort and alert the nurse that this medicine might be required. However on the records we looked at there was no indication of the circumstances in which PRN medicines should be offered

We looked at the arrangements for the storage of controlled drugs and saw that these were kept in a locked cupboard. We were told that the supplies were reconciled by the two nurses on duty at the beginning and end of each shift. This was intended to reduce the opportunity for errors or discrepancies to go unnoticed. However when we checked the record we saw that on the past three occasions this reconciliation had been undertaken by only one signatory. We were told that this must be because an agency nurse had been used for the last three nights and they probably did not know that they had a responsibility to do this.

We asked the assistant manager about the use of psychotropic medication in the home. We saw that records of this medication were not kept separate to general medication records. Good practice would dictate that a separate record should be kept for those taking antipsychotic drugs and that these should be reviewed at three monthly intervals. This is because there can be serious side-effects when these drugs are used for people living with dementia.

We recommend that the registered provider reviews its training arrangements so as to make sure that wider safeguarding concerns such as abuse are given appropriate emphasis.

We recommend that the registered provider urgently reviews its safeguarding policies and procedures and ensures that they are written in way that is relevant to the requirements of the home.

Is the service safe?

We recommend that a note is made of the circumstances in which a person might require PRN or "as required" medicines.

We recommend that the registered provider puts procedures in hand to make sure that staff working temporarily in the home such as from agencies are aware of expectations of them.

We recommend that the service considers the appropriate guidelines (such as from the National Institute of Health and Care Excellence) on dementia and use of antipsychotic drugs.

We recommend that the registered provider consults with the local Clinical Commissioning Group infection control service to make sure the use of commodes is being managed in the most hygienic way.

Is the service effective?

Our findings

We noticed that in parts of the common areas of the home such as the hall and small lounge that the carpet was stained and needed replacing. The carpeting on a set of stairs at the side of the building was very sparse and not homely. The matting near one of the exit doors was stained and black with dirt. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the second day of our inspection we found that the home was cold when we arrived at 8 a.m. One of the people who lived in the home told us "The nurses are great" but we saw that they were wearing a blanket over their clothes. This person told us it was not unusual for the communal areas of the home to be cold in the morning when people came downstairs from their rooms. We raised this immediately with the assistant manager who agreed that some parts of the home could be cold.

We saw that the communal areas were heated by a separate system to the bedrooms and checked that the heating was working in these other areas. We were told that the areas we were concerned about worked from a separate gas boiler which was problematic. The assistant manager undertook to see what could be done. We saw that there was a thermostatic control in one lounge but it appeared to be broken with electrical wires exposed. We were assured that this was not live but asked the assistant manager to check this. We saw that an inspection of the electrical system of the home conducted in 2012 had found it to be unsatisfactory. The registered provider was unable to provide us with evidence that the defects had ben corrected.

We monitored the temperature of radiators in the communal areas but they did not supply appreciable heat until later in the morning at around 11.15 a.m. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked in the lounge we did not see any chair risers in use so that chairs could be raised to make it easier for some people to use them. We also noticed that a number of chairs did not have the lower cushion in place but instead pressure cushions were placed directly on the frame of the chair. We were told that this was done to adjust for peoples' different heights. However this would compromise the efficacy of pressure cushions which are designed to be placed on the cushion of a chair. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked the staff training records. We saw that there was a training programme which included subjects such as dealing with hazardous substances, dementia awareness and person-centred care, fire safety and first aid, food hygiene, health and safety, infection control, challenging behaviour, the Mental Capacity Act 2005 and safeguarding adults. The records showed that most staff had completed training in the last year as appropriate to their role with training for the remainder of topics in progress.

Staff told us that the training had been delivered by a face to face trainer until recently but had now been replaced by eLearning which meant staff used a computer instead. Staff told us that they thought the training was good and that they were paid for their time whilst undertaking modules. However given staff responses to our discussion of safeguarding we were concerned that some areas such as this and moving and handling might need to be reinforced with a practical assessment of competency although we saw no instances of poor moving and handling practice during our inspection.

We saw that there was basic training available on the Mental Capacity Act 2005. Most staff were only in the process of completing this but all the staff we spoke with understood what it meant. The staff could all identify those people living in the home who were subject to Deprivation of Liberty Safeguards (DoLS) which are part of these arrangements. We saw that training was also available on challenging behaviour and that care plans referred to this behaviour and what staff should do if confronted by it. The manager told us that the home did not use any forms of restraint and therefore training in this was not required.

We saw that there were arrangements for two people to have their medicines administered covertly. The assistant manager told us that when this was the case they insisted that the prescription be changed from tablet to liquid form as they were aware that crushing tablets could change the way they worked. We saw that authorisation for this had been given by the registered manager and the general practitioner but we did not see evidence that for those people without capacity that a best interests meeting had been convened to make this decision. Where a person is

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assessed as not having the capacity to make a decision for themselves a best interest meeting of people who know the person should be convened to agree the best course of action.

The Mental Capacity Act 2005 makes provision for people who are unable to consent. We checked five care records to see how the provider managed this. We saw that where appropriate care files included a mental capacity assessment however in some instances these were very basic and consisted only of a tick to indicate that a condition had been met rather than any narrative to explain the circumstances of the assessment or the person being assessed. This information is important because a person's capacity must be judged only in the context of the decision being made and the time at which the assessment was completed.

We saw that a number of files contained forms on which consent could be recorded. We saw that where an individual had been assessed as not having the capacity to consent themselves that an agreement to the care provided had been provided by a relative usually a next of kin. It was not clear if the next of kin always had the authority to do this. It is important that the home distinguishes between consulting with a relative and obtaining consent through a best interest decision.

The DoLS are part of the Mental Capacity Act 2005 and provide arrangements where people need to be protected whilst living in a care home. The registered manager had arranged for all the people in the home to be assessed which had led her to submit applications for every resident. We checked the documentation for those DoLS which had been authorised and found that it was in order. However we could not find any reference to people who were acting on behalf of people subject to the safeguards. Although the responsibility for appointing these representatives does not lie with the home it needs a note of who this is because they can challenge decisions made on behalf of the person subject to the DoLS.

We were told that there was a system of staff handovers at major changes of shifts within the home. These took place at 8 a.m. and 8 p.m. We were told that this verbal briefing involved all staff and the care staff we spoke with confirmed that they were included. Anything notable was recorded in the communications book for any staff to refer to throughout the day. We looked in the communications book and saw detailed notes of significant events on each shift including visits by health professionals or any refusals of care by people who lived in the home. This meant that at all times the most up to date information about people was made available to support the care that staff provided.

People and their visitors were very complimentary about meals in the home. Lunch and tea were at set times but people told us they could choose when they got up in the morning. We saw people still being served breakfast at 11 a.m. We saw that people were offered choices with their meals and one visitor told us "The food is lovely and the kitchen staff really look after my relative. I can come and have a cup of tea any time. We can have something to eat at any time of the day."

We looked at physical conditions in the home and saw that the registered provider was in the process of replacing some of the dining room furniture where this had become old and stained. We saw that the dining area was located next to the lounge area with a divider in between. The dining room was not large enough to accommodate all of the people living in the home at the same time and so some people were served their meal in the lounge. The layout of the home allowed staff to move between both groups easily as well as with the kitchen so as to provide assistance.

We saw that in the dining room the tables were set with flowers, cloths, napkins, cutlery and cruet sets. Where people were served in the lounge meals were placed on small trays in front of them. We saw that people were offered a choice of meal at lunchtime as well as at tea and could choose this on the day depending on how they felt. We talked with the cook who told us they did it like this because if people were asked to make a choice the day before they might have forgotten it by the time the meal time arrived. Staff helped people to choose what they wanted by explaining the different dishes to them.

The cook told us "I love the residents to get what they want – It's only like being at home". They told us they had worked in the home for more than 20 years. Training records showed that they had completed appropriate training such as in food hygiene and that the kitchen had recently been awarded four out of five stars for cleanliness. The kitchen was well-equipped. The dishwasher was broken but was repaired during our inspection and a new range cooker had been delivered and was being fitted. The cook told us there

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were no budget restrictions on menu planning which was over a four-week cycle to avoid repetition. The cook told us "If I say that I need something they (the registered provider) will get it for me."

We saw that once people were seated food was served promptly. People were offered drinks of juice and we saw that people sitting at the tables interacted with each other as well as with staff serving the meal making it a pleasant communal experience. We sampled one of the dishes being served and found the meal to be attractive and well presented. It looked and smelled appetising. Whilst portion sizes were large we saw that there was little wastage.

Some of the people who ate in the lounge needed special diets. We saw that where pureed meals were served the ingredients were kept separate so as to preserve their individual flavour and smell. We saw that arrangements were made for people who had preferences or special requirements. For example we saw that the cook had made arrangements for someone who was a vegetarian and this person confirmed to us that they were happy with the way this had been arranged.

Because the lounge/dining room was adjacent to the kitchen we saw that people approached the serving hatch to chat with the catering staff and be served with drinks. A bowl of fruit was available as well as crisps and biscuits for people to help themselves. The cook said that they arranged it this way because "If the residents see (fruit, crisps, and biscuits) they will remember they like them and ask for them". We saw that jugs and glasses of water and juice were made available throughout the day in all the communal rooms.

Relatives told us that people received good healthcare support in the home. One told us "Staff here do seem very good. They noticed my relative's chest rattling and got the GP to come straight away." One of the people who lived in the home told us "They (the staff) are always friendly but professional and they know all about me. I have (a long-term condition) and they get the GP in whenever they feel I need it." One relative told us that they had no concerns about the health care of their relative who lived in the home. They told us that when there had been a recent illness "They got the doctor out immediately and they kept in touch with me."

We saw that on each care plan there were records of referrals to and visits from different health and social care professionals such as opticians, the community mental health team, social workers, speech and language therapists, and general practitioners. There was also a log of professionals who had recently visited together with their comments so that these could be taken into account in the care provided. We saw that people living in the home were served by four GP practices but that people could retain their own choice of GP if they wished.

We saw a health professional visiting the home during our inspection. We noted that the discussion between them and the care staff was very focussed on what would be the best course of action for that person rather than purely on clinical detail.

A number of relatives of people living in the home approached us during this inspection wishing us to record their views. One said "It (the home) isn't the Ritz but it's the staff and what they give. Don't let's have a posh place where people can't be bothered to care." Another said "This place is tired but so are a lot of them (care homes) and from what I have seen I am happy with it so far."

We recommend that the registered provider ensures that competency checks on staff are available so that it can be reassured that staff are able to apply their eLearning in the workplace.

We recommend that the manager refers the matter of identifying representatives for people subject to DoLS back to the supervisory body for further advice.

We recommend the addition of pictures to menus to assist people in making choices of what meals they eat.

Is the service caring?

Our findings

A number of relatives told us that the staff who worked at the home were caring. They told us "the staff have been brilliant with my relative. They are caring and compassionate but always banter and are jolly with him and other residents whenever we come and we come every day" and "Staff are very respectful, very caring I noted this from day one even when I settled my relative in. They take a real interest in (my relative) - they look after them." One person told us "I have to be helped to get washed and dressed but they always treat me with respect and I don't feel embarrassed."

One relative told us that they had not expected their relative to settle easily but on the day after admission the person had told them "I love it here. I have got a lovely room and the people are so friendly." This person told us directly "I am fine here. I wake up happy and would tell them if I was not happy. I have my own room with a chair. I choose what I want to do – I like to read my magazines and my family bring me books and crosswords. I can have a drink when I want it and the food is good. I can choose what I want and even have a cooked breakfast."

There were a number of occasions when we saw that the relationship between the staff and the people who lived in the home was caring. We saw that where people required assistance with eating at meal times that staff provided this sensitively and patiently, giving full attention to the person they were with, talking to them individually and pacing their assistance to the individual. Where a member of staff was doing this but another person wanted to interrupt them we saw that the staff worked as a team to support this. Another staff member attended to this person so that the staff could continue assisting the first person with eating and drinking. It was clear that staff knew people well so that when they noticed that one person was not eating they knew what alternatives to explore saying "Try this ice cream instead – I know you prefer it to your dinner".

We saw that there were frail residents who needed help with eating and drinking throughout the day some of whom were in the lounge. We saw that when giving morning drinks staff were sensitive and attentive. They made sure that people were comfortable and we heard them asking people if they were ready to drink some more, always matching the pace to the person they were with. We saw that staff used their discretion when approaching people asking them quietly if they required some assistance.

We saw that there was a board with photographs of all the staff who worked in the home together with their names and roles. Throughout the home there were photographs of the people who lived in the home together with staff at various activities and events. This created an atmosphere of community.

We saw that staff regularly checked to make sure that they knew where everyone was and recorded this on a chart so that no one would be forgotten if say, they chose to remain in their bedroom for an extended period. We saw that people were not rushed when staff were carrying out care and that they explained what they were about to do, sought the person's agreement and went at a pace appropriate for them.

We asked staff how they made sure that when they provided care that this was done with the consent of the person receiving it. They told us that they did so by talking to people, explaining what was proposed and asking the person what they would like. One member of care staff told us that they thought it important that they "built relationships" with people to support this.

We saw several instances of this. For example we saw one instance where a person became anxious during a particular procedure despite reassurance from the staff who were helping them. As soon as the person became distressed staff stopped what they were doing and made the person comfortable immediately by helping them to sit down. The staff suggested a different way of achieving what was required and explained this in detail to the person. Throughout the procedure they explained every step, described what was going to happen next, and reassured the person.

We saw that a person was anxious about using a wheelchair partly because they could not see the person who was pushing it. Another member of staff calmed the situation by walking backwards in front of the wheelchair. This meant that the person could see their face as well as hear the reassurance they were offering to them.

A relative told us of another incident where a person had been uncooperative and aggressive. This person had refused to move from where they were sitting and posed a

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risk to staff and the people around them. Rather than be confrontational and force the issue the staff had exercised patience, made sure the person was safe, and waited until they decided to move themself. This relative told us that this person was sometimes uncooperative but that staff knew to leave them and try again a bit later. Staff told us that this was how they responded to any refusal to consent to important aspects of care such as this. They said "We would come back later and see if the person has changed their mind. If necessary I would report refusal to a member of senior staff".

We could see that staff understood people's preferences. For example one person liked to sit on their own in a smaller lounge. Their relative told us "They have been brilliant with (my relative) for the five years they have been here. (My relative) likes to be in here where it is quieter. They stay in their chair which is their choice, has meals here and watches TV and the staff always ask what he wants to watch. I am just happy that (my relative) is happy. It's the best thing that could have happened – there are always plenty of staff and they pop in to check on (my relative). (My relative) banters with them and they give it back in a nice way and just have a laugh. (My relative) is always clean and tidy and the home is beautifully clean."

We saw that staff talked with people so as to agree how things that would affect them should be done. We saw that domestic staff needed to clean an area of one of the lounges where a person was sitting. They asked this person if they could continue to clean and if the person would like to move because the staff needed to open the window and because of the noise. When the person declined they delayed the cleaning until a more convenient time. Instead they asked this person whether and where they would like their breakfast served, what they would like to eat and then brought this to them on a tray.

We observed the use of call alarms during the day and found that where they were in use that they were responded to promptly. However we did not see call bells in use in the lounge and one person told us that they felt uncomfortable having to attract a member of staff's attention if they needed help with going to the toilet.

We undertook a Short Observational Framework for Inspection in the lounge. We saw that some people were engaged in chats with each other whilst other people slept. We saw that staff engaged in conversation with people and tried to move around the group attending to people's needs. On one of the days of our inspection we saw that staff engaged with people using puzzles and games.

It was clear from the views of relatives that they were welcomed when they visited the home. One told us "They look after me – I am not treated as a stranger. I feel involved and do the quiz every week. I'm one of the family. I have my tea here and I am told I am here for Christmas dinner – so I have given up arguing about it!"

We checked the arrangements for storing confidential information about people so as to ensure it was kept private. The registered manager's office was kept locked but most direct care information was stored in filing cabinets which were out of sight and could also be locked. The front desk provided both a reception area and a work area for staff. Although not readily visible we saw that certain care information such as review arrangements was displayed on the desktop. Outside the dining room there was a noticeboard with details of people who had special nutritional requirements. Although people were identified only by initials this meant the information was on display for anyone who passed by. The inspection team was based in a small lounge which could not be secured. We found a file containing confidential information about a person living in the home together with two recent care monitoring charts. These documents were not stored securely and could be seen by anyone entering the lounge.

We recommend that the registered provider ensures that all confidential information is stored with appropriate security.

Is the service responsive?

Our findings

When we asked the people who lived in the home if they could influence the care they received they told us that they could. One person said "They talk to you about what you want and when they can they go along with your wishes. For example staff don't check on me from midnight to 6 a.m. I am a light sleeper and it disturbs me so they leave me …. I asked them to do this." Another person said "I can choose what I want to wear and they get it out for me and help me to get it on". A third person told us "I can choose pretty much what time I get up and can stop in bed if I want to. I can choose what I want for breakfast, whether I want help to wash and dress and how I spend my days." We saw that people expressed choice in how they used their time with some people choosing to stay in their room but visiting the kitchen from time to time to get a hot drink of tea.

We saw that there was an activities coordinator at the home and that there was a programme of activities advertised on the noticeboard in the hall. During our inspection we saw staff using the supplies of jigsaws and other games which were available. We saw that the programme included trips out to the local museum and to a garden centre. Photographs from these various activities were on display. Other activities included exercise classes, a quiz, bingo, arts and crafts, reminiscing and board games.

One person told us "there are plenty of activities and things going on but no one makes you do them which is how it should be". On the first day of our inspection we saw that several of the people who lived in the home were going out to a Halloween party about 10 miles away. People were transported by staff in their own cars. We noticed that people who were subject to Deprivation of Liberty Safeguards were included in this excursion.

We asked the manager how they would provide transport for people who used a wheelchair and she told us that they had an arrangement whereby they used a taxi which could accommodate these as well as using the main bus. We saw that for those people who chose not to go to the party the remaining staff spent time with them providing them with company, chatting to them, and reading magazines with one person. We saw that when the members of the excursion returned they had clearly enjoyed themselves and their experience led to much animated conversation with others in the lounge. We saw that another person was able to pursue their hobby of making things and that examples of what they had made were displayed around the home.

We saw that the physical environment at the home had been partially adapted to try to reflect people's individuality. Some people's bedroom doors were painted in different colours and in most instances had a photograph of the person whose room it was together with a name board that was sometimes decorated. However in other areas of the home bedroom doors had not been distinguished like this and so it might be difficult for a person living with dementia to easily find their way. People who lived in the home were able to personalise the interior of their room according to their tastes and one relative told us "We have personalised (my relative's) room and (my relative) has their own things from home. Their room is always spotless."

We saw that care plans were written from the person's perspective and tried to identify how a particular need might be experienced by that person. This was then expressed as a goal with the corresponding actions required by the staff to achieve that goal. We saw that the care plans were reviewed on a monthly basis so that any changes could be taken into account. However we did not see any evidence that people's views or those of their relatives were taken into account in these reviews. Relatives we spoke with said that they did feel involved. One told us "They show me the care plan quite regularly" and others told us that they felt "fully informed" of any changes. However no-one we spoke could recall actually being involved in reviews other than those carried out by the local authority where they supported them financially.

None of the people we spoke with or their relatives said that they had had cause to formally complain. One person who lived in the home said "Never had to complain – if I did I would go to the manager – she's a good-un." One visitor told us "When (my relative) first came here I was trying to find faults but couldn't find any. I have had one or two little niggles over two years but I had a word and it was sorted. If you ask them to do something they do it right away." Another relative told us "no real issues, just minor ones. Mainly clothes-related – things like socks going missing and on a couple of occasions I am sure I've seen other residents in mum's trousers even though they are marked. Spoke to the person in the laundry and seems sorted now."

Is the service responsive?

We recommend that the registered provider consults best practice guidance on adapting the environment for people living with dementia.

Is the service well-led?

Our findings

There was a registered manager in place at Minshull Court Nursing Home.

During our inspection we saw that all of the staff including the assistant manager and the registered manager spent most of their time either in direct contact with or close to the people who used the service. Even when completing administrative tasks such as record-keeping senior and other staff tended to undertake these in communal areas where they could be in easy reach of people who used the service or staff if they needed advice. We saw that the registered manager was included within the rota in addition to the staffing numbers and worked in this way for three days of the week. This allowed her to keep in direct contact with the people living in the home as well as to observe staff care directly.

The staff we spoke with said they enjoyed working at the home. They told us "I enjoy it here. Morale is good". Another said "The management is very approachable. Nothing is too much trouble". We saw that the assistant manager was able to step in and act for the registered manager during a short holiday. The assistant manager could not readily think of a situation where they might have to call for assistance but told us that the nominated individual for the company that owned the home was always available if there were difficulties which demanded this.

We were told that the registered manager was reintroducing supervision following her return from a period away from the home with the intention of making it more formal and less ad hoc than it had been before. Staff confirmed that they received this supervision. We saw a series of records which confirmed that for most this had been held in the last month. We did not read the content of these records in detail but saw that where appropriate issues of performance management and practice were raised and appropriate action recorded. The records were signed by the supervisor and supervisee and retained in the office. Annual appraisals were planned. We saw evidence which showed that when appropriate the registered provider took disciplinary action in order to improve staff performance.

We saw that there were a number of audits maintained so that the registered manager could monitor the quality of service provided. One was a care plan audit in which the content and accuracy of care plans was sampled. We tracked back one of the entries to see if the corrective action which had been identified as required had been taken and found that it had. Other audits we saw included of water temperatures and the operation of call bells, infection control, weight loss and falls, nutrition and hydration, environment and medicines. We saw that the registered manager undertook and checked the results of these audits. Any action needed was then passed to the appropriate person.

We saw the minutes of meetings with people who lived in the home and their relatives as well as staff. We could only find minutes for the last two months but these showed that topics included the level of care provided and activities. We saw that there had been surveys earlier in the year which gave complimentary feedback about the service and the staff. One visitor's comment described the home as "very knowledgeable and professional." A staff survey undertaken at a similar time included comments such as "respect you as an individual", "respect from staff and management", "encourage suggestions towards any changes in the well-being of residents", "feel valued in my role" and "promote team work."

The registered manager is required to notify the Care Quality Commission (CQC) of particular incidents which might occur and affect the running of the home or the wellbeing of the people living there. We reviewed these with the registered manager and were satisfied that they had reported appropriately. There had been one incident in the last year where a person had contacted the CQC anonymously to express concerns about the home. The registered provider had investigated the matter independently of the registered manager and the CQC was satisfied with the results of that investigation.

When we talked to staff they were all clear about the meaning of whistleblowing and what to do if they suspected that something was wrong in the home. However when we asked the home to provide us with a copy of all of its policies and procedures (including whistleblowing) we found that these had been supplied by a trade association, were not customised to the home and some had not been reviewed since 2002.

We recommend that the registered provider thoroughly reviews all the required policies and procedures so as to make them up to date and tailored to the needs of the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: People who use services and others were not protected against identifiable risks of acquiring an infection because a bathroom and toilets were not maintained adequately

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance of some of the carpet in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable equipment because appropriate means of providing chairs at different heights were not available.