Care Quality Commission

Solehawk Limited

Craigielea Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 16, 17 and 28 September and 5 October 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Craigielea Nursing Home in March 2015. At that inspection we found the service was not meeting the legal requirements in force at that time and issued two warning notices relating to staff training and the management of quality in the service.

Craigielea Nursing Home provides personal care for older people for up to 64 people, including people living with dementia. Nursing care is also provided at the home. At the time of our inspection there were 39 people living at the home.

The service had a registered manager who had been in post for fifteen years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe at Craigielea. Staff were trained in and understood the importance of their duty of care to safeguard people against the risk of abuse.

People expressed mixed views about staffing levels and there was no formal mechanism to help calculate staffing levels based on people's needs. New staff were suitably checked and vetted before they were employed.

The home was undergoing extensive refurbishment, and those areas where work was completed were decorated and equipped to a high standard. Some areas were clean, others areas, along with pieces of medical equipment, were not. Safety checks were conducted to ensure people received care in a safe environment.

On the whole, medicines were managed safely to promote people's health and well-being. One person did not receive their medicines in line with their care plan and this was addressed during the inspection.

Staff were supported in their roles to meet people's needs. Extensive training had been carried out since we last inspected and further training was being undertaken.

People's nutritional needs and risks were monitored and people were supported with eating and drinking where necessary. People were supported to meet their health needs and access health care professionals, including specialist support.

People were consulted about and were able to direct their care and support. Formal processes were followed to uphold the rights of those people unable to make important decisions about their care, or who needed to be deprived of their liberty to receive the care they required.

Staff knew people well and the ways they preferred their care to be given. People and their relatives told us the staff were kind, caring and respectful in their approach. On the whole our observations confirmed this, however the delay in responding to a person's requests for support did not promote their dignity. Response times to call alarms were varied, but at times were excessively delayed.

A range of methods were used that enabled people and their families to express their views about their care and the service they received. Concerns or complaints were clearly documented, investigated and the outcome reported to the individual concerned. Where necessary practice was changed or other measures taken in response to the concern raised.

Staff assessed people's needs and risks before they moved in and periodically thereafter. Staff ensured care plans were in place and regularly reviewed. A variety of activities were made available to encourage stimulation and help people meet their social needs.

The management arrangements ensured clear lines of accountability. Systems to monitor and develop the quality of the service had improved since we last inspected, but required further refinement to ensure standards of hygiene and safety were more consistently assured. Quality monitoring arrangements included seeking and acting on feedback from the people using the service and their relatives.

We made a recommendation for the provider to assess staffing levels in relation to people's levels of need.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the cleanliness and security of the premises and equipment and to the deployment of staff. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not consistently safe.

Appropriate arrangements were in place to minimise risks and make sure people were cared for safely, although they were not consistently applied. Work and storage areas remained accessible. Some areas of the home and equipment were not clean.

Staff had a good understanding of safeguarding people from harm and abuse and how to report any concerns. A thorough recruitment process was followed when new staff were employed. A system to assess and monitor safe staffing levels was not in place.

People were supported in taking their prescribed medicines at the times they needed them. Safe administration practice for one person was raised as a concern.

Is the service effective?

Good

The service was effective.

Staff provided effective care that met people's needs. Arrangements for training staff had improved, with further training planned.

The service acted in accordance with mental capacity legislation to ensure people's rights were upheld.

People accessed health care services and were supported to maintain their health and welfare. Risks to good nutrition were assessed and people supported with eating and drinking needs.

Is the service caring?

Good

The service was caring.

People and their families had positive relationships with the staff team.

Staff understood people's needs and preferences and treated people with dignity and respect.

People were encouraged to express their views and be involved in making decisions about their care and support.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care needs were regularly assessed and recorded in care plans which were kept under review. Staff provided personalised care and were responsive to people's changing needs. There were periodic and at times lengthy delays in responding to nursing call alarms.

Summary of findings

Various social activities were offered and people were supported to access and engage in their local community.

There was a clear complaints procedure and any concerns raised were investigated in a timely way.

Is the service well-led?

Requires improvement

The service was not consistently well led.

An experienced manager was in post who was registered with CQC.

The registered manager provided visible leadership and was committed to developing and improving the service. There was an emphasis on addressing the shortfalls identified at the last inspection and in safely managing the extensive refurbishment of the home.

The registered manager was responsive to feedback from people and this was acknowledged and acted upon. The quality monitoring processes had been strengthened since our last inspection, but further improvements were necessary to ensure these were consistently robust.

Craigielea Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 16, 17 and 28 September and 5 October 2015 and was unannounced. The inspection team consisted of one adult social care inspector, an inspection manager, a specialist advisor 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.

We reviewed information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We spoke with the local authorities safeguarding and commissioning teams before the inspection.

During the inspection we talked with eight people living at the home and five relatives. We spoke with an operations manager, the registered manager, an activities co-ordinator and with 11 nursing, care and ancillary staff. We spoke with a visiting professional. We observed how staff interacted with and supported people, including during a mealtime. We looked at seven people's care records, people's medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People using the service and their relatives told us about their safety, the approach of staff and their views about staffing levels. All of the people using the service and the relatives we spoke with said they felt safe there. One person said "Most of the girls are lovely, you get the odd one who's not very helpful and sometimes they seem short of staff but on the whole they're ok." Another person commented to us, "Sometimes I press the buzzer and they come after a few minutes but say they are busy and will come back, but sometimes they forget. I get exasperated."

One relative told us, "I don't think they have enough staff, sometimes they seem to be rushing about and they forget to come back to see to Mam." A further comment was, "I've no complaints about the staff; they're always caring and never lose their temper or raise their voice even when residents are being difficult."

The registered manager undertook periodic checks on the cleanliness of the home and arrangements in place to limit the spread of healthcare acquired infections, although these were not consistently applied. We saw the registered manager had completed audits and shortfalls they had identified were raised with the relevant staff and follow up checks made. One example was deep cleaning arrangements for bedrooms that had been vacated. Staff said they had sufficient stocks of personal protective equipment. Instructions for effective hand washing were posted at sinks in shared facilities, such as in toilets and bathrooms. There were appropriate hand wash facilities in toilets and bathrooms, however hand gel units placed in corridors in the nursing unit did not have any content. The registered manager informed us these were to be removed. We observed a nurse not wash her hands after attending to different service users during their medicine round. This was raised with the registered manager to address with the individual concerned. Nursing and care staff were observed to be 'bare below the elbows' which reflected accepted practice to help prevent cross infection between different service users.

Mattresses we checked had covers that were in good condition. Hoists were of a generally acceptable standard, although some had light marking and a build-up of dust at the base. The refurbished half of the home was clean and there were no persistent malodours. This was in contrast to the non-refurbished side, which formed the original nursing home. On the first day of the inspection the sluice rooms were unlocked and items, such as nasal cannulas (tubes), a denture brush, cotton buds and ornaments were stored there. The floor cover in one sluice room was not intact making it difficult to keep fully clean. We highlighted these items to the registered manager who took steps to ensure these areas were cleared of inappropriate items and informed us these areas would be attended to as part of the homes refurbishment.

The medicine storage rooms were not clean. In one, dressings were stored on the floor in boxes which did not allow for effective cleaning of the room. The poor condition of the room would not allow for effective cleaning as there was old wallpaper, cracks in the plaster and damaged skirting boards.

A suction machine was kept on the floor, with no evidence that it had been cleaned. We discussed the appropriate cleaning and storage of equipment after its use with the registered manager. They told us there was a cleaning schedule but no one was using it so it was blank. They stated all equipment such as this was serviced regularly. However calibration and servicing records were not available which meant the accuracy of the equipment was not fully assured.

The sharps bin in this room was approximately ¼ full and appeared to have no inappropriate items in it. An open 'Dressit' pack was stored on a shelf in this room. Such packs remain sterile only until opened and after this they should be discarded.

All surfaces in this room were visibly dirty. The floor had visible dirt and bits of paper on it. The bins were both dirty. The sink was also dirty and appeared not to have been used recently. There were no hand towels by the sink meaning good hand hygiene was not promoted.

A cupboard that the nurses used to store items such as blood bottles was dirty on the top. Blood bottles in this room were in date, however several were due to expire in two months.

The ground floor medication room also appeared dirty and disorganised. There were boxes of prefilled medication cards and boxes and bags of dietary supplements on the floor. The sink area and the radiator were dirty. Supplements were also stored on top of a high cupboard. This made them difficult to reach, to monitor stock levels and to check expiry dates for effective stock control

without a ladder. There was no ladder in the room. The fridge in this room appeared clean. Checks for the fridge temperature had been missed on a few occasions, but checks were not outside the appropriate temperature range. Some equipment in this room was visibly dirty, including the blood pressure monitoring machine, a stethoscope and a pulse oximeter machine. The home had its own machine for monitoring blood glucose levels. There was no calibration record or cleaning record for this. One person had her own machine (which is good practice). However, there was no evidence of cleaning or calibrating of the machine.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to explain how they would protect people from harm and deal with any concerns they might have. They were familiar with the provider's safeguarding adults' procedures and told us they had been trained regarding abuse awareness. This was confirmed by the training records we looked at. Staff told us they would report any safeguarding concerns to the manager, or if necessary to social services or to CQC.

To support the training staff had received there were also procedures and guidance documents available for staff to refer to. These provided explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The registered manager was aware of when they needed to report concerns to the local safeguarding adults' team. There was evidence of safeguarding concerns having been reported to the local authority and investigated appropriately. Where necessary, procedures and updated plans of care were put in place to protect people from further harm. Informal guidance and support, or more formal procedures would be initiated to deal with any staff conduct or practice issues. This meant incidents would be responded to and steps put in place to reduce the risk of a re-occurrence.

At the time of this inspection, the home was subject to a major refurbishment programme to update facilities to a more modern standard. One half of the home had been fully refurbished. Individual bedrooms were all fitted with en-suite facilities and were clean, well decorated and safe. For example, night light facilities were fitted in the en-suites to make these more visible and help people find these at night; reducing the risk of accidental falls. Bathrooms had also been refurbished and fitted with modern bathing facilities; these enabled safe moving and handling. Baths had the water temperature controlled to a safe and comfortable level.

The other half of the home was awaiting refurbishment. On the first day of the inspection we found sluice rooms on this side of the building were accessible and vacant bedrooms used to store surplus equipment were also left unlocked. A bathroom and toilet area had excess storage of equipment, such as a mobile hoist and laundry skip, blocking access to the hand wash basin. We discussed this with the registered manager, who informed us people using this area of the home were not at risk of wandering and entering these areas. Once highlighted the registered manager took action to address these items.

Arrangements for identifying and managing risk in relation to the building and equipment were in place. Gas and electrical safety certificates were available and up to date. There were no significant safety concerns identified by these checks. Equipment, such as the passenger lift, adapted baths and mobile hoists were all subject to regular examination and servicing by specialist contractors. These checks ensured the equipment was appropriately maintained and safe for use.

We were shown a fire safety log book. This prompted staff to review the safety of key parts of the service on a regular basis. Checks included nightly reviews of the building to look for fire hazards, ensure fire exists were free from obstructions and to check if the fire alarm panel showed the system was operating appropriately. Some emergency lighting was identified as requiring replacement, which was due to be carried out as part of the home's refurbishment programme. This had been first identified in May 2015 and refurbishment had yet to commence in the area concerned. We therefore highlighted this as an area requiring prompt action.

Nursing and senior care staff completed people's care plans and risk assessments to identify areas where hazards to safety were present and to outline the steps needed to reduce the risks to people's safety and wellbeing. These included areas such as manual handling, choking and specialist feeding techniques. Where a risk was identified, there was clear guidance included in people's care plans to help staff support them in a safe manner. Risk assessments

Is the service safe?

were also used to promote positive risk taking and maintain people's independence as much as possible. Staff we spoke with were able to explain how they would help support individual people in a safe manner.

Before the inspection we received information about staffing levels at night. On arrival at the service (during the night shift) there was one nurse, one senior carer and five care staff on duty. During the day time there were two nurses (excluding the registered manager) and the care team was complemented by a large team of ancillary staff, including cleaners, catering staff, a laundry worker and a handyman. Staff we spoke with (including night shift workers) stated they felt staffing levels were sufficient to meet people's needs safely at night, although they expressed the view these would need to be increased should occupancy rise. We received mixed comments from people using the service and their relatives, particularly regarding how promptly staff were able to attend to people's needs.

There were also differing comments made about the consistency of nursing staff. One visitor commented there was inconsistency due to the use of bank staff, however the registered manager indicated the same agency workers were used to help ensure they got to know people using the service and their needs.

A staffing rota was drafted to help plan staffing deployment and record actual shifts worked. The registered manager informed us staffing levels were not based on a formal assessment and aggregation of people's level of need. The area manager told us they were researching dependency tools to determine and guide the overall recommended levels of staffing.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were recruited safely. Before staff were confirmed in post the registered manager ensured an application form (with an employment history where relevant) was completed. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions.

People using the service told us they got their medicines regularly, at the right time and that staff stayed with them whilst they took their medication.

A monitored dosage system (MDS) was used to store and manage the majority of medicines. This is a storage system designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. There was secure storage within locked treatment rooms. These areas were locked when staff were not in attendance. There were cold storage facilities available for medicines. Staff monitored the temperature of this to ensure medicines were stored at a safe temperature, although we saw some recording dates had been omitted. Stocks of medicines held corresponded to the records kept and our sample stock check did not highlight any administration errors. Some stocks requiring destruction remained in the home and nursing staff told us they were awaiting specialist denaturing kits to enable this to be carried out safely and securely. Items, such as eye drops, were dated on opening so they weren't used beyond their shelf life.

Some people using the service required their medicines administered through a Percutaneous endoscopic gastrostomy (PEG) tube. This is a tube inserted directly into a persons stomach through their abdominal wall. Where this was the case, a care plan had been developed to guide staff on completing these tasks safely. We observed a member of staff undertake this task and saw this was not done in a manner consistent with the plan of care. This was discussed with the registered manager who acknowledged our concerns and confirmed what we observed was not appropriate practice. The registered manager dealt with this matter directly with the nurse concerned to ensure this practice was not repeated.

We recommend the provider seeks advice from a reputable source on assessing and determining staffing levels on the basis of service users dependency levels, the layout of the home and an analysis other key indicators, such as call response times.

Good

Is the service effective?

Our findings

People using the service said staff 'Had the skills to do the job' and confirmed that staff were caring, supportive and helpful. One person told us, "It's very good here, the staff are all alright and quite helpful." Another person said, "It's good here, I like to have a bit of a crack with people but not everyone is able to talk." Another said, "The foods nice, you can have as much or as little as you want and if you don't fancy what they've got you can always have a sandwich."

A relative commented to us, "My mind is totally at rest. I used to worry about my relative eating when they were at home but their food, hydration and weight is monitored here and I'm kept informed of any concerns or if the GP has been called for any reason." Another relative said, "The staff are great, if my relative needs to see the doctor, optician, chiropodist and such like they will organise this for them."

Staff told us about the training they had received and this was confirmed by the records we examined. Staff told us they felt supported. Planning and monitoring records showed staff were provided with periodic supervision, although records were not retained on the staff files we looked at. Performance appraisals for 2015 had either been conducted or were planned. The provider had policies relating to training and staff supervision, last updated in 2012 and 2013 respectively. A detailed training matrix was available and updated to track progress in staff attending key safety and care related training.

Following our last inspection, the majority of staff had attended an intensive range of safety and care related courses, including fire safety, food hygiene, adult protection, infection control and first aid. Dementia awareness and supporting people with distressed behaviour were also covered. The registered manger was aware of gaps in individual staff members training which required updating. Training or awareness raising sessions on some health related conditions, such as Parkinson's disease were not evident. Our observations regarding wound care assessments and monitoring indicated a need for further training in this area. This was discussed with the registered manager and arrangements for staff to receive this were made before the inspection was concluded.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure decisions are made in people's best interests. DoLS are part of this legislation and they ensure where someone may be deprived of their liberty, the least restrictive option is taken.

People told us that staff sought their permission before carrying out any treatment or providing support, for example with mobilising (getting around) or with personal care. Records showed the majority of staff had received training in this area. Staff we spoke with were aware of the MCA and DoLS and had received training, which one described as 'Useful'. This was also a topic discussed at staff meetings.

Staff recorded people's capacity to make decisions for themselves in care plans and capacity and decision making was considered as part of a formal assessment. These assessments were recorded on documentation supplied by the authorising authority (Gateshead Council). Where people were subject to a DoLS the registered manager had notified us of the outcome of this application.

The people we spoke with told us they liked the food provided. People had a nutritional assessment carried out using a nationally recognised assessment tool. This was reviewed periodically and people's weight and body mass was regularly monitored. We saw advice had been sought from a speech and language therapist about what foods were appropriate for people, for example when they needed a soft diet. The input of the dietitian had also been arranged where people were at risk of malnutrition.

We observed the meal time and saw staff were attentive to people's dietary needs and people were given sensitive assistance to eat their food. One to one support was seen carried out by some staff, who engaged with people at the table, making the meal time a social experience. Time was taken to provide explanation when people were assisted with eating. Drinks were offered to all, although an explanation of what was on each person's plate was not given to everyone.

One dining room had a malodour present. The other dining room was bright and airy with gently music playing in the background. Diners were chatting together and with staff. The hot cabinet for lunch was left in a small area adjacent

Good

Is the service effective?

to the dining room and one staff member told us that they were disappointed that the hot cabinet could not be in the dining room. She also told me that often they were running up and downstairs as there were insufficient utensils.

Staff served the lunch and enquired what portion size people wanted and if they wanted a Yorkshire pudding. Staff serving the food onto the plates wore plastic disposable aprons but no gloves. We observed a domestic carry a bag of rubbish through the dining area during the meal time.

The meals during lunch looked appetising and everyone had a meal consisting of pork, mashed potato, swede, cauliflower, Yorkshire pudding and gravy. Pudding was an apple crumble with custard or ice cream or yoghurt. There was a choice of hot or cold drinks. Disposable aprons were available for those who wished to wear them and staff were available to provide support to people. Staff and people using the service appeared comfortable and happy in one another's company and staff were friendly, supportive and attentive. People told us they had enjoyed their meal.

People using the service said staff would say hello and chat when they could. They and their relatives confirmed that GP's, dentists, nurses, chiropodists and opticians could all be accessed as and when required by making a request via staff or the registered manager.

Records we looked at showed us people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. People's healthcare needs were considered within the care planning process. We noted assessments had been completed on physical and mental health needs.

From our discussions and a review of records we found the staff had developed links with other health care professionals and specialists to help make sure people received appropriate healthcare. An external healthcare professional visited regularly to provide additional guidance and support.

There was evidence of individualised care planning relating to healthcare needs, which were up to date and completed appropriately. Medical history information was gathered and some people had advanced health care plans which detailed their wishes and the care and treatment to be provided in certain situations, such as when they became seriously ill. We looked in detail at a person's 'Formal Wound Assessment' and related records. This included photographic monitoring of a wound site and saw two different classifications of the wound had been made. The wound had been reassessed and measured weekly, although the photographs were not always dated and a piece of paper rather than a sterile ruler had been used in the picture. This was discussed with the registered manager, who acknowledged our concerns and obtained sterile rulers before the inspection was concluded. The support offered to support a person's continence did not appear consistently effective due to the type of products used. We raised this matter with the registered manager, who undertook to review the support offered to staff regarding this.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "The girls are lovely, they're smashers." Another person said, "I'm happy here, the staff are alright, the foods alright, I've got a nice room with a big bathroom and a big mirror and I've made some friends."

People using the service confirmed that staff knocked on the door or called out, awaiting a response before entering the room. We observed staff doing this in practice. People also told us that staff asked their permission before providing care or assistance. People using the service and their relatives said visits could be made to Craigielea at any time and that visitors were made to feel welcome

During lunch staff interacted well with people; providing support when asked or required and regularly checking if people required more food and drink and encouraging others to eat more. Several people requested and received prompt help.

People using the service and staff were very comfortable in each other's company. We observed staff to be caring. For example, a nurse we observed spoke kindly and gently to the people they had contact with. The nurse expressed concern for them and used therapeutic touch in their interactions.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. Staff were knowledgeable about people's individual needs, backgrounds and personalities. They explained how they involved people in making decisions. We observed people being asked for their opinions on matters, such as drink choices and they were routinely involved in day to day decisions within the service.

Of the people we spoke with all were aware of their care plan but not everyone said they had been involved in developing them. Relatives said that they had been involved in the care plan of their relative. One relative said, "The care plan gets changed as and when a change is needed, there's no problem."

The registered manager and staff described the practical steps they would take to preserve each person's privacy and dignity. We found some confidential records were left out in a link corridor leading from a nurses station to a separate unit. This area was accessible to non-clinical staff such as ancillary workers. This was raised with staff who removed the records to a secure area. We also saw personal information displayed on a white board in the ground floor office in the refurbished unit. Information was visible from the corridor through the large glassed partition. This was highlighted to the registered manager who took action to remove this information from view before the inspection was concluded.

People said their privacy and dignity were respected. We did not observe any instances of people receiving personal care within public areas. Staff we spoke with were able to clearly explain the practical steps they would take to preserve people's privacy, for example when providing personal care or knocking and awaiting a reply before entering a person's room.

Requires improvement

Is the service responsive?

Our findings

People and their relatives said they were listened to and they had confidence in the way staff responded to concerns and complaints. All the people we spoke with confirmed that their privacy and dignity was respected as were their individual choices. Furthermore relatives confirmed that they were aware of regular 'resident' and relative meetings where they and their loved ones could express their views or make any suggestions. This was confirmed by the meeting minutes we looked at. Topics covered included changes to the service, care delivery, catering and laundry arrangements, complaints and suggestions, quality management and general feedback. Meetings were well attended and involved the registered manager. The meetings documented concerns raised, and how they were discussed and responded to. Areas of care practice and topics such as DoLS were also discussed to raise people's awareness of these issues.

We observed several instances of staff being responsive to people's various requests, such as when using their call alarms and when they were mobilising (moving around) although this was not consistent. We observed and saw there were several occasions when there were excessive delays in responding to call alarms, which meant staff did not act in a consistently responsive manner. For example we observed an incident where a person requested support on several occasions over a 15 to 20 minute period from different staff before being helped. Staff failed to act in a responsive manner which compromised the persons dignity. On another occasion an alarm sounded and we observed it take nearly 15 minutes for staff to enter the person's room to attend to their needs. These incidents did not demonstrate that staff were responsive to requests for assistance. We raised this as a concern with the registered manager who undertook to raise the matter of prompt support with staff.

The call log for a sampled five hour period showed the alarm activated 33 times, with four calls not deactivated for at least ten minutes, with one call taking 27 minutes to be responded to and another 36 minutes. Both of these were for the same person. We informed the registered manager of this and when we conducted another sample ten days later we saw all but one call was answered in between one and four minutes, with one taking six minutes to answer.

People's care plans included needs assessment before a service was provided. From the information outlined in these assessments individual care plans were developed and put in place to ensure staff had the correct information to help them maintain people's health, well-being and individual identity.

Care plans covered a range of areas including; diet and nutrition, psychological health, personal care, managing medicines and mobility. We saw if new areas of support were identified then care plans were developed to address these. Care plans were reviewed regularly. Care plans were sufficiently detailed to guide staffs care practice. The input of other care professionals had also been reflected in individual care plans and these documents were generally well ordered.

To monitor people's needs, and evidence what support was provided, staff kept individual progress notes. These offered a record of people's wellbeing and outlined what care was provided. Staff also completed a daily handover record, so oncoming staff were aware of people's health and immediate needs and forthcoming appointments. These were quite brief and were used by staff as a prompt. Staff periodically reviewed care plans, documented people's changing needs and progress and these documents were up to date. The language used in care records was factual and respectful. Records also focussed on people's strengths and were positively worded.

When talking about personalised care, staff had a good knowledge of the people using the service and how they provided care that was important to the person. The staff we spoke with were able to answer the queries we had about people's preferences and needs.

We saw visitors coming and going freely and an activities worker had been recently appointed to offer a range of occupations and encourage participation in events on offer. Examples included movement to music, jewellery making, 'Pictionary', wool craft, sensory games and bingo. Staff spent time socialising with people as well as providing care. For example we saw staff discussing programmes on the TV on several occasions and staff helped people attend the visiting hairdresser.

People using the service and their relatives told us they were aware of who to complain to and expressed confidence that issues would be resolved. Most said they would speak to the registered manager or a nurse if they

Requires improvement

Is the service responsive?

had any concerns. A copy of the complaints procedure was available in a public space. We reviewed the records of complaints received since April 2015 and saw there were 21 logged and a range of themes apparent. These included cleanliness of the home, communication and practice issues. There was evidence of complaints having been investigated and where necessary action taken, including using the providers HR procedures to address individual staff conduct.

Requires improvement

Is the service well-led?

Our findings

People we spoke with told us they were happy at the home and with the leadership there. People using the service and their relatives were of the view that Craigielea was well organised and well-led. They told us that staff interacted well with people using the service and that they were caring, supportive, empowering and helpful. People confirmed that they knew who the manager was and felt that Craigielea was well run. One person using the service said "I would rate this place as good because they do their best to look after you."

One relative said, "My relative's quite settled here, he eats well and he's well looked after, I can't complain and neither would he."

The management arrangements ensured clear lines of accountability. The registered manager held overall responsibility for the operation of the home, and they were supported by nursing staff, responsible for leading the staff within the nursing unit, and senior carers, leading the 'residential' teams. Care staff were aware of who the registered manager was and confirmed she had a visible presence in the home. One staff member stated, "I like it here. The manager works nights up to midnight." Staff said they would recommend the home to a friend or relative.

At the time of our inspection there was a registered manager in place and was initially registered under the Registered Homes Act 1984, before the Care Quality Commission was founded. Her registration transitioned to the Commission in October 2010. The registered manager was present and assisted us with the inspection, including when we visited during the night shift. They walked round with us for part of the inspection and appeared to know the people using the service, their relatives and the staff well. Records we requested were produced for us promptly. The registered manager was able to highlight their priorities for developing the service and was open to working with us in a cooperative and transparent way. They were clear about their requirements as a registered person to send CQC notifications for notifiable events.

The registered manager told us about the extensive work carried out since our last inspection in March 2015 to improve the service. They were of the view that the service had improved considerably, but acknowledged there was further work to do to ensure consistent standards. There had also been insufficient time since our last inspection to be assured the improvements made would be effectively sustained.

The registered manager's stated philosophy for the home was to promote professionalism amongst the staff, advocate for the home and to ensure good standards of care. They said they wanted staff to be able to see things from the viewpoint of people using the service to ensure they were sensitive to people's needs and understand how they would feel.

When we last inspected the service in March 2015 we found arrangements for assessing and monitoring the quality of care were not robust. Systems to monitor and develop the quality of the service had improved since we last inspected, but required further refinement to ensure standards of hygiene and safety were more consistently assured. Arrangements that had improved included, for example, conducting care plan and fire audits. There were infection control and medicines audits, however further work to proactively identify the areas where we identified shortfalls in practice, such as with specialist medicines administration, hygiene and care, would ensure the service was more consistently safe, effective, caring and responsive. For example, there was a newly installed nurse call system where call response time could be checked. There were no regular audits of alarm response times at the time of our inspection. Monitoring such information could help identify patterns and trends in the use of and response to calls for assistance, and enable practice to be reviewed and improved.

We did find areas of improvement. Where shortfalls had been identified by the registered manager these were documented and addressed within a defined time period. The registered manager, and other staff such as the handyman, carried out a range of checks and audits at the home. Audits covered areas such as medicines, care plans, infection prevention and control, falls and accidents. The registered manager had highlighted areas which required follow-up action and checked these had been concluded. We saw that they reported back to the provider organisation on a regular basis and an external line manager also visited the home to check the quality of care and track progress with agreed actions.

Quality monitoring arrangements included seeking and acting on feedback from the people using the service and

Requires improvement

Is the service well-led?

their relatives. A satisfaction survey was also carried out and an overall scorecard had been laminated and placed on public display. We saw practical steps had been taken to address areas for improvement and those areas we highlighted to the registered manager were all acknowledged and where possible addressed promptly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered person had not ensured all premises and equipment used by the service provider was clean, secure, and suitable for the purpose for which they were being used.** Regulation 15(1)(a)(b)(c)(d)(e). **The registered person had not ensured, in relation to the premises and equipment, they maintained standards of hygiene appropriate for the purposes for which they were being used.** Regulation 15(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.** Regulation 18(1)