S.E.S Care Homes Ltd

Crossways Nursing Home

Inspection report

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Date of inspection visit:
28 June 2016
29 June 2016

Date of publication:
16 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 28 and 29 June 2016.

Crossways Nursing Home is a home which provides nursing and residential care for up to 18 people who have a range of needs, including those living with dementia, epilepsy and diabetes and those receiving end of life care. At the time of our inspection 16 people were living in the home.

Crossways is a two storey building set in secure grounds in a village on the outskirts of Basingstoke town centre. The home comprises of 10 single rooms and 4 double rooms for residents, some with ensuite bathroom facilities. There is a secure garden to the rear of the home which houses a marquee allowing people to enjoy sitting in the garden in all weather conditions.

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

Staff provided care to those living with dementia however the environment did not always support people to move around the home safely and to remain independent. Corridors were not often well lit and flooring was not always appropriate to support those with limited eyesight. This would not assist those with limited vision as a result of their condition to be able to move effectively around the home.

We have made a recommendation that the provider seeks further guidance on the environmental factors which can be adapted to meet the needs of those living with dementia.

The provider was not always able to provide person centred activities for all persons to ensure they lead full and meaningful lives.

We have made a recommendation that the provider promotes activities identified as appropriate for people living with dementia to those living in the home.

Relatives of people using the service told us they felt their family members were cared for safely. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

Detailed recruitment procedures were in place to protect people from unsuitable staff.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such as a loss of accommodation as a result of fire or flooding. Fire drills were documented, known by staff and practiced to ensure people were kept safe.

People were protected from the unsafe administration of medicines. Nurses responsible for administering medicines had received additional training and were subject to competency assessments to ensure people's medicines were administered, stored and disposed of correctly.
People received sufficient food and drink to maintain their health and wellbeing. Snacks and drinks were encouraged between meals to ensure people remained hydrated. People assessed as requiring a specialised diet, for example a pureed and diabetic diet, received these and the food was pleasantly presented.

People were supported by staff who had received an effective induction and period of support from more experienced members of staff. This enabled them to acquire the skills and confidence to deliver safe effective care. Regular supervisions ensured that staff were able to express concerns and they felt supported as a result.

People were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

The staff and registered manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

Staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The registered manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which were personalised to their needs and wishes. They contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives told us and records showed that they were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People told us they did not always know how to complain however all said they would speak with senior staff if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings and participation in the completion of annual survey questionnaires.

The provider's values were displayed within the home but were not immediately known by staff. However staff were able to describe how the registered manager wanted people to treat residents and they demonstrated they knew these standards. We could see these standards were evidenced in the way care was delivered.

The registered manager and staff promoted a culture which focused on providing care in the way that staff would wish to receive care themselves. The registered manager provided strong leadership and fulfilled the requirements of their role as a registered manager. The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

There was a detailed recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

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

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

Is the service effective?

Requires Improvement

The service was not always effective.

The home design did not support those living with dementia. The decoration did not support those living with poor eye sight associated with old age and dementia to move around the home independently.

People were able to eat and drink enough to maintain their nutritional and hydration needs. People who required a specialised diet received the food in an appropriate way to meet their health needs.

People were supported by staff who had the most up to date knowledge available from detailed care plans to best support their needs and wishes.

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met.

People were supported by staff who sought healthcare advice and support for them as required.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff had developed positive and caring relationships with people.

People were encouraged to participate in creating their personal care plans. Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People received care which was respectful of their right to privacy whilst maintaining their safety.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always sufficient opportunities to ensure all people were involved in meaningful activities to support their social needs.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis and when people's needs changed.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Good

The service was well led.

The registered promoted a culture which placed the emphasis on people receiving quality care from staff in a homely environment which promoted people's independence.

The registered manager provided strong leadership and informed the Care Quality Commission about important and significant events that occurred at the location.

Staff were aware of their role and felt supported by the nurses, registered manager and the provider's operations manager. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The provider and registered manager regularly monitored the quality of the service provided so that continual improvements could be made.	

Crossways Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory function. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 and 29 June 2016 and was unannounced. The inspection was conducted by an adult social care inspector, a Specialist Advisor and an Expert by Experience.

A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a nurse who had extensive experience and knowledge of caring for people with respiratory illnesses and those receiving end of life care. The Specialist Advisor reviewed people's care plans to ensure their health needs were being met, spoke with staff, observed meal time sittings and interactions between staff and people living at the home.

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

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

During the inspection we spoke with five people, two relatives, one nurse, the chef, two care staff, the registered manager and the operations manager. We looked at five care plans, five staff recruitment files, staff training records and four medication administration records (MARS). We also looked at staff rotas for the dates 1 June to 30 June 2016, quality assurance audits, the provider's policies and procedures,

complaints and compliments and staff and relative meeting minutes. We also reviewed the results of the 2016 completed residents and relative's quality assurance questionnaires. During the inspection we spent time observing staff interactions with people including during two lunch time sittings.

After the inspection we spoke with two healthcare professionals who worked closely with the home.

We previously inspected the service on 4 September 2013 where no concerns were identified.

Good

Is the service safe?

Our findings

People, relatives and the healthcare professional we spoke with told us that people living at Crossways Nursing Home were safe. A relative told us, "Yes, safe, no question, the staff are very good." Another relative said, "Oh yes (family member is safe) they (staff) are just so amazing, always have her best interests at heart".

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe the physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns within the home. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert which included contacting the Care Quality Commission. Staff received training in safeguarding vulnerable adults and were required to refresh this training annually. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility and safety, nutritional risks and where required risks associated with people who could display behaviour which could challenge. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. Additional risk assessments were completed when required to manage new risks to people's safety. This included risk assessments regarding the emotional wellbeing of people whilst they were visiting friends and family. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Risks to people's care were identified, documented and staff knew how to support people's needs safely.

There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood. Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home. This provided an easy to follow guide for staff and emergency personnel about the support people required in the event of a fire. Staff knew the fire drill procedure and told us this was practised monthly to confirm their understanding of the actions to take should the situation occur. In the event of an evacuation the provider would use the providers other home in the county and the local hospital in Basingstoke to ensure people were kept safe. These plans allowed for people to continue receiving the care they required at the time it was needed.

There were sufficient staffing levels to meet people's needs. The registered manager identified that the staffing levels across the home consisted of one nurse and two staff during the day with one nurse and one member of staff working during the night. The registered manager was able to identify when additional staffing numbers were required. When people were receiving end of life care or required additional support as a result of their deteriorating health needs staff told us that additional staff were used appropriately.

Records and observations during the inspection showed the deployment of sufficient numbers of staff to meet people's care needs safely. Where shortfalls in the rotas had been identified these had been covered by existing staff. The registered manager had identified an agency who would be appropriate to deliver care however had not had the need to use their services. Existing staff were happy to deploy in order to fill any gaps in the rota. A member of staff told us, "It's very rare here (that a member of staff calls in sick)….it's very rare I get that here." People told us they were receiving care when they required, one person told us, "There are people (staff) around day and night".

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

People living at the home received their medicines safely. Nurses were responsible for administering medicines. Records showed that medicine administration records were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to annual competency assessments to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance. A medicines round was observed during which the nurse appropriately supported people to take their medicines as prescribed. Medicines were stored, administered and disposed of correctly which included those which require refrigeration to remain safe. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented monthly by the registered manager and operations manager, to check that records and stock levels were correct.

Requires Improvement

Is the service effective?

Our findings

People, their relatives and the healthcare professional we spoke with were positive about the ability of staff to meet their care needs. People said that they felt staff had sufficient knowledge and skills to deliver care. One person we spoke with told us, "I feel comfortable with them (staff)". One relative had written to the home saying, 'The staff are excellent', another said, '(staff) deserve a big thank you, you're all brilliant'.

Despite providing care to those living with dementia we could not see that the environment had been adapted to support people to live as independently as possible. The home was an older building which had not been specifically designed or decorated to meet the needs of those living with dementia. The corridors in places were not very wide and where not naturally lit, despite the provision of lighting, the corridors were not always bright. This did not support those with limited eyesight associated with old age and those living with dementia. There were also no handrails to support those who were able to mobilise independently. Toilets, bathroom doors and doors leading to communal areas such as the lounge and dining room did not always have pictorial signage to make identification easier for people. The carpet and flooring was also not appropriate for those living with limited eyesight as it was dark with multiple, repeated small patterns. Changing colours and patterns of flooring can be disorientating for those who have limited visual capacity as a result of their dementia.

We recommend that the provider seeks advice and guidance from a reputable source about developing a dementia friendly living environment.

People were assisted by staff who received a thorough and effective induction into their role. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. New staff were required to complete an induction which followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. All staff had undergone training in areas such as, moving and handling, first aid, nutrition and fluids, health and safety, safeguarding vulnerable adults and challenging behaviour. All training was repeated annually to ensure staff skills remained current. Nurses had also undergone additional training on care planning and medication record keeping and were supported to retain their nursing accreditation.

Staff were also encouraged and enabled to seek additional qualifications. Some of the staff at Crossways were due to complete NVQ level 2 qualification in social care which was supported by the registered manager and the provider. A number of staff were also undertaking training in dementia care in conjunction with a local college. This involve undertaking case studies, completing work books and provided a greater insight into the behaviours associated with those who live with dementia. Staff who wanted to further their on-going professional development were supported by the provider and registered manager to do so.

People were assisted by care staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. The provider's policy stated that all employees were to receive regular supervisions at least every eight weeks.

Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. Staff told us and records confirmed supervisions occurred every other month. These supervisions were undertaken by the nurses, the registered manager and the operations manager. Staff told us they were able to speak to their colleagues, registered manager and the operations manager at any time if they required additional support. Processes were in place so that staff received the most relevant and current knowledge and support to enable them to conduct their role effectively

People's freedom was not unlawfully restricted without the appropriate authorisation being sought. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager showed an understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications. Staff were able to discuss how they would support people subject to a DoLS to leave the home safely if they wished.

Staff were able to describe when a best interest decision would be most appropriate. Best interest decisions are made when someone no longer has the capacity to make a specific decision about their life. Records showed that decision specific mental capacity assessments and accompanying best interest decisions were made in relation to a number of aspects relating to people's person care and wellbeing. We saw that best interest meetings had been held for people when they no longer had the capacity to agree to a certain course of action involving their care. This included documenting and recording decisions that people had verbally agreed or a best interest decision had been made. This included the use of bed rails for people being supported in their bed to ensure their on-going safety.

Consent to care and care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves. The provider promoted the use of Independent Mental Capacity Advocates (IMCA's) for people unable to make key decisions in their life. This is a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views. Records showed that the registered manager was able to respond appropriately. When people were no longer able to make decisions which could affect their wellbeing and did not have relevant persons to act on their behalf the provider ensured an IMCA was identified to assist them. This including involving an IMCA is care plan reviews and assisting in making best interest decisions when people's physical and mental wellbeing were at risk of deteriorating due the person not being able to provide their consent to a certain aspect of care. People were supported to have their views known and the provider ensured appropriate representation was sought for those with no family or friends to assist them with their decision.

People and relatives were mainly complimentary about the food provided. One person told us about the food, "It is quite good". A relative told us about the food provided, "It's always very good, since the new cook has arrived it has greatly improved, they have choices including diabetic foods, cakes etc".

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

The chef was aware of people who had specific dietary needs such as diabetic or those who required a pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained an appetising visual appeal and was separated on the plates to allow people to identify what they were eating. The chef had recently joined the home however had taken time to know the residents. They had found out people's likes and dislikes to ensure that meals could be prepared to meet their specific needs and preferences.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of illness could be identified. Where people had difficulty eating or swallowing, a speech and language therapist's assessments had been requested and completed. One assessment completed confirmed the home was providing food in the appropriate format to meet that person's specific need. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to support staff on how to manage people living with certain illness or injury for example those with pressure ulcers. There were a number of people living at Crossways who were being nursed in bed which placed them at risk of suffering a pressure ulcer due to their lack of mobility. We could also see that people had moved to the home suffering from significant pressure ulcers. Care plans provided detailed guidance for staff and showed regular healthcare professional input had been provided to ensure that these situations were managed effectively. We could see and records showed that those suffering with pre-existing areas of injury had been healed as a result of the positive actions taken. Those persons being nursed in bed were being supported in a way to ensure that their skin integrity remained healthy and none had developed a pressure ulcer as a result.

Good

Is the service caring?

Our findings

People, their relatives and a healthcare professional we spoke with told us that support was delivered by caring staff. A relative had sent a written compliment which read, 'Mum is cared for in a friendly and kind way, they (staff) know us know her inside out'. One healthcare professional told us, 'Staff have gone over and above to provide care for certain patients', another said, 'The two lead nurses are caring and compassionate'.

Professional and caring relationships with people had been developed by staff. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans also included information and guidance for staff when interacting with people who were not always able to clearly verbally communicate. This included using non-verbal gestures and speaking clearly and slowly to people so they understand what was being said and were supported by giving time to respond in a way that staff could recognise. When responses were made these were repeated back to people so they could indicate if they agreed with how staff had interpreted their responses. We could see that staff followed this guidance and took time greeting people using their preferred name and gave people additional support to express their needs.

Staff knew the people they were supporting because their plans included information about what was important to them such as their food preferences, their important family relationships and what help they required to support them and when. People's care plans included 'Lifestyle and Preferences Forms'. This was a detailed list of people's preferences regarding their favoured bathing routine, including details of the bath temperature they wanted and whether people wished to be supported to express their sexuality by means of wearing make-up, aftershave and perfume. We could see people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked. Care plans provided staff with a detailed insight into people's wants and needs which we could see were followed during the inspection.

Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and gave them to respond appropriately.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Staff were able to evidence they knew how to support people when they were experiencing a period of a low mood. Staff told us they had the time to be able to spend with people if they were feeling sad or upset. All the staff we spoke with were able to describe how they would support people in a caring way and raise their concerns to the nurses when they were worried someone was becoming upset. People who did not have family or friends to support them were cared for by staff who took an active interest in their emotional wellbeing. On birthdays, Christmases and other significant celebratory days staff would purchase gifts for these people to ensure they knew they were cared for despite not having immediate family to support them. We saw that on people's

birthdays effort was made to ensure that a family party atmosphere was present in the home and photos showed that these were well participated. We saw that friends and family were involved and cakes were prepared for these people providing an enjoyable experience to celebrate special events.

Where appropriate physical contact was used as a way of offering reassurance to people. We saw that used touch support to interact with people to engage with them. When communicating with people staff would lower themselves to eye level to ensure that people were engaged in conversation. Staff would also often gently place a hand on people's arms to communicate that they were to be engaged in conversation. We saw that people were comfortable and actively support this physical contact with staff.

During a lunch time sitting we observed one person starting to become distressed, the registered manager responded appropriately by reassuring them and holding their hand telling them that they were alright. This calmed the person who was then happy to continue enjoying their meal. A healthcare professional provided an additional example where the registered manager had offered support in a very caring way. The healthcare professional told us, 'Last year, (the registered manager) was coming out of his hours (when he was not rostered to work), morning and evening to try and encourage a certain lady to eat, at the time she was rather unwell and seemed to be accepting food only from (the registered manager).' People were supported by staff who knew how to respond appropriately to people's emotional needs.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear, eat and drink and where they would like to spend their time.

People told us they were treated with respect and had their privacy maintained at all times. A number of written compliments had been received from relatives confirming people were treated with respect and dignity at all times. One relative had written 'I would like once again to say thank you for looking after and caring so much for our mum. Right to the end you gave her kind and dignified care …you made her passing away as comfortable as possible, you always treated her as though she was your parents….whenever we called to see her, whatever time of day you looked after us as well as her, thank you so much for your help.' Another relative wrote, 'To all staff at Crossways, sincere and grateful thanks to you all for the care thoughtfulness and dignity you have shown to (family member) during his final three weeks, we much appreciated all you did for him and us, once again many thanks and best wishes for the future'.

Staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. People's care plans detailed that privacy and dignity should be respected at all times and offered specific guidance which was followed by staff. This included ensuring that people were given privacy during visits from friends and family which we could see was respected. Care plans also documented how staff were to provide privacy and dignity during care delivery including bathing routines. This included covering people during personal care with a towel to help maintain people's modesty. Staff were seen to ask people before delivering or supporting with the delivery of care. People told us that staff were respectful through their interactions with them and gave the choice regularly, one person told us, "I choose what to wear and do." We could see that people were supported by staff who understood and demonstrated that they supported people in a way that was respectful of their right to lead a dignified life.

Requires Improvement

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. One relative wrote to the home and said, 'You know the residents inside and out and you always do what's needed'. A healthcare professional told us, 'Yes, (staff) do try and involve the person…I have observed the patients being involved in their care planning'.

People's care needs had been assessed and documented by the nursing or managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. Records showed that when a person was reviewed it was identified that they required prompting at meal times to ensure their health and well-being needs were met. Where reviews identified a change in situations which presented a new risk to someone's wellbeing this was appropriately documented. For example, during a monthly review it was established that a person would be visiting with their family members regularly. This required a new risk assessment to ensure that guidance was provided to keep this person safe for both staff and this person's family member. People were receiving care which was reviewed regularly to ensure it remained relevant to their needs.

Handover between all staff were held at the change of shift twice a day. These were held between the nurses and the care staff. The handover contained specific and detailed information in relation to people's needs such as their moving and handling needs, their emotional wellbeing and any changes in health such as new medication. The home also had a communications book which included information of when people had appointments or other important information to ensure that all staff were aware of people's immediate needs. People were supported by staff who knew their health needs and ensured that all members of staff responsible for their care were aware of any changes in the physical or mental wellbeing.

The provider sought to engage people in meaningful activities however there were not always enough activities provided to be able to meet everybody's individual needs.

Not all of the people we spoke with talked positively of the activities that were available to participate in. One person told us, "No, I don't (participate in activities) I do like Bingo but I can't remember the last time we played", another person told us, "No, there are no activities." A resident and relative survey was completed in March and April 2016 where people were asked what improvements they would like to see. Two of those who responded stated they felt there should be more activities with one relative commenting, 'The range of activities for residents seems very limited, TV, monthly (religious) service, plus visit by dogs and Christmas show and summer open day fete, feel the residents need more stimulation despite their limited ability to understand and respond'. Staff had mixed views when asked if there were enough activities available to be able to meet everybody's needs. One member of staff told us they required additional

funding to provide people the opportunities to participate in more activities, "We need money to do more activities, if they (provider) give us more money we can do more things…we manage, we try our best."

The home did not have an activity coordinator; the registered manager told us it was the responsibility of all staff to encourage people to participate in activities to remain active and socially involved. However we could not see there were enough meaningful activities to keep all people engaged. During the second day of the inspection the activities advertised included 'Name that Tune' however we could not see that people were actively participating in any activity. The lounge TV was showing a sports programme whilst music played in the background. One member of staff was engaging people in the lounge in conversation as was a visiting relative. We could not see that any activities were provided for those who were being supported in their room. This was confirmed by a healthcare professional who told us, 'Yes, they have activities but could have more 1 to 1 maybe an allocated person to do this'.

Care plans detailed people's particular social interactions and guidance was provided on how to support them to do so. Care plans also detailed people's hobbies and previous enjoyments to help staff to encourage people to participate in as broad a range of social activities as possible. However we could not see that this was also being supported. One persons' care plan stated that they needed to be encouraged to participate in positive activities such as clothes folding, pairing socks and mixing a cake. However during the inspection we could not see that this positive activity was being encouraged.

A typical month activities programme was viewed which had defined activities each day. These included pet dog visits, one to one interaction, nail care/spa day, exercising, pastoral visits, cheese and wine afternoons and ball games. External organised activities were not regularly included in the activities programme due to the lack of mobility of a number of the residents. However external groups were encouraged to come into the home and we could see that musical groups had performed in the home, there had been external agencies attending the home to hold Christmas shows. The home also held summer fetes and invited people, family, friends and the local community to the home to participate in events with stalls, tombola and raffles. The proceeds of which were then used to support residents with other activities. The homes activities files identified activities which would be appropriate for those living with dementia. This included home style activities such as gathering laundry, dusting and setting the tablets and reminiscence tasks such as looking at photographs and creating memory boxes. These types of activities can help a person living with dementia feel connected to their life before receiving care and can maximise their choice and control. Some activities such as those involving reminisce can help people seek an emotional connection with others. However we could not see that these activities were being actively promoted to ensure people were being encouraged to participate.

We recommend that the provider actively promotes the activities identified as appropriate for those living with dementia. This is to ensure that all people are offered the opportunity to participate in meaningful activities.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. The provider's complaints policy was available in people's rooms as part of their service user guides and accessible to their visitors and relatives. This provided information regarding how people could complaint and the actions that would be taken in response to a complaint being received. The provider's complaints policy included information on how to raise concerns with the Care Quality Commission if a complainant remained dissatisfied with the outcome of their complaint. People's care plans also included information providing guidance to staff on how to support people to make a complaint if they expressed a wish to do so. This guidance stated that for those people who did not know how to complain how staff would support them.

This included guidance for staff on signs to recognise in people's body language, facial expressions and changes in behaviour that would express a person's unhappiness. As a result people's family members would then be involved to ensure that people were given every opportunity to express any concern they may have.

Complaints made in writing and verbally received were documented and recorded in a complaints folder in the registered manager's office. There had been one informal complaint received since the last inspection. This had been received informally however the registered manger had documented this as per their complaints policy to show transparency in their investigations. Records showed that the complaint regarding a staff member's attitude during care delivery had been investigated by the registered manager and steps taken to address the causes of the complaint. The complainants were then responded to appropriately in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

The registered manager promoted an open, family orientated and happy culture at Crossways Nursing Home and actively sought feedback from people living at the home, their friends and family. Most people we spoke with were confident in the registered manager's ability to manage the service and address concerns. People and relatives told us they were happy with the quality of the service provided. One relative told us, "All the care is centred around her (family member)". Another relative said, "Very good quality care".

The registered manager wanted the home to feel like a family orientated home where each individual felt and treated Crossways as their own home. This aim was underpinned by providing a comfortable homely environment where care was delivered to support people to remain as independent as possible. The registered manager also wanted people to continue living their lives and participating and following the same interests they had prior to moving to the home. This family orientated culture was understood by staff and promoted. This was evidenced in the positive comments received from friends and family members of those who had and continued to live at Crossways Nursing Home. Compliments was viewed which included, 'We were pleased she was able to spend her last years in a home from home environment'. Another complement received said, 'Staff treat her like their own family'.

The provider had a 'Philosophy of Care' which was openly displayed in the home. This included a documented list of rights people had whilst living at the home and receiving care. These included that people live in a secure, relaxed and homely environment in which their care, medical requirements, wellbeing and comfort was of prime importance. The Philosophy of Care also stated that people would have their cultural, psychological, spiritual and emotional needs met by the service. Staff were not always able to identify the providers philosophy of care however this philosophy was evident in the way they delivered people's care. One member of staff told us, "I give them (people) help as if they're family". This caring culture was reinforced with staff through supervisions and appraisals, training and observations conducted daily by the registered manager and operations manager around the home.

The registered manager was a visible presence to people, relatives, visitors and staff. Staff were positive about both the registered manager and the operations manager and the support they received to do their jobs. They told us that the registered manager was open to their concerns and needs. One member of staff told us, "Yes if there is any problem we always go to him…yes (helpful and supportive) always there when we need help". This was reinforced by people and relatives feedback received. A relative had written to the home saying the staff and registered manager were open to them, 'The staff at Crossways are very helpful team and the manager is very approachable'. During the 2016 people and relatives feedback all respondents had replied positively to the question whether they found the staff helpful and the registered manager approachable'. People and their family were able to communicate freely with staff and the registered manager creating an open and honest environment to share feedback and concerns.

The registered manager sought to make themselves visible and available to people and staff by completing a daily walk of the home. The registered manager was also present during lunch time sittings to assist staff in supporting those who required additional assistance. These walks were in in order to see if there were

sufficient levels of staffing to meet people's needs and to interact with people, staff and those visiting the home. One relative told us, "The registered manager has an open door policy and are usually on the floor"

The registered manager was able to evidence that they knew what was required of their role. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We use this information to monitor the service to ensure they respond appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance

The quality of the service people experienced was monitored through regular care plan reviews and the use of residents and relatives surveys. These surveys were conducted annually and the results reviewed by the provider to see where improvements could be made. The results from the 2015 and 2016 surveys were viewed. People were asked to rate the home in areas including, whether they were happy at Crossways, if they felt cared for, if people enjoyed the food provided and what improvements people would like to see. The 2015 survey identified that all the people who responded had done so positively who were unable to find fault with the quality of the service provided. The operations manager had reviewed and analysed the results to see if areas of improvement could be made however none had been identified. The last survey completed prior to the inspection asked if people were happy with their rooms, if they received staff from the help when they needed it, if they were happy with the food, activities provided and anything that could be done to make them happier. Again the results received were positive with no suggestions for areas of improvement. The provider actively sought feedback from people and saw this as a way to improve the quality of the service provided.

The provider also completed a number of quality assurance audits at the home to monitor the service provision. Audits were required to be completed on a monthly by the operations manager. These gathered evidence of compliance with the regulations from a range of sources which included audits of care plans, infection control audits and medication management audits.

When these audits identified areas for improvement the actions were recorded and monitored for completion to ensure that the home was meeting the identified standards. The last audit had been conducted by the operations manager in May 2016 identified that four members of staff needed their supervision to ensure they were happy in their role. This audit also identified that 'Crossways has a very 'homely' environment but carpets and curtains need replacing'. Steps had already been taken at the time of the inspection to replace some furniture from another nursing home however due to the short timescale since being identified this had yet to be completed at the time of the inspection. During this audit it also identified that whilst there was an activity programme in place there were no activities staff to ensure these were completed and they were completed on an 'ad hoc' basis. The operations manager was aware of the need for staff recruitment to support a more structured activities programme. Action was in the process of being taken at the time of the inspection to seek additional support for staff to enable additional activities. The provider and registered manager had audits in place which were used effectively to identify areas where improvements could be made of the quality of the service provided.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home thanking them for the quality of the care provided. One relative spoke very highly of the quality of the care provided to their family member whilst at Crossways.

Staff identified what they felt was high quality care and knew the importance of their role to deliver this. Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We

saw interactions between the registered manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.