HC-One Limited

Snapethorpe Hall

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 June 2017 and was unannounced. Snapethorpe Hall provides personal care and nursing care for up to 62 older people, some of whom are living with dementia. Accommodation is provided on two floors with lift access between floors. Communal lounge and dining areas are provided on both floors. On the day we inspected there were 51 people living at the home; 15 people were in the specialist dementia unit, 15 people in the residential unit and 21 in the nursing area.

There was 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.

We had previously inspected the home in April 2016. At the previous inspection, we found staff did not have access to written instructions for the safe moving and handling of people. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there was no consistent recording or understanding about people's ability to consent to care. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we checked whether there had been any improvement in the service. We found there had been and the provider was no longer in breach of the regulations.

We saw safeguarding matters and accidents and incidents were responded to appropriately. We checked staff files and found all recruitment checks had been carried out as required. Staff felt supported and had regular training and supervision.

We checked staff rotas and saw all shifts had been covered up to two weeks in advance where gaps had been identified, particularly in the nursing staff. We observed call bells were responded to in a timely manner. We observed a number of people who needed assistance to eat would have had to wait some time if relatives had not been available. We recommend that the provider assesses the staffing levels around mealtimes.

We saw systems were in place for the ordering, recording and disposal of all medicines received into the home. Medication Administration Record sheets (MARs) were completed with the detail and the amount of the medicine received. We were concerned medicines which needed to be taken before food were not always administered in line with the manufacturer's instructions. The registered manager rectified this issue on the day of inspection.

Staff understood the basic principles of the Mental Capacity Act (2005). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed most bedroom doors in the home were open, although we checked with the people we spoke with and they did confirm this was what they wanted. We recommend that the provider needs to evidence people's choice to have their bedroom doors open permanently or whether it has become standard practice.

We found people were appropriately supported to eat and drink. People's weight was monitored, some on a weekly basis where concerns had been identified. People had access other healthcare professionals when required.

The people we spoke with told us staff were caring and friendly. They also told us staff knew them well and understood their needs. People's independence was promoted well and staff encouraged people to do as much for themselves as they were able.

People's care records were detailed and person-centred. Care plans were in place for communication, personal care, mobility, eating and drinking, safety, medication, activities, sleeping, continence and skin care.

The provider monitored the quality of the service. Regular audits took place in areas such as; care records, medication, health and safety, infection control and catering. We saw complaints were recorded and responded to appropriately. The complaints were reviewed by the provider's head office to ensure they were actioned within a timely manner.

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.

Care records provided sufficient information to ensure risks were assessed or mitigated.

The provider's recruitment process was robust to help ensure staff were of good character.

Medicines were managed appropriately. Where issues were found these had been immediately rectified.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they were well supported, and had regular supervision. Staff told us they received training. We saw evidence which confirmed this.

Staff understood the basic principles of the Mental Capacity Act 2005.

It was not clear whether people had chosen to keep their bedroom doors open permanently or whether it has become standard practice.

Is the service caring?

Good

The service was caring.

People's privacy and dignity were respected.

People's independence was promoted well and they were involved and informed about matters relating to their care and support.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the

service, and we saw they were reviewed with people and their relatives.

There were systems in place to respond to complaints.

Is the service well-led?

Good

The service was well-led.

We found the provider had sufficient systems in place to assess and monitor the quality of the service.

We received positive feedback about the management of the service. Staff said they were happy to work for the provider and felt supported.

Staff and people were involved in the running of the service through meetings, regular contact and surveys.

Snapethorpe Hall

Detailed findings

Background to this inspection

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

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

The inspection was carried out by four adult social care inspectors 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. Their area of expertise is in relation to older people and dementia care.

We reviewed information we held about the service, such as notifications, information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England.

The registered provider completed a Provider Information Return (PIR). This 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.

During the inspection we spoke with six people who used the service and six people's relatives. We also spoke with five members of care staff, the cook and the registered manager.

We looked at a variety of documentation including; care documentation for four people, three staff recruitment files, meeting minutes, policies and procedures and quality monitoring records. We observed care practices and lunch in the residential and dementia units.

Good

Is the service safe?

Our findings

At the previous inspection we found there was as a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not able to refer to the correct procedure for the safe moving and handling of a person. At this inspection we found moving and handling records had been improved to incorporate details of the equipment used including the person's sling number and type of hoist. There was also photographic evidence of how the equipment was to be used, providing further support for staff. We observed care staff moving people safely when using a hoist and ensuring the equipment was correctly used. We concluded the provider was no longer in breach of this regulation.

People were complimentary about the care provided. One person told us, "It's very good indeed, excellent, no nagging here you can do what you want." Another person said, "I didn't like it at [another care home] because I didn't like the staff. Here they are nice, always bringing you drinks and things." All the relatives we spoke with told us they were happy with the care their relative received. One relative commented, "It's a good standard of care and staff attitude is good."

People and their relatives told us they felt safe at Snapethorpe Hall. One person said, "I know there is someone here all the time, I have only to press my buzzer." Another person told us, "I feel safe here because the girls are always checking I am okay; I am not left on my own for hours." One relative said, "They treat everyone the same, any problems and they are on it straight away."

Staff clearly and confidently explained the signs of abuse and what they would do to make sure people were safeguarded. Staff said they did regular safeguarding training and would not hesitate to report concerns in order to keep people safe. Staff said they felt supported to use the whistleblowing procedure to report poor practise if they witnessed this.

We saw safeguarding matters and accidents and incidents were responded to appropriately. These were recorded and, where appropriate, reported to the Care Quality Commission and the Local Authority Safeguarding Team.

We checked staff files and found all recruitment checks had been carried out as required. References had been obtained, identity and other checks such as the Disclosure and Barring Service (DBS) checks were in place to ensure people were suitable to work with vulnerable people. The DBS is a national agency which holds information about people who may be barred from working with vulnerable people.

All the people we spoke with told us there were enough staff to care for their needs. Although at times people said they had to wait for assistance, such as if staff were "seeing to someone else" or during lunch time. We observed call bells were responded to in a timely manner.

Relatives had observed agency staff were used, but acknowledged the provider had been trying to use the same agency staff so they knew people's needs. Another relative told us there used to be a lot of agency staff and a lot of staff shortages but things had improved over the last year.

The registered manager told us a dependency tool was used on each unit to help calculate the appropriate staffing levels. People's dependency needs were assessed according to the level of support required for personal care, nutrition, continence, mobility, skin integrity, behaviour and communication. They were reviewed monthly to ensure they reflected current need. The registered manager said the dependency tool was used as a guide. The registered manager said they also listened to staff views and used their daily observations to determine whether staffing levels were appropriate. We checked staff rotas and saw all shifts had been covered up to two weeks in advance where gaps had been identified, particularly in the nursing staff.

Staff said they felt there were enough staff on the whole. One member of staff said additional staff were needed on the nursing unit to ensure people's high dependency needs were met. This was particularly around people who required one to one support with meals. They told us relatives often visited in the evening to support at mealtime, although without their support people would have to wait longer for staff to assist. We observed a number of people who needed assistance to eat would have had to wait some time if relatives had not been available. We recommend that the provider assesses the staffing levels around mealtimes.

Staff told us they knew how to keep people safe and they were aware individual risk assessments were in care plans. Staff said as well as information in the care plans, information about individual risks was shared at handovers, the communication book and informally with one another. Staff said where there were particular risks, such as a choking risk, the information was clearly available in people's individual rooms, so for example if they required thickener in their drink the details of how this should be used were readily accessible.

Risk assessments were in place for falls, skin integrity, continence needs, choking, equipment such as bed rails and dependency needs. Each reflected a person's specific needs and provided guidance for staff as to how best meet the need.

Three people we spoke with told us they received their medicines when they should and had access to pain relief when they needed it. All the relatives we spoke with said everything was fine with their relative's medication and access to pain relief.

During our inspection we looked at how medicines were managed within the service. We saw medicines were stored in locked clinical rooms which could only be accessed by people with the appropriate authority. Temperatures of the rooms and fridges in which medicines were stored were recorded on a daily basis.

We saw systems were in place for the recording of all medicines received into the home. Medication Administration Record sheets (MARs) were completed with the detail and the amount of the medicine received. We saw the MAR sheet folder on the residential unit had the 'Seven rights of medication' fixed to the front cover. This is a good reminder for staff about the safe way to administer medicine.

MARs included a front sheet which gave details of the individual including a photograph, their GP, any allergies, any difficulties the person had in taking their medicines and how they preferred to take them. We saw MARs had been completed appropriately with signatures of administration or the code denoting the reason the medicine had not been administered. However, when the medicine had not been administered, staff had not consistently recorded the reason for this on the reverse of the MAR. This was raised with the registered manager at the time of inspection who told us they would address the matter.

For medicines prescribed on an 'as required' (PRN) basis a protocol was in place detailing the medicine, the

dose and frequency of administration, the maximum number of doses within 24 hours, what the medicine was for, how the person might indicate they needed the medicine and the effectiveness of the medicine. We saw the PRN protocols were reviewed on a three monthly basis. However, we noted one person had been receiving their PRN painkilling medicine on a regular basis for the previous nine months with the purpose of administration consistently recorded as either 'Given if awake' or 'Given regular'. The outcome of the administration was consistently recorded as 'Appears comfortable'. We did not see record of this being reviewed with the prescriber to establish if the prescription remained appropriate or whether it should be prescribed to be taken on a regular rather than PRN basis. We raised this issue with the registered manager who told us this would be addressed.

We saw body charts were in place for the application of topical medicines such as creams and eye drops. Where the medicine was prescribed as a patch, body charts showed where the patch had been applied.

We were concerned medicines which needed to be taken before food were not always administered in line with the manufacturer's instructions. We found on three of the four units people had eaten before they received this medicine. We discussed this with the registered manager who said they would immediately introduce an additional medicine round to make sure people received the medicine before their meal. We saw evidence that this had been put into place by the end of the inspection.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We saw care plans were in place for people taking antibiotic medicines although one of these had not been fully completed. People taking Warfarin (a blood thinning medicine) also had related care plans in place which included the helpline number for the anti-coagulant clinic the person used for regular blood tests to establish the dose needed.

The registered manager confirmed none of the people living at the home at the time of our visit received their medicines covertly (hidden in food or drink). Medicines audits were completed on a monthly basis. The registered manager told us that where four consecutive medicines audits did not identify any issues, a further audit was completed by a senior person from within the company.

All staff who administered medicines undertook annual e-learning and a three yearly robust competency check. We saw staff administered medicines to people in their preferred way and with a patient and kindly approach.

Staff said they knew what to do in an emergency situation, such as a fire and they practised evacuation regularly. Staff told us they received regular fire safety training. We saw evidence which confirmed this.

The provider had a business continuity policy and procedure in place. There was a dedicated 'fire' folder which contained resident list, evacuation register, fire alarm tests and fire zone plans. We saw people had Personal Emergency Evacuation Plans (PEEPS) in place. However, we found these were basic and provided minimal information as to the equipment needed. For example, there was no mention of a person's cognitive ability or whether they had other specific needs. We noted the plans were undated which meant it was not clear whether the information was current. The registered manager told us this matter would be addressed.

We saw the provider had a maintenance schedule in place and that any issues identified were responded to

promptly. We saw evidence to show equipment and appliances were maintained. We found the home was clean and odour free.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we found there was as a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have capacity or best interest assessments in place where a person lacked capacity to make a specific decision. At this inspection we found this matter had been addressed. We concluded the provider was no longer in breach of this regulation.

All the people we spoke with felt the staff were sufficiently skilled and trained to provide the care they needed. One person told us, "I cannot find any fault in any of them." All the relatives we spoke with agreed with this and told us the staff were well trained.

We found the environment to be much improved from the previous inspection with lounges decorated in a homely manner, promoting a sense of calmness. In the dementia unit there was display of the Queen celebrating her sapphire jubilee which promoted conversations for people. People were offered the choice of which television programmes to watch and where they would like to sit, with gentle guidance from staff where needed, for example, out of line of the TV.

The registered manager told us they worked alongside staff and held group supervisions to ensure staff were competent to carry out their role. The staff confirmed this and said they found this approach supportive. Staff said they had regular opportunities for training and although most of this was online there were opportunities for practical training, such as moving and handling. Staff told us they discussed training needs in supervision sessions with the registered manager. Training records evidenced most staff had up to date training in all key areas, and where training had expired this had been planned for renewal. Records showed staff had received an induction which included all key areas of training and ensured they were competent before working in the home. This training included: moving and handling, safeguarding, health and safety, infection control, person centred care, medication and dignity.

Staff told us they received regular supervision, and they found this to be supportive for them to carry out their role effectively. We saw evidence to show staff received regular supervision which was both generic and specific. Key topics were identified, the most recent being nutrition which had stemmed from a complaint showing the registered manager was keen to embed learning in the home. Other supervision sessions were tailored to individual need and focused on areas for development. Staff were supported to progress in their career and we saw in one file one staff member had been supported to undertake development to a nursing assistant role. We also saw, where necessary, disciplinary action had been taken following evidence of poor practice.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found improvements had been made in this area since the last inspection.

We found appropriate action was taken when people lacked capacity to make decisions. The registered manager was knowledgeable regarding how to conduct 'best interest' meetings and when to make DoLs applications. We saw appropriate mental capacity assessments in people's care records. They were both decision and time specific, providing clear evidence of how a person's decision-making ability had been assessed.

Staff understood the legislation around the MCA. All staff said information about people's mental capacity was in their care records, including whether they had a DoLS in place.

Relatives told us people were supported to make day to day decisions, even when they lacked capacity to contribute to their care plan. Most of the people we spoke with told us they had a say in how their care and support was provided: "I can say anything to them." and "They know of my likes and dislikes." People told us staff always explained things to them and gave them time to take the information in.

We observed most bedroom doors in the home were open, although we checked with the people we spoke with and they confirmed this was what they wanted. We checked with staff who told us it was people's choice to have their bedroom doors open. However, one member of staff said they unsure whether it was down to choice and told us; "It's always been like this, I think we have to keep the doors open." It was not clear from the care documentation whether it was people's choice to have their door open, particularly when we saw people were sleeping. We recommend that the provider needs to evidence people's choice to have their bedroom doors open permanently or whether it has become standard practice. We observed some staff were not knocking before entering rooms where the doors had been left open.

We also noted clocks were not set at the correct time in dining room on the nursing unit and in the lounge on the dementia unit. This may confuse people and disorientate them as to the time of day. The registered manager took the clocks away in order to change the batteries.

We observed tea and other drinks being served at various times throughout the inspection. We saw everyone we spoke with in their rooms and lounges had juice/water besides them. All the relatives told us the food was good, there was plenty of choice and there were enough fluids available.

People told us they had access to drinks and snacks and they could have food to eat outside of 'normal' mealtimes. One person told us, "They look after you good, it's a lovely cup of tea and I can have one when I want." Another person commented, "Food is very nice, they don't give me a big plateful because I don't like that." One person said, "The food's lovely, really good and plenty of it."

We observed lunch time in the dementia unit. We saw people ate well and were given plenty of choice. If people decided they did not want their first choice of meal they were offered alternatives. At lunch the atmosphere was quiet. Staff were very helpful and people were supported to make choices as staff provided clear explanation. We saw staff were aware of people's needs and preferences. We saw when people wanted assistance they were provided with this. We observed one staff member sitting with a person and assisting them to eat. This staff member was patient and engaged with the person whilst helping and encouraging them to eat for themselves.

We observed lunch time on the residential unit and saw this was relaxed and sociable. Staff were attentive to people's needs and they worked closely together to ensure people had what they wanted. People were given choices of sandwiches and staff asked how many they wanted. We heard one member of staff supported the request of a person who wanted alternative sandwiches. Staff were polite and courteous with people and observed them discreetly, offering support when required. We saw one person was unable to reach their soup easily without having to keep leaning forward from their chair. Staff supported them to sit more comfortably by offering a cushion for their back, to avoid them having to reach. We saw the provider had completed a dignity in dining audit which had looked at how attentive staff were and how they provided assistance to support people make a choice

People's weight was monitored, some on a weekly basis where concerns had been identified. Food and fluid charts were kept which recorded amounts eaten and drunk. However, not all were specific enough to identify the exact amount someone had eaten. For example, they referred to 'all' instead of specific amounts. Although we did not find any evidence this effected the monitoring of people's health, it may make it difficult for healthcare professionals to effectively monitor a person's weight loss. We spoke with the registered manager who told us they were addressing this matter.

Staff we spoke with told us they thought people had good food in the home, and they made sure people were not hungry or thirsty by offering regular snacks and drinks. Staff said in the warm weather they had been especially mindful to promote drinking, through additional drinks provision and offering ice lollies. Staff said people could have snacks whenever they wanted, not just at mealtimes. One member of staff on the dementia unit told us even if a person had eaten plenty all day, if they felt confused and forgot, then they could have something else. They said, "It's real to them, if they believe they are hungry, then we take this seriously and provide something for them, even when we know they've eaten."

The cook was knowledgeable about people's dietary needs. The cook showed us a whiteboard which listed each person's particular dietary needs where this needed to be catered for specifically in relation to their health. The cook told us they worked closely with care staff to make sure consistency of meals was prepared according to people's care plans.

They told us they followed corporate menus but responded to feedback from people who used the service. The cook said they catered for people's birthdays with a cake. Where people had diabetic diets, the cook said low sugar alternatives were prepared.

Good

Is the service caring?

Our findings

The people we spoke with told us staff were caring and friendly. They also told us staff knew them well and understood their needs. One person said, "You can stay up as long as you want if there is something on tele. It's all cosy and they make you some supper." All the relatives we spoke with told us the staff were kind, compassionate and caring. Comments included: "Very, very helpful.", "Very kind, I appreciate what they do, they are very patient." and "Brilliant, good with my relative." Another relative said, "My relative is always clean, well groomed, they wash their clothes, then hang them up nicely and the rooms are spotless."

We saw people received quarterly newsletters to update them on issues at the home. The newsletters gave dates for people's diaries for activities such as; coffee mornings, when resident/relative meetings were and for trips out.

All the people we spoke with said staff worked at a pace to suit their needs. One person told us, "I am not quick, but they come up and walk beside me. They don't rush me. They say, don't rush, there's plenty of time." People felt staff encouraged them to be as independent as possible. One person said, "I walk with a zimmer and they plan to let me use it on my own, it's in my care plan. They only wash my legs and feet because I can wash the rest myself." The relatives we spoke with told us staff encouraged people to be as independent as possible. One relative told us, "They support [my relative] in her independence, they encourage her to dress herself." Another relative said, "My relative didn't walk for three months after going into hospital but since he came here they have persisted and got him walking."

People's independence was promoted well, and staff encouraged people to do as much for themselves as they were able. Staff told us they tried to involve people in their care as much as possible, and we saw staff offered explanations and reassurance to people whilst assisting them. For example, we saw one member of staff encouraged a person to walk across a room and reassured them they could take all the time they needed, without feeling hurried. At lunch time we saw one person was provided with a rimmed plate to stop food dropping off their plate. Staff gently guided the person's hands to help them feel where the plate was. Staff then put a spoon in the person's hands to encourage them to eat independently and then repeated this process. Staff also did the same with the person's mug. This showed staff understood person-centred approaches to care.

People told us staff treated them with dignity and respect and respected their privacy. The relatives we spoke with confirmed this was the case. For example, one person we spoke with described how staff ensured they were appropriately covered when providing personal care so they never felt exposed. One person who was in bed told us, "I have to stay in bed, that's how it is. But the staff always make sure I have nice hair and a clean nightie on. I like my door to be open because I'm nosy and I can see what's going on. They turned my bed round so I could see out the window and out of my door."

Staff said they respected people's privacy and dignity and always ensured people had appropriate clothing on. Staff said they encouraged people to choose what to wear and if they needed help they would give them a visual choice. One member of staff said, "It's not just about whether their clothes are suitable, I would

always make sure they matched too. I'd never suggest clothes for a person if they didn't go together, that wouldn't be fair, it's important to people to look nice."

We observed staff speaking discreetly to people when they needed assistance with personal care and guided them carefully, ensuring they walked at their pace and in a manner to promote a person's safety, such as holding both hands to provide stability.

Staff we spoke with said they enjoyed their work; some staff had been at the home a number of years and it was clear they knew people very well. We observed care interactions that were caring and person centred. For example, we saw staff displayed positive body language and maintained good eye contact with the people they spoke with. We saw calm and patient interaction between staff and the people in the home.

The care records had a current Do Not Attempt CPR in place and some also had evidence of advanced care. This helped to guide care staff on what actions to take in the event of a person at the end of their life.

Good

Is the service responsive?

Our findings

Two people told us staff picked up changes in their needs. For example, staff recognised a person's needs had changed which meant it was more appropriate they received nursing care. Five relatives told us they had been involved with their relative's reviews; although one person commented this had only happened when their relative first moved into the home.

The registered manager explained that either they or the deputy manager completed a pre-admission assessment prior to a person moving into the home. This helped to ensure people's needs could be met. A seven day care plan was completed straight away and risk assessments within 48 hours. We saw evidence to show this was done. The registered manager had introduced a 'Resident of the day' system, which meant a person on each unit was selected to have focus placed on them. Areas such as the person's care plan, body maps, weight, capacity and equipment they used was reviewed. The person's room was looked at to ensure they had everything they needed. This helped to ensure the person's health and welfare was regularly assessed.

People's care records were detailed and person-centred. Most had a profile outlining important people and significant information about the individual to assist staff in caring for them. They also had a photograph to aid identification. Some records also had a detailed life history document providing further information about a person's family, career and interests. These were used to develop appropriate care plans and we saw in one person's care record their interests in painting had been pursued by the activity co-ordinator to try and engage the person. The provider was working towards every person having a detailed life history within their care plans.

Where required, body maps were in use to show areas of skin damage. These contained details of treatment and actions taken to minimise further pressure damage. Positional changes for people nursed in bed were recorded at regular intervals to document appropriate support was given.

Care plans were in place for communication, personal care, mobility, eating and drinking, safety, medication, activities, sleeping, continence and skin care. Each reflected the person's wishes wherever this was possible. They focused on a person's abilities and how best to engage with the person. Each record was evaluated on a monthly basis and amended if required. People's preferences for gender of care worker were recorded. We saw evidence in care records of regular contact for people in the home with their GP or other health professionals as required.

Daily notes were also in people's files and were completed twice daily. Although we noted they tended to be task-focused and showed what support a person had received during the day. The registered manager told us they were working with staff to improve this.

We observed the activities coordinator was completing life portraits for people on the dementia unit in order to add to their memory boxes. These memory boxes were outside people's bedrooms on the wall in the dementia unit. We saw two other staff were looking at old photos with people and reminiscing. However, we

did not observe much activity for those confined to their rooms. There was evidence activities took place within the home. We saw photographs on display of the previous month's activities and the activity schedule in people's rooms. The activities room was full of craft resources, games, books and films.

We observed care delivery in the dementia lounge during the morning and saw people were offered a choice of magazines or books to look at and discuss with staff. It was evident from one conversation how much staff knew about the person as they were able to talk about the person's pets and knew their names. This generated a discussion around the importance of pets and how some staff occasionally brought their pets in to the home for people to engage with.

We saw in people's care records evidence of outings to other care homes to attend coffee mornings or other events. The home had a 'big get together' event planned for the following week in line with a national event which showed a keen sense of community.

People we spoke with were not familiar with the formal complaints process. However, they told us they would speak to the manager if they had any concerns/complaints. Two relatives told us they had made complaints which had been resolved to their satisfaction.

Staff we spoke with said they would always support a person if they wished to make a complaint. They said they would inform the registered manager and ensure people's views were heard.

We saw complaints were recorded and responded to appropriately. The complaints were reviewed by the provider's head office to ensure they were actioned within a timely manner.

We saw evidence of many compliments which were stored in a file in the nursing facility. Comments included: "[Name] was so well looked after" and "I was grateful for every small gesture." Other compliments reflected people's high regard for all staff members including domestic, laundry and care staff acknowledging the positive impact they had all played in promoting a sense of wellbeing for their relative. Also in this file were copies of people's memorial services ensuring they were not forgotten by people in the home.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of the inspection. It was clear the registered manager knew the people who used the service well.

People told us they felt the home was well managed, although they told us they were not aware who the registered manager was. Comments included: "It's clean, spacious, never have to worry if anything is clean.", "I am happy with what's going on, I never feel miserable." and "People talk to you, I came here for two weeks respite and decided to stay." All the people we spoke with said they would recommend Snapethorpe Hall. One person said, "It's very comfy here, everyone pleasant, food perfect, all very good."

Most of the relatives knew who the registered manager was and felt Snapethorpe Hall was well-led. One relative commented, "As you walk in people are busy but the atmosphere is calm. The manager and staff greet you. Everything seems to work." Another person said, "The manager is always about, I've heard her giving instructions, she's on the ball and 'hands on'."

Staff we spoke with said the home was well managed and they thought the registered manager had made a difference. Staff all said the registered manager was approachable and they felt supported at work and to achieve a good work life balance. They said morale was good in the home. One member of staff said, "Things have changed for the better." Another said, "She's made a big difference, there's been some changes, some good ones." A member of staff told us, "She's firm but fair. She's not always liked but she runs the home well and knows what's going on." One member of staff said, "She'll do any of the jobs, even personal care. She's even worked shifts."

Staff also said the organisation's senior managers visited the home from time to time. One member of staff said, "They walk round and look round everywhere. They say hello to staff."

We looked at the systems in place to assess and monitor the quality of the service. We saw evidence to show the manager completed a regular walk-around and visual monitoring of the home. Regular audits took place in areas such as; care records, medication, health and safety, infection control and catering. The providers head office ensured they were completed. We saw regular meetings were held with the management team in relation to issues identified in relation to falls and weight loss. Appropriate referrals were made to other healthcare professionals when required. The provider had a system in place for auditing accidents and incidents. This enabled patterns and trends to be identified.

The provider also had a training and supervision matrix to help ensure staff received training and support in a timely manner.

The quality of the service was also monitored by the Area Director who looked at key clinical indicators in areas such as pressure ulcers, weight loss, infections, medication audits, hospital admissions, bed rails, falls and deaths. We saw any issues highlighted resulted in action plans being created. These were followed up by the manager and area director. The home also internal inspections which took place as a minimum of

twice a year, to ensure standards were maintained and any outstanding actions have been completed.

Staff said they attended regular staff meetings, and where this was not possible, they always had access to the minutes afterwards. Staff said they felt able to "have a say" and the meetings were supportive and informative. We saw staff meeting minutes which evidenced this. A variety of issues were discussed, including staff culture and care documentation. The minutes showed what action would be taken to address issues. Resident and relative meetings took place and issues, such as activities and entertainment people would like to see, were discussed.

We saw in staff files and on a display, some staff had been awarded a 'kindness in care' award which acknowledged their contribution in promoting people's well-being and a positive atmosphere in the home. This showed staff were valued and appreciated.