Grace and Compassion Benedictines

Holy Cross Care Home

Inspection report

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Ratings

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

Overall summary

Holy Cross Nursing Home provides general nursing care including end of life care and personal care and support for up to 60 people within purpose built accommodation over two floors. There are also self-contained flats within the grounds where people can live independently or with domiciliary care support. This meant as people's needs change and increase they could choose to increase the support within their own flat or move in to the care home for 24 hour care and support. This provided people with the assurance of continuity of care and support from staff they were familiar with. There were only two people at this time who received personal care from the domiciliary care service provided at Holy Cross Nursing Home. We spoke to these two people who used the domiciliary care service following the inspection. They told us that the support was excellent and non-invasive, allowing them to be independent.

The inspection took place on the 14 July 2014. There was a registered manager at the home. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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

There were 53 people living in the service on the day of our inspection. Holy Cross Nursing Home welcomed people from differing faiths including nuns from closed orders. We saw that the staff employed included Sisters of the Catholic faith who were also trained nurses.

People told us they felt safe living at the service. All staff had received safeguarding vulnerable adults training and staff were able to tell us what they would do if they had any concerns. Although the service did not look after people who had a primary diagnosis of dementia, staff had received training on the Mental Capacity Act (MCA) 2005 alongside safeguarding training. Staff also had access to an organisational policy related to the MCA 2005 and Deprivation of Liberty Safeguards (DoLs).

The service provided a safe environment for people, whilst giving them freedom to make everyday choices, such as walking around the grounds and meeting friends and family. Care plans contained individual risk assessments in order to keep people safe. People interviewed felt safe and respected, and there were no obvious safety risks.

Staff told us they felt there were enough staff on duty each day to provide safe care. One staff member said, "We get the work done, so the staffing levels are okay." Another staff member said, "We have staff that live here and so if needed due to sickness they can be there quickly." Some staff told us they would like to be able to spend more time with people socially, but this was not always possible. One member of staff told us, "I think this is something we could do better." One person who used the service told us, "A chat now and again would be good, but they try hard." Another said, "They are lovely but so busy, they don't get much time to just sit and talk." People we spoke with said, "I am well looked after, if I have to wait, it's because some else needs them."

Staff told us they were encouraged to progress professionally and attend training appropriate for their role. Staff received annual appraisals and had regular group supervision with their line managers. Staff told us they felt supported to deliver safe and effective care.

People were encouraged or supported to make their own decisions about their food. We saw there was a weekly menu which gave people choice. People who did not like the choice on the menu could ask for an alternative. The feedback from people was positive about the choice and quality of the food provided. People were cared for by very kind and caring staff. Staff demonstrated they knew people well. One person told us, "They are kind, so very kind." Another said, "Just wonderful, everything I could want is here." Everyone we spoke with told us they felt staff treated them with respect and dignity and that they could have privacy whenever they needed it.

One person who told us that they were involved in reviewing the care and treatment they received. They told us, "The nurse asks me about how I feel and if I am happy with the care." The staff we spoke with said, "We always ask people for their input, thoughts and agreement." The service clearly involved people in designing their own care.

Care plans showed us that people had access to other health care professionals as and when required. Staff followed guidance from health professionals. However for one person who had declined to follow professional advice there was little documented about the risks of ignoring the advice. There was also no evidence of communication with the health professional that informed them their advice was not being followed. This was an area identified as requiring improvement.

There was an activity co-ordinator and an assistant co-ordinator who visited people individually. Events such as 'bowls' always took place each week, with an afternoon cream tea, weather permitting. From our observation and feedback, individualised activities was an area that needed improvement. People told us that some of the group activities were not to their taste and therefore did not attend them. Only two people attended the art session on the day of the inspection. No other activity was offered and people retired to their room. There was little documented about people's personal preferences for life choices and how staff could support them to achieve them. This was an area identified as requiring improvement.

People were given information on how to make a complaint on admission to the home. We also saw the

Summary of findings

complaint procedure displayed on notice boards in the corridors. The manager told us that there had been one complaint received in the last 12 months which had been fully investigated.

There was a central code of 'care' which staff had contributed ideas to. This included to maintaining people's self-respect and dignity, treat people how they'd like to be treated themselves, show compassion and treat people all in the same way.

The people told us that the registered manager was approachable and supportive. One person we spoke with told us, "If I had any concerns I would go straight to the manager." Another told us, "I go to the office or speak to a sister."

Staff carried out regular audits of the service which included a monthly provider's visit. The monthly providers visit is part of the quality assurance system used by the service. This showed us that the provider checked that the service provided the care and treatment in an appropriate and safe way and that where necessary, improvements were made.

The service held an accident and incident log which recorded details of the incident, together with the outcome and action taken.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe and knew who to speak to if they had concerns. People were cared for in a safe environment.

Staff knew how to recognise and respond to abuse in accordance with the local safeguarding authority guidance. All staff had received recent safeguarding training which included training in the MCA and deprivation of liberty safeguards (DoLS). At this time there was no one that required a DoLS, but staff had an understanding of the protocols should the need arise. We discussed scenarios with staff who were assured and confident in their replies.

Risk assessments such as nutrition, moving and handling and skin integrity were reviewed monthly. Risk assessments recorded the current measures required to keep people safe and reduce the risk of harm.

The provider had a plan in place to deal with foreseeable emergencies. This reduced the risk of people's care being adversely affected in the event of an emergency such as flooding or a fire.

Registered nurses had provided evidence of their qualification and updated their registration yearly.

Is the service effective?

Good

The service was effective. Staff had a good understanding of peoples care and support needs. Verbal and written communication systems were well established with information on people's needs, preferences and risks to their care held within the care documentation.

People received appropriate support from healthcare professionals when required. This included referrals to other professionals such as GPs, speech and language therapists (SALT) and the tissue viability nurse.

Nursing staff reviewed people's health assessments regularly and if a person's health deteriorated or a health complication arose. Staff responded appropriately and quickly to seek expert health professionals advice. This meant that people had access to health care professionals when they needed it. Staff had received training and supervision and staff were encouraged and supported to progress professionally.

Is the service caring?

Good

The service was caring. People and their relatives were positive about the care provided by staff. We saw that people were treated in a kind, caring and respectful way. People felt that staff showed concern for their wellbeing in a caring and meaningful way and respond to their needs at the time they need it.

Summary of findings

People were encouraged to maintain and develop their independence. For example, people made decisions about their day to day lives with support from staff when they needed it. Staff knew people well and they were thoughtful, kind and attentive.

People were encouraged to maintain and develop their independence. For example, people made decisions about their day to day lives with support from staff when they needed it. People told us they felt their privacy and dignity was respected. We saw people assisted by staff with moving, eating and drinking in a way that ensured their dignity and, privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's individual needs.

Care plans were not all personalised and did not reflect people's individual specific needs. This meant that new staff would not know how people wanted to be supported.

We saw that advice had been sought from the speech and language therapist (SALT) A report was seen with in the care plan from the SALT but it was not being followed. This was no detail in the care plan that explained why it had not been followed and what actions they were taking to ensure this persons safety and welfare.

People were made aware of the activities available to them. Staff told us that people's individual social needs were not easy to meet especially in the afternoons and evenings due to lower staffing levels. They said it is an area that they could improve. We saw that people in their bedrooms had little interaction or input from staff. Hobbies and enjoyed past-times had not been identified within their care delivery as an identified need. People were made aware of how to make a complaint or give feedback.

Is the service well-led?

Good

The service was well-led.There was a registered manager in place who was aware of the day to day culture of the service. This meant they were able to monitor the service effectively.

There was a central code of 'care' which staff had contributed ideas to. This included to maintain people's self-respect and dignity, treat people how they'd like to be treated themselves, show compassion and treat people all in the same way.

The provider had systems in place to monitor the quality of the service and facilities. The service held monthly residents meeting in which people could attend if they wished to. This gave people the opportunity to be involved in the running of their home.

Summary of findings

Satisfaction surveys were undertaken to encourage people to give their feedback or make suggestions on how to improve the service. We saw that the surveys were analysed and shared with people along with actions the home would take

Incident and accidents were recorded but were analysed for any emerging trends, themes or patterns. This showed us that the home had systems in place to identify and manage incidents effectively.

Holy Cross Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 14 July 2014. We spoke with 48 people who used the service and seven visitors, ten care staff and the registered manager. We also spoke with five people who lived independently in the flats in the grounds of Holy Cross Nursing Home who had access to the communal areas and facilities of the service. We observed the care and support given by staff in the communal areas and looked around the home, which included visiting people in their bedrooms, the dining area, the grounds, lounge and reception area. Everyone we spoke with were able to share their experiences verbally with us.

Before the inspection the 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. Before our inspection, we reviewed the information included in the PIR along with information we held about the home. This included notifications of events that have affected the service, and deaths. We contacted the commissioners (social services) of the service and two healthcare professionals from the local GP surgery to obtain their views about the care provided.

The inspection team consisted of two adult social care inspectors and an expert by experience (Ex by Ex). An Ex by Ex is a person who has personal experience of using or caring for someone who uses this type of care service.

Over the course of the day we reviewed ten care plans and the quality assurance audits and documentation. We also looked at the policies together with general information available for people such as safeguarding, infection control and medication administration policies.

At the last inspection in September 2013 we had not identified any concerns with the service.

Good

Is the service safe?

Our findings

Everyone told us they felt safe at Holy Cross. One person told us, "Very safe, there's always someone looking after us." Another person told us, "I like to be left alone as much as possible and do things for myself and I know I can do this safely here." One other person told us, "I chose to come here because I needed someone to look after me, but still wanted to be able live. I get that here, I'm safe but still have my freedom." We spoke with one person who lived independently in a flat. They told us, "Very safe and comfortable, I can leave the building and have independence but come home and know I'm safe from worry and stress."

The security of the home had been designed to promote safety for people whilst also continuing to encourage and support independence. There was a reception area that was open 24 hours and an intercom system to each floor of the home. Key pads to the separate floors were in place. This had been installed as to protect people's privacy and to keep them safe from people wandering in by mistake. There were self-contained flats on the top floor and these people had visitors and deliveries. People told us, "I can remember the code, took me a while but there is always someone around to help." Another said, "I feel safe here, no one can just wander in unless they know the code and that is good, I would lock my front door at home and here is no different." We asked staff about how they ensured that people understood the key code pad and were able to use it appropriately. We were told, "We accompany people until they are comfortable with using it, and if someone prefers to ask us to help, we do." Throughout our inspection we saw that people both left and entered their floor when they wanted to and without assistance. We observed how people reacted to the keypad, we did not see anyone react as if they were restricted from leaving. One person told us, "I find it reassuring, it was explained to me before I moved here about the keypad, and if I thought it was a problem I would not have moved in."

People were assisted with appropriate mobility aids to move around the home both inside and out and individual moving and handling risk assessments were in place and reviewed regularly. We saw a training plan that identified that staff had had regular moving and handling training that enabled staff to move people safely.

The provider was able to help protect people from harm as they had systems in place to identify risk. Each person's care plan had a number of risk assessments completed. The assessments detailed what the activity was and the associated risk. For example, these related to mobility, accessing the community, risk of choking, nutrition and individual specific health needs (incontinence and wounds). We saw that assessments were up to date and were reviewed regularly which meant staff worked to the most up to date information about a person.

Staff told us they received regular fire training and fire emergency evacuation training. There was firefighting equipment placed around the home that had been recently checked and ready for use. We saw that the fire emergency evacuation procedure was displayed throughout the home. Arrangements were in place to respond to emergencies and included the moving of people to nearby homes as a place of safety on a temporary basis. Two people who told us that they knew what to do if a fire was identified, and said, "Staff have explained the procedure to us." There was an emergency on call rota of senior staff and staff told us that they were always available for help and support. This showed us that the provider had plans in place to deal with any emergency.

Staff had received training in safeguarding adults at risk. It was clear that staff understood their responsibilities to keep people safe from abuse. They had a good understanding of the types of abuse and who they would report any suspicions or concerns to. The safeguarding adult policy and safeguarding flow chart available for staff supported them to follow the protocols set by the local authority who lead on all safeguarding concerns. Flow charts show staff who to contact initially and where to take their concern. Staff told us that they would immediately inform the manager or senior nurse and call the local authority safeguarding team. Another staff member said, "I would not hesitate to raise a safeguarding if I felt someone was at risk."

People were allowed to come and go as they pleased in the home and no one was subject to any restriction on their movement. Staff had access to a training DVD and policies on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs). We saw that staff had signed to say they had read the policies. We were told by the registered manager that they did not have anyone who had a primary

Good

Is the service safe?

diagnosis of dementia. They said that if people's mental health deteriorated they would seek advice and manage the changes within the care plan and undertake a mental capacity assessment. Staff were able to tell us of triggers they had used for certain people, for example, forgetting what they had just asked the staff and not retaining the answer staff had given. Staff told us that subtle changes in people's behaviour were documented and discussed at handovers and that led them to undertake a cognitive assessment. They also told us that people's capacity could change overnight if they had an infection and so the assessments for assessing people's capacity could be done daily to ensure peoples safety. We saw that evidence of monitoring of people's capacity was clear and staff recorded the actions taken. For example short term care plan for urine infection with reference to slight confusion and a note to encourage fluids.

We asked how the provider managed its staffing levels to make sure people were kept safe. The registered manager explained how they assessed people's dependency on a daily basis and if a person was distressed or nearing end of life, additional staff would be brought in to meet their individual needs. We talked to both staff and the people about staffing levels. Staff felt that the staffing levels were sufficient at all times to deliver a good standard of care. One staff member said, "We know who is frail and needs more supervision and we prioritise." Another staff member said, "We would request more staff if we felt it was unsafe." A regular visitor said, "I see plenty of staff and have never had any concerns about my relative's safety." Another visitor said, "very good here, I never worry or feel concerned, I am impressed with their dedication." One person said, "I feel very safe and happy here, everyone is marvellous." Another person said, "Sometimes, very rarely we may have to wait but it's usually because someone needs something more urgently." We saw during our inspection that there were enough staff to supervise people and to meet their care needs.

We looked at accidents and incidents records and audits. There had been very few accidents and incidents in the past six months. The audit and monitoring processes in place showed that there were no trends or repeated accidents. This meant that showed that there were sufficient staff to keep people safe.

People were cared for by staff who had been recruited through safe procedures. Each member of staff had undergone a criminal records check before starting work, this also included any volunteers. We also saw evidence that all nurses had a personal identification number (PIN) demonstrating they were qualified and safe to work as registered nurses. The provider ensured as far possible that they only employed staff who were suitable to work with vulnerable adults.

Good

Is the service effective?

Our findings

We asked people if they felt their needs, preferences and choices for care and support were met by the staff at Holy Cross Nursing Home. One person told us, "We have a lovely life here, we choose how we live, obviously we fit in with certain constraints such as meal times, but that is good as it gives me structure to my day." Another person said, "I can choose to eat at another time, there's no restrictions, we can change our plans any time."

People were involved in making their own decisions about the food that they ate. We saw that there was a well-balanced and nutritious range of food offered. Menus were available on notice boards in communal corridors but not in dining areas. Not everybody we spoke with could remember seeing a menu, but told us they were offered always offered a choice. We confirmed that they were offered a choice by observation of the midday meal. One person told us, "Can't remember what I'm having today but I'm sure it will be nice." Another said, "It will be a surprise." Fresh fruit and salad was available to people and there was water and juice available in all communal areas. There was also a drinks machine which people could use in the reception area with a selection of cakes. We were told tea and coffee making facilities were available on each floor in a kitchenette for people and visitors to access. The atmosphere in the dining rooms during meals was relaxed and friendly and people were sitting chatting to each other. During lunch time we saw people sitting in groups, chatting, and being able to eat at their own pace.

People were offered a choice to meet their personal wishes on where they ate their meals. Some people chose to eat their meals in their rooms which they confirmed was their choice. One person told us, "I like to eat in private as I'm not used to eating with other people." Another person said, "Yes, I like my own company." The meals were nicely presented from a hot trolley and it was clear from the conversations in the room that people enjoyed them. People that required soft or pureed food had the same choices as those that had a normal diet. One person told us, "The food is fabulous, always hot and tasty." Another said, "I usually have a nice salad as I'm not a lover of big dinners."

Some individuals had specific dietary requirements either related to their health needs or their preference and were detailed in their care plans. These were followed by the kitchen staff who had lists of people's dietary needs, allergies and preferences.

People had an initial needs assessment when first admitted. The care plans were well recorded and contained clear instructions as to the care needs of the individual. They included information about the needs of each person relating to their communication, nutrition, and mobility.

Individual risk assessments including falls, bedrails, mobility and manual handling had been completed. We saw that each care plan also contained a summary of potential areas where people would require support. There with clear instructions for staff on how to provide support tailored and specific to the needs of each person. This meant that the processes in place to meet people's needs were effective.

Where appropriate, specialist advice and support had been sought in relation to meeting people's health needs and this advice was included in care plans. We saw advice from speech and language therapists, dieticians, and tissue viability nurses. Staff said they valued input from external health specialists and enjoyed learning from them. One staff member said, "We can share learning from the specialists among the team, it then improves the care we give.

People identified at risk of developing pressure ulcers had air mattresses in place to minimise the risk of pressure sores occurring. We saw that staff checked the settings regularly to ensure that they were maintained in line with people's assessed needs. People's weights were monitored regularly and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. Staff described how they had been concerned over a person's leg ulcers and had sought advice from the GP and tissue viability nurse. Staff told us how they would react if someone's health or support needs changed. They told us that they had good relationships with the GP surgeries and would not hesitate to seek advice and support if they had concerns. We spoke with two health professionals who had visited the home when staff had requested advice. They told us that the staff had been proactive when seeking advice and were open to advice

Good

Is the service effective?

and instruction. For example, where dressings had been applied, they looked fresh, competently applied, and people reported good and frequent wound care, "Excellent treatment, they have managed to clear up my leg."

Staff told us that they checked the care plans regularly to update themselves with any changes to each person's care. We saw that each person had regular reviews of their care plan, with assessments updated as necessary. Staff told us that they used shift handovers and a communications book to share any changes in people's care, and we saw a communications book where staff had highlighted or referenced any changes to each person's care plan. This meant that staff had the most appropriate and up to date care directives for the person.

Staff said that they received regular appraisal and supervision. Staff had undergone recent appraisals with staff who had yet to be appraised had dates booked in. Staff had received regular group supervision and had set up individual supervision dates now there was a deputy manager in post. We were told that group supervision had been undertaken and proved successful. One staff member said, "It's ideal to share experiences and get other staff views and opinions. Staff told us they were encouraged to progress professionally and it was their choice whether or not they undertook additional training. One member of staff told us, "I get all the training I need." A newer member of staff told us, "I have been told that I can attend any training that is specific to my role." The staff had received a range of training which included, moving and handling, safeguarding, infection control, fire, and food hygiene. We saw evidence of further specific training for staff, for example, wound care, nutrition and continence. The manager informed us that health led training took place such as diabetes and if they had a person admitted with a specific illness that staff were not familiar with training would be put in to place, for example syringe drivers and end of life care.

Good

Is the service caring?

Our findings

We spoke to people about how they found living at Holy Cross Nursing Home. People told us, “Lovely place and people”; “Well set up place”; “If you want a cup of coffee or tea at night, it’s never any trouble”; “It’s lovely here; the food and drink are good”; fellow-residents and staff are a nice crowd,” and “Staff here know my ways.” A visitor said, “I have never had a moments worry, they give so much to X, they care, simple as that.” Another said, “Excellent, everyone is well cared for, well dressed and seem happy here.”

Staff positively interacted with people and offered care in a kind and compassionate manner. We saw one staff member approach a person who was upset, quietly offering sympathetic support and assistance. We saw staff show compassion and genuine affection at the mid-day meal service, supporting those that required helped, people were given time to enjoy the meal and were not rushed.

People told us that resident meetings were held monthly and were beneficial in making improvements to life in the home. People told us they felt listened to and supported by staff and that they felt cared for. One person told us, “They listened to me when I suggested having a painting class, now they are a regular thing.” Another said, “Nothing is too much trouble, we suggest something that would makes us happier and they do their upmost to make sure we get it, couldn’t be in a nicer place. They really care.” A relative said, “The management immediately responded to our concern of bright lights and they changed the bulbs immediately.”

Holy Cross Nursing Home was a clean, spacious environment which allowed people to move around freely without risk of harm. There were handrails in corridors that promoted peoples independence to move safely and non-slip flooring for those that used mobility aids. The building had two lifts, one to allow people access to the upper floors and a service lift. The grounds were well maintained with clear pathways for those who used mobility aids and wheelchairs. We saw records and certificates that demonstrated that the home was subject to regular safety checks and maintenance. This included environmental risk assessments. The home had been designed with insight and care to ensure it was welcoming and homely and met the needs of all the people who lived, worked and visited the home.

Staff showed respect to people, they knocked on people’s doors before entering and greeted people respectively, using their name including their professional title, such as Father or Sister.

Staff members were able to give examples of how they treated people with respect and dignity. One said it was about, “Patience and understanding” and that it was, “Important to listen, letting people make a choice and support them in what to do.” Another staff member said, “A lot of the residents have come to us from a religious order and we have staff here who are nuns, they are very gentle and serene, it’s lovely.” One person told us, “I am very happy here, they are angels to care for us so well, kind, considerate and treat us with respect.” Another said, “I am so lucky to live here, best place in the country.” We observed that staff provided care and support in a professional and discreet way. For example, when helping people to the bathroom before lunch staff were conscious not to cause any embarrassment. We saw that when any personal care was provided bedroom doors were always closed. People who were in bed or sitting in their rooms were appropriately dressed and covered.

The manager told us that the people had been involved in developing their care plan. Although some people could not recall being involved in their care plan, a relative we spoke with confirmed that they were very much involved in their relatives care. Staff explained how people were involved in their own care, “Through talking to them, asking and double checking what step you are going to take, gaining their consent all the time.” Care plans were up to date and we saw evidence that they were reviewed regularly. Staff explained that care plans were developed through reports from care workers and their (staff) continuous assessment. Any changes were reassessed by the nurse in charge and the care staff members own observations.

Visitors told us, “We feel welcome, we are greeted at the reception desk and offered coffee. Staff always come and tells us how X has been, really a caring place to be.” We were told that there were no restrictions to visiting and so they could fit it in with work and other family commitments.

Requires Improvement

Is the service responsive?

Our findings

During our discussions with staff we found that they knew people and their individual needs well. We noted that one person wished to sit in a certain room looking out at the gardens, the staff checked this person regularly and ensured that they were comfortable and moved their chair at certain intervals so the view was changed. Another person told us, "They know me so well, they make sure that the little things I enjoy are achievable." Staff told us that they enjoyed learning about people's likes and dislikes, as "I can then make sure they are happy." However the care plans contained limited evidence of the personal preferences, likes and dislikes that staff knew about people. For example, one person had a special cushion that they had on their lap and staff ensured that this was always with them, however this was not documented anywhere for new staff to know. Another example a staff member gave was that X liked to wear certain shoes and have their shower/ wash at a certain time, this was not documented for new staff to know and therefore had not ensured continuity of care.

We looked at daily records and found they were written in a task orientated way with no mention of people's mental and social health. For example, were they happy and content, lonely or sad or feeling tired and unwell. Staff told us that they knew people well and would tell the RGN of any changes to their mental health, "It's something we would discuss on handover." Due to the stable work force and low staff turnover this did not at this time impact negatively on the people. However we identified this as an area for improvement as there may be new staff employed who did not have that knowledge of people. Staff told us that the activity co-ordinator was in the process of putting together a social background and plan for each person in the home.

One person had been referred to the speech and language team (SALT) as there had been concerns about their difficulty swallowing in January 2013. The report from the SALT with specific guidance for that person in March 2013 stated that the person required a soft moist diet and thickened fluids under close supervision. The care plan for nutrition had been put in place in March 2013 and stated normal diet and fluids. We could not find any explanation written or evidence of further discussion with SALT as to the rationale of not following the specialist advice. We saw that this person received a normal diet and fluids unsupervised. We spoke to staff for clarification and a care worker told us "Yes X does have thickened fluids, the thickener is in their bedroom." We spoke with a senior nurse who told us, "X made a choice to have a normal diet and does not like thickened fluids, it was their informed choice." The deputy manager agreed that this rationale and the person's personal wishes should have been referenced in the care plan. We did not see any further evidence that this had been discussed with SALT and there was no documentation in the person's care plan of these factors or of the person individual preference for normal diet and fluids. This meant that we could not evidence that the person was aware of the risk of not taking the specialist advice.

We talked to people and staff about whether Staff said they felt they did not have enough time to give people "Quality time." Comments from staff included, "We get the tasks done, but don't always get the chance to chat and initiate conversations," and "It's generally very quiet after lunch because people go to their rooms to rest and then stay there." We asked staff how they met people's social needs and prevented people from becoming lonely and isolated. They told us that this was not always easy especially in the afternoons and evenings due to lower staffing levels and said it is something that they could improve. One staff member said, "It would be really good to get people to stay in the lounges but we don't always have time to organise anything." One person said, "I have brought it to the manager's attention that we need more stimulation and am hopeful that things will be introduced." Another person said, "I think some afternoon events would be good, and more trips out." The activity co-ordinator said, "We have had two trips out which were enjoyed, but there are plans to do more trips during the summer and I do think we could provide more one to one time with people in their rooms."

We observed staff checking on people who were confined in bed regularly, to ensure they had enough to drink and to see if they needed any support. Most people said that staff were quick to respond to calls for help and support. During our inspection we observed staff responding to call bells in a timely manner during the morning, but noted lapses late afternoon when people had retired to their room. We were told this was because people wanted to be settled and got ready for bed. One person told us, "No complaints, very quick to help, we have to wait after lunch because so many

Requires Improvement

Is the service responsive?

of us want to go back to our room." They added that in the morning sometimes things "Can be a little late, when everyone wants everything at the same time." We spoke with people about the care at night and were told, "They check to make sure we are okay and the staff will always help you." We looked to see if anyone had raised a complaint or grumble about call bell responses and found none recorded.

We looked at the social activities that were available for people. The activities co-ordinator told us they had started to build up activities to suit everybody, "We aren't quite there yet but we are getting there." We saw an art class in a communal area that was held regularly as there were people who enjoyed painting and experimenting with different techniques. This however was only attended by two people. They told us that people enjoyed bowls and attending afternoon tea events, and saw these occurred weekly, weather permitting. The resident meetings had identified a need for more afternoon and weekend activities and we were told this was being explored. Whilst group activities were held, there was a lack of people being involved in activities linked to their personal preferences and hobbies. For example, one person said she would love to learn how to use a computer. We saw a personal computer in the hobby area which according to the manager was 'hardly used.' Another said she was sorry not to be able to cook any more. Someone else was cultivating some pot-plants, including an orchid, and said they would enjoy a trip to the garden centre for some orchid compost. Photographs of a recent event were being uploaded on to the communal computer and left showing alternating pictures for people to enjoy. The computer was not used often by people but the facility was available if someone should choose to use it, but this had not been actively advertised or supported. Holy Cross Nursing Home did not facilitate person specific activities for everyone.

People were encouraged to make their room their own with items and personal effects. One person told us, that they had put extra hooks on the walls for their photographs, which meant everything to them. One care staff member told us, "X had asked for more pictures on the walls and a cooked breakfast and this had been responded to."

People maintained relationships with friends and relatives and on the day of our visit we met one person who had just returned from meeting a friend. To assist people in maintaining their own independence there was a shop that sold items of toiletries and stationary in the reception area along with a hair dressing salon.

Peoples' cultural and support needs were met by the premises and equipment supplied. For example, the building contained a chapel where services were held each day. People were involved in leading these services. People told us, "It was something I looked for before moving in, the church has been a big part of my life and I didn't want to lose that, "I regularly use the chapel on my own, it brings me comfort," and "I was in a closed order before coming here, it's important for me to have this retreat."

Everyone that we spoke with told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and would know how to make a complaint. One person said, "Yes, to the manager or a sister." The relative that we spoke with told us, "You can say anything to anyone of the staff, it feels comfortable. If I had any problems I would go straight to the manager."

We asked staff what they would do if someone wished to make a complaint. Staff told us they would advise people to contact the nurse in charge for any minor complaints and if they could not help them, then they could speak to the manager or a senior nurse. We saw that complaints were evaluated by the management team and where necessary an action plan put in place. As there had only been one formal complaint made, we looked at the processes in place that ensured that complaints were taken seriously, responded to appropriately and investigated. The complaint procedure was clear and written in plain English. It had time scales for the complainant to be responded to and told the complainant who to approach if they were not satisfied with the provider's response and actions. The complaint procedure was accessible to everyone who lived and visited Holy Cross Nursing Home. We saw the complaint procedure and policy had been reviewed regularly.

Good

Is the service well-led?

Our findings

People knew the manager by name and said she was a 'lovely lass," and "The manager knows her stuff." Staff told us, "The manager is supportive and knowledgeable." Another staff member said, "Really good team, everyone works together, I respect the manager because she is fair, approachable and available." The provider had recently appointed a deputy manager to strengthen the management structure within the home.

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a trained nurse on duty who took a lead role in ensuring people's clinical needs were met. There was also a senior care worker on duty who was responsible for ensuring other care staff knew what their role for each shift was. Staff felt supported in their work and enjoyed working at the home. One staff member said, "I love my job, the residents are lovely and the other staff are team workers, we all help each other and support each other." Another staff member said, "I enjoy working here, it's got standards of care to adhere to and we give quality care, the manager is approachable and knows everyone in the home, a really good manager."

There was a central code of 'care' which staff had contributed ideas to. This included to maintain people's self-respect and dignity, treat people how they'd like to be treated themselves, show compassion and treat people all in the same way. The manager told us they used Skills for Care common induction standards (CIS) to develop the skills, knowledge and values of their care staff. CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. This was a clear set of vision and values which we saw were promoted by all staff. It also meant the provider worked in partnership with other organisations to provide an environment that works hard to improve and excel.

We were told by staff, people and visiting health professionals that there was on open culture at the home with clear lines of communication. One health professional said, "They are open to advice and willing to learn and work with us." Staff we spoke to had a good understanding of the whistleblowing policy and that they could contact senior managers or outside agencies if they had any concerns but they felt that the culture in the home allowed them to discuss concerns or issues with the management team.

Staff meetings were held regularly. Staff told us these were opportunity to discuss any issues relating to individuals as well as general working practices and training requirements. We saw minutes for the previous two staff meetings which verified this. Minutes were kept and shared with staff who had not been able to attend.

We saw that the manager had a quality assurance system in place which included monthly checks on medication administration records, care plans, laundry, and environmental checks on cleanliness, safety and maintenance and security arrangements. We saw that if a shortfall had been identified, an action was put in place with a time scale. Each month the director of services did a visit, which formed part of their quality assurance system, which included speaking with people, staff and reviewing information provided to them by the manager in relation to health and safety checks, care plan audits and room checks. Where actions were required, a plan was put in place. For example trained nurses now have a seven hour shift once a month to do their care plan reviews as it had been identified on the audit visit that care plans had not all been reviewed. This showed us the provider had systems in place to regularly review the safety and quality of the service provided. It also showed that any actions identified were acted on.

Residents meetings were held monthly which were chaired by the manager. We saw the minutes of the last meeting which showed that they were well attended. Satisfaction surveys were sent out at various times throughout the year. All feedback was evaluated and responded to. We saw that people comments were taken forward and actioned. The results of surveys were displayed on notice boards along with the organisations actions. The manager also showed us the results of the most recent satisfaction survey. We saw that people were happy with the care that was provided, that included food and how they were supported. Compliments were kept and shared with staff by the manager.

Incident and accidents were recorded but were analysed for any emerging trends, themes or patterns. This showed us that the home had systems in place to identify and manage incidents effectively.

Good

Is the service well-led?

The service had a business continuity policy in place. This made sure that the service had a plan in place to deal with foreseeable emergencies. This reduced the risk of people's care being adversely affected in the event of an emergency such as flooding or a fire.