Pegmar Limited

St Annes Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 February 2016 and was unannounced. The home provides accommodation for up to 58 older people with nursing care needs. There were 37 people living at the home when we visited. All areas of the home were accessible via lifts and there were two lounges, dining room and accessible outdoor space. All bedrooms were for used for single occupancy and had en-suite facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous comprehensive inspections in January 2015, we identified that improvements were required to ensure people's legal rights were protected and mental capacity legislation was complied with. We made a compliance action telling the provider they must make improvements. We received an action plan from the provider stating what they would do to meet the legal requirements in relation to improving their service. At this inspection we found improvements had been made.

Staff followed legislation designed to protect people's rights and freedom to help make sure decisions were only taken in the best interests of people.

Although there where suitable arrangements were in place for managing medicines administered one nurse failed to fully follow safe administration procedures.

People felt safe at the home. Care staff knew how to prevent, identify and report abuse.

Safe recruitment procedures were in place although a full employment history had not been sought for two new staff. Staff were suitably trained and appropriately supported in their role.

People and relatives were positive about the service they received. They praised the staff and the care provided. People received personalised care from staff who understood their needs and they were supported to make choices although they had not acted to prevent a person inappropriately assisting another person with their meals. We observed occasions when staff failed to acknowledge people when they entered communal rooms. However at other times staff treated with respect.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. Individual risks to people were managed effectively. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People had access to healthcare services and were referred to doctors and specialists when needed. Reviews of care involving people or relatives (where people lacked capacity) were conducted regularly. Staff

recognised that people's needs varied from day to day and responded effectively. The provider had identified a need to increase activities staff and was recruiting to this post.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely. There was an environment maintenance and improvement program in progress.

Staff treated people with kindness and compassion and formed caring relationships with them and their relatives. Staff protected people's privacy, promoted their independence and involved them in planning the care and support they received. People were also positive about meals and the support they received to ensure they had a nutritious diet.

People liked living at the home and felt it was run well. There was a clear management structure in place. Staff understood their roles, were happy in their work and worked well as a team.

There was an open and transparent culture. The provider encouraged staff feedback and visitors were welcomed. Complaints, when received, were investigated and responded to. Quality assurance processes were in place to assess key aspects of the service. Where these had identified a need for improvement action had or was being taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was usually safe.

Procedures were in place to ensure medicines were managed safely but not all nursing staff followed the correct procedures for safe administration. Individual and environmental risks were managed appropriately.

There were enough staff to meet people's needs. The process used to recruit staff helped ensure staff were suitable for their role but had not ensured that full employment histories were known for all new staff.

People felt safe. Staff had completed safeguarding training and knew how to report abuse. All staff were aware of how to respond in an emergency situation.

Is the service effective?

Good

The service was effective.

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision and staff meetings.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs. They had access to healthcare services when needed.

Is the service caring?

Requires Improvement

The service was usually caring.

People were positive about the way staff treated them. However, independence and choice was not always promoted.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People (and their families where appropriate) were involved in assessing and planning the care and support they received.

People's privacy was protected and confidential information was kept securely.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

Staff were responsive to people's needs.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The management team were approachable. People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the registered manager and director with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

St Annes Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 the 15 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience in the care of older people.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the registered manager 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.

We spoke with 12 people living at the home and six family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with one of the provider company directors, registered manager, ten care and nursing staff, the administration staff member, one catering staff member and activities staff member. We also spoke with health and social care professionals who had regular involvement with the home. We looked at care plans and associated records for seven people, staff duty records, staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records. We observed a staff handover meeting and care and support being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

The recruitment process did not always ensure that all necessary pre-employment checks were completed to check potential staff were suitable to work with vulnerable people. Although all of the recruitment files we looked at contained information in respect of references, police checks and identification, two of the six files did not have a full past employment history for the members of staff. One new member of care staff's employment history showed they had finished one employment on 19 April 2015 and commenced their next employment on 1 September 2015, a gap of four months. In addition, the application form did not contain any employment history prior to 2010, even though they would have been eligible to work for at least 30 years prior to that date. The employment history detailed in the application form for a second member of care staff, who had started with the service in 2016, listed two previous jobs, which did not have information regarding their start or leaving dates. There was no information recorded in either of the relevant recruit files which provided an explanation for the reasons for the gaps or lack of information. The lack of a full employment history meant that the provider was not able to assure themselves that the staff they employed were of good character and suitable to work with the people they supported. We raised this with the registered manager who told us they were aware of the requirement for a full employment history but could not explain why this had not happened or the reasons for the gaps. They told us they would ensure these records were completed correctly and put in place a new audit process to ensure recruit files were completed correctly and up to date. Newly recruited care staff told us they felt the recruitment process had been thorough and fair. They confirmed they had completed an application form and attended an interview as well as undertaking a police background check.

People did not always receive their medicines in a manner that was safe and hygienic. We observed a nurse administering medicines touching tablets with their fingers instead of placing them from the pack directly into the pot without handling them. They stated this was to ensure tablets did not fall onto the floor. However, medicines should not be handled by staff during administration. The other nurse observed administering medicines was seen to do so in a safe way.

Medicines were administered by qualified nurses who told us they had received medicines update training within the previous year. Nurses were aware of how and when to administer medicines to be given on an 'as required' (PRN) basis for pain or to relieve anxiety or agitation. Where people had been prescribed PRN medicines, they had a PRN plan which explained when the medicine should be given. Where people were not able to state they were in pain, a recognised pain assessment tool was in use. A person told us "they [the staff] would bring me something [if I had a headache]".Prior to administering of as required medicines the nurse was seen to check records to ensure this was given when required. We observed nurses administering medicines; they explained what the medicines were for and did not hurry people. There were suitable systems in place to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people. Care staff were aware of which routine topical creams should be applied for each person and topical cream application records confirmed these were correctly applied.

All medicines were stored securely and appropriate arrangements were in place for obtaining, recording and disposing of prescribed medicines. A comprehensive medicines audit program was in place which focused

on medicine management, medicines requiring addition legislative governance and homely remedies. The latest series of these audits were completed in February 2016.

Without exception, everyone we spoke with said they felt safe at St Annes Nursing Home. One person said, "Oh yes quite safe, no problems here". Another person said "I feel safe here". Relatives and visitors also reported that they felt the service was safe. One said "Absolutely" when we asked if they felt their relative was safe. Visiting health professionals said they had no concerns about people's safety.

Staff had received training in safeguarding adults, knew how to identify and report abuse and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member said, "If I had any concerns I would tell [name registered manager]". Another member of staff told us "If I had a concern I would go to the nurse, then the manager. If they didn't do something I would go somewhere else, like CQC or safeguarding". A new staff member said "I had safeguarding as part of my induction, I would tell the manager". Members of the administration team and kitchen staff also confirmed they had received safeguarding training and correctly explained the action they would take if they had any concerns. All staff were aware of who they could contact outside the organisation if the registered manager failed to take the necessary action.

There were appropriate policies in place to provide guidance on how to protect people from abuse. The registered manager and provider followed local safeguarding processes and responded appropriately to any allegation of abuse. Staff recorded when they identified injuries or bruising on people and what action was taken as a result. This helped keep people safe by identify any changes to the care provided, which may be necessary to reduce the risk of any recurrence.

There were sufficient staff to meet people's needs. Although busy, we observed that staff responded to people's needs promptly. Staff were allocated to different parts of the home, meaning they were usually close by people when they required assistance. Systems were in place to enable staff to be informed promptly when people required them. We saw people had call bells to hand when in their bedrooms. Staff stated they felt they usually had sufficient time to meet people's needs. One said "Most days its fine, although I would like more time to spend with people who stay in their rooms".

The provider told us that staffing levels were based on the needs of people using the service. They explained they had assessed staffing in line with guidance from the regulation and quality improvement authority, who are Northern Ireland's independent health and social care regulator. There was a duty roster system, which detailed the planned cover for the service, with short term absences being managed through the use of overtime or agency staff. The registered manager, a qualified nurse, was also available to provide support when required.

Risks were managed safely and supported people to be as independent as possible. Where risks were identified action was taken to reduce the risk. For example, people who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, according to the person's weight and in line with the manufacturer's instructions. Where people needed to be assisted to change position to reduce the risk of pressure injury, their care records confirmed this was done regularly. Moving and handling assessments clearly set out the way to support each person to mobilise and correlated to other information in the person's care plan. For example, one person had a left sided weakness following a stroke. Their care plan detailed the approach staff should use to protect the person's left side during repositioning and when using moving equipment. Staff described this approach when talking about the care they provided for this person. Staff had been

trained to support people to move safely and we observed equipment, such as hoists and standing aids being used in accordance with best practice guidance. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, use of bed rails, nutrition, moving and handling, and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. Care records and risk assessments were updated when people had been the subject of a fall or other incident. These procedures helped ensure people were safe from avoidable harm.

Environmental risks were assessed and managed appropriately. Records showed essential checks on the environment such as gas, electricity, lifts and equipment such as hoists were regularly serviced and safe for use. Reviews were completed annually and in line with best practice and the manufacturer's guidelines. The registered manager had identified risks relating to the environment, such as, fire, use of the lift, slips and trips on stairways, the use of electrical appliances and health and safety in the home. A system was also in place to capture details of all accidents and incidents in the home, so any patterns could be identified and action taken to reduce the level of risk. Where an incident or accident had occurred, there was a clear record of this and an analysis of how the event had occurred and what action could be taken to prevent a recurrence.

There were arrangements in place to deal with foreseeable emergencies. There was a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm was activated. Staff had completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and fighting equipment was regularly checked. Staff were also aware of how to respond to other emergencies. Care and nursing staff described how they would respond to a medical emergency and were aware of the correct action they should take.

Good

Is the service effective?

Our findings

Following the inspection in January 2015 we found improvements were needed to ensure people's legal rights to make decisions were upheld and the Mental Capacity Act 2005 was fully implemented. We made a compliance action and an action plan was received telling us how improvements would be made. At this inspection we found improvements had been made and systems were in place to ensure people's legal rights were ensured and the Mental Capacity Act 2005 was fully complied with.

Where people could consent and agree to care this was sought prior to care being provided. One person said "The staff let me stay in bed". Another person said they could choose when to receive care. They told us "I choose 8 o'clock when the night staff come on, but if I wasn't feeling well they [day staff] put me to bed." One relative said "Normally the night team get [person's name] up, that's their choice, and [person's name] doesn't like to lie in". Before providing care, we observed staff sought consent from people using simple questions and gave them time to respond. One staff member said "If a person has dementia I have to help them to an informed decision, like showing them two tops so they can pick which one they wanted". We observed staff providing people with choices throughout the inspection. Staff respected people's choices. For example, when a person did not want to take their medicines at the time they were to be administered, the nurse was seen to return later to administer these.

Some people living at the home had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relieving mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what is in the person's 'best interests'. They added they would complete any relevant risk assessments to determine that the proposed action was the most appropriate and least restrictive option.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Decision specific mental capacity assessments and, where necessary, best interest risk assessments were seen in care files in respect of care people required such as medicines, bed rails and pressure relieving mattresses.

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 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. We found the provider was following the necessary requirements. DoLS applications had been made with the relevant local authority where necessary. There was a system in place to identify when approved DoLS applications required renewal, any conditions which were included in approval and whether there had

been any changes in the person's assessment. No additional conditions had been added to any of the approved DoLS however the system in use would ensure these were known and met.

People's general health was monitored and they were referred to doctors when required. One person said "My doctor comes when I need him, the staff organise it for me". Another person said "We show the nurse if we are worried and if they think it is bad they get the doctor to come and see us ". A third person said "Often the staff notice I need to [see a doctor] before I do and they get the doctor". The nurses checked people's blood pressure monthly or as required. Where people had specific health needs such as diabetes this was managed safely. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments.

Wound care was managed effectively. We saw nurses used the correct procedures to assess and manage wounds. Where necessary contact was made with external tissue viability nurses who had visited the home to provide advice and guidance on specific wound care concerns. An external health professional told us they were consulted appropriately and staff followed their recommendations. People were supported to access other healthcare services when needed. People were seen regularly by doctors, dentists, opticians and chiropodists as required.

People received the support they required to meet their nutritional needs. One visitor said "[person's name] has a soft diet, but they always eat it. The staff help [person's name] with meals". Discussions with staff showed they were aware of the specific needs of individual people. For example, a staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Staff were also able to describe how they reduced the risk to the person from choking such as ensuring they were in the correct upright position when receiving food or drinks. Where necessary and as identified in nutritional care plans and prescribed by medical practioners, people were receiving supplement drinks or fortified soups.

Most people told us they liked the food and were able to make choices about what they ate. One person said, "The food is very good, I get food and drinks offered all the time, it is sometimes too much". Another person said, "It's very good". A third person said "the foods alright". Catering staff were aware of people's special dietary needs and described how they would meet these. Snacks were available to people at any time with staff having full access to the kitchen and food stocks to prepare these when a chef was not on duty.

Drinks were available throughout the day and staff prompted people to drink often. Staff monitored the fluid intake of people although the individual amount each person should be aiming to drink per day was not specified. Therefore staff may not be aware if people were drinking inadequate amounts. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place.

People were cared for by staff who had received appropriate training. Staff had completed a wide range of training relevant to their roles and responsibilities. All staff regardless of their role, had undertaken essential training in areas such as dementia, safeguarding, MCA and health and safety. They praised the quality of the training and told us they were supported to complete any additional training they requested. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, medication, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focused on the specific needs of people using the service, such as, end of life care, dementia awareness, meaningful activities and tissue viability. Staff were also supported to achieve a vocational qualification in care.

There were arrangements in place to ensure staff received an effective induction into their role. New staff completed the Care Certificate while being supported by an experienced staff member acting as their mentor. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Each new member of staff spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. We observed staff put training into practice when providing care for people. For example, staff were able to describe how they assisted people who were at risk of pressure injuries to safely reposition.

Staff were supported appropriately in their role. Staff received formal supervisions on a regular basis. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at subsequent supervision meetings. Staff meetings provided opportunities for group supervision. Staff said they felt supported, and the registered manager had an open door policy and they could raise any concerns straight away.

The environment was appropriate for the care of people accommodated although the dining room had minimal pictures on the walls meaning it did not have a homely feeling. Many people living at the home were living with dementia and required a high level of support with to meet their physical care needs. The home was suitable to meet the physical care needs of people as it had wider corridors and doorways and bedrooms were large enough for the use of any specialist equipment required. All bedrooms were for single occupancy and had ensuite facilities of at least a toilet and wash hand basin. Individual bedrooms had been personalised to meet the preferences of the person living there. People were able to bring in items of their own including furniture to make their rooms feel homely and familiar. This would help people with dementia to settle in and feel at home. Hand rails in a contrasting colour to the walls were available in corridors which would make them readily identifiable by people moving around on their own. There was a passenger lift connecting the three floors of the home with a bathroom and assisted shower room on each floor. People had access to an enclosed garden which we were told was popular in the warmer months.

Requires Improvement

Is the service caring?

Our findings

People were consistently positive about the way staff treated them. People said they were treated with kindness and compassion and that all the staff were kind and caring. One person said "I find them very nice. If you treat them with respect, they treat you with respect". When asked if they thought the staff were caring another person said "No problem there at all". Another person said of the staff "They are very good, nice, they are very sensible". Relatives also felt staff were caring. One said "They [the staff] are always very friendly". Another relative said "The staff are friendly and welcoming". In the lounge we saw a person calling to staff specifically by their name showing they knew staff. A visiting professional said the people they visited "always look well cared for – cared about". They added staff were always pleasant and knew the people they were caring for.

Staff had failed to ensure a person received the correct support to maintain their independence. At lunch time we saw a person assisting another person with their meal. The registered manager who was clear the person should not be helped with their meal which they could manage independently with verbal prompts. The procedures used were not dignified or safe. For example, we saw the person using their hands to put food back onto the plate which had fallen off the spoon before giving this to the other person. We asked staff present if the two people were related which they were not. We were told "they started helping [person's name] about two weeks ago".

People were not always treated with respect. When some staff entered the lounge they spoke with people, often by name and interacted in a positive way with them. However, we also observed occasions when staff entered the lounge and did not speak with people but proceeded to sit in an area behind people and write care records. In the morning the television was on in the lounge showing a shopping channel with the volume muted and radio 2 playing. There was no discussion with people as to what they would like to watch or listen to and the combination of muted television and radio would have been confusing for people. This did not show consideration of the needs of people, particularly those living with dementia.

At other times we saw staff met people's individual needs. In the lounge we saw a person who was upset and unsure what they should do. Staff reassured them and spent time sitting with the person suggesting things they could do such as their knitting. At lunch time we saw most people were offered a choice of drink and offered gravy to go on their food. During the meal interactions were primarily between staff and people in relation to their meals. For example ""You've got meatballs and mashed potato, do you want gravy? You do, where?" One person asked "can you help me". A staff member moved their chair and sat with the person and talked with them before moving their chair to assist another person with their meal. In the afternoon we saw a care staff member chatting with people in the lounge and encouraging a person to do some colouring. Care plans contained information about people's preferred names, which discussions and observations with staff showed were used. Care plans included specific preferences such as whether a person liked a light on or off at night or their door closed or left ajar.

People's dignity was protected during the provision of care. When asked if they had a choice about the gender of care staff one person said "It's mostly female [care staff]. There is one male in particular who is

very good. He doesn't make you feel embarrassed". Another person said "I don't mind if it's a man". From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Care plans identified if people had a preference for the gender of staff providing personal care. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. A staff member said "If you have to speak to someone privately, I take them to their room first so you can't be overheard". The home had a dignity champion who had completed dignity training. The registered manager described the role of the dignity champion in the provider information return (PIR). They said 'We have a dignity champion that bring examples of best practice and demonstrates this to other staff and reinforces the best principles." We saw staff knocked on people's bedroom doors and asked permission to enter. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

People received individual care and support from staff who knew and understood their needs and preferences. Staff were aware of the actions they could take to promote choice and ensure people were cared for in accordance with their individual wishes. One staff member said "I always offer a choice. Like we do personal care in the morning but if they don't want to do it then I respect that". We observed staff offered people choices, took time to listen to people and gave them time to respond. Staff had knowledge of people and their preferences and beliefs; they referred to care plans and also said information was provided at handovers. Care plans contained information for staff as to how to promote choice and independence for individual people. For example, one care plan stated the person was able to wash their face and hands. It also stated the person could make choices about clothing and directed staff to 'hold them up so [name person] can see and choose what to wear each day'.

Staff showed a good understanding of the communication needs of people living at St Annes Nursing Home. When it was difficult to understand what people were saying, staff used facial expressions, body language and appropriate touching to aid communication, to reassure people and make them feel listened to. One staff member said "We have one lady who doesn't speak but I can understand her facial expression". Staff were observed explaining to people what they were going to do before offering support. When people were supported to move using equipment such as hoists staff talked to people throughout explaining what they were doing.

People and when appropriate relatives were involved in care planning and reviews of care. One person told us "I have a care plan and have been involved with it". A relative said "Staff involved us with care plans". Care plans contained information about people's backgrounds and family history. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said "they [staff] tell us of any changes, for example, the nurse rings us if [person's name] is on antibiotics". Another visitor said of the staff "all have been very good and keep us informed".

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. We met one person who was receiving care at the end of their life. Although unable to speak with us they looked comfortable and pain free. Staff had put a radio on playing soft music and opened curtains to allow the sunshine into the room. Records of their care and discussions with staff caring for them showed the person was receiving appropriate support. We heard a family member providing positive feedback to staff in respect of the end of life care provided to their relative. Information about people's preferences for their end of life care were included within care files. When necessary, doctors had completed do not resuscitate forms which would mean that staff would not have to commence resuscitation for people who were expected to die. Nurses were aware of how to obtain emergency medicines should these be required for end of life care

and had received training in new equipment for the administration of end of life symptom management medicines.

Good

Is the service responsive?

Our findings

People and visitors told us they felt that there were insufficient activities. One person said "it's very quiet, not much to do. Three different people come once a month but there's not someone every day or even every week". They told us One does music, someone from the local church does a service and one does a quiz – It's very good and keeps you awake." Another person said they would like more things to do adding "the days are long, we grin and bear it".

The registered manager had recently reviewed the activities provision within St Annes Nursing Home. As a consequence an additional activities staff member was being employed to provide activities over five days per week. Many people required individual activities within their bedrooms. The registered manager explained they felt the provision of activities staff five days per week would help meet the need to provide people with activities within their own bedrooms as well as communal areas.

People and relatives were happy with the personal and health care provided. One person said "The care is good here, they really look after you". Another person said they were happy with the care and "[staff] are good to me". Other people made similar comments when asked about the care they received. People looked cared for, in that they were wearing clean appropriate clothing with hair styled. People looked comfortable in bed and when required were assisted to change their position on a regular basis.

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints, if they were dissatisfied with the service provided at the home. One person said "I would go to the head person, but anyone would listen. I've never had to complain". A relative said "I've no concerns now. I raised things in the past and they were dealt with quickly".

The registered manager asked people and their relatives to complete satisfaction surveys twice yearly. The registered manager analysed the responses to each survey and told us that if issues were identified they would use the information to help develop an improvement plan for the home. The latest survey had recently been sent out to people and their families and there was a box on the reception desk for returned forms. We look at the forms already returned in the box and these were all positive with comments such as "Very pleased" and "Staff are very good". We saw cards from relatives thanking staff for the care provided to their relatives were displayed on the reception desk for staff and visitors to read.

There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. The registered manager told us they recorded any concerns raised by people, even minor issues, as a complaint. The complaints file showed there had been seven complaints over the previous year, all of a minor nature. We reviewed these and saw that they had been investigated and the result of that investigation fed back to the person concerned. For example, one person raised a concern that their relative who was living with dementia had told them staff had not acknowledged their birthday. The registered manager investigated the concern and confirmed that a cake had been made and staff had sung happy birthday. She feed this back to the relative who was happy with the outcome. She then arranged for a photo to be taken during people's birthday

celebrations to enable family members who could not be present to share in the memory.

Care staff said they were able to be responsive to people's needs. For example, staff told us people could have a bath or shower when they wanted one. One care staff member said "I know they have a bath or shower once a week but I offer them one even if it is not their day". Care staff responded promptly to call bells. At a busy time of the morning we saw call bells were answered within one minute of being used.

Care staff were able to describe the care and support required by individual people. For example, they were able to describe the help a person required with repositioning to reduce the risk of pressure injuries occurring. They were also able to describe the support people required to meet nutritional needs. It was evident that they and other staff knew everyone living at St Annes Nursing Home and how their needs should be met. Within each room there was a short version of the person's care plan which detailed essential information for care staff. One member of staff told us "I use the care plans in [people's] rooms. I can use the full care plans if needed but the care plans in the rooms give you enough information". Another member of staff said "I have read people's folders in their rooms but not the ones locked in the cupboard". Staff were kept up to date about people's needs through a formal handover meeting at the start of each shift. Relevant information about risks or concerns about specific people was handed over. All oncoming staff were present and the handover was of an appropriate duration to allow staff to ask questions or clarify information. Care staff stated that they felt able to ask questions during handovers if required.

Care plans provided comprehensive information about how people wished to receive care and support. Individual care plans were well organised and the guidance and information for staff within them was individualised and detailed. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, a care plan contained specific guidance as to how often a person should be repositioned. The care people were receiving corresponded to information in care plans. For example, one person's care plan stated there should be a pillow beneath the person's feet with heels over the edge. We saw that this was in place.

Care plans and related risk assessments had been reviewed monthly and amended when required to ensure the information continued to reflect people's needs. The registered manager told us a nurse was employed one day per week to write and update care plans. Care staff told us the allocated nurse spoke with them to clarify how people's needs were being met and other specific information. This helped ensure care plans reflected how people were being cared for. Care plans were centred on the individual, considered aspects of their individual circumstances and reflected their needs and preferences.

Good

Is the service well-led?

Our findings

The provider and the registered manager were not aware of the requirement to display the rating from their latest inspection in a place where it is accessible to people and their families. At our last inspection, which took place on 23 January 2015, we rated the home as 'requires improvement'. At this inspection we identified that the rating had not been displayed. We pointed this out to the provider and registered manager who told us they were unaware of the requirement to display their rating. They took immediate action to ensure a poster displaying the rating was displayed in line with the requirement.

One of the directors told us their vision was to provide a high quality service which met people's needs. They said, "As a provider we want to deliver the best service we can; that means making sure we have the right staff who we listen to". They added that when positive comments were received from people or relatives they made sure relevant staff were aware of these. The director also said, "We need to listen to the residents and continually look at the service we are providing to see if it can be improved." The director was at the home on the day of the unannounced inspection. The registered manager explained the provider's vision and values for the home as "providing a friendly and homely environment where people receive a good standard of that engenders trust in us by the residents and their families". Staff were aware of the provider's vision and values and how they related to their work. One staff member said the goal of the home was to be "homely an extended family". They said they tried to achieve this by "being welcoming" to people and visitors. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service.

There was an open and transparent culture at the home. Relatives said they could visit at any time and were made welcome. People and relatives said they would raise any concerns with the management team. A person said "I'd go to the [name registered manager] or one of the office staff". A visitor also named the registered manager saying "I'd go to [name registered manager], no hesitation".

Staff members said that the service was well-led and they felt supported. There was an opportunity for staff to engage with the management team on a one to one basis through supervisions and through informal conversations. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They said that they enjoyed their jobs and described management as supportive. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one to one or staff meetings and these were taken seriously and discussed. One member of staff told us, "I have a good relationship with [the provider and registered manager] they have a family culture, very relaxed. I have no concerns speaking with them". They added "I like the way we have adopted person centred care here. That's what makes us feel like a family". Another member of staff said "The management is very supportive. If you have a problem or something worrying you can always speak to them [the provider ad registered manager] and they listen to you". They added "They are good people to work for. The atmosphere is very good; we are always helping each other".

The service had a whistle-blowing policy which provided details of external organisations where staff could

raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

There was a clear management structure with the provider, the registered manager, a clinical nursing lead, head of housekeeping, a head chef, nursing staff and senior care staff. People benefitted from staff who understood their roles, were motivated, and worked well as a team. A visiting health professional said, "the staff seem to work together and the owners are often there". Comments from staff included: "I love my job, I really love it". Another staff member said "Management are very supportive, if I went to management with a concern it would get sorted". Other staff also commented on the providers saying they were able to talk to them. Care staff said they felt able to ask the provider or registered manager to help them such as "getting a towel or something if I didn't want to leave the person on their own". Nurses said the directors would collect out of hour's prescriptions if required. There was the opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities such as the resident meetings and the bi-annual feedback survey.

The director and registered manager sought feedback from staff, including through staff meetings and individual supervision. Staff were encouraged to make suggestions about how the service could be improved and these were acted upon. The provider told us they visited the home on a daily basis. They reviewed the results of all of the audits, maintained oversight of the health and safety management, staff training and monitor concerns and issues through attendance at staff meetings.

The provider understood the need for clinical governance and quality assurance systems which involved staff and other stakeholders. There were systems in place to monitor the quality and safety of the service provided. The provider had recently created a new quality monitoring post to support the registered manager in understanding the quality of the service being provided. There were regular audits of medicines management, including the use of homely remedies, people accommodated under the depravation of liberties safeguards, infection control and care records. Where issues or concerns were identified remedial action was taken. For example, a recent audit of the use of bedrails identified that one person did not have a safety buffer to protect them. This was raised with the registered manager and a new buffer was purchased.

The registered manager completed the Provider Information Return (PIR) and demonstrated an understanding of legislation related to the running of the service. Through the PIR the registered manager showed they were aware of key strengths and areas for improvement, in respect of the home. The provider ensured CQC was notified of all significant events and was aware of the need for a duty of candour policy, had sought guidance and put one in place. Where necessary this policy had been followed such as notifying relatives when accidents or incidents had occurred.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. We were told policies were reviewed by the registered manager yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run.