Bupa Care Homes (CFHCare) Limited

Shaw Side Residential and Nursing Home

Inspection report

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16 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 14, 15 and 16 March 2016. Our visit on the 14 March was unannounced.

We last inspected Shaw Side Residential and Nursing home in October 2013. At that inspection we found that the service was meeting all the regulations we assessed.

Shaw Side Residential and Nursing Home is a care home which provides residential and nursing care for up to 150 service users and is owned by Bupa Care Homes. Care is provided in five separate purpose- built houses, set within landscaped gardens. Each house can accommodate up to 30 people and caters for different needs: Miller House and Royton House both provide residential and nursing care, Oldham House provides nursing care for people with dementia and Beech House provides residential care for people with dementia. At the time of our inspection there were 131 people living at the home.

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

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

In all the communal areas of the houses we found there were issues regarding the level of cleanliness and maintenance of some equipment. Some of the furnishings of the home were in need of repair or redecoration.

Some pressure relieving mattresses had not been maintained to an adequate standard to ensure that they functioned safely and protected people from the risk of infection.

Regular safety checks were carried out on the environment and equipment of the home but these had not identified the poor quality of some of the pressure relieving mattresses. There were on-going problems with the functioning of the nurse call bell system, which meant that when it was faulty people who used the service were not always able to summon assistance when needed. A new call bell system was scheduled to be installed later in the year.

Staff had an understanding of safeguarding procedures and what action they should take in order to protect vulnerable people in their care. Risk assessments had been completed to show how people should be supported with everyday risks, such as risks to their nutrition or mobility.

Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting

with vulnerable people.

We found that people who used the service and staff did not feel there were always sufficient staff available to provide high quality care.

Medicines were administered by staff who had received appropriate training. However, we observed that medicines were not always given at the correct time and that doses were not always evenly spaced. This meant that people might not receive the optimum benefit from their medication. In addition, there were problems with the delivery of some medication from the pharmacy used by the service, which meant that medication was not always delivered when required.

Staff had undertaken a variety of training to ensure they had the skills and knowledge required for their roles. Although staff received supervision to monitor the standard of their work and identify any problems they might have, this was not carried out in line with the Bupa supervision policy.

Staff understood the importance of encouraging people to make choices where they were able and sought consent before undertaking any care. We saw that overall staff were kind and patient with people who used the service. Care plans we looked at were 'person-centred' and had been reviewed regularly.

People were supported to eat and drink sufficient amounts to meet their needs and people told us the food was good.

Activity coordinators organised a variety of different activities for people who used the service, although staff told us that they did not always have time to participate in activities or spend time chatting to people due to the pressure of their work-load.

Members of staff we spoke with told us they found the registered manager to be supportive and approachable, but we found there was a negative 'us and them' attitude amongst staff in two of the houses. Carers expressed the view that the majority of 'hands on' care fell to them, as the nurses' time was spent administering medication and completing paperwork.

Systems were in place to regularly monitor different aspects of the service, such as completion of medication records and care plans and the maintenance of equipment. However, these systems had not always identified where failings had occurred in the maintenance of equipment.

Complaints were investigated and responded to appropriately, although the complaints procedure was not adequately displayed in all five houses.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A lack of cleanliness of some equipment and areas of the home, meant that people who used the service could not always be protected from the risk of infection.

Equipment, in particular mattresses, were not adequately maintained to ensure that they functioned correctly and safely.

Arrangements were in place to safeguard people from harm and abuse.

Staff had been recruited to work in the service following an appropriate selection process.

Medication was not always given in a timely way to ensure that people who used the service received the maximum benefit from it.

People who used the service and staff felt that there were not always sufficient numbers of staff on duty to provide high quality care.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used the service received the appropriate support from staff to ensure their health and nutritional needs were met.

Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) authorisations were, where appropriate, in place for people. Staff had received training on the MCA during their induction.

Staff received training to help them care for people appropriately. However, the frequency that staff received supervision was not in line with the Bupa supervision policy.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service were complimentary about the staff.

Staff did not always treat people in a considerate manner.

People were encouraged to make choices about their daily life style.

Is the service responsive?

Good

The service was responsive.

Care plans, risk assessments and associated care documents were detailed, personalised and reviewed regularly.

Complaints were responded to appropriately

Some activities were available for people who used the service to take part in.

Is the service well-led?

Requires Improvement

The service was not always well-led.

In two of the houses there was a negative culture and staff did not work well together as a team.

The home had a manager who was registered with the CQC.

People spoke positively about the registered manager and found her approachable and supportive.

Governance systems, such as audits, which monitor the quality of equipment and care, were not always effective.

Shaw Side Residential and Nursing Home

Detailed findings

Background to this inspection

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

The service met the regulations we inspected at our last inspection in October 2013.

The inspection took place on 14, 15 and 16 March 2016. Our visit on 14 March was unannounced. The inspection team consisted of four inspectors and a specialist advisor in tissue viability.

Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also reviewed the inspection report from the previous inspection and contacted the Local Authority (LA), the local NHS Clinical Commissioning Group (CCG), two local General Practitioners (GPs), NHS Community Dieticians and NHS Tissue Viability Service for their comments about the service. Comments we received from them included concerns about poor communication and the provision of urgent medication. During our inspection we did not find evidence of poor communication. However we found that there were problems with the provision of urgent medication.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined people's care records and observed the care and support being provided to them in communal areas to capture their experiences.

During our inspection of the home we spoke with 20 people who used the service, six relatives, the management team, including the registered manager, 23 of the care staff, the cook, a house keeper and the maintenance worker.

We looked around the buildings, observed how staff cared for and supported people, reviewed records and looked at other information which helped us assess how people's care needs were met. We spent time observing the lunchtime meals and watched the administration of medication to check that this was done safely.

As part of the inspection we reviewed the care records of 13 people living in the home. The records included their care plans and risk assessments. We looked at four staff files, which included their recruitment checks. We also reviewed other information about the service, such as quality assurance records, staff rotas, complaints and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

During our tour of the premises we saw that there were problems with the cleanliness of some of the buildings and equipment, and that where these problems occurred there was a risk of the spread of infection. In Beech House, all the areas were clean and odour-free apart from a small lounge which contained a cat litter tray. The lounge smelled of cat urine and faeces and cat litter had spilled onto the carpet. We brought this to the attention of the house manager and it was cleaned up immediately by a member of the housekeeping team. In one of the bathrooms we saw a used paper towel in the sink, blood on the toilet seat and a male urinal left on the toilet cistern. We saw that a hoist frame was dirty and stained. In Royton House, although most areas were clean, some of the equipment was dirty and stained. For example we saw ingrained dirt around the wheels and base of the weighing scales and dirty foot rests on a motorised wheelchair. In Miller House we saw that skirting boards and window sills were dusty and in one of the toilets both the toilet seat and call bell were stained with faeces. In Shaw House a pedal bin in one of the toilets was broken as the lid could not be opened without it being touched.

We found that hoist slings were used for multiple people, rather than each person having their own sling. We spoke to the Clinical Services Manager about this and she advised us that further slings had recently been purchased so that all people who required to be moved by hoist would have their own personal sling. She told us that in the meantime, slings were laundered regularly and anyone known to have an infection was allocated their own sling in order to prevent the potential spread of infection between people who used the service. However, one member of staff we spoke with told us they did not know how often slings were laundered and one sling in Beech House was visibly dirty.

The home had a Bupa 'Housekeeping Handbook' which contained cleaning schedules and each housekeeper completed a daily checklist of cleaning tasks. In several of the houses we saw that these had not been completed fully and that comments had been added such as '' stopped cleaning to do the breakfast trolley until care staff available''. The home employed a 'Housekeeper Supervisor', but she was currently on sick leave. The registered manager informed us that she had appointed an 'acting housekeeper supervisor' in the interim.

As part of our inspection we looked at the condition of service users' mattresses and in every house we found some that were not fit for purpose. This was predominantly because there had been a breach in the top cover of the mattresses, resulting in the internal foam or air cells being contaminated with bodily fluids. This meant there was a potential for the foam to harbour harmful bacteria. Foam mattresses have a waterproof zip cover to enable the foam inside to be checked for damage or contamination. One senior carer remarked that she did not know that the mattresses unzipped. Each house reported different processes for checking mattresses and there appeared to be some confusion as to whose responsibility this was. Subsequent to our inspection the registered manager informed us that four mattresses on Royton house had been immediately replaced and that there was now an on-going programme for replacing damaged mattresses and monitoring their condition.

We saw evidence that regular safety checks were carried out on the equipment and environment of the home, such as the fire alarm system, boilers, window restraints, and hoists. Several people commented that there were on-going problems with the 'call bell' system not working adequately, and staff confirmed this. One person in Royton House said that when her call bell did not work she used her personal phone to contact staff and summon assistance, and another person said she had been told to shout out to summon help when her call bell was not working. This meant that during the times when the call bell system was not functioning correctly people who used the service might not be able to summon the assistance they required from staff. The registered manager confirmed that a new call bell system was scheduled to be installed throughout the home later in the year.

We inspected the fabric of the different houses and saw that they would benefit from redecoration. In Miller House we saw that in the lounge there were areas where the wall paper was coming away from the wall, and in both Miller House and Shaw House the varnish on the corridor bumper rails was badly chipped. In Shaw House, paint was peeling off some skirting boards and others were water stained. We saw water stains on the ceiling in Miller House. In Beech House, one person spent time sitting in a specialist chair. The fabric of the chair was ripped and foam showed through in several places. Staff explained that although a new specialist chair was available it was not in use as they ''had not got round to it yet''. This meant that the person was not receiving the appropriate care and support that they needed.

In Shaw House, in one of the bathrooms which contained a walk-in shower area, we saw trailing wires. The provider told us following our inspection that these were earth wires, which had become detached from the water pipe and had been rectified by the maintenance man. The registered manager told us that she had received cost quotations for the refurbishment of Miller house and that she would be requesting confirmation from her manager that the refurbishment could be carried out.

A Legionella survey and risk assessment for Shaw Side had been undertaken in December 2015. The purpose of the survey was to assess the risk of the home water system containing the bacteria Legionella and present recommendations to control and minimise the risk. Legionnaires' disease, a type of severe pneumonia, is caused by breathing in small droplets of water that contain Legionella bacteria. Outbreaks of Legionnaires' disease are often associated with large or complex water systems, like those found in hospitals and nursing homes. The survey made a number of recommendations of remedial work that needed to be carried out to ensure that risks were minimised. It also pointed out that recommendations made in a previous risk assessment had not been completed. We received assurances from the Registered Manager that all recommended actions would be completed within the recommended time frames, which would ensure that legionella risks were kept to a minimum.

These failings in both cleanliness and the maintenance of equipment meant there was a breach of regulation 15 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the procedure and systems for the receipt, storage, administration and disposal of medicines. Medicines were stored safely in locked trollies within medication rooms, which also contained the locked controlled drugs cupboards. Some prescription medicines are controlled under the Misuse of Drug legislation e.g. morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. The temperatures of the rooms and the medicine fridges were checked daily to ensure that medication was stored at the correct temperature and our observations of the temperature recording sheets confirmed this.

Health professionals we spoke to prior to our inspection commented that sometimes urgent medication was not delivered to the home on the same day that it was requested. This meant that people who used the

service might not receive vital medication when it was required. The service had changed to a different dispensing chemist the previous year, in line with all Bupa homes, and this chemist was situated some distance from the home. We saw that the request for a prescription for a drinks thickener, used to reduce the risk of choking, which had been made four days prior to our visit, had still not been delivered. The last of the thickener had been used in drinks at the breakfast time on the day of our inspection. As the person was a high risk for choking if they drank un-thickened fluids, they were unable to receive their morning medication which included a nutritional supplement drink. Staff later telephoned the chemist and the prescribed thickener was delivered before lunchtime that day. Staff told us that at weekends and after 5pm carers sometimes took new or urgent prescriptions to a local chemist which was situated a few minutes from the home, in order to get them dispensed quickly. The registered manager explained that the home now had a dedicated phone line directly to the chemist to help speed up the process of dispensing urgent medication and that regular meetings took place between the home and the chemist in order to iron out any dispensing problems.

We observed the administration of medication in all houses and saw that it was carried out by people who had received appropriate training. Staff were patient when assisting people to take their medicines. The Medication Administration Sheet (MAR) was always signed after the person had taken their medication. This is important because people may refuse medication that has been prepared. Each MAR sheet contained a photograph of the person, which helped minimise the risk of the medication being given to the wrong person. Medication that was supplied in patch form was applied safely and recorded on a body map chart. This helped staff manage the rotation of the application site, which helped to maintain skin integrity and ensure absorption of the medication.

We looked at the administration of medication that was to be taken 'as required' (PRN) and was not administered from blister packs but kept in its original packaging. Medication protocols were in place for each person, for each medication. For example an inhaler was prescribed to be given as required for a person with asthma if they became breathless. In Beech and Royton houses the expected amounts of remaining medication in each packet was not always correct. One package of medication checked should have contained 14 tablets, but only three remained.

Medication was administered four times a day; at breakfast, lunch, teatime and night time, with breakfast medications being timed to be given between 09.00 and 10.30. On the first day of our inspection the breakfast medications in one of the houses were still being administered at 11.00. This meant that those people receiving medication which was meant to be taken at specific times of the day and with an appropriate length of time between doses might not receive their medication in evenly spaced doses. One person was prescribed an antibiotic three times a day at breakfast, lunch and night, but actual times of administration had not been recorded. Instructions on the antibiotic package said ''space doses evenly''. Medication should ideally be given in equally spaced intervals throughout the day and taken at the same times each day. This helps to maintain a constant level of medication in the blood stream and ensures that the person taking the medication receives the optimum benefit from it. We saw that one person had been given their medication at breakfast time and lunchtime. The senior carer reported to us that she had given the medication at 09.20 and 14.00. However, the recommendation was that it should be given with or just after food. This person had their lunch at 12.30, an hour and a half before they received their medication.

Failure in safe medicine management constituted a breach of Regulation 12 (1) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training on infection prevention and control during their induction period, and subsequently every two years. We saw that all staff were compliant with this training. Staff we spoke with were able to give

examples of methods for preventing the spread of infection, such as the use of personal protective equipment (PPE), including disposable vinyl gloves and plastic aprons and we observed staff using these appropriately. Bathrooms and toilets contained adequate supplies of soap and paper towels and displayed posters detailing safe hand washing technique. We saw certificates confirming that all staff had completed an audit of their hand washing technique within the last year. Good hand washing technique helps to prevent the spread of infection between people who use the service.

The service had a 'Safeguarding Vulnerable Adults' policy and staff received training in safeguarding vulnerable adults during their induction programme, followed by an annual refresher course. We saw from the records we reviewed that staff were up-to-date with this training. Staff we spoke with were able to describe different types of abuse, such as physical, and financial and were confident that they would be able to raise any safeguarding concerns they might have with their manager. One carer said 'I'd report it to whoever was in charge'. Staff knew to be vigilant about the possibility of poor practice by their colleagues and knew how to use the home's whistleblowing policy, which was called 'Speak Up'. Whistleblowing is when a person raises a concern about a wrongdoing that may place a person at risk of harm in the workplace. One carer said ''if you see something happening that shouldn't be happening you have a duty to report it''.

We asked people who used the service and staff if there were sufficient numbers of staff to deliver all the care and support people needed. The answers varied between the different houses. One person living in Royton house said ''we need more nurses on a regular basis, and more carers. They used to have time to spend with residents''. A recent review by a nurse to assess continuing healthcare needs said '' (the person) continues to report that she sometimes waits a considerable amount of time for staff to attend to her needs''. Staff in Beech house said there were always enough staff. In Oldham house staff felt that although care was safe, there were insufficient staff to deliver all the care and support people needed and that staff were under pressure and as a result people had to wait for assistance. In Miller house, a person who used the service commented that her call bell was answered promptly, but another person reported that on a number of occasions she had been incontinent due to the wait for assistance to use her commode. A visiting health care professional talking about Miller house said '' there's always a staff member around''. In Shaw house one carer commented that a shortage of staff sometimes meant that ''residents can't get up at the time they want'' and that they didn't always have time to talk to people. Another carer commented ''We have enough staff to be safe''. A third carer we spoke with in Shaw House told us that she felt they had enough staff.

The registered manager told us that recruitment of registered nurses had been difficult, but that it had improved during the last three months. Where they had to employ agency nurses they tried to request the same people in order to promote continuity. In Royton house we saw that six of ten of the signatures of staff who administered medicines were by agency staff.

Staff employed by the service had been through a thorough recruitment process. We inspected four staff personnel files and found that they contained all the relevant documentation, including references checks and confirmation of identification. All staff had Disclosure and Barring (DBS) criminal record checks in place. These help the service provider to make an informed decision about a person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

We checked with the Nursing and Midwifery Council (NMC) that the registration details of the Registered General Nurses (RGNs) were up-to-date and found that there were no discrepancies. The NMC is the regulator for all nurses and midwives in the United Kingdom. When nurses register with the NMC they are given a personal identification number (PIN) which is renewed annually.

We inspected the kitchen and saw that food was stored correctly and the fridge and freezer temperatures monitored daily by the cook. A 'Food Standards Agency' inspection had been carried out in March 2016, by the Local Authority. The home had been awarded a rating of five, which is the highest rating possible.

The provider had an Emergency Plan folder, which contained details of arrangements in place to ensure business continuity in the event of a major incident such as a fire, loss of power or water supply. The folder contained plans of the site, guidance for staff to following in the event of an emergency and a list of alternative locations identified should people need to be evacuated. Inspectors noted that some of the telephone numbers listed in the contacts list were not up-to-date: the registered managed confirmed she would rectify this immediately. People who used the service had a personal evacuation escape plan (PEEP) in place, which explained how each person would be evacuated from the building in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Newly recruited staff had completed a Bupa induction programme, which involved several classroom based training days, followed by a period of 'shadowing' more experienced carers. All new carers were enrolled on to the 'Care Certificate', a national qualification which, when completed, demonstrates that they have the skills and knowledge to provide high quality care and support.

Training was planned and organised by a Bupa Training Manager, who in addition to Shaw Side, was responsible for training in two other Bupa care homes. We saw that staff were up-to-date with their training schedule. Staff had received a variety of training which enabled them to carry out their roles effectively, including manual handling, communication, medication awareness and food and nutrition. The training manager had recently completed a university based dementia course entitled, 'People first, dementia second' and planned to cascade their knowledge to other staff throughout the home. The registered nurses received additional clinical training organised by the Clinical Services Manager, in topics such as tissue viability and nurse accountability.

Regular supervision meetings provide an opportunity for staff to discuss their progress at work and identify any learning and development needs. Bupa's supervision policy specified that staff receive six supervision sessions per annum. Although we saw evidence that staff received supervision, some staff received this more frequently than others and no staff received six sessions per annum as stated in the provider's supervision policy. This meant that staff were not receiving the supervision support identified by the provider in order to help staff talk about and improve their practice, as well as discuss any concerns they may have.

This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation s 2014.

Staff we spoke with felt that when supervision occurred it was helpful. One person said '' lots of good things have come out of my supervisions''.

We saw that staff sought people's consent before care and support were provided and that where possible people were offered choices, for example what they would like to do or what they would like to drink. One carer described how a person's facial expressions or actions could indicate that they had consented to care, if they were unable to communicate their consent verbally. We saw evidence that the need for consent and choice were incorporated into care plans: for example 'staff to explain to (the person) all aspects of care so that they can make an informed decision', and '(the person) chooses to remain in bed this morning'.

The Mental Capacity Act (2005) 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 decision, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that all staff had undergone training in the MCA during their induction period and staff we

spoke with had a basic understanding of what it meant in relation to their role. We saw evidence that mental capacity assessments of people who used the service had been undertaken where appropriate.

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 Deprivation of Liberty Safeguards (DoLs) provides a legal framework to protect people who need to be deprived of their liberty in their own best interests. The Care Quality Commission is required by law to monitor the operation of the DoLs and to report on what we find. The Clinical Services Manager was responsible at Shaw Side for submitting DoLs applications. At the time of our inspection, as well as those applications already in place, there were several waiting to be approved by the local authority. This meant the home was following the correct procedure for depriving people of their liberty.

The majority of the people we spoke with were happy with the quality of food provided. One person said ''it's great, I've put on loads of weight since living here''. Another person also commented that they had gained weight due to the ''excellent food''. However, one person said ''it's just not nice; slopped onto the plate''. The home followed a Bupa four-weekly menu plan which was on display in the dining rooms and identified the nutritional value of each meal, such as its calorific content. The chef followed a set recipe for each meal to ensure that the food he prepared met the Bupa nutritional requirements. He explained that if he wanted to cook a different meal, for example for a special occasion, he submitted his meal plan and recipe to Bupa Head Office to ensure that it met their standards.

We observed the lunchtime meal being served in different homes and saw that the tables were appropriately set and that people were offered cold drinks to accompany their meals. People were assisted to move to the dining areas, or could choose to remain in the lounge or in the privacy of their own room if they preferred. The house manager in Beech House said they encouraged people to sit at the tables 10 or 15 minutes before each meal because they found people would drink a glass of juice while waiting. People were given a choice of food and at lunchtime people could choose a hot meal, or soup and sandwiches: extra helpings were offered. Alternative meals, such as salads and omelettes were on offer for those people who did not like the available choices.

During our observations of the lunchtime meals we heard staff asking people if they were enjoying their meal and they laughed and joked with them and engaged in friendly conversations. We saw that where people required assistance with eating, staff provided this in a gentle manner, explaining what they were doing and what food they were offering them. However, we saw one carer who was supporting a person with their meal walk away from the person without offering any explanation for their actions. She did this on two occasions. This meant that the person did not receive the required support to eat their meal properly.

People's nutritional requirements had been assessed and were reviewed either weekly or monthly, depending on their level of need. New residents were commenced on a 'food diary' for the first week of their stay, so that staff could gauge their eating habits and identify if there were any problems. People were weighed and malnutrition universal screening tool (MUST) scores were recorded. The MUST tool helps to identify adults who are malnourished, at risk of malnutrition or obese. Where a nutritional risk had been identified the appropriate action had been taken, for example referring to a dietician, district nurse or to the GP. Where nutritional supplements had been prescribed we saw staff encouraging people to drink these. One person who used the service, whose nutrition and hydration required careful monitoring, reported that all the staff supported her needs extremely well. She confirmed that she was weighed weekly and had regular contact with the community dietician.

People who had swallowing difficulties had been referred to the Speech and Language Therapist (SALT) and

information about the use of thickening their fluids recorded in their care files. Laminated signs providing information about the quantities of thickening agents to be used to achieve different consistencies of fluid was on display in the house kitchens and this helped to guide staff to thicken fluids correctly.

From inspection of the care records we saw that people using the service had access to other health care professionals, such as GPs and community nurses. One of the local GPs visited the home routinely every week to deal with non-urgent problems and the local NHS Trust Care Home Liaison Nurse visited the home fortnightly to review patients and offer support to staff.

To help meet the needs of those people using the service who were living with dementia, an attempt had been made to make some houses 'dementia friendly'. Bedroom doors were all 'front-door' style and painted in different bright colours, and on the walls outside people's bedrooms we saw glass fronted memory boxes containing photographs and keepsakes which helped people locate their bedrooms and inspire reminiscence. In the communal areas a board displayed information in pictures and words about the day and date, season and the weather. The registered manager informed us that the home had recently purchased some dementia friendly 'signage' which helped people identify rooms by the use of pictures.

The five houses of Shaw Side are set within extensive landscaped gardens, which have wheel chair access. We saw that the gardens were well maintained with lawns, floor beds, trees and garden furniture and provided a pleasant environment in which people could spend time during the warmer months. People who used the service who enjoyed gardening were encouraged to help maintain the gardens.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the staff. One person said ''there's nothing they wouldn't do for me'' and another person commented ''the staff are very, very good; very obliging''. A 'thank you' card we saw said ''thank you so much for your loving care''.

We observed staff interactions with people and saw that overall staff were patient and responded to people in a kind way. We saw one carer ask a person ''how are you?'' and put their arm around the person. We saw that where staff spoke to people who were sitting, they crouched down, so that their interaction with them was at eye level. However, on one occasion we saw that staff ignored a person who was sitting alone at a table and calling out in distress. The inspector had to ask staff to assist the person, who immediately became calmer once staff had responded to them.

We saw that overall people in the home looked cared for: their clothes and appearance were clean. One visitor we spoke with was impressed with the level of care their relative received, including the choice of when they could get up. He was pleased with their appearance as they were getting their hair done every week, which they enjoyed immensely.

However, we saw one person whose appearance was unkempt as their clothes and teeth were dirty. This person's care plan stated that they were independent with maintaining their own personal hygiene and staff had recorded that their offers of assistance were declined. The inspector advised staff that the care plan did not adequately reflect the level of support the person needed to look after their personal care needs and that further discussion was needed to ascertain the level of support they would accept in order to maintain their personal appearance.

Staff received training about 'privacy and dignity' during their induction period and staff we spoke with were able to give examples of how they would promote dignity with people who used the service. One carer said she would ask new residents what name they would like to be called by, and another carer told us she would always knock before she entered a person's room. We observed carers doing this and people who used the service reported that staff were polite and knocked before entering their rooms. Another carer said she would ask someone if they would like to wear a clothes protector while eating their meal, rather than putting one on them without first asking their permission. We observed staff consulting with people before giving them clothes protectors. One carer said ''we look after people how you'd like your parents to be looked after''.

Staff understood the importance of promoting independence with people who used the service. One carer said ''we encourage them to do as much as they can for as long as they can, but let them know we are there if they need us''.

From the staff training matrix we were shown, we saw that care staff had not received any specific training in 'end of life care', even though part of their role involved caring for people approaching the end of their life. One staff member said that she had previously received training in use of the 'Liverpool Care Pathway for the

Dying patient' (LCP) which was a UK care pathway covering palliative care options for patients in the final days or hours of life. She was aware that this was now no longer used nationally, but had not received any training to update her on current practise. The registered manager told us that senior staff in Shaw House had attended part of the 'Six Steps to Success - Northwest end of life care programme for care homes' during 2014, but had not completed the final module. However, she told us that four staff were registered to attend this course starting in July 2016. The Clinical Services Manager had completed the 'Six Steps' programme in her previous employment. Subsequent to our inspection we were shown information about the launch of Bupa's new 'End of Life Care Strategy' to be implemented throughout Bupa care services. This strategy combines policies, documentation and training on topics such as Advanced Care Planning, bereavement care and care during the last days of life. The registered manager informed us that she would be implementing the strategy in the near future.

Staff we spoke with felt that caring for someone at the end of their life was an important part of their role. One staff member said ''it's very special to me…I just think it's probably the most honourable thing you can do, it's a privilege to look after the person and their family''. We saw a 'thank you' card which said ''Thank you so much for making my Nan's last few days so perfect''.

We did not see any information about advocacy services on display in any of the five houses, or the main reception of the home. The registered manager confirmed that she was aware of organisations that could provide this service and would be able to advise people on whom to contact if they required this assistance. She explained that in particular she would use Age UK and that she had developed a good relationship with the local Age UK team. Advocacy services support people to express their views, access information and help people to make important decisions about their lives.

Good

Is the service responsive?

Our findings

Prior to moving into Shaw Side a pre-admission assessment was carried out by a registered nurse. This assessment usually took place at the person's home, or if the person was in hospital they were assessed there. People were also invited to visit the home prior to finalising their decision. This enabled people to make an informed choice as to whether or not the service could meet their needs.

We reviewed 13 care files and saw that they were 'person-centred' and contained descriptions of each individual person's care needs and how they should be managed by staff. Information in the care file included a nursing assessment, risk assessments, care plans and a document entitled 'My day, my life, my portrait', which summarised the person's life history and things that were important to them. Risk assessments included those for nutrition, mobility, falls, continence and skin integrity. MUST and Waterlow scores had been completed. A Waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy. Staff we spoke with understood what being 'person-centred' meant. One carer said ''you need to know your residents…knowing what they like and dislike and trying to attend to their needs''.

We saw evidence that people who used the service were involved in formulating their care plans, and that the care plans were detailed and personal. For example, one care plan said '(the person) likes to sleep with door ajar and night light on in the far corner''. Another said '' prefers her own company, watches TV in her own room. Likes to vote, likes to go on day trips''. This care plan also contained the information ''staff should make regular visits to her room to prevent her feeling isolated''. Staff we spoke with were able to discuss details of people's lives, preferences and dislikes and care needs. The relative of one person who used the service commented that the staff '' know what my Mother likes'' and another relative reported that they were impressed with the staff's response to their Mum's needs and reported they quickly understood what she liked and disliked. They felt reassured that in a short space of time the staff treated their Mum ''like one of the family''.

We saw that care plans were reviewed monthly which ensured the information was up-to-date. We reviewed the care file for a person who had complex nursing needs and saw that the plans were detailed and had been reviewed and updated. For example, a risk of pain had led to a care plan and the effectiveness of medication had been regularly reviewed.

We saw that 'handover' meetings were undertaken at the start of each change of shift to ensure that information about any change in a person's condition, care plan, or treatment was properly communicated and understood. One member of staff commented '' we're quite well informed of any changes with the residents''.

The home employed four activities coordinators who worked across all five houses and helped people who used the service take part in a variety of activities, such as painting, table top skittles, dominoes, reminiscence and sing-a-longs. In addition, local schools visited the home to provide entertainment and the Rotary Club took residents out for lunch. One person commented that they went to a church service once a

week and that they were pleased with their ability to choose what they did on a day to day basis. Staff we spoke with felt that there were not enough activities on offer. One person said ''I feel they need more to do'' and another carer said that if people wanted to go out for the day, for example to go shopping, this had to be planned well in advance, as there were not enough staff to facilitate this happening without prior notice. Several staff commented that they rarely had enough time to spend time chatting to residents, as they were busy carrying out hands-on care. The calendar of activities on display in Oldham House showed next week's activities, not the current week. In Shaw House the activities board was blank, but subsequently had an A4 sheet listing the week's activities displayed. The home had a small café in the main reception building. We did not see anyone using this facility during our inspection. However, the registered manager said its use was dependent on the weather being fine. The activities coordinator ran a mobile shop for people who used the service, which sold essentials such as toiletries and underwear and a 'tuck shop' which sold sweets and crisps.

How to make a complaint posters were on display in the main reception of the home: the poster informed people on how to make a complaint, who they should speak to, how the service will respond and who can be contacted if a person is not happy with the response from the service. These posters were also displayed in three of the five houses. This information should be readily available in all of the houses across the site. This was brought to the attention of the Registered Manager who rectified this. The Registered Manager and House Managers explained that they did not get many complaints. Staff in each of the houses, and the house managers explained that when a person who used the service or their relatives had any concerns they usually raised the matter with the House Manager who in the majority of instances was able to resolve the matter there and then. Should a matter remain unresolved or the person making the complaint wished to escalate the matter these were recorded on a complaint form and brought to the attention of the Registered Manager. A log of complaints were maintained and demonstrated that where complaints had been made they had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

Shaw Side Nursing and Residential Home is owned by the organisation Bupa Care Homes, which owns over 300 care homes in the UK. At the time of our inspection there was a registered manager in post who had been registered with the Care Quality Commission (CQC) since 2010. The registered manager was supported in the day to day management of the home by the Clinical Services Manager who oversaw all clinical aspects of care delivery and clinical risk across the home's five houses. A Bupa Care Homes Area Manager had oversight of the running of the home and visited the service at least once a month, as did a Bupa Quality Manager. Each of the five houses had a manager who was responsible for the day to day management of their particular house and the provision of care to people who used the service.

The registered manager and the clinical services manager met twice a day to review the general day-to-day running of the home. In addition, they both met the five house managers for a daily morning meeting to discuss issues such as staffing levels and concerns about people using the service. These meetings provided the registered manager with an overview of the service provision for each house, and ensured that issues were brought to her attention and any actions that were required were discussed and agreed upon. People spoke positively about the registered manager. One carer said ''I think she does the best she can for the site as a whole'' and another person said '' if there are any issues we bring them to (the registered manager)''.

We asked staff and people who used the service for their opinion on how each individual house was managed and whether or not staff worked well together as a team and we received a varied response. Staff and people who used the service felt positive about the management of three of the houses. In these houses staff found the house managers approachable and supportive and a carer commented that she felt action would be taken on any issues raised by staff. Comments made by staff included '' I can talk to the manager in confidence'' and ''her door is always open''. In these houses staff felt that they worked well together and that there was a positive culture with good teamwork. One carer commented ''we work as a team'' and another said they are a good team here''. One person who used the serviced described her house manager as ''a gem'' and said that she felt confident in speaking with the manager as she knew she would sort out any problems. The registered manager told us that on the whole she had a good team in all houses and where problems with staff performance were identified she dealt with these appropriately.

However, in two of the houses we found there to be a lack of leadership and a negative culture among some of the staff. This was predominantly due to an 'us and them' attitude displayed by some carers towards the registered nurses. One carer commented that the hands on work was left to the carers, as the nurses had to administer medication and complete paperwork. Another carer, commenting about one of the nurses said ''she doesn't help with the caring of the residents''. We observed negative gestures made by carers towards the nurses. Speaking about one of the house managers, a carer commented '' if she comes in and she's having a bad day she says get out of my office'' and another carer described the house manager as ''volatile'' and commented that sometimes she shouted at staff. This negative attitude among staff and poor collaboration between carers and nurses meant that in two of the houses the workforce did not always work well together as a team, and this had the potential of impacting on the quality of care provided to people who used the service.

The registered manager demonstrated a good understanding of their responsibilities with regard to CQC registration requirements and their legal obligation to notify us about important events that affect people using the service. We saw that where specific incidents had occurred the registered manager had carried out an investigation and taken the appropriate action. All falls were investigated by the clinical services manager.

We saw evidence that staff meetings were held for both the day and night staff and topics discussed included mobile phone use, the use of food diaries and medication. Resident/relatives meetings were held every three months and covered topics such as laundry, the quality of the food, activities and staffing levels. Regular meetings help to promote an open and transparent culture, and improve communication between people who use the service and staff.

The home had a number of governance systems in place to monitor the quality of the environment and the standard of care provided by staff. The Bupa area manager and quality manager visited every month to undertake a review, and the frequency of their visits ensured that all houses were reviewed every two months. Some of the areas identified in one month's review included food and fridge temperatures not being correctly recorded, signature omissions on MARs sheets and environmental and infection control issues. Actions plans to address identified problems were instigated following the review and these were checked at subsequent reviews to ensure they had been implemented.

The home carried out audits, both on a monthly and three monthly basis. These included checks on the correct completion of MARs sheets and care plans and health and safety audits. However, despite having some processes in place to monitor the quality and standard of equipment, care and documentation, the provider had not always identified where failings, such as in the poor quality of mattresses, had occurred.

This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation s 2014.

People living at the home and their relatives were provided with the opportunity to comment on the service through an annual survey, which included questions about staffing, the quality of the food and the housekeeping and laundry service. 45 people who used the service completed the December 2015 survey. We were shown the results of the survey, which were not very comprehensive, but gave an indication of 'areas of strength' and 'areas of improvement' for the home. Areas of strength included 'quality of care a resident receives' and 'happy and content living in the home' and areas of improvement included 'staff available when needed' and 'promptness of staff attending to needs of resident'. We saw that an action plan had been devised to address the issues highlighted in the 'areas of improvement'.

People who used the service were provided with a brochure which gave details about the home and its facilities. However, from the evidence we obtained during our inspection we found that some of the information given in the brochure was not reflective of some of our observations and findings during the inspection. For example, the brochure states the home ''maintains the highest standards of care and hygiene'', but as detailed in the 'safe' domain of this report we observed many examples of poor cleanliness and maintenance of some of the equipment within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and other were not protected against the risks associated with unsafe medicines management. Regulation 12 (1) ()

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with poor standards of cleanliness and the poor maintenance of equipment. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place did not always monitor the quality of the service provided. Regulation 17 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service did not receive appropriate supervision. Regulation 18 (2) (a).