Solehawk Limited

Craigielea Nursing Home

Inspection report

739 Durham Road
Gateshead
Tyne And Wear
NE9 6AT

Tel: 01914874121
Website: www.craigieleacare.co.uk

Date of inspection visit:
23 November 2016
07 December 2016
13 December 2016

Date of publication:
07 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Craigielea Nursing Home on 23 November, 7 and 13 December 2016. The first day of the inspection was unannounced. We last inspected Craigielea Nursing Home in September 2015 and found the service was not meeting some of the relevant regulations in force at that time. We identified breaches related to cleanliness and staffing levels.

The Craigielea Nursing Home provides accommodation, nursing and personal care for up to 64 people, including people living with dementia. There were 38 people living there on the day of our inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the 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.

People told us they felt safe. Staff took steps to safeguard vulnerable adults and were trained and guided on safe care practices.

Those areas of the home subject to recent refurbishment were pleasantly decorated, with well-furnished lounges and seating areas. A new 'café' area had seating less suitable for people with physical support needs. Most areas of the building were safe and well maintained. There was excess storage in some bathrooms. The property was adapted from an older building with a later purpose built extension. Adaptations had been made and additional signage provided to improve safety and highlight potential hazards. Other risks associated with the building and working practices were assessed and steps taken to reduce the likelihood of harm occurring. On the whole, the home was clean.

We observed staff acted in a courteous, professional and safe manner when supporting people. We heard mixed views about the adequacy of staffing levels. These were subject to ongoing review and shortfalls in nursing were covered by the use of agency staff. The provider had a robust system to ensure new staff were subject to thorough recruitment checks.

Medicines, including topical medicines (creams applied to the skin) were, in most cases, safely managed, although the stock rotation and disposal of sharps required attention.

As Craigielea Nursing Home is registered as a care home, CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for a DoLS. Arrangements were in place to assess people's mental capacity and to identify if decisions needed to be taken on behalf of a person in their best interests. People's mental capacity was considered through relevant areas of care, such as with medicines and distressed behaviour. Where necessary, DoLS had been applied for. Staff routinely obtained people's consent before providing care.

Staff had completed safety and care related training relevant to their role and the needs of people using the service. Further training was planned to ensure their skills and knowledge were up to date. Staff were well supported by their managers and other senior staff. Staff performance was assessed annually and objectives set for the year ahead.

People's nutritional and hydration (eating and drinking) status was assessed and plans of care put in place where support was needed. People's health needs were identified and external professionals involved if necessary. This ensured people's general medical needs were met promptly. People were provided with assistance to access healthcare services.

Staff displayed an attentive, caring and supportive attitude. We observed staff interacted positively with people. We saw that staff treated people with respect and explained clearly to us how people's privacy, dignity and confidentiality were maintained.

A limited range of activities were offered within the home on a group and one to one basis. An activity worker post was vacant. Staff understood the needs of people and we saw care plans and associated documentation were clear and person centred.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

People using the service and staff spoke well of the registered manager and nursing staff felt she provided good clinical leadership. Communication was evident between staff working different shifts. Systems to assess and monitor the quality of the service included seeking feedback from people receiving care so their views could be incorporated into ongoing improvements.

We found breaches of the regulations relating to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People said they were safe and were well cared for. New staff were subject to robust recruitment checks. Staffing levels needed further review to ensure they were sufficient to meet people's needs in a consistently prompt and responsive manner.

Routine checks were undertaken to ensure the service was safe. There were systems in place to manage risks and respond to safeguarding matters.

Some aspects of medicines and hygiene were not managed safely.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were well supported and who received safety and care related training. Further training reflective of people's needs was planned.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had developed good links with healthcare professionals in most cases, and where necessary actively worked with them to promote and improve people's health and well-being. People's needs related to eating and drinking were assessed and met.

Is the service caring?

Good

The service was caring.

Staff displayed a caring and supportive attitude.

People's dignity and privacy were respected.

Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

Is the service responsive?

Good

The service was responsive.

People were satisfied with the care and support provided. There was a limited range of social activities pending the recruitment of a new activities worker.

Care plans were person centred and people's abilities and preferences were recorded.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Requires Improvement

The service not consistently well-led.

The service had a registered manager in post. People using the service and staff made positive comments about their managers.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service and staff.

Although action had been taken to address identified shortfalls these had not been effective in identifying and managing shortfalls we identified in the safe operation of the service.

Craigielea 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 November, 7 and 13 December 2016 and the first day was carried out during the evening and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor, specialising in nursing care for older people and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home, including observations, speaking with people, interviewing staff and reviewing records. 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 six people who used the service and five visiting relatives. We spoke with the registered manager and 11 other members of staff, including two nurses and four care workers, a domestic worker, two kitchen staff, an administrator and a maintenance worker.

We looked at a sample of care records, including six people's care plans and other associated documentation, such as risk assessments and medicine records. We examined four staff files, which included staff training and supervision records, and a further three staff member's recruitment records. In addition we viewed complaint, accident and incident records, policies and procedures, risk assessments and audit documents.

Requires Improvement

Is the service safe?

Our findings

Staff undertook checks to identify and deal with potential hazards, such as those relating to the premises and equipment. The premises and equipment was designed to reduce the risk of harm. For example, bath hot water temperatures were automatically controlled by thermostatic mixer valves. Those we tested were within a safe and comfortable range. Sharp or hard fixed furnishings which could cause injury were minimised and doors to different areas of the home had key pads to keep people safe from leaving by wandering from the home and coming to harm, for example in unobserved stairwells. Lounge areas were free from other obvious hazards, such as excess storage and level access was provided throughout the home. Utility services were subject to safety checks and copies of service records including electricity, gas and water system checks carried out by external contractors were retained for inspection. Shared areas of the home were free from unpleasant odours and were clean.

A number of safety and hygiene hazards were highlighted to the registered manager and a maintenance worker for immediate attention at the time of the inspection. These included air flow mattresses that had been set to the maximum weight setting, irrespective of people's weights, worn crash mats, lose or broken fittings (such as a loose toilet seat), excess storage in the nursing unit bathroom, solid bars of soap in shared bathrooms, excessively stained water beakers and jugs, and a mobile stand aid that had been missed during routine servicing. These items had not been identified through the provider's routine audits and safety checks.

In addition arrangements for the management and administration of medicines were not consistently safe. We observed medicines being offered to people safely. The medicines store room was locked when not in use and during the medicines administration round and the trolley was locked when unattended. The nurse administering medicines offered gentle encouragement to people and waited to check they had taken their medicine before signing the administration records. Medicines were well accounted for, with clear records of administration kept, corresponding to stocks held. Records and stocks were accurate for controlled drugs (medicines at risk of being abused), variable dose medicines, and those where doses were regularly reviewed and changed. Eye drops were correctly dated and labelled once opened.

Improvements were needed in the way some medicines were stored, in how stocks of related equipment controlled and with general hygiene in the treatment room. Although we were unable to witness a nurse giving medicine via a Percutaneous Endoscopic Gastrostomy (PEG) tube, we were satisfied by their knowledge regarding the safe and correct procedure to follow. (PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines). However, on examination of the calibration machine and the flushing syringe and jug, we found the machine stained and dusty and the flushing syringe was not kept in the jug, but lying on a magazine. The medicines trolley needed cleaning and we saw an unsheathed fine bore needle placed on the top of the trolley in a blue tray. There were no sharps boxes available on the trolley. The nurse had to leave the medicine trolley to wash medicine pots half way through the medicine round and return to the treatment room to dispose of used sharps. This was not an efficient use of time. We found a sharps container was over filled, with tubing hanging out of the top of the container which was left open.

A pot of previously dispensed medicine was in the cupboard with no name to identify who this belonged to. We found medicine dispensing syringes that were out of date (expired June 2016) and normal syringes that were also out of date (expired April 2016). These were disposed of immediately. Staff did not consistently monitor the temperature of the medicines fridge which contained a substantial amount of medicines. The fridge temperature had been checked on the day of the inspection. A specimen fridge contained a faecal specimen with no resident identifiers. The nurse was not able to account for this but stated they would dispose of the specimen. A large store cupboard contained insulin syringes and water for injection stored on the floor. The floor was not clean.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following a recommendation made at our last inspection a dependency tool was used to assess how much care people needed and to calculate minimum staff cover requirements. The view of the registered manager was that this required further refinement to ensure staffing levels were sufficient to ensure people remained safe and to take into account the layout of the home.

Staff told us, "The staffing's safe at the moment but if anyone else comes in we'll need extra", "We're having a shuffle around because we're filling up quite fast", "Manageable? The 'floater' will come across and I will go out and help", "Yes, levels are safe" and "I often just take my breaks whenever I can and do feel that the workload is heavy, and I sometimes am unable to leave on time when my shift finishes."

People using the service, visitors and staff expressed mixed views about the adequacy of staffing levels. For example, one person using the service expressed the view that staff were prompt in meeting their needs. They said, "I've got a buzzer. The staff come very quickly." In contrast another person remarked, "You do hear bells ringing for a long time." A visitor told us, "I have spoken to [Name - Operations Manager] about staff shortages numerous times. We came in yesterday and there were no staff in the lounge but at least four residents, three of whom had challenging behaviour. It can take up to 40 minutes for [my relative] to be ready. I think this is because of lack of staff." Other comments from visitors were "They need more staff here. They can be run ragged" and "I know the response times are good."

When we last inspected the home we found some calls took over 15 to 20 minutes to answer. On this occasion some improvements were apparent when we looked at call response times over a sample 24 hour period. We found nine calls took five or more minutes to be responded to. Two took 11 minutes to be answered. We observed a lack of visible presence of staff on nursing floors. We heard a person shouting in their bedroom complaining of being in pain. As no care staff were present we intervened to offer some assurance and along with a maintenance worker activated the alarm to call for staff assistance.

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

Staff were vetted for their suitability to work with vulnerable adults before they were confirmed in post. The application form included provision for staff to provide a detailed employment history. Other checks were carried out by the registered manager and included ensuring the receipt of employment references and a Disclosure and Barring Service (DBS) check before an offer of employment was confirmed. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and/or children. This helps support safe recruitment decisions. Records for the most recently recruited staff members showed appropriate documentation and checks were in place for them. They had not been confirmed in post before a DBS check and references had been

received.

People who used the service said they felt safe at Craigielea Nursing Home. Comments made to us included, "Yes I feel safe", "Yes the staff come quick. I feel safe" and "Feel safe? I do actually." The visitors we spoke with expressed the view that their relatives were safe at the home. Comments included, "I know dad is comfortable here with the staff and I know he feels safe here. They've put crash mats in his room and cot sides because he has a lot of falls" and "Craigielea is excellent, we both feel very safe here."

Staff we spoke with were clear about the procedures they would follow should they suspect abuse. Those we spoke with confirmed they had attended relevant training and were able to explain the steps they would take to report such concerns if they arose. One staff member said, "If we suspect anything is untoward we put it to safeguarding." Another remarked, "My job is to make people safe. If there's a problem I'll approach [name – registered manager] first." Another staff member told us, "I've been on training. I'd report to [name – registered manager], a senior or a nurse; further if necessary."

They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. The registered manager was aware of when they needed to report concerns to the local safeguarding adult's team and where appropriate to other agencies. We reviewed records and saw that concerns had been reported appropriately so steps could be taken to protect people from the risk of further harm. Alerts raised included incidents where inappropriate moving and handling equipment or techniques had been used by staff. For example, the registered manager informed us, "We've reviewed the types of slings used, for who and in which circumstances." A staff member confirmed, "I've had training on moving and handling and we're given guidance." Another staff member said, "There's enough equipment. Some things can be obtained quickly, such as crash mats."

To identify and manage risks to people using the service, staff and visitors, the registered manager, nurses and senior staff undertook risk assessments and implemented suitable control measures. These covered concerns such as people's falls risks, susceptibility to pressure ulcers or risk of choking on food or fluids. Relevant care plan and risk management guidance ensured a consistent and safe approach was taken. Staff regularly reviewed needs assessments, support plans and risk assessments to keep them up to date and to ensure they accurately reflected people's level of need, and the associated level of risk. We discussed wound care and availability of pressure relieving mattresses and other supporting equipment. A nurse informed us "We are experiencing no problems obtaining any pressure devices." We also witnessed two members of staff provide a hoist transfer from a lounge chair to a wheelchair with safe moving and handling techniques, they showed humour, care and respect for the dignity of the individual.

Good

Is the service effective?

Our findings

People who used the service made positive remarks about the staff team and their ability to do their job effectively. One person said, "The staff are dead nice and the nurses are really nice too." Another person told us, "Oh they look after me and the carers are alright." A visitor said, "The staff are amazing, approachable. The girls on the shop floor work so, so hard. They are lovely with mam."

Staff made positive comments about the support they received and training attended. One said, "I'm happy with training and supervision." Another staff member said, "Training and supervision is okay. I've done an oral hygiene course." A further remark was, "I have supervision or you can go to the office; it's an open door."

Staff felt the supervision they received was helpful. Records confirmed staff attended regular individual supervisions and group meetings. The records of these supervision meetings contained a summary of the discussion and the topics covered were relevant to staff roles, service users and staff's own general welfare.

A staff member told us, "I'm starting the care certificate and have done an induction here." Nursing staff received training appropriate to their role, and those we spoke with made positive comments about the clinical support they received. Records showed staff had received safety related training on topics such as first aid, moving and handling, and food hygiene. Topics and learning opportunities relevant to the health and care needs of people using the service were also offered. Further training was planned, including refresher training once training was deemed to be out of date. Staff also had access to additional information and learning material relevant to the needs of people living at Craigielea Nursing Home.

A nurse we spoke with informed us that she viewed staff as being well trained and she was supported by senior carers who held relevant qualifications and possessed relevant skills. The nurse confirmed that the care home provided 'in-service' training covering a wide range of topics, including safeguarding, MCA and DoLS, catheterisation, mouth care, use of bed rails and risk assessments. They did not feel that staff were asked to do anything they were not trained to do. The nurse stated "I never feel that I am left to deal with situations I am not fully equipped to manage safely and professionally." Agency nurses received mandatory training with the agency, but were also encouraged to attend 'in-house' training at the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met.

We discussed the requirements of the MCA (and the associated DoLS) with the registered manager. They told us people's capacity to make decisions for themselves was considered as part of a formal assessment. We also saw people's decision making capacity and consideration of 'best interests' was considered in relevant care plans and risk assessments. Staff recorded in daily notes where consent was sought and given for care and treatment interventions. Those people living with dementia had their capacity to make decisions assessed. Where they lacked capacity and decisions were taken in their best interests, a DoLS had been applied for. A copy of the authorisation was retained on file so staff were aware of any relevant conditions attached to the authorisation. Staff confirmed they had received guidance on the MCA and DoLS. One said to us, "We've had a distance learning booklet to complete. I'm aware of the process (to apply for a DoLS)." Staff tried to identify what each person's known beliefs and wishes were in relation to any best interest decision taken, with the least restrictive options considered, so they could anticipate people's wishes in relation to their care. Staff also sought consent for day to day decisions, and one told us, "We involve people in decisions and ask for consent."

People's comments about the food and drink provided included, "It's comfortable enough. I get food and a cuppa in my room", "The food's fine", "They're good meals", "The food's wonderful. My family eat here. I get enough to eat and drink" and "Oh goodness yes I get enough to eat and drink."

Staff undertook nutritional assessments and if necessary drew up a plan of care for meeting dietary needs. This was reviewed periodically; either monthly or weekly depending on people's needs. People's weights were regularly monitored to ensure care was effective and to identify the need for additional advice and support from the GP or dietitian. We saw this support and advice had been arranged where people were at risk of malnutrition and supplementary food products had been prescribed for them. Staff in the kitchen confirmed they were aware of those people who needed their meals fortified, for example with full fat milk and butter. Kitchen staff were made aware of people's other dietary needs and preferences, such as those related to health conditions, cultural beliefs and medicine interactions.

We observed people living at the home being offered drinks (and asked their preference) at regular intervals and drinks were available for people in their bedrooms. Care plans and risk assessments on supporting eating and drinking were in place. For people at risk of dehydration, their fluid intake was monitored and a running balance was kept. Minimum target fluid intake levels were not set, which would enable staff to identify if intake was below suitable levels. We highlighted this finding to the registered manager to review and address for those people concerned. They acknowledged this feedback and undertook to ensure this was addressed without delay.

People using the service and their relatives confirmed that health care from practitioners, such as the General Practitioner (GP), chiropodist, dentist and optician could be accessed as and when required. People with mental health needs had external contact with appropriate services. The input of a consultant psychiatrist and community mental health staff was sought to support a person with more complex needs. Care plans relating to healthcare needs were up to date and completed appropriately. Medical history information was gathered and was available in a way that could easily be communicated with other services, for example when someone needed to be admitted to hospital at short notice.

A relative informed us, "We are very involved with all aspects of dad's treatment, I'm very impressed with the nursing and pain management; everything is documented." Staff explained how they worked with other professionals. One visitor expressed concern about how responsive their relatives GP practice was stating, "The GP from [Name] surgery has been slow to address my mother's needs. The home dissuaded us from continuing with our old GP because they prefer only dealing with the one medical practice." A staff member commented to us, "We get on well with the district nurses, opticians and dentist."

Good

Is the service caring?

Our findings

People using the service and their relatives told us they were happy living at the home and were treated with dignity and respect. One person commented to us, "I have nothing but praise for all the staff, they seem very caring and patient." Another person said, "Care? They ask and you just say what you want." Other comments from people using the service included, "It's perfect" and "All in all it's been better than what I'd thought. It's a quiet and calm place." Visitors said, "My mam is treated with respect and dignity", "I'm very happy with the staff, they are kind, understanding and extremely patient, they always say hello to you and they know all the visitors names", "It really is smashing here, I like the way the staff all spend time with my dad, I can't explain how really nice they are" and "We often stay over here as dad is on end of life care and the staff look after us very well, above and beyond what they have to do."

We saw people's privacy and dignity were promoted. We observed staff supported people in a professional, friendly and dignified manner. People we met were well groomed and smartly dressed. Staff spoke with people with consideration and staff were seen to be polite. We observed the people using the service to be relaxed when in the presence of staff. We also observed staff members interacted in a caring and respectful manner with people using the service. For example, support offered at meal times was carried out with patience and at a pace that suited each person. Where staff provided one to one support they sat with, chatted to and interacted politely with the person. We observed appropriate humour and warmth from staff towards people using the service.

Staff also acted appropriately to maintain people's privacy when discussing confidential matters or helping people with their medicines. Staff we spoke with were clear about the need to ensure people's privacy; ensuring personal matters were not discussed openly and records were stored securely. One staff member told us, "We get to know the person, use a sheet to preserve dignity and make sure doors are not ajar." Another said, "If hoisting someone we will put a blanket over them or towel if they're wet. We always keep doors shut." We saw staff knock on bedroom doors before entering.

People and their relatives told us they were involved in decisions about their care and stated if they had any worries they could approach the staff and they would help. A staff member told us, "Families are part of the care and have a good working relationship. We make ourselves visible." People explained to us that routines were relaxed and based on their preferences, such as when they went to bed and rose in the morning. One person said, "I can go to bed and rise anytime I want here." Another person commented, "You can please yourself about bedtime."

Relatives also informed us that they were kept up to date and involved in important decisions about their loved ones care. People were encouraged to go out with families if they were able. There was an abundance of areas for privacy and 'time out' if needed. We observed in people's care records that there was evidence of people's involvement in decisions. There was also evidence of the involvement of advocates. Advocates work with people to help them express their views on important matters, such as decisions relating to care and treatment. The registered manager was aware of local advocacy services available to support decision making for people should this be needed. We observed people being asked for their opinions on various

matters, such as meal choices, and that staff discussed and encouraged participation in day to day activities.

People's spiritual beliefs were supported. A Eucharist Minister was present at Craigielea Nursing Home during our visit. They informed us, "I say holy mass for the Catholics and prayers for other denominations. I don't force myself on other people, only if they want to take part. I only visit this home and I think it's nice. The staff are always pleasant and friendly. I've never seen anything to concern me."

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to their needs and they were listened to. People were aware of and involved in planning their care. One relative told us, "Staff respond very quickly here, I asked for more heating the other day and they brought blankets and turned the heating up."

Staff identified and planned for people's specific needs through the care planning and review process. We saw people had individual care plans in place to ensure staff had the correct information to help them maintain their health, well-being and individual identity. When people had moved to Craigielea Nursing Home a senior member of staff undertook an initial assessment of their needs to ensure they could be met at the home. Their needs had been reviewed and re-assessed since that time. From these re-assessments a number of areas of support had been identified by staff and care plans developed to outline the care needed from staff. There was evidence to show that people's care and treatment was reviewed and re-assessed in response to changes. For example, staff acted on feedback from people, or instances where people's needs had changed or risks increased. Areas included changes in people's tissue viability, nutritional risks and personal care needs.

Care plans were sufficiently detailed to guide staffs' care practice. Staff developed care plans with a focus on maintaining people's wellbeing and where possible independence. Care plans covered a range of areas including; physical health, psychological health, leisure activities, and relationships that were important to people. Care plans were evaluated regularly to ensure there were meaningful. There were evidence based updates on the progress made in achieving identified goals, such as helping people to gain weight and manage distressed reactions. If new areas of support were identified, or changes had occurred, then they were modified to address these changes. Staff also detailed the advice and input of other care professionals within individual care plans so that their guidance could be incorporated into care practice.

Progress records were available for each person. These were individual to each person and written with sufficient details to record people's daily routine and note significant events. Such records also helped monitor people's health and well-being. Additional monitoring records helped evidence the care and support provided, for example with distressed reactions, diet and pressure area care. Areas of concern were recorded and these were escalated appropriately, for example to the GP, or to mental health and community healthcare professionals, such as the dietitian and tissue viability nurse.

Staff told us they were kept well informed about people's changing needs. One staff member informed us, "We get well informed at handovers." We saw a staff handover book was positioned at the nurse's station and contained information on daily routines and duties. This also contained information relating to people's care needs and requirements for the next shift. Examples included, doctor's appointments, visits by other health professionals and general change in people's conditions who may require more input and support.

Staff had a good knowledge of the people living at the home and could clearly explain how they provided support that was important to each person. Staff were readily able to explain people's preferences, such as those relating to health and social care needs and personal preferences. A staff member said to us, "We find

out about people's preferences straight away, such as gender specific care."

The people living at Craigielea Nursing Home accessed occasional activities in the service. One person told us, "We had a concert and other things are planned." A relative stated to us, "Entertainment is not there now. They used to get one to one, the girls don't have time. It gives people a break when they are shouting. [Name] screams and yells. It snaps her out of it when you speak to her." The post of activities worker was vacant after the person moved to a care worker position. The registered manager informed us activities still occurred and acknowledged there had been an impact on the availability of activities in the home. They had identified recruiting a new activities worker as one of her priorities and informed us they were in the process of undertaking this process. The home benefited from an attractive enclosed garden to enable people to spend time outside when the weather permitted. We saw people were able to accept visitors throughout the day and could receive their guests in private or shared lounges.

People using the service expressed a good understanding of to whom and how to complain. Most said they would speak to a member of staff and the registered manager if they had any concerns. One person said, "I cannot complain. I'd go straight to [manager]. If I wasn't happy she'd sort things out." A visitor informed us, "I've never had the need to complain about anything but I know how to do it." We saw information about making a complaint was available on the service's notice board. There was a low threshold for recording complaints, including those made verbally. There were 44 complaints recorded within the service during the 12 months from November 2015. Records showed the complaints were acknowledged, investigated, an outcome communicated to the person concerned and apology offered where appropriate. Themes included fees, personal care issues, falls, food and issues with the premises.

A record of compliments was also kept, as well as numerous thank you cards, where people expressed thanks and gratitude for the care given and approach of staff. Comments from compliments included; "Thank you to everyone at Craigielea for their care, support and friendship they gave to our mam during her seven year stay. This is greatly appreciated", "Thank you for your kindness and attention in caring for [name] in his last difficult weeks and days", "A great big heartfelt thank you to all caring for [name] this past couple of months, It was nice having him so close and thank you for letting us visit any time. We are very grateful" and "To all the loving angels at Craigielea. Thank you for the 90th birthday buffet."

Requires Improvement

Is the service well-led?

Our findings

We saw the registered manager carried out a range of checks and audits at the home. A representative from the provider organisation also visited to carry out a quality check on care and staffing issues, and staff confirmed senior managers attended the service periodically, seeking their views and those of the people living at Craigielea Nursing Home. A staff member said, "The management's alright. A senior person comes in and says hello." During the inspection a senior manager attended the home to support the registered manager.

Routine checks and systems of work did not identify and lead to effective management of the shortfalls we found regarding the safety of the service. These included premises and equipment maintenance omissions, poor specimens handling, and medicines management issues.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection there was a registered manager in place. People and their relatives told us they were happy with the leadership there. One person's relative told us while pointing to manager, "This is a good boss." Another person said, "The one in charge is wonderful. She has a walk around. Very friendly." A relative told us, "[Manager's name] has a really difficult job. If you go to [name] she's on the case." They were less complimentary about the care provider, stating, "The home's changed since it was taken over. They've promised the earth and delivered nothing. They treat the home like a hotel not a nursing home." They supported this by highlighting difficulties with the heating concerns and linked concerns about the welfare of service users, when people were wrapped up in blankets." They also commented, "The lighting in the dining room's so dark."

Staff were complimentary about the leadership of the service. Their comments included, "I find [the manager] very approachable", "I have a good working relationship with [manager]" and "She considers what's best for the home. She's fair with myself, she's been brilliant." A nurse informed us, "The Manager is very approachable and her clinical skills are excellent." The nurse continued by stating "The manager will assist in any clinical procedure nurses are not comfortable with such as compression bandages and care of supra pubic catheter." She added, "The Manager is 'hands on' and has good leadership skills."

The registered manager was present and assisted us with the inspection. They appeared to know the people using the service and the staff well. Paper records we requested were produced for us promptly and we were able to access care records on the provider's IT system. The registered manager was able to highlight their priorities for the future of the service and was open to working with us in a co-operative and transparent way. They were aware of the requirements to send CQC notifications for certain events and had done so. We saw the registered manager had a visible presence within the home and was known to the people using the service. The registered manager told us about the underlying values they saw as important, including ensuring people were treated with dignity and respect.

The registered manager was clear about the challenges facing the service as they provided care for people with increasing levels of complex needs. The underlying values of the service were clearly expressed and staff at all levels saw that ensuring people were treated with dignity, respect and as individuals was central to the service offered. This was supported by the designation of staff as 'champions' including a dignity champion.

To ensure a continued awareness of current good practice the manager attended on-going training and had networked with other managers within the provider group and more widely. They had supported the learning and development of colleagues, including agency nursing staff. The registered manager sought the advice and input of relevant professionals, including in relation to people's general medical and mental health needs.

Staff said they were well informed about matters affecting the home. The registered manager told us there were staff meetings and meetings for people living in the home. Records confirmed this was the case. There was a broad range of topics discussed at the meetings. The resident and relatives meetings included discussion on activities, staffing, care delivery, catering and building related matters. Team meetings included discussions of care related, safety, policy and personnel issues. Feedback from people using the service, their relatives and staff was also sought by questionnaires. Survey results highlighted areas of satisfaction with the service as well as suggestions for improvement. Areas for further improvement had been identified and actions commenced to address these. This gave the people using the service, their relatives and staff the opportunity to be involved in the running of the home and to be consulted on subjects important to them.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the equipment used by the service provider for providing care or treatment to a service user was safe for such use and used in a safe way. Regulation 12(2)(e). The registered person had not assessed the risk of, prevented, detected and controlled the spread of infection, including those that are health care associated. Regulation 12(2)(h). The registered person had not ensured the proper and safe management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems and processes were operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured there was sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to provide person centred care and ensure safe care and treatment of service users.