Czajka Properties Limited

Staveley Birkleas Nursing Home

Inspection report

8-10 Staveley Road
Nab Wood
Shipley
West Yorkshire
BD18 4HD

Tel: 01274588288
Website: www.czajka.co.uk/staveley.html

Date of inspection visit:
03 January 2018
10 January 2018

Date of publication:
06 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Staveley Birkleas is a nursing home. People in nursing homes receive accommodation, nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Staveley Birkleas provides accommodation to a maximum of 60 people, spread over three floors most of whom are living with physical disabilities. All the accommodation is in single rooms and the service is located in the residential area of Nab Wood, in Shipley, West Yorkshire. At the time of the inspection 51 people were living in the home.

The inspection was undertaken on 3 and 10 January 2018 and was unannounced. At the last inspection in September 2016 we rated the service 'Good' overall and 'Requires Improvement' in the 'Is this Service Well Led?' domain. We identified a breach of regulation relating to 'Good Governance' as care records did not always demonstrate people's needs were met. At this inspection we also found issues with care and support records which impacted on the service's ability to evidence appropriate care.

A registered manager was not in place, although a manager was in post who told us it was their intention to apply to be the registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's feedback about the home was positive. They said they felt safe and secure living at Staveley Birkleas and were satisfied with the care provided. We found the home adhered to some good areas of practice. For example, there was a person centred culture with people able to pursue their preferred routines, interests and aspirations. Staff genuinely cared for people and we saw evidence the service had gone the extra mile to ensure people were provided with social opportunities, activities and bespoke and individualised equipment. However improvements were needed to care plan documentation, in order to evidence that appropriate care was consistently provided. There was a lack of oversight, review and audit of some areas of care and a lack of nursing leadership within the home. Because of these issues and despite the good areas of practice we identified, this meant we were unable to rate the service better than 'requires improvement.'

People said they felt safe and secure living in the home. We saw safeguarding procedures were in place and had been followed to help keep people safe. Following incidents, investigations were undertaken and learning took place following each incident to help ensure continuous improvement.

Most medicines were managed safely and given as prescribed. However records were not always kept for the application of topical medicines such as creams.

Overall staffing levels were appropriate and enabled people to experience prompt care and support. However nursing staffing levels were not always maintained at the same level and some staff raised

concerns about this. We made a recommendation in relation to nurse staffing levels.

Most risks to people's health and safety were appropriate assessed and mitigated, however nutritional risks were not always properly monitored or reviewed. Where people's nutritious input was being monitored, charts did not always evidence they had received a suitable diet.

Staff received a range of training tailored to their individual requirements. Care staff received supervision, however supervision for nursing staff required bringing up-to-date. We made a recommendation in relation to carrying out nursing supervision.

The service was compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw people were given choices and control over their lives and consent was sought before care and treatment interventions.

The service worked in partnership with other agencies and health professionals to help ensure people's needs were met. Technology was utilised to make these relationships effective and timely.

People all said staff were kind and caring and treated them well. Good positive relationships had developed between people and staff. People's independence was encouraged and the service had a high regard for people's privacy and dignity.

People living in the home were not discriminated against and the service took steps to ensure individualised equipment was provided and adjustments were made to meet people's diverse needs and requirements.

People's care needs were assessed and in the most part appropriate plans of care put in place which met their individual needs and requirements. People's preferences were reflected in care planning. People said care needs were met by the service.

People had access to an excellent range of activities and social opportunities. The service had developed strong links with the local community which benefited people who used the service.

People's complaints were recorded, investigated and acted on. People said they knew how to complain and felt comfortable raising issues with staff and management.

We found a good culture within the home with staff committed to ensuring people received person centred care. Feedback from people, relatives and staff about the home was very positive.

The home had achieved accreditation with external organisations such as the Investors in People award as a method to help ensure high quality and continuous improvement.

However systems to assess, monitor and improve the service were in place but some of these needed to be more robust. Greater nursing oversight was required of daily charts and care and support plans. Care records showed a lack of nursing input and nursing staff said they did not always have the time to review care plans and charts. Some audits such as care plan audits were not undertaken at the frequency specified by the provider. This was also the case at the last inspection.

People were involved in the running of the home through various mechanisms including the resident and relative meeting. Some people were also involved in the recruitment of staff. People's views and opinions were valued and used to make improvements to the service.

We identified two breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked 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 told us they were happy with the service and felt safe and secure. Learning took place following incidents and accidents to further improve safety.

Although most risks to people's health and safety were appropriately managed, monitoring of nutritional risks did not consistently take place.

Overall there were enough care staff to ensure people received timely care and support. Nurse staffing levels were inconsistent at times and nurses told us they were sometimes too busy to review paperwork. Staff were recruited safely to the service.

Most medicines were safely managed and given as prescribed. However improvements were needed to documentation to evidence that topical medicines such as creams were given as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received a good range of food with plenty of choice. However monitoring of food and fluid input needed improving to ensure people were receiving an appropriate diet.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS).

Staff praised the training which they said was high quality and tailored to their role. We saw staff received a range of training. There was a lack of supervision for nursing staff and these staff told us they did not always feel well supported.

The service worked with a range of health professionals to help ensure people's needs were met. This included sourcing additional training and support to improve the effectiveness of care and support.

Is the service caring?

Good

The service was caring.

People said staff consistently treated them well, with kindness and compassion. This was confirmed by our observations of care and support. Good positive relationships had developed between people and staff.

People's independence was promoted and freedom was given to people to allow them to remain as independent as possible.

People had choice and control over their daily lives. People were able to adhere to their preferred routines and activities.

Is the service responsive?

Good

The service was responsive.

People and relatives said care needs were met. Care plans demonstrated people's needs were assessed and appropriate plans of care put in place for staff to follow.

People had access to an excellent range of activities and opportunities. This included activities in the local community, holidays and opportunities to achieve their dreams.

A system was in place to log, investigate and respond to complaints. People said they felt able to approach and confide in the management team.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A registered manager was not in place, although the home manager told us it was their intention to apply. There was a lack of clinical leadership in the home although plans were in place to address this.

People, staff and relatives spoke positively about the home, the culture and said high standards of care and support provided.

Audits were undertaken, however these were not always at the planned frequency and better oversight was needed of some care documentation to ensure it was completed to a high standard

Staveley Birkleas Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At this inspection we followed up on the requirement notice we issued at the last inspection in September 2016 to see if improvements had been made.

The inspection took place on the 3 and 10 January 2018 and was unannounced. On the first day the inspection team consisted of two inspectors and two Experts 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. The Experts by Experience had experience of physical disabilities. On the second day the inspection team consisted of two inspectors and an inspection manager.

During the inspection we spoke with 14 people who used the service and five visitors. We also spoke with three nurses, ten care workers, a care lead, the activities co-ordinator, a chef, the deputy catering manager, the manager and the regional manager. We observed care and support, including the mealtime experience and looked around the home. We looked eight people's care records and other records such as medication records, meeting notes, accident and incident reports, training records and maintenance records.

Before visiting the home we reviewed the information we held about the service which included notifications sent to us by the provider. We contacted the local authority commissioning and safeguarding teams to ask for their views of the service. We spoke with one health professional who works with the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service

does well and improvements they plan to make

Requires Improvement

Is the service safe?

Our findings

We saw some examples where risks to people's health and safety were assessed and mitigated. Care records showed that risks in areas such as bed rails, falls, skin integrity and moving and handling were assessed and plans put in place to help keep people safe. Where people had capacity to make decisions for themselves we saw the risks and benefits of particular interventions for example bed rails and PEG (Percutaneous endoscopic gastrostomy) had been discussed with them to help then make informed care and treatment decisions. This increased people's freedom and independence to make risk based decisions. Specialist equipment was in place to reduce the risks in areas such as moving and handling, with ceiling hoists installed in rooms. People had individualised moving and handling equipment in place such as slings. Everybody who needed it said that specialised transfer equipment was always available, one person said, "The hoist is there when I need it, it is always on charge, there are always two to hoist me." We saw bespoke equipment had been provided to people to reduce risks, for example one person had a specialist call buzzer as they could not summon assistance using a standard call bell.

The home employed an in house physio aid, who provided physiotherapy to people should they request or require it. The physio aid also provided specialist skills to ensure that moving and handling assessments and practices were maintained to a high standard. They provided training to care and nursing staff within the home to help maintain safe practices. This helped ensure the safety of people.

However, despite some of these positive examples we saw that risks to people were not always consistently managed and mitigated. For example, nutritional risks were not always effectively monitored and mitigated. People were required to be weighed either weekly or monthly dependant on the level of assessed risk, and nutritional risk screening tools completed to determine the risk level. However this was not always happening at the required frequency, which increased the risk that poor nutrition would not be promptly identified. For example one person's care plan stated they should be weighed weekly, however they were last weighed on 13 October 2017 and 28 December 2017. This person was also having their food and fluid input monitored however food charts were poorly completed and did not give accurate information on their input to properly assess the level of risk . Food charts were not subject to regular review by nursing or care staff to ensure people was getting enough to eat and drink. Nursing staff told us they did not have time to do these checks.

Another person's care plan stated they required weekly weight checks. However there were no weight records within their care file and no nutritional risk screening tool. Another person's nutritional screening tool had not been completed since October 2017 despite records stating it should be done monthly. A fourth person's care records had information from the speech and language therapist (SALT) advising the person required a fork mashable diet and that bread should not be offered. Records showed this person had sandwiches and buffet food which was not in line with their safe plan of care. This had not been identified and investigated by the service.

Some people had air mattresses in place to reduce the risk of skin damage. Regular checks should have occurred to ensure they were on the correct setting however these checks were not taking place. We saw

this lack of checks meant equipment was not always set correctly. For example, we saw one person whose weight was 68kg had their pressure relieving mattress set at the level for people over 90kg.

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

Everyone we spoke with said they felt safe and secure living at Staveley Birkleas. One person said, "I feel safe and well looked after." People said they were consistently treated well by staff. They said when incidents occurred they were dealt with effectively by staff. For example one person said "I have seen some arguments between some people, the staff manage them well and calm them down." Another person said "the staff calm people down well, I have never seen any of the staff being nasty."

Staff had received training in safeguarding vulnerable adults and knew how to identify and act on allegations of abuse. We saw appropriate safeguarding referrals had been made to the Local Authority and the Care Quality Commission by the manager and investigations undertaken to help keep people safe.

The premises were safely managed with safety features installed to reduce the risk of harm to people. For example window restrictors were installed to reduce the risk of falls and hot water temperatures were restricted to reduce the risk of scalds and burns. The premises was suitable for its intended purpose with adequate amounts of communal space for people to spend time including a pleasant garden area. It was kept well maintained with key safety checks taking place. Fire evacuation procedures were in place for each individual person. People knew about the fire evacuation procedures and one person explained them to us in detail.

We concluded there were enough care staff on duty to ensure people's needs were met. People and care workers told us that there were no problems with staffing levels and people received prompt assistance when they needed it. One person said, "There are enough for me personally." Most people felt there was a good response to the buzzer or when asking for assistance one person said, "I might wait a couple of minutes only, even at night. Some people received 1-1 support. People and staff told us these hours were consistently provided to ensure people's needs were met. We looked at rota's which showed although there were some variations in staffing levels due to sickness, appropriate levels were usually maintained. Call bell response times were monitored and showed that on the whole people did not have to wait for an unacceptable amount of time for staff to respond.

Nursing staff raised concerns with us about a recent reduction in daytime nursing staffing levels from three to two. They said this meant they had little time to do other nursing tasks other than administer medicines due to the complex needs of some of the people living in the home. We found there was a lack of nursing review and oversight of some care plans and daily charts and nursing staff said they did not have time to undertake these. We spoke with the manager who said they thought three nurses were currently required each day shift but that a decision had been made by senior management to only allow three nurses per shift if this didn't require agency use. This was part of a plan to reduce the number of agency staff used. Rotas' showed it was a common occurrence for only two nurses to be on shift, for example between 1 – 7 January, 10 out of 14 day shifts saw only 2 nurses on duty. However this approach was likely to lead to variations in the quality and availability of nursing care. We saw there was a commitment from the provider to provide additional nursing staff through the recruitment of further nursing staff.

We recommend the provider ensures consistency in nurse staffing levels based upon the needs and dependency of people who use the service.

Safe recruitment procedures were in place and were in the most part followed. New staff were required to complete an application form and attend a competency based interview. People who used the service were involved in recruitment. This allowed them to have a say in the people who supported them. The required checks took place on new employees. This included a Disclosure and Baring Service (DBS) check, references from previous employment and a check of any qualifications. We did identify one person's application form was dated after their offer of employment letter which suggested the correct recruitment procedure was not followed. Application forms should be completed at the start of the recruitment process in order for the service to review whether candidates experience, qualifications and personal attributes are compatible with the role. We raised this discrepancy with the manager to investigate.

All of those who were given medication were happy that this was given in a timely manner. One person said, "They give me the right things at the same time every day." We observed a nurse giving a person their medication. We saw they were kind, caring and took their time. They knelt beside the person and asked, "Am I all right to give you your medication now?" They stayed with the person until they had taken them.

We looked at the medicine administration records (MARs) which indicated people had received their medicines as prescribed. Where people had medicines prescribed on an 'as required' basis, we found there were protocols in place to guide staff as to dose, time interval, allergies, preference and side effects. Where people required medicines as specific times arrangements were in place to ensure this took place.

However, we found consistent records were not always kept regarding the provision of topical medicines such as creams. For example we saw one person was prescribed two creams and instruction in the care plan stated one of these should be applied four times a day. We saw no records were kept showing administration. Other MAR charts said 'see topical MAR's for cream application' but there were no records kept and no information on when and where to apply these creams. We raised this with the manager who agreed improvements were needed in this area. By the second day of the inspection, the service was in the process of implementing these improvements. However, the provider should have identified and addressed these issues through their own systems and processes.

We found medicines were stored securely, and storage for medicines classed as control drugs was compliant with current legislation. Medication which required refrigeration was stored correctly. Safe stock control measures were in place for medicines stored in the lockable trolley. The person responsible for medicines administration counted boxed medicines each time these were administered, including when PRN medicines were offered. This ensured any discrepancies were identified and actions taken immediately. We checked a number of stock balances and saw these corresponded to what should have been present. However, for medicines stored in the stock cupboard the records were not always correct, new stock had been booked in but old stock not added to the total balance. This meant there was a lack of accountability for these medicines.

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

We observed the environment was clean and tidy with no offensive odours. Everybody felt that the standards of cleanliness and hygiene were good one visitor said, "It is clean and hygienic, the kitchen is always clean." The home had been awarded a five star food hygiene rating by the Food Standards Agency. This is the highest rating that can be awarded and indicates that food is stored and prepared under hygienic conditions. The home had achieved 97.5% in a recent infection control audit conducted by the local authority which showed improvement on the previous year.

Incidents and accidents were managed appropriately. We saw these were recorded on specific forms with the information then transferred onto the corporate database for review by senior management. Incidents investigation reports were completed for serious incidents, with care plans reviewed and preventative measures put in place. For example, one person had absconded from the building. This was reported to the Police, Local authority and the Care Quality Commission. The person's care plan had been reviewed with the person and information added to provide staff with additional guidance on how to reassure the person and ensure plans were in place to take the person out. We saw separate falls analysis was taking place to mitigate risks to people living at the home. This included looking at total falls, causes, time, trends and action taken. We saw actions had taken place which included the use of sensory pads, crash mats and lowering people's bed. We were given further examples which led us to conclude there was a culture of learning from adverse incidents. For example there was a small fire within the home and the service had reviewed the CCTV to monitor staff responses. A training session was to be prepared to highlight the areas that staff could have acted differently to further improve any future emergency response.

Requires Improvement

Is the service effective?

Our findings

People's care needs were assessed in the care planning stage, taking into account their individual needs and preferences. Care needs were assessed monthly or more frequently if changes were required. Specialist input was sought to help ensure the service worked to recognised and evidence based guidance. For example the service had entered into a contract with the local Speech and Language Therapist (SALT) team to provide enhanced training and support to the chefs and care team. The service had achieved Gold Standards Framework accreditation which meant that it adhered to best practice in regards to end of life care. Nursing staff had assigned champion roles for example around end of life care, learning disabilities, mental health and tissue viability. This meant these staff were responsible for keeping up-to-date with best practice and disseminating their knowledge to others. We spoke with a nurse about this who was clear of their responsibilities in these areas and said the use of their colleagues to obtain specialist knowledge and guidance worked well. However we did find there was a lack of nursing input into the review of some care and support plans which could impact the effectiveness and appropriateness of care and support plans.

People and relatives spoke positively about staff and the level of training they had received. One visitor said, "There are a lot of training classes, they are well trained". Another person said, "They are well trained, they wouldn't be in the job if they weren't." The service had its own training centre and dedicated training staff which allowed all training to be personalised to the needs of the service and delivered face to face. Both nursing and care staff spoke positively about the training they received, and said if they asked for additional training it was provided to them. For example one person who used the service had displayed behaviours that challenge. Staff had been on training to help them meet this person's specific needs. Another staff member told us they had asked to do a sign language course so they could effectively communicate with one person and this had been provided. During the inspection we saw staff using sign language to communicate with this person. Staff said they were supported to do further qualifications in health and social care to further develop their skills.

Staff new to care were enrolled to complete the Care Certificate. This is a government recognised training scheme, designed to equip staff new to care with the required skills for the role. New staff also received an induction to the service and received classroom based training in a range of subjects. Existing staff received regular training updates, we looked at training records which showed these were mostly up-to-date.

Care staff said they felt well supported and we saw they received supervision and support from the management team. However nursing staff told us they felt less supported. We saw they had not received any supervision in over 6 months, due to the lack of nursing management in the home to undertake this. This meant that a key support and developmental mechanism for these staff was missing.

We recommend the service ensures that clinical supervision is provided for nursing staff.

Everyone we spoke with was positive about the food and quality of the meals provided in the home. One person said "The food is alright, they will make cooked alternatives if I don't like the choice". Another person said "The meals are very good, plenty to eat, good choice." Menu's confirmed people had a good choice of

meals which rotated over a four week period. For example at breakfast there was a range of options including a cooked breakfast. At lunchtime there were two main meals available, as well as alternatives such as omelettes, salads and sandwiches, with lighter options available in the evening. We saw there was a philosophy of providing people with what they wanted to eat. The deputy catering manager told us "If someone asks for a steak we will go out and get them a steak." We saw staff undertook trips to the supermarket to meet people's individual requests for off menu items, showing a service dedicated to ensuring people were happy and had their requests met. People's diverse needs were taken into account, for example one person required halal food, so this was purchased separately and trips were undertaken to an Asian supermarket to obtain spices so that their preferred foods could be cooked. We spoke to a relative of someone who was diabetic who said the service and staff were knowledgeable and acted appropriately with their diet to keep them safe. People had access to regular drinks and snacks were available between meals. Smoothies were made daily to help meet people's nutritional needs. People's independence was promoted with some people encouraged to prepare their own drinks and meals.

We observed the lunchtime meals and saw people were provided with appropriate support by staff. The atmosphere was good and tables were decorated and set appropriately. People appeared to enjoy their foods and care staff offered gentle encouragement.

Whilst people's weights were not always undertaken at the required frequency, we saw that most people maintained a stable weight and we saw examples where weight loss was identified and appropriate action was taken. Food and fluid charts were in place for those assessed as being at nutritional risk. However these were often poorly completed, did not always evidence people were receiving a good diet and were not subject to review by staff. People's charts did not have a target of an amount of daily fluid to be taken. Based on people's weights the charts demonstrated people were not receiving the required amount of fluid. One person's nutritional care plan review dated 26 August 2017 stated the previous advice that they should have three milkshakes a day as supplements had recently been stopped. On the 11 September 2017 the dietician wrote to the home raising concerns about incomplete charts and lack of evidence of snacks and milkshakes being offered. We reviewed their food and fluid intake charts for seven days from 1 January to 7 January 2018. Records were still inconsistently completed and charts did not evidence the required snacks and milkshakes were being provided. Nurses told us they did not have time to review these charts. This risked that timely action may not be taken to address any issues. Improved record keeping was required to better demonstrate people's nutritional needs were being consistently met by the service.

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

The service worked with a range of other services to help meet people's individual needs. A general practitioner completed a weekly ward round each week to review people's health. A physio assistant worked at the service and the physio support was also provided by the local hospital. We were given examples by staff of how they had worked effectively with others as part of a multi-disciplinary team to meet people's needs. For example one person had suffered a head injury and the input of head injury specialists had been sought to plan appropriate care and support. A diverse range of equipment was in place to improve and support people's independence and this had been sought in conjunction with other health professionals.

Everybody felt that there was good access to other health care professionals. One visitor said "There is good access, the optician comes in yearly, the doctor weekly." Another visitor praised the home on picking up on a medical condition promptly so they could receive treatment. A third visitor told us "They get them in on a regular basis, so he can see them if he needs to". Relatives said they were kept well informed about their relatives healthcare needs. For example one relative said "They phone up straight away if he gets referred",

and another relative said, "They tell us when we come in about small changes."

Care records showed people had access to a range of health and social care professionals such as GP's, district nurses, dieticians, opticians and dentists. For example, we saw the service referred people at nutritional risk to the speech and language therapy (SALT) team. Where required, we saw appropriate equipment such as crash mats, hoists and bed sensors was in use. We saw people had been assessed for equipment appropriately.

The premises had been adapted to meet the needs of people who used the service, namely those with physical disabilities. Bedrooms had large en-suite areas for ease of accessibility and ceiling hoists were installed for convenient and prompt moving and handling. Appropriate handrails were installed throughout and plates along the walls to avoid scuffing of the furniture. Bedrooms were spacious and people had been encouraged to personalise their bedrooms with their personal possessions. People and relatives were positive about the premises. One visitor said "The decorations are OK, they decorate the rooms to suit the occupant, the outside is quite impressive." Internally there was a sensory room with music, lighting and games as well as a dedicated games room. There was a kitchen for residents to do their own cooking and increase their independence. Externally there was a pleasant wheelchair accessible decking and outdoor seating area surrounded by attractive grounds. We saw adaptions had been made to meet people's individual needs. For example one area had been converted into a flat to meet the needs of one person who used the service and allow them a greater level of independence.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw examples where people lacked capacity that a capacity assessment and best interest meetings had taken place. An example included appropriate action being taken for a person in relation to changing the harness on their wheelchair. The individual was involved in the decision making process, as well as the manager, family and physiotherapist. The nurse told us two individuals received their medicines covertly. However we checked one person's records and found relevant information from the GP and pharmacist but no evidence the best interest process had been followed and no evidence of consultation with the person's relatives. We raised this with the manager who said the documentation must have been misplaced but said they would ensure it was promptly reviewed.

The registered manager had a list of the DoLS applications which had been made. We saw appropriate applications had been submitted. When DoLS authorisations had been granted with conditions we saw these conditions had been complied with. Staff we spoke with had a good understanding of the Act and what impact this had on people living at the service who had DoLS in place.

People said that care workers explained and asked for consent before carrying out care and support tasks. For example, one person said, "They always tell me what they are going to do and make sure I am happy."

Another person said "They explain things and ask if it's OK to do it." Care plans showed people had consented to plans of care.

Good

Is the service caring?

Our findings

Everyone we spoke with said they were treated well and thought staff were kind and caring. One person said "They are very happy and friendly, they are lovely." Another person said "staff have very good practical skills and are also caring, they know my little quirks." A third person said they felt "well looked after" by "kind and capable" staff. A visitor said "On the whole they are more than very good, respectful and caring." Most people said care workers had time during the day to sit and have a chat with them. One person said, "I get involved, they have the time for chats about how I feel."

We observed care and support which supported people's description of staff. We saw interactions between staff and people who used the service were warm and affectionate. Staff were cheerful and friendly and people appeared comfortable in the company of staff. Staff warmly greeted people as they entered communal areas and sat and chatted to them. We observed some instances where staff engaged with people and reassured them when providing assistance. For example, we observed one staff member offering a person reassurance when a person could not get in touch with their relative on the phone. These observations lead us to conclude good caring relationships had developed between people and staff.

The home had received compliments from people's family for their caring attitude. These included "There was a very good atmosphere at Staveley on Christmas Day and we enjoyed our visit," "a heartfelt thank you for your tender care in the last days, [care staff] making [person] smile, [care staff] being like [person] big brother, [care staff] for the crazy dancing that made [person] giggle."

Staff we spoke with demonstrated a good knowledge of the people we asked them about. We saw people's likes, preferences and life history had been sought as part of care planning to aid staff to fully understand the people they were caring for. Staff addressed people by their preferred name and people knew the staff that were supporting them.

We saw staff genuinely cared about people and took steps to ensure their individual requests were adhered to, demonstrating a caring service. For example one person had wanted a special meal with their partner, so staff had arranged and cooked a restaurant style meal for the person and their partner for their anniversary. There were plans to repeat this for Valentine's day. People's birthdays were celebrated, for example cakes and snacks were prepared depending on people's individual preferences.

Staff had received training in equality and diversity and we saw discrimination was not a feature of the service, with the environment and equipment being adapted to suite people's individual needs and requirements. We saw action was taken to ensure people were not discriminated against because of their disability. For example one person was nil-by-mouth, so on their birthday, instead of a cake, an appropriate gift was provided to them by the home.

People and relatives said they were involved in decisions relating to care and support. Relatives said communication was good and that they were always promptly informed about any changes in their relative's condition. Whilst some people had received formal care plan reviews, we saw some of these were

overdue. We raised this with the manager who said they would ensure this was addressed.

We saw a person centred approach to care and support. People reported control over their daily lives. For example one person said "I choose when to go to bed for myself, I wait until I am tired. Another person said" They come to help me get up and dressed but I can say I want to stay in bed." During the inspection we saw people were able to follow their own routines and preferences. For example some people preferred their lunchtime meal later and this was saved for them. A staff member told us that one person wanted a large, late breakfast and did not eat lunch and staff respected this preference.

The service promoted and encouraged people's independence. Everyone we spoke with said they felt they were encouraged to be as independent as possible. One person said "I am as independent as I can be, they let me do things for myself." Another person said they were being given additional living space to practice cooking and organise their routines, they said "I am supported very well to be independent." The service had utilised equipment such as specialist cutlery and adapted call bells to allow people to maximise their independence and do as much as possible for themselves. A therapeutic kitchen was also available, to allow people to practice their cooking skills.

Everybody felt that people were treated with respect and dignity by staff and that care was taken to ensure their privacy. For example one person said, "They close the door and the curtains before helping me to have a bath." Staff routinely knocked on doors and asked permission to enter. One person said "My privacy and dignity are always respected, they knock on the door."

Another person who was hearing impaired had a lighting system in place which alerted them as to when someone was at their door. This demonstrated an adaptable approach to ensure the person's right for privacy was upheld and they were not discriminated against for having a disability. Through conversations with staff they demonstrated a good knowledge and understanding of people's needs and were able to explain how they maintained an individual's dignity whilst delivering care.

People reported no restrictions on visitors and we saw they attended the service throughout the day.

Good

Is the service responsive?

Our findings

People and relatives spoke positively about the standard of care they received in the home and said it met their individual needs. They said care was person centred and appropriate. One person said about staff "they know me as a person not just as a job." Another person said "They know the things I don't like." Relatives said people always looked well cared for, one visitor said "She always looks well groomed." We observed people looked clean and well cared for. Staff assisted people to wear makeup if they wanted and people reported they had regular baths and showers.

People's care needs were assessed and individualised care plans put in place to provide instructions to staff in areas such as mobility, mental health, personal care and around any specific medical or health conditions. Each care plan contained a goal and action needed to meet that goal. Care plans were reviewed monthly by staff. The people and relatives we spoke with said they felt involved in their care and support and it was regularly discussed with them.

Equipment was sourced to help meet people's individual needs. For example where people were assessed as being at high risk of pressure sores, specialist mattresses were sought. However we saw that these were not always being used at the correct setting for the person's weight. At the time of the inspection nobody in the home had any pressure sores. We saw one person was at high risk of poor skin integrity and received regular pressure relief in line with their plan of care.

The service had made use of technology to meet people's individual needs and monitor their welfare. The call bell system logged the response time to each buzzer which helped management assess whether they were able to respond to people in a timely way. Specialist equipment had been sourced such as bespoke lighting to inform people when staff were entering their room and a sensitive call bell for one person who could not use their hands. The service used the telemedicine scheme run by a local hospital trust. Telemedicine provides remote video consultations between hospital nursing staff and the home. It helps support care outside hospital, including avoiding unnecessary visits and admissions to hospital.

People's communication needs were assessed as to the level of support they needed to effectively communicate. We saw staff adapting approaches to meet people's individual needs. We saw staff effectively using sign language to communicate with one person, having received sign language training organised by the provider. Some staff also spoke Polish and Hindu which allowed them to communicate with others that used the service. This showed us the service recognised the importance of communicating effectively with people.

Care planning considered people's end of life needs and wishes. The service had achieved accreditation with the Gold Standards Framework. This meant the organisation was sustaining best practice in End of Life Care, for example staff had been provided with training and care planning and processes had been assessed as being at a good standard. The service worked with the local hospital trust to deliver a Gold Line Service. The Gold Line is a dedicated service for people who are being cared for on the Gold Standards Framework. This is about offering a gold standard of care for people with a serious illness who may be in their last year of

life. It provides 24/7 telephone support to the home to help them meet the needs of people at the end of their life.

The home had access to a range of facilities and resources to ensure people were kept occupied and busy and maintained good links with the local community. The service owned a complex which included a bowling green and clubhouse and numerous events were held there where people from the service attended and mixed with the wider community. People were involved and encouraged to be involved in disability sports such as bowling which were undertaken by an external charity in conjunction with the provider. This provided excellent opportunities for people.

Numerous trips out were undertaken and staff volunteered their time for these to reduce the costs to people who used the service, increasing accessibility. If people wanted to go on holidays, staff supported them to do this through planning and organising staff, recent holidays to Blackpool and Skegness had taken place. People said there was plenty to do in the home. One person said "There are activities, exercises, dance classes, outings." Another person said "Sometimes I choose to join in, there are plenty of things to do." A visitor said "[Person] goes to concerts, there are other things [person] could do if he wanted to". Another visitor said, "[Person] joins in with the exercise classes, [person] likes the pictures, theatre and trips." Two activities co-ordinators were in place who undertook a varied range of activities with people and helped them maintain links with the local community. On the first day of the inspection, a trip took place to a restaurant where approximately 10 people attended, with staff volunteering their time to allow this to take place. Records demonstrated people have accessed a range of internal and external activities including the theatre, canal boat and shopping trips.

There was a 'wish tree' in the corridor where each person placed a wish or goal and then staff worked with the person to achieve it. For example, one person had wanted to drive a performance car and this had been arranged. Another person who was nil-by-mouth wanted to taste chocolate again. The service worked with the Speech and Language Therapist to ensure this person was able to do this as safely as possible. This approach showed the service was committed to maximising people's opportunities and making their dreams become a reality.

The service took steps to involve people to maximise their independence and confidence. People were involved in the creation of the homes newsletter sharing their stories. One person was also involved in recruitment of staff and had been given the role of 'admin assistant' to give them purpose, self-confidence and occupation.

People reported they were satisfied with the service and had no complaints or concerns at the present time. People said where they had made complaints previously they had been fully listened to. One person said "I have made a complaint about somebody shouting out at night, they have sorted it out." A visitor said "The office is always open, I have made a complaint, they wrote back to say they were investigating and then to tell us the result, quick and efficient. People knew how to make a complaint and knew who the management staff were whom they could approach. Information about the service's complaints procedure was displayed in the reception area. The complaints records showed complaints were dealt with in line with the provider's policy. Complaints were investigated and the complainant responded to in writing.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post. The previous manager had deregistered in September 2017. A new manager was in post, who told us they would be applying for the role of registered manager. Because the manager was non-clinical, the home was currently also recruiting to the post of clinical lead, to ensure appropriate nursing leadership and governance. Nursing staff highlighted with us that there was currently a lack of clinical leadership within the home. They raised concerns with us that with the current structure and organisation people's care and support needs were not always fully reviewed by qualified staff. Whilst we saw that initial care plans were created by nursing staff, monthly reviews were sometimes undertaken by nurses but on other occasions, senior and care workers. This meant that there was a lack of nursing oversight into some care and support plans. The manager agreed that this was an issue and that they would be working with nursing staff and the clinical lead once appointed to address this.

People and relatives spoke positive about their overall experience of the home. One person said "The atmosphere, the staff, the care, they are friendly and approachable." A relative said "I am definitely happy, I fought hard to get him here." Another person said "It's a lovely, bubbly place, always something going on." A visitor said "It is well run, the owner is a nice bloke." Everybody made positive comments about the atmosphere in the home one relative said, "It's like a real home". People felt comfortable approaching the management team to raise concerns or talk through any queries. A visitor said "The manager is approachable and will listen and respond to suggestions." A person said "The manager comes to talk to us, she is nice". Everyone said they would recommend the home to others.

The service had a well-defined set of values to ensure people were treated well and standards maintained which were 'compassion', 'adaptability', 'respect', 'excellence' and 'safety.' Staff we spoke with were very familiar with these values and were able to explain how they were used to enhance people's care and support experience. Care staff we spoke with was enthusiastic about their role, told us they enjoyed working at Staveley Birkleas and gained satisfaction from their job. Comments included, "I love my job and working here, I have just applied for a senior role". "I find [manager] approachable, they are open to new ideas". "This is a great place, there are some great characters amongst the residents". "I can go in (the office) whenever I need anything. Staff morale is really good. Staff all work together really well", "I would recommend this as place to work." "I feel able to raise concerns with the management team. "Staff pull their weight," and, "I feel supported." However, nursing staff said they felt less supported.

Systems were in place to assess, monitor and improve the service but some of these needed to be made more robust. We found issues with food and fluid charts not being completed to an acceptable standard. This was also an issue at the last inspection in September 2016. Topical medicines records such as creams were not completed and there was a general lack of review and audit of daily charts which were kept in people's rooms. Audit documentation stated 10% of care plans would be audited a month, but these had not been done in recent months. Some files contained audits but it was not clear when they were done or if they had been acted on as the actions section was blank and there was no date on the document. People's weights were not always taken and there was a lack of organisation around consistently taking and recording weights and using this to inform risk planning. The provider had identified greater oversight was

required in some areas and a new care lead had been appointed to bridge the gap between management and senior staff. The manager told us part of their role would be auditing and checking care documentation which would help address some of the issues we found. We found some issues in relation to the systems and processes in place to manage the recording of some medicines which should have been identified and addressed through the provider's own audit systems. However, we saw that no recent medicines audits had taken place at the home despite the manager saying these should be done monthly.

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

The service had enlisted the support of external consultants to help enhance the audit and governance arrangements within the home. We saw these staff had conducted a series of audits in August 2017 which the management team had worked through to further improve the service. A health and safety contractor completed health and safety audits and we saw the manager had worked through the actions to improve the safety of the home. We saw accidents and incidents were fully investigated and used as an opportunity to develop learning. In addition, the provider took an active role in a local provider forum to help share and keep up to date with best practice. These things helped continuous improvement of the service

Regular staff meetings were held. This included nurse meetings, health and safety meetings and daily flash meetings to check how the how was operated. These meetings provided a key mechanism for addressing any quality issues with staff and helping ensure the service was properly organised.

People's feedback was regularly sought and people were involved in the running of the home. Regular resident meetings were held, the manager explained how people were being given a greater level of independence to run this themselves with minimal staff input. People's views around activities and food, and recruitment were taken into account demonstrating the service valued and respected people's input. We saw people's comments around food, activities and room configuration had been taken into account to improve the service. One visitor said "We attend the meetings and speak to the main man". A person said "I have been to residents' meetings, they responded to what I said."

We saw people living in the home and their relatives were asked for their opinion of the service through an annual quality survey. We saw the results for the 2017 survey had been analysed. We saw responses were generally positive with most people very satisfied with Staveley Birkleas.

The service worked closely with a range of external agencies to help provide a high quality service. For example, the Telemedicines scheme helped provide people with remote nursing consultations to help reduce hospital admissions and ensure the service was responsive to changes in people's condition. The home worked closely with a professionals such as physiotherapists to assist with people's rehabilitation. The service had achieved accreditation with the Gold Standards Framework (GSF) which showed the provider was committed to working with external agencies to achieve recognised accreditation. The service was also accredited with the Investors in People award. This hallmark is accredited to organisations that can demonstrate high performance according to 9 key indicators which include: leading and inspiring people, living the organisations values and behaviours, empowering and involving people, managing performance, recognising and rewarding performance, structuring work, building capability, delivering continuous improvement and creating sustainable success. The home collated and submitted information on a monthly basis for the Local Authority and NHS Commissioners to help keep these agencies updated on events and occurrences 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (a) Risks to people's health and safety were not always fully assessed

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 (1)(2a) (2c) Systems and processes were not effectively operated to ensure compliance with the regulations. Systems to assess, monitor and improve the service were not always operated correctly. (c) A complete and contemporaneous record was not always maintained in relation to each service users care.