Care Quality Commission

Sidmouth Nursing Home Ltd

Sidmouth Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out a comprehensive inspection on 1 and 3 September 2015.

Sidmouth Nursing Home is registered to provide accommodation for up to 29 adults who require nursing or personal care. The home has people with complex physical nursing needs and people with dementia or mental health needs. There were 28 people using the service on the first day of our inspection. We last inspected the service in January 2014, at that inspection the service was meeting all of the regulations inspected.

The responsible individual was in day to day charge at the service and everyone referred to her as 'The manager'. The service had a registered manager who was known at the home as 'Matron' who was mentoring a clinical lead nurse to apply for the role when they stepped down and took on lighter duties. 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.

Summary of findings

Everyone gave us positive feedback about the responsible individual and the registered manager and that they were very visible at the service and undertook an active role. They promoted a strong caring and supportive approach to staff as they felt this was then the culture in which staff cared for people at the service.

Staff were compassionate, treated people as individuals and with dignity and respect. Staff knew the people they supported, about their personal histories and daily preferences. Staff showed concern for people's wellbeing in a caring and meaningful way. They showed people compassion and had developed warm and caring relationships with them.

The provider and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) (2005). Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA.

People were supported by sufficient staff who had the required recruitment checks in place, were trained and had the skills and knowledge to meet their needs. Staff had received a full induction and were knowledgeable about the signs of abuse and how to report concerns.

People were supported to eat and drink enough and maintain a balanced diet. People and relatives were very positive about the food at the service. People and relatives were seen to be enjoying the food they received during the inspection.

People received their medicines in a safe way. There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Where possible, people were involved in making decisions about how they were looked after. People and relatives said staff were caring and compassionate and treated everyone with dignity and respect at all times. The service made sure staff knew how to manage, respect and follow people's choices and wishes for their end of life care and as their needs changed. There was a clear message given to us from staff that they treated everyone at the service as their own family.

People had the opportunity to partake in a range of activities which were personalised to their preferences.

Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's needs and gave staff clear guidance about how to support them safely. They were personalised and people where able and their families had been involved in their development. Accidents and incidents were reported and action was taken to reduce the risks of recurrence.

People were involved in making decisions and planning their own care on a day to day basis. They were referred promptly to health care services when required and received on-going healthcare support. Healthcare professionals were very positive about the quality of care provided at the home and the commitment of the whole team to provide a good service.

The premises were well managed to keep people safe. There were emergency plans in place to protect people in the event of a fire or emergency.

The provider had a quality monitoring system at the service. The provider actively sought the views of people, their relatives, staff and outside professionals. There was a complaints procedure in place, although the service had not received any complaints the responsible individual had responded to niggles to the same level.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

People were protected from abuse by staff who could recognise signs of potential abuse and knew how to raise safeguarding concerns.

People's risks were assessed and action taken to reduce them as much as possible.

There were sufficient numbers of suitable staff to keep people safe and meet their needs.

People were protected because recruitment procedures were robust.

Accidents and incidents were reported and action was taken to reduce the risks of recurrence.

People's medicines were managed so that they received them safely.

Is the service effective?

Good 

The service was effective.

People were supported by staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decision making about people in their best interest.

People were supported to maintain good health and access healthcare services. Staff recognised any deterioration in people's health and sought medical advice appropriately.

People were supported to eat and drink enough and maintain a balanced diet.

Is the service caring?

Outstanding 

The service was caring.

People, relatives and health and social care professionals gave us positive feedback. They said staff were compassionate, treated people as individuals and with dignity and respect. Staff knew the people they supported, about their personal histories and daily preferences.

Staff showed concern for people's wellbeing in a caring and meaningful way. They showed people compassion and had developed warm and caring relationships with them. Staff responded to people's needs quickly and took practical action to relieve people's distress.

The service made sure that staff knew how to manage, respect and follow people's choices and wishes for their end of life care and as their needs changed.

People were involved in making decisions and planning their own care on a day to day basis.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Arrangements were in place for people to have their individual needs regularly assessed, recorded and reviewed.

People were supported to follow their interests and take part in social activities.

People knew how to raise a concern or complaint, and said they felt comfortable doing so.

Is the service well-led?

Good

The service was well led.

Leadership was visible at all levels at the service and inspired staff to provide a quality service.

People, their relatives and outside professionals had high praise for the management at the service. The management team understood their responsibilities and were supported by the responsible individual who was in day to day control.

People, their relatives, staff and professionals were actively involved in developing the service.

There was an effective audit program to monitor the quality of care provided and ensure the safe running of the service.

Sidmouth 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.

The inspection took place on the 1 and 3 September 2015 and was undertaken by one inspector.

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. We reviewed this and all information about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

The majority of people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to help us understand their experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided.

We met most of the people living at the home and spoke to five people to ascertain their views, and seven relatives of people who lived there. We also spoke with eleven staff, including the responsible individual for the service, the registered manager, nursing staff, care staff; ancillary staff and an agency worker. We received feedback from nine health and social professionals who visited the service regularly, including hospice nurse advisors, clinical nurse specialists and GP's from the local practice.

We reviewed the care records of four people and a range of other documents, including medication records, four staff recruitment and training records and records relating to the management of the home.

Good

Is the service safe?

Our findings

People using the service said they felt safe living at Sidmouth Nursing Home. Comments included, "Safe, I am safe yes". Relatives and health and social care professionals were equally confident that people were well cared for and safe. Relative's comments included, "(The person) is safe, very safe, and when I leave here I don't have to worry." Visiting health and social care professionals comments included, "I feel Sidmouth Nursing Home are effective in providing a comfortable, safe, well managed environment that is not only full of clinical duties but provides emotional security and entertainment too."

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. People received care and support in a timely way. Staff took time to engage with people and interact with them in a friendly manner. The responsible individual said, "I continually assess the staffing levels and react quickly if someone's care needs increase. I have feedback from night staff if someone's needs have increased at night. "They gave us an example of a person who had become unsettled and confused during the night and had placed themselves at risk. The responsible individual had put into place the following night one to one support while they discussed with health professionals how to support the person to become more settled. The staff confirmed that the staffing levels were adjusted as people's needs changed, with one staff member saying "Yes there are enough staff, if dependency increases they increase the staff." One health professional said, "The home appears well staffed with regular visits to residents to check on their holistic needs and put safety measures in place." Another said, "Staff take as much time as is necessary to provide care."

The provider ensured there were suitable staff to keep people safe. There were robust recruitment checks for new staff, that included ensuring all pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The responsible individual said "We have an extremely low staff turnover and agency staff are only used in exceptional circumstances." They gave an example where they had needed to use an agency nurse to cover planned staff leave. The agency nurse had worked three weeks of shadow shifts with a nurse from the service. This was to ensure they were knowledgeable about people's needs before working alone in order to keep people safe. The responsible individual was happy to challenge poor practice, they had clear staff disciplinary procedures which they followed when they identified that staff had poor practice. Records showed they had managed an altercation between two staff members where they had needed to take disciplinary action in line with their disciplinary procedure.

People received their medicines safely and on time. We observed people being given their medicines. The nurses were very calm and explained the medicines they were giving out and ensured people had a drink and a tissue to wipe their mouths if they required. They stayed with the person until they were satisfied the medicines had been safely taken. The nurses were very knowledgeable about people's medicines and had been assessed to make sure they were competent to administer people's medicines and understood their importance. Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine administration records were accurately completed and had a current photograph of the person and indicated if the person had any known adverse reactions to medicines. There were protocols in place to guide staff when it was appropriate to use 'when required' medicines. One person who was known to suffer from pain in their shoulder said, "They (staff) offer tablets for the pain all the time."

Medicines which required refrigeration were stored at the recommended temperature and staff were knowledgeable about the procedure when the fridge temperature was outside of the recommended range. In June 2015 a pharmacist had visited the service and completed a medicines check. They had raised a few minor concerns regarding the management of people's medicines at the service, which the staff had taken action to put right.

There were clear procedures for giving medicines, in line with the Mental Capacity Act (2005). Where a person who lacked capacity had found it difficult to take their tablets, staff had undertaken a best interest decision. This included speaking with the person's GP and nominated family member and a plan had been put into place.

Staff ensured people who were able and wanted to be supported to take their own medicines safely could. They

Good

Is the service safe?

undertook an assessment for people who wished to self-medicate, which was regularly reviewed with the person. One person said, “They let me do my tablets, they give me my tablets for the day which suits me.”

People were protected because risks for each person were identified and managed. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people’s mobility, choking, nutrition; pressure damage and falls. Each assessment reviewed had clear instructions for staff to follow to reduce the risk. If a person had been identified as having a risk of choking, a referral had been made to the speech and language therapist (SALT).Their recommendations had been recorded and were followed by staff. People identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included, pressure relieving mattresses on their beds and cushions in their chairs.

People were protected by staff that were very knowledgeable about the signs of abuse and had a good understanding of how to keep people safe. They had received training in safeguarding of adults and had regular updates. They had a good understanding of how to report abuse both internally to management and externally to outside agencies if required. The clinical lead nurse had undertaken a safeguarding audit. The audit had concluded all staff were knowledgeable and worked in a manner that protected people in the service from discriminatory abuse. Staff were reminded in a staff meeting on 30 July 2015 that the service had a zero tolerance attitude towards any kind of abuse to residents or staff. They discussed the different types of abuse and the various ways it could be reported and told staff the local authority safeguarding team telephone numbers were on the staff notice board. The PIR sent by the provider stated, ‘We seek help from the safeguarding team where difficulties have arisen.’

Accidents and incidents were reported and reviewed to identify ways to reduce risks as much as possible. Records demonstrated that if someone had an accident the nurse would raise an accident investigatory log if required as well as record the details in the services accident book. For example, if a person fell the staff would look to see if they were doing enough to keep the person safe. They would take measures to review their practice and the investigatory log would not be completed until the registered manager or responsible individual had signed to say they were satisfied with the measures taken.

Communal areas and people’s rooms were clean with no unpleasant odours. Three relatives were very complimentary about the high level of cleaning standards at the service. Comments included, “Her room smells clean and fresh, you can’t fault them here.” Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person’ mobility needs and what to do for each person in case of an emergency evacuation of the service. This showed the home had plans and procedures in place to safely deal with emergencies. There were evacuation chairs around the building to assist staff to move people safely in the event of a fire without using the lifts.

Premises and equipment were managed to keep people safe. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, gas, electrical and lift maintenance. Fire checks and drills were carried out weekly by a designated staff member in accordance with fire regulations. Staff were able to record repairs and faulty equipment on the provider’s intranet system which would highlight it to an external maintenance contractor and to the responsible individual. The responsible individual had systems in place to ensure action had been taken to resolve the concerns raised.

Good

Is the service effective?

Our findings

People's needs were consistently met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service.

Staff had undergone a thorough induction which had given them the skills to carry out their roles and responsibilities effectively. The responsible individual recorded in their PIR, 'Staff selection and recruitment is paramount. We ensure that all the people we employ are reflective of our morals, ethos and purpose.' They said it was very important to recruit the right staff and only employed staff which had been recommended to them. Staff on induction shadowed senior staff for a week; they looked at policies and procedures and undertook the provider's mandatory training. These included, manual handling, infection control, understanding dementia, safeguarding vulnerable adults, fire, food hygiene, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The management and senior nurses would decide when they were satisfied the new recruit was able to work alone. One staff member said senior staff had guided them and instructed them while they were shadowing them. They went on to say, "When I was new here, I asked for training how to use the hoist, they organised it straight away. Things are always acted upon quickly."

Nursing and care staff were very experienced and had regular opportunities to update their knowledge and skills. As well as the provider's mandatory training, staff had received training in health and safety in the workplace, legionella awareness, incontinence and first aid. Staff were also encouraged to undertake additional qualifications in health and social care including leadership and management. Two senior nurses were also undertaking mentor courses. The responsible individual said they had outside training providers, e-learning courses on the computer which were backed up by in house training. The nurses also undertook courses and then cascaded it to other nurses and to care staff as required. For example, one nurse was scheduled to undertake a wound management course and this would be cascaded to the nurses and the nursing assistant. Staff were very positive about the training they received. Comments included, "Training is very informative they explain everything, what to do, how to handle a resident with dementia." "The training is very good it included live demonstrations and on line training which was very helpful." Training was backed up by senior staff during day to day delivery. A nursing assistant said, "I enforce the training we have, I guide staff and teach them and tell the nurses if they need more training". A visiting health professional said, "It is evident that (the responsible individual) is proud of her team and invests a lot of time in ensuring that all new members of staff are selected well and that on-going high quality training is actively encouraged."

Staff received a formal one to one supervision every six months, and were also observed by senior staff during their day to day practice and given constructive feedback. Staff had an annual appraisal where they had an opportunity to discuss their practice and identify any further training and support needs.

People who lacked mental capacity to make particular decisions were protected. Staff had received appropriate training on the MCA (2005) and DoLS and demonstrated a good understanding of how these applied to their practice. The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Where people lacked the mental capacity to make decisions the staff followed the principles of the MCA. Records demonstrated that relatives, staff and other health and social care professionals were consulted and involved in 'best interest' decisions made about people. People's consent for day to day care was sought. Staff were skilled at looking for visual signs of consent for people unable to express their wishes. They were very patient and demonstrated a good knowledge of the person's usual choices but still offered the chance to have something different. People's consent was sought by staff if able or their nominated relative were asked to sign their care plans to confirm they agreed with them. Staff had recorded where a person had nominated a relative as a Lasting Power of Attorney (LPA) to make decisions about their care and treatment and involved them appropriately in all relevant decision making.

The Care Quality Commission (CQC) monitors the operation of the DoLS and we found the home was meeting these requirements. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The senior staff were aware of the Supreme Court judgement on 19 March 2014, which

Good

Is the service effective?

widened and clarified the definition of deprivation of liberty. They had made appropriate applications to deprive people at the service of their liberty to the local authority DoLS team. People's liberty was restricted as little as possible for their safety and well-being. For example an assessment was undertaken whenever the use of bedrails or a pressure mat was considered for the person's safety.

People were supported to have regular appointments with their dentist, optician, chiropodist and other specialists. Staff referred people quickly to relevant health services when their needs changed. One person said, "If I wasn't well they get a doctor very quickly, it would take some beating." Staff had arranged numerous dental appointments for a person with ill-fitting dentures who had difficulty chewing their food. The person had been fitted with new dentures but had decided they would still have a soft diet.

The service monitored people's health and care needs, and acted on issues identified. For example, some people at the service had complex physical needs which included the risk of the breakdown in skin integrity. Staff documented the concerns and the actions required, they undertook regular monitoring and made changes when required. When they needed specialist support they contacted the tissue viability team for guidance. The tissue viability nurse said, "They are always interested in my recommendations and will ensure any equipment is sourced that I may recommend." Another said, (The responsible individual) and her team are always prepared to listen and discuss, and follow guidance when appropriate."

People were very complimentary about the food at the service. Comments included, "The food is fantastic" and "The best cook in the whole of the south west, they do beautiful meals, we feel very lucky."

The lunchtime meal was a very sociable occasion, several relatives joined people to eat lunch with them, they chatted and socialised with other people. On the second day of our visit the staff had arranged a table in the conservatory where two people were enjoying their lunch with close family members. After the main meal a dessert trolley was taken around with pavlova, fruit and jelly, roulade, fruit and gateaux and people had the opportunity to choose. One person said, "It is very nice, always a good selection, especially the afternoon cake. They make a beautiful birthday cake here." Another said, "At tea time there is homemade soup, a large selection of sandwiches and sweets." A relative said (The person) has choice here, they do ask him what he wants." The cook said there was always plenty of food available at the home and people could always have alternatives. They gave an example that one person had expressed a wish to have wild salmon roe and that had been arranged.

Where a person had swallowing difficulties, and needed pureed food it was well presented with each food type separated. When people were identified at risk of malnutrition or dehydration, care plans instructed staff to monitor the person's food and drink intake as well as checking their weight regularly. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. One person said, "The cook came and saw me and said you are not eating, what can I get for you."

People were offered drinks and snacks regularly throughout the day. People's care records showed staff were managing people's weight well, some people had gained weight and no significant weight loss was seen. Two visitors said their relative had gained weight since being at the service. A health professional said, "Residents dietary and hydration needs are met well and those that require support with this receive it in a timely manner, mindful of the need to maintain their dignity."

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Outstanding ☆

Is the service caring?

Our findings

People and relatives were very positive about the high standard of care and caring attitude of the staff. Comments included. "Very pleased with it here, not exactly like home but they do their utmost to be friendly and caring" and "Nothing is ever too much trouble, they really look after her well, they are lovely." One person said, "I originally came for two weeks respite care and I asked if I could stay, it is definitely the best. Staff are always smiling and don't lose their tempers, I can have a nice banter with them."

All of the health and social care professionals gave positive comments about the caring nature of the staff. Comments included, "There is a genuine feeling of warmth in the home and I have only ever witnessed impeccable care, delivered with dignity and great affection by all members of the team" and "The care is exemplary."

The provider offered end of life care, although no one needed this when we visited. People had access to support from specialist palliative care professionals. The responsible individual had signed up to the Hospiscare End of Life Initiative (end of life best practice) to improve staff knowledge and skills. This involved a worker from the local hospice team working alongside staff at the home. Their role was to support staff, giving them knowledge of how to support people at the end of their lives to have a dignified death. However the hospice team had decided there was no need to complete the program at the home. They said to the responsible individual and recorded in a letter that the care seen at Sidmouth Nursing Home was of the highest standard and that staff were attentive and would go the extra mile to make sure people were happy and well cared for. They were impressed by the person-centred attitude and approach to the care provided which was always caring and respectful. They concluded by saying that all staff were highly trained which showed in the exemplary care provided.

Hospice nurses fed back to us that they had no concerns about the quality of care provided at the service. Their comments included, "I have no hesitation in stating that Sidmouth Nursing Home provides excellent quality care, without exception, to every person residing there. Never before have I witnessed such dedication and commitment. They provide true holistic care to residents and the same level of care and support is afforded to the families and friends of their residents. Due to the specialist nature of our work many of the people we refer to Sidmouth Nursing Home have complex needs which require a high level of knowledge and skill. I am always confident that the staff are competent and able provide this care." One relative of a person who had been unwell said, "I have recently been away and I knew they would follow our wishes. We have talked about Mum's views about her wishes when the time comes".

Every member of the staff team were highly motivated and inspired to give kind and compassionate care. This went across the whole team, including the responsible individual. The responsible individual took time to speak to people each day along with visitors and health and social care professionals that visited the home. They knew everyone's names and the needs of all of the people living in the service. They said they were confident in the care the staff provided but to assure themselves they undertook unannounced spot checks at the home.

The responsible person took pride that the service retained a consistent staff group. They said they selected new staff carefully and ensured they were supported, trained and supervised to deliver the high level of care and kindness that was required by people at the home. They went on to say it was important that people and their visitors were happy with the calibre of the staff employed at the home. People and visitors were asked for feedback about new staff members and their caring approach to help inform the responsible individual if the staff member should complete their probation period.

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people on their first encounter with affection and by their preferred name and people responded positively. The atmosphere at the home was very calm and peaceful. During lunch a staff member supported a person eating their lunch in the main dining area. They were discrete and not rushed in their approach; they engaged in conversation and was seen gently rubbing the person's back, which appeared to reassure the person.

The whole staff team were respectful and compassionate in their behaviour. There was a clear message given to us from all staff about people at the service being treated as their own family. One staff member said, "The residents are the priority here, we ensure there is a harmonious relationship within the staff team."

Outstanding ☆

Is the service caring?

One relative said they had chosen the home because they had looked at a lot of others and this one was different, everyone (staff) smiled at them and said hello, which made them feel welcome. A second relative said, "There is a happy atmosphere here, staff all go around smiling and happy and it doesn't smell."

Staff knew the people well including their preferences and personal histories. The provider recorded in their PIR, 'I would describe our team as a 'family'. Our staff treat our residents like family members and are very familiar with their characters, preferences and abilities. Good links with family and friends are essential in ensuring we are well informed as many residents have dementia'. Staff showed concern for people's wellbeing in a caring and meaningful way, and responded to their needs quickly. A health professional gave an example, "Not only the care staff, but from the domestic staff through to the senior management, each staff member takes the time to familiarize themselves with the patient, their family, their history, their likes and dislikes and their interests. I once arranged admission for a patient with dementia for a short period of respite. I called unannounced the next morning and the staff reported she had been unsettled overnight, not unexpected. But they had tried very hard to support this lady and on my arrival were spending time with her and painting her nails. That is just one small example of the wonderful holistic care that they provide."

Staff supported people to be involved in making decisions about the care and support they received. Care records demonstrated that staff whenever possible had involved people to review their care needs each month. This included how they wanted to have their hygiene needs met and refreshments they liked. One person's care plan recorded they wanted a gin and tonic at lunchtime and a glass of wine in the evening, which we observed they were given. The person hadn't been able to sign the care plan themselves due to a physical disability. Staff had recorded that the person's nominated person had signed on their behalf in their presence. Staff had worked with another person to decide how they wanted their room arranged so they could use the toilet independently. The person said it was very important to them to be remain independent and not have to call for assistance

Staff supported people to be as independent as they wanted to be. People were walking around the communal areas and throughout our visits staff took people out for a walk in the local community. One person said, "I go down to the shop, they like to know I am going and sometimes will ask if they can come with me." People were offered choices; staff asked people their preferred preference. For example, if they wanted to go to the lounge; like to watch television, had they finished their breakfast or did they require more. People had the choice which drinking cups they preferred to use. For example, plastic beakers, mugs or cups and saucers. One person said, "I like the plastic beakers, I find the cups are too heavy."

Staff communicated effectively with people using the service, no matter how complex their needs. For example, where a person was unable to verbally make their needs known, staff used good eye contact, touched them gently and observed the person's facial features for their response. Where one person had very poor hearing, staff used a white board to write down messages. The person responded well to this and became calmer and entered into a conversation about the weather and the lunchtime meal. Where a person had difficulty to communicate their needs because at times they became confused or disorientated, staff had been guided in the person's care plan to be patient and give them time to think and reply. Staff were seen interacting positively with this person, they did not rush them and gave them time to respond to questions about their choice of drink and where they wanted to sit.

Staff took practical action to relieve people's distress or discomfort. For example, where one person was calling out the staff were very quick to respond and reassure. They sat with the person holding their hand talking gently to them. They tried to ascertain if they were in any pain, needed to be repositioned or were feeling the cold. The person became calmer and the outcome was they wanted a blanket and to have their feet repositioned. The person's family member praised the staff saying how much more settled the person had been since arriving at the home. Their comments included, "When Mum was at the hospital she was calling out all of the time, and since she has been here she has been much better".

People's relatives and friends are able to visit without being unnecessarily restricted. The responsible individual said, "We look at whether our residents are contented, do they want to be here, what we can do to bring their family to them. We encourage them to come in and be involved, we are a family." One person during our visit was supported by

Outstanding ☆

Is the service caring?

the staff to use a system called 'skype' on a computer to speak to their family who lived abroad. Staff said they made the call each week and it really had a positive impact on the person being able to see and speak to their family. One staff member said, "Some residents have no visitors, I am even more geared to those to help make them feel at home." A relative said, "As guests we are always treated with great friendliness and warmth and welcomed into this true home."

People's religious beliefs were supported. There was a monthly church service at the home and staff assisted people to attend. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, such as the person's views about resuscitation in the event of unexpected collapse.

Good

Is the service responsive?

Our findings

People received personalised care that aimed to meet their individual needs. People confirmed the daily routines were flexible and they were able to make decisions about the times they got up and went to bed; how and where they spent their day and what activities they participated in. One person said they had everything they needed in their room so they chose to stay in their room as they had when at home. They said they could go to bed and get up when they wanted to and go downstairs if there was something they wanted to join in with. This person said staff popped in regularly for a chat. This meant they had companionship and didn't feel isolated. Another person said, "They asked how often I would like a shower, there is always someone around, I only have to say nurse and someone comes, I am extremely happy here and have no regrets about my decision."

The staff ensured people had the time they needed to receive their care in a personalised way. A health professional said, "No person ever seems to be rushed or forced into doing something they don't wish to do. They (staff) take time to know the residents habits and actively encourage them to achieve these."

Before people moved to the home an assessment of their needs was completed to ensure the service could meet their needs. Senior staff would go and meet with people and their families and discuss their care needs and what was important to them. This information was then used to generate care plans to guide staff to know how to provide the care they required when they moved into the home. This ensured people's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. The care plans covered people's nutritional needs, communication needs, continence, sleep, mobility, personal hygiene, medical history, skin and general appearance.

People and relatives said they were aware of their care plan and they had been involved in discussions about how they wanted their care and support. One relative said, "They sat down with me and asked me about (person) and what she needed to have done and her little ways and these have been followed. We sat down a month ago and went through and signed them all. All the care plans are spot on and reflect the conversations I have had with staff." Another relative said "I have had to fill a lot of forms in with him about his background, interests, likes and dislikes." The relative was pleased because the name plaque on her husband's bedroom door was personalised with a picture that reflected his previous occupation. They said it is things like that that make you feel welcome and individual. We noted that everyone's bedroom name plaques had a picture that reflected their previous occupation or interest. For example, a teacher, business man, pilot and doctor.

People's care plans and risk assessments were reviewed monthly by the nurses and more regularly if people had a change in their needs. A health professional said, "We have talked about the care planning and risk assessments, and these are always re-evaluated and up to date." Where changes had been made to people's care plans the person had been asked to review and had signed, where the person lacked capacity the person's assessed nominated relative had signed on their behalf.

People and relatives were very positive about the responsiveness of staff to identify people's needs. One person said, "I was checked every hour when I was not feeling well, they gave me hot lemon." One relative said, "The nurses are very good, everything you say they write down in the diary so it is not missed." A second said "Everything I raise with them they are already aware of, I have never yet raised something they were not already aware of."

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the nurse, matron or the responsible individual and it would be dealt with straightaway. The provider had a written complaints policy and procedure. Written information was given to people when they came to live at the home, which included how to raise a complaint. One person said, "I would complain to (responsible individual) but I have not had any reason to, I think they are very good to be quite honest, I think they are really marvellous." A relative said, "If I had a complaint I would tell the girls, the nurses or the matron they are brilliant and would sort it out." Another relative said, "If I had a concern I would raise it with whoever is on duty. I know all of the nursing staff by name, I feel confident they see them all as individuals, I couldn't be happier."

Although, the provider had not received any formal complaints since the previous inspection, the responsible individual had recorded grumbles or issues that people or

Good

Is the service responsive?

relatives had raised. For example, concerns raised included a person not having any tissues and a second person wanting fresh fruit daily. The responsible individual had taken action to ensure these concerns were resolved. These showed the provider responded appropriately and professionally to any criticism, offered apologies when things went wrong and had taken action to make improvements.

People were supported to follow their interests and take part in social activities. Each person had an activities plan about their social needs requirements and activities they would like to engage in. For example, it was identified that one person liked to stay in their room. Staff had recorded in this person's activity plan that they like to be engaged in a variety of activities to keep them active, alert and amused. Activities were geared to their personal choice and included watching television, listening to the radio, doing puzzles and crosswords and enjoying sitting in the garden. Staff were guided to spend time for personal conversation with the person, provide reading materials of interest, to enable them to watch television ensuring the remote control and reading glasses were in reach and taken to the garden when requested.

The responsible individual arranged activities at the home. They said and staff confirmed there was not a dedicated activity person and that all staff were involved in providing activities. On the first day of the inspection, flower arranging was organised by staff and people were happily engaged in the activity. People and relatives were very complimentary about the amount and quality of the activities at the home. They said there was always something going on at the home; they gave examples of a harpist and pianist regularly visiting, church singing, arts and crafts, a Christian service each month, an opera singer, drama and keep fit. Throughout our visits people were going for walks out in the local area appropriately supported by staff.

Good

Is the service well-led?

Our findings

People living at Sidmouth Nursing Home, their relatives, visiting professionals and staff were positive about the management of the service. People and visitors comments included, "The manager is wonderful, so approachable" and "I go and see (the responsible individual), a busy lady but always has time to speak." Staff comments included, "The manager is always open to ideas" and "(The responsible individual) is great, it is not only the residents that matter, she wants us all to be happy."

All of the health and social care professionals fed back very positive comments about the leadership at the home. Comments included, "This is an extremely well run home"; "The manager is aware of the needs of all the people in the home including staff and leads a well-run home. She is an effective leader, and in her absence her team continues to function well. She makes herself available each time I have visited, and the people I have assessed (when able) speak highly of her and her staff" and "Senior Management are always to be found on the premises and make themselves available for discussions and appear to greatly value their staff and provide incentives and rewards."

Leadership at the home was very visible, the responsible individual was in day to day charge supported by the registered manager, known as 'Matron' and a senior nurse who undertook the clinical lead role and a non-clinical lead who had a level five national vocation qualification in leadership and management. The responsible individual recognised the limits of their roles and although they were involved in clinical discussions, the final decisions were taken by the matron and the clinical leads. The responsible individual said the registered manger had been mentoring the two clinical leads in order for them to take on the position when she stepped down. Along with the management there were nurses on each shift who were supported by a designated nurse assistant who assisted them with small clinical responsibilities and senior care staff, care workers and cooks. Staff had delegated roles and responsibilities, for example, leads for medicines and health and safety. The registered manager took the lead for supporting people living with Parkinson's disease and mental health needs.

Staff worked well as a team, most had worked at the home for a long time and there was a very low turnover of staff. Staff felt well supported and were consulted and involved in the home and were passionate about providing an excellent service. A staff meeting is held monthly with the exception of December. Records recorded there were good staff attendance at these meetings and staff had the opportunity to put forward issues they would like to discuss. For example, staff breaks and pad disposal had been put forward and discussed. A care review was also carried out at each of these meetings for each person at the service giving staff the opportunity to discuss their observations, views and ideas. The meetings were also used as an opportunity for refreshing staff knowledge by discussing training topics. The responsible individual explained that this involved looking at different scenarios and how they would be managed. For example, what they would do if there was a fire in a specific bedroom. One staff member said, "(The matron and responsible individual) are very supportive, we are able to say about training, we have a meeting every month which is well attended."

There were good communication systems in place for staff through daily handover meetings and information recorded on the provider's computer data base which included the record of staff meetings for staff who had been unable to attend. Staff had also completed a survey in July 2015 which had not been collated at the time of the inspection. However the responses we looked at were all positive and the responsible individual said they would be collated and the findings feedback to staff.

The staff promoted strong links with the local community. For example, a group of students from the local college had visited the home and met with people as part of a social action project. A letter sent by a representative of the group thanked the team for their open mindedness to help them integrate with people at the home. They stated 'Your friendly residents allowed for everyone in our group to leave feeling that they had contributed to something bigger than themselves'. One person said meeting the students from the college was lovely and how nice it had been to chat to such nice young people.

In the PIR, the provider outlined a clear vision and values for the service. It stated, 'We try to create a non-confrontational, no-blame-culture environment where we can talk about our problems in an open and transparent way... Happy staff result in happy residents.' Staff were clear about the ethos of the service and that the management were role models in their manner and the way they dealt with situations.

Good

Is the service well-led?

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. These included audits and risk assessments for medicines, practice within the service regarding safeguarding, care plans, accidents and health and safety which included environmental issues. Records demonstrated that audits were used to improve the service and robust actions were put into place. For example, a safeguarding adults audit in July 2015 where the majority of questions had scored the highest rating ten. In two areas where a nine and an eight had been scored for being polite and courteous even when under pressure, this had been discussed at staffs' individual supervisions and staff meetings. A care plan audit had identified consent to have a photograph had not been signed for one person and action had been taken to address this.

The environmental risk assessment looked at all areas at the service including the accessibility and use of personal protective equipment (PPE's), disposal of waste and the safety in the kitchen area. As well as the environmental audit the responsible individual said they also undertook visual checks at regular intervals as they went around the home, although these checks were not documented. The responsible individual regularly monitored response times to call bells to make sure they were responded to promptly and to check anyone at increased risk of harm had their call bell responded to immediately. They were knowledgeable about why people were ringing their bells throughout our visits and had taken action about a bell to an external door which was showing a fault.

Accident and incidents were monitored and a falls audit was carried out quarterly to identify any trends or individuals at increased risk and showed that actions were taken to reduce risks. The responsible individual said and records confirmed as a result of a falls audit a new stair lift had been ordered.

Each month the nurses were allocated care plans to be reviewed and made sure that risk assessments and management plans were comprehensive and being implemented. They would continually monitor people's needs and if they identified any new risks would act promptly to reduce them and keep the person safe. The responsible individual said, "The nurses are allocated in the diary which people's plans they will review each month, it works better to have different nurses doing the reviews to have a fresh look." The nurses met regularly for a clinical meeting to discuss people's presentation and changing needs and to share ideas. They also used these meetings to allocate staff supervisions. They matched the most appropriate person to meet with individual staff formally to get the most positive outcome and support for the staff member.

The provider had an annual satisfaction survey to seek feedback from people, relatives and health professionals. The survey results showed high levels of satisfaction were reported by people living at the home. The resident's survey in July 2015 was in the process of being collated but the responses received were very positive especially regarding the quality of nursing and caring approach of care staff at the service. The survey of professionals in July 2015 had eleven responses with no negative comments. Responses ranged from staff being very respectful and considerate and that they were very well informed. The responsible individual showed us the results of the surveys that had been carried out in 2014. These were all positive and had been collated and made available to people, visitors and staff to read.

The staff had a good working relationship established with health and social care professionals which benefitted people at the service. This ensured people received appropriate support to meet their health care needs. Care records showed evidence of professional involvement, for example GPs and specialist nurses. Professionals contacted as part of the inspection said the service made appropriate referrals and always acted on their advice or recommendations. Comments included, "Staff are quick to respond to patient needs and thorough in their assessment"; "They make referrals promptly" and "They respond well to needs."

The responsible individual kept themselves up to date with social care and regulatory changes. They had a computer system that would flag up any news or updates on the internet to their computer system. They kept the Care Quality Commission (CQC) informed of events or incidents which had occurred at the service. The commission had received appropriate notifications, which helped us to monitor the service.

In January 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored the highest rating of five, confirming good standards and record keeping in relation to food hygiene had been maintained.