Private Medicare Limited

# St Marys 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? | **Good** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

St Mary's Nursing Home is a single storey, purpose-built home, situated in its own extensive grounds in a residential area of west Hull. It is registered for accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury and diagnostic and screening procedures. The home can accommodate 48 people including 12 people who need rehabilitation following a stroke. People's stay in the stroke unit varies according to their rehabilitation needs and rate of improvement. The stroke service is commissioned by the local Clinical Commissioning Group [CCG].

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

# Summary of findings

The last full inspection took place on 19 June 2013 and the registered provider was issued with a compliance action regarding the management of complaints. We completed a follow up inspection on 2 October 2013 and found the registered provider was compliant in this area.

We undertook this current unannounced inspection on the 10 and 11 June 2015.

We found there were sufficient staff on duty to meet people's assessed needs. Staff had been recruited safely and received induction, training and supervision to ensure they were competent to look after people. The registered manager had an open-door policy which encouraged staff to raise issues.

We found people in the main unit and the stroke unit had their health care needs assessed and met. They had access to a range of health and social care professionals for treatment, advice and support. Risk assessments were completed and measures put in place to minimise risk.

Care plans for people in the main unit were person-centred and provided staff with guidance about how to meet their needs. Care plans for people in the stroke unit could be more person-centred. There was a lack of integrated care notes for nursing and therapy staff and an inadequate handover of information from the Acute Trust when people were admitted from hospital with a stroke. This meant staff at the service had to rely on verbal handovers and may not have all relevant written information to hand. We have made a recommendation about this which can be seen in the Responsive section of this report.

Medicines were managed well. People received their medicines as prescribed.

People's nutritional needs were assessed and met. There were varied menus with alternatives and the meals provided during the inspection looked well-presented and hot. Those people with special dietary needs were catered for and dieticians and speech and language therapists visited specific people for nutritional advice and treatment.

We found staff supported people to make their own choices about aspects of their lives. Staff followed best practice in relation to the Mental Capacity Act 2005 when people were assessed as lacking capacity to make decisions; these were made in their best interest by people involved in their care. We found people were treated with dignity and respect. The staff approach was observed throughout the day to be kind and caring.

There were some activities provided to people to ensure they were stimulated and to help them participate in things that interested them. Therapy staff assessed people who used the stroke unit and assisted them, where possible, to regain skills and a level of independence.

There was a quality monitoring system in place that ensured checks were made and people were asked for their views about the service provided. Complaints were listened to and investigated. These monitoring systems enabled learning to take place and quality to improve.

We found people who used the service lived in a safe and clean environment. Equipment was maintained and repairs completed quickly.

# 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 who used the service were provided with safe care by staff who had been recruited properly and were in sufficient numbers to meet their needs.

People who used the service were protected from the risk of harm because staff assessed and managed risk and knew what to do safeguard people from abuse.

People received their medicines as prescribed.

**Is the service effective?**

Good

The service was effective.

People's health care and nutritional needs were met. They accessed a range of health care professionals when required and were provided with a varied and nutritious diet. Those with special dietary needs were catered for.

People who used the service were supported to make their own choices. When assessed as lacking capacity for this, decisions were made for them in their best interest and in line with mental capacity legislation.

Staff received training, support and supervision to enable them to look after people and provide them with the care and treatment they required.

**Is the service caring?**

Good

The service was caring.

The staff approach was observed as kind, caring and patient. They listened to people, provided explanations and gave them time to respond.

People who used the service were treated with dignity and respect and involved in decisions about their care and treatment.

**Is the service responsive?**

Requires improvement

Despite some good practice in certain areas, the service was not consistently responsive to people's needs.

People who used the main unit had their needs assessed and person-centred plans of care developed to guide staff in how to meet them. People who used the stroke unit had care plans that could be more person-centred.

There was inadequate handover from the Acute Trust regarding information about the health and care needs of people who had been admitted with a stroke. Also nursing, therapy and multi-disciplinary team review notes that were documented and stored separately meant they were not accessible to the whole team. This could potentially impact on people's care.

# Summary of findings

People felt able to raise complaints.

**Is the service well-led?**

Good

The service was well-led.

There was a supportive and open culture where people who used the service and staff were able to express their views.

The quality monitoring process included checks, surveys and analysis of incidents. When shortfalls were identified, these were addressed. This enabled learning to take place.

The registered provider visited the service which made them accessible to people who used the service and staff.

# St Marys 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 June 2015 and was unannounced. The inspection was completed by one adult social care inspector, a specialist professional advisor in stroke rehabilitation and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered provider was asked to complete a Provider Information Return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received this, appropriately completed and on time. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection we spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service. They told us there were no concerns about the service.

We spoke with seven people who used the service and five of their relatives who were visiting during the inspection.

The discussions included two people who were using the stroke rehabilitation service. We observed how staff interacted with people who used the service and monitored how staff supported people during lunch.

We spoke with the registered provider, the registered manager, the deputy manager, two nurses, one of whom was responsible for the stroke rehabilitation service, three health care workers, an activity coordinator and the head chef. We also spoke with a physiotherapist and an occupational therapist. The therapists were based at the service and provided direct treatment, support and advice to people who used the stroke service and staff who provided stroke rehabilitation care.

We looked at four care files of people who used the main part of the service and reviewed eight care files of people who used the stroke rehabilitation service. We also looked at other important documentation relating to people who used the service such as incident and accident records and 12 medication administration records [MARs]. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with legislation.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, the training record, the staff rotas, minutes of meetings with staff and people who used the service, complaints management, quality assurance audits and maintenance of equipment records.

We completed a tour of the building and grounds to make sure it was clean, tidy and safe.

Good

# Is the service safe?

## Our findings

People told us they liked living at St Mary's Nursing Home. They said there were sufficient numbers of staff on duty, they didn't have to wait long for attention, they received their medicines on time and the service was clean and tidy. Comments included, "I've found it very, very good", "They come and wash all around the skirting boards every week which can't be easy in my room",

Relatives were also happy with the service. Comments included, "The place is clean and tidy and they keep her room beautifully clean", "I pressed the call bell accidently one day and I was surprised at how quickly it was answered" and "There appears to plenty of staff. There never seems to be a lack of staff on the shift floor."

We found the service ensured people were safe. There were policies and procedures to guide staff in how to safeguard people from the risk of abuse or harm. Staff had completed safeguarding training, were aware of policies and procedures and in discussions demonstrated they knew what to do should they become aware of abuse or poor practice. They said, "We use a risk matrix and flow chart and complete an alert form." They knew the different types of abuse and the signs and symptoms that may alert them to concerns. Staff also described the range of people and agencies they would notify of any safeguarding alert and this corresponded to policies and procedures.

We saw risk assessments were in place for specific areas such as pressure damage, nutrition, choking and aspiration, falls, moving and handling, the use of bedrails and personal evacuation plans. These were kept under review. We saw some people admitted to the stroke unit had bedrail and falls risk assessments whilst others did not, although all had nutrition and pressure damage risk assessments completed. We spoke with the registered manager and nurse in charge of the stroke unit about this risk management. The nurse in charge of the stroke unit described the policy regarding mobility for new admissions. They said when people were admitted and a full assessment had not been completed by the stroke team, they had to be moved and handled using a full hoist to maintain safety until their mobility had been fully assessed. Those people missing bedrail and falls risk assessments were to be completed straight away.

We observed a shift handover and saw this was comprehensive and focussed on risk and care issues. However, we saw the information provided to nurses and health care workers at handover was far more comprehensive than the written handover record. This was mentioned to the registered manager to address with nursing staff.

We looked at the management of medicines. Medicines were signed for when received into the service and when administered to people. They were stored correctly and securely, and disposed of in a safe way. We observed nurses administered medicines to people appropriately and in line with their assessed needs; one person was encouraged and supported to administer their own insulin injection. We saw the medicine trolleys were locked when unattended and staff washed their hands in between each administration. During a shift handover, we observed staff shared information on the best way to administer medicines to people which included their preferences. For example, staff were told one person preferred to have her tablets in a spoonful of jam. We found there were some minor recording issues regarding the administration of medicines; these were mentioned to the registered manager to address.

We found there were sufficient numbers of staff employed day and night to meet the needs of people who used the service. As well as the registered manager and deputy manager, there were nursing staff of different grades including one specific nurse to manage the stroke unit. When this nurse was not on duty their role was filled by a nurse from the main unit. The service had health care workers, a training officer, an activity co-ordinator and ancillary staff for catering, domestic, laundry and maintenance tasks. In discussions, staff confirmed there were sufficient numbers of staff on duty, which enabled them to meet people's assessed needs. They said, "Yes, it's ok; we have time to talk to people and if staff are off sick they always try to cover." The registered manager told us there was a manager on-call system and staff were always willing to cover shifts at short notice.

The registered manager described how they calculated staffing needs in line with a dependency level tool which determined whether the people they supported had high, medium or low needs. However, they also told us they looked at how it 'feels' on the shift and took into consideration people's assessed needs, any end of life care

Good

# Is the service safe?

and staff capabilities. We observed that although call bells rang throughout the day, none were left unattended. During lunch, there were sufficient staff to assist people to eat in the dining room and serve and assist those who chose to remain in their own bedrooms.

We looked at how staff were recruited and found this was completed in a safe and effective way. Checks were carried out, such as gaps in employment, references and disclosure and barring [DBS] to ensure only appropriate staff were employed to work with vulnerable people. There was a system in place to check the registration of nurses was valid and had no conditions; this was monitored to ensure nurses maintained their registration.

We found the service was clean and tidy throughout with no areas of clutter and no slip or trip hazards. There were policies and procedures for infection prevention and control and staff had completed training. We observed staff washing their hands in-between supporting people and personal, protective equipment such as gloves and aprons were worn and disposed of appropriately. We observed infection prevention measures were followed during clinical procedures such as blood glucose monitoring and equipment, such as needles, was disposed of correctly. We noted some items were out of date in first aid boxes and these were addressed during the inspection. Nurses checked stocks of shelf-limited clinical products to ensure these remained safe to use.

Equipment used in the service was maintained and serviced in line with manufacturer's recommendations. This included fire safety equipment, the fire and nurse call alarm systems, moving and handling items such as hoists and specialised baths, portable electrical items and catering equipment. The registered provider told us they had plans to upgrade the fire alarm system by the end of June 2015 in line with a recent inspection from a fire safety officer. The service had combination locks on the main doors, the sluice and specific rooms to restrict access. Visitors to the service were asked to sign in to comply with fire regulations and to ensure there was a record of who entered and exited the building.

Good

# Is the service effective?

## Our findings

People told us they had choices about aspects of their lives and staff asked for their consent prior to carrying out treatment or care tasks. They also said staff gave them the option of being independent during personal care tasks. Comments included, "I do as I please. I've got all my gadgets here; It makes me feel as though I'm home" and "They always ask if they want to do something or ask if I want to do it." People also said they could see their doctor when required and they enjoyed the meals provided for them. We saw one person newly admitted, had recently had a visit from her new GP.

Relatives were pleased with the care and treatment provided to people. They said, "They know how to treat her and seem to know what they're doing", "If she wants a doctor, they get her a doctor" and "He's now clean and is eating well."

We found people's health care were assessed and met. People had access to a range of health and social care professionals when required including GPs, consultants, specialist nurses, dieticians, opticians and podiatrists. There was a multi-disciplinary team [MDT] to provide treatment, advice and support to people who'd had a stroke. These included a consultant, physiotherapists, occupational therapists, a psychologist, a speech and language therapist and a social worker. MDT meetings took place to plan treatment and review care. A concern that there was no cover for the social worker when they were not at work had been escalated, as it had the potential to affect discharge plans.

We observed there was a good handover of information between staff within the service relating to people's health care needs. On the stroke unit, there was also important information regarding occupational therapy plans and moving and handling guidance in each person's bedroom.

We found people's nutritional needs were assessed and met. Nutritional risk assessments were completed using a recognised tool and people were weighed in accordance with the risks identified. Menus provided alternatives and those people who required special diets such as sugar-free, pureed, textured or enriched were catered for. We saw meals were served in an appetising way with good portions. The chef told us they received information from nursing staff about people's nutritional needs within 24 hours of their admission to the service. We saw the diet sheets for people admitted to the stroke unit. These identified food and drink likes and dislikes, the consistency of food required, any equipment needed and whether people required assistance with eating and drinking. The chef told us they were informed if meals were not eaten and they liaised with the nurse in charge. We saw hot and cold drinks were available throughout the day and people who stayed in their bed rooms were provided with jugs of fresh water.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people with a DoLS authorisation at the time of this inspection although the registered manager had submitted an application to the local authority for one person who may meet the DoLS criteria. Nursing staff outlined the procedure for this process and how they supported people in the least restrictive way to ensure their safety.

We found the application of the Mental Capacity Act 2005 [MCA] in regards to the recording of assessments of capacity and decision-making could be clearer each time they are completed. This would ensure the decision being made, at a specific time, is identified clearly rather than just a decision about the person lacking capacity. We found this was very clear in one of the files we looked at which included an assessment of capacity and a decision made in the person's best interest which was the least restrictive course of action for them. However, another person's care file had an assessment to state they did not have capacity, but it did not relate to any specific decision regarding care or treatment. Training information indicated most staff had completed MCA and DoLS training.

Staff were clear about how they gained consent from people prior to carrying out care tasks. They said, "We gain consent for even little things and don't make decisions for people; we know what people want to drink but we still ask" and "If people are assessed as having no capacity we have best interest meetings." In the stroke unit, staff told us consent was gained verbally. We saw there was space for staff to record when consent had been obtained but this was not always completed. Staff were aware of who had a lasting power of attorney [LPA] and who had a 'do not

Good

# Is the service effective?

attempt cardiopulmonary resuscitation' [DNACPR] order in place. They were also aware that one person had made an advanced decision to refuse treatment [ADRT]. Information about these issues was recorded clearly in people's care file so their wishes were respected and their human rights protected.

The training officer showed us the training plan, which had been completed for the next 12 months. This identified they were to develop the new Care Certificate into a training tool for new and existing staff. They were also to ensure all new staff completed competency training based on the 15 standards of the Care Certificate during induction. Induction for new staff included a meeting with the training officer to look at policies and procedures and complete an analysis of their training needs. New staff completed a three month probationary period which included observations of their practice, specific training such as moving and handling, two supernumerary shifts and they were mentored/buddied by more experienced staff.

The training completed by staff consisted of essential training such as safeguarding, fire safety, moving and handling, healthy eating and food hygiene, end of life care, MCA/DoLS, dementia awareness and infection prevention and control. There was also specific training such as stroke awareness, diabetes and person-centred assessment and care planning. Staff who worked in the stroke unit had completed specialised stroke training including national stroke competencies. The training officer has sourced first aid training and was awaiting dates for this. We saw nurses were able to complete specific clinical training in order to complete nursing tasks and to maintain their registration. In discussions with nurses and health care workers, it was clear they received appropriate training and felt confident they were skilled to meet people's needs. Comments included, "There is always plenty of training." One relative said, "The staff are very qualified" and our specialist professional advisor stated, "The lead nurse for the stroke patients showed a high level of clinical competence."

Staff confirmed they were supported in their roles and received supervision and appraisal. The registered manager had meetings with the registered provider and was able to speak to the registered manager of another service within the registered provider's portfolio for advice and guidance. The registered manager did not receive clinical supervision but this was to be arranged.

The environment was suitable for its intended purpose with wide corridors, moving and handling aids and specialised equipment. Some bedrooms were very individualised whilst others lacked a personal touch and signage throughout the service could be more dementia-friendly. This was mentioned to the registered manager to address.

Good

# Is the service caring?

## Our findings

People who used the service told us staff treated them with kindness, they respected their privacy and dignity and they assisted them to be as independent as possible. People said staff knocked on the door prior to entering their bedroom. Comments included, "I have a shower every day; they [staff] are very considerate and preserve my dignity", "The staff are more mature and there isn't such a high turnover", "The staff are wonderful, they do anything for you", "They seem as though they enjoy their job; they're always smiling" and "They are very professional. They treat me with dignity and respect; I can't fault them."

People who were using the stroke unit described the staff as, "Wonderful", "Very caring" and "Patient." They also said staff were very quiet at night. One person described how staff were quick to respond when they required the toilet at night.

Relatives said, "All the staff are lovely", "During the day everything seems to be done regularly by everyone; they're all very good", "The place doesn't smell, not like some places", "They are all really good to her; they seem to do their best to look after everyone" and "They treat the residents alright and they treat me alright too." Relatives also told us staff kept them informed about issues. Comments included, "They tell me what she's eaten at breakfast. Every time I visit, they tell me about her medication and if she's taken it."

The registered manager showed us a very recent letter from a relative which was very positive about the care their family member had received. It stated, "Thank you all so much. The change I have seen in dad this week has been remarkable. I know it's only been a week but he appears to be pain-free, more alert, eating and talking again plus he's clean and doesn't smell."

The expert by experience said, "Every person and relative I spoke to praised the staff highly."

We observed staff spoke to people in a gentle tone and a kind manner; they were patient and gave people time to complete tasks or answer questions. We saw staff approach people by bending down to their level and making eye contact. We saw staff knew people who used the service well; they were able to talk to them about their families and their lives. We observed staff assist people to eat their meals. Some staff were more competent than others in engaging the people they supported during this task; this was mentioned to the registered manager to discuss with them. We also noted the music, which was played at lunchtime on the first day of the inspection, may not be to the taste of people who used the service. This was also mentioned to the registered manager to check out and monitor.

We observed people's dignity was maintained. We witnessed staff knocking on doors before entering bedrooms, and they explained processes and procedures to people before the intervention was carried out. We observed people who used the service had call bells within reach.

In discussions, staff described how they maintained people's privacy, dignity, independence and choice. They said, "We knock on doors and ask people and give choices", "We speak to people as we would expect our mum or relative to be spoken to", "We give people information and explanations; we ask people", "We step back, see what people can do and assist when needed" and "We know what our service users can do and we try to maintain existing skills and develop them." Staff described how they assisted when required but also promoted people's independence by handing them items such as flannels for their faces and hair brushes to use by themselves. Staff said, "One person likes to wear makeup, jewellery and perfume each day and we assist" and "For simple choices we hold up two outfits for people to help them choose." Staff went to describe how they had supported one person with practicing walking, standing and transferring. They said this had gone so well it had improved the person's mood and health.

We saw staff provided information to people who used the service and their relatives. Each person's bedroom had a laminated notice with a picture of their keyworker along with their name and qualifications. There was a notice board in reception which held a range of leaflets and notices. These included a newsletter from the local Safeguarding Adults Board's, Care Quality Commission guidance on hidden cameras and the registered provider's duty of candour, and information about church services. There was a notice board which detailed the staff responsible for 'championing' specific areas within the service such as dementia awareness, safeguarding adults from abuse, lasting powers of attorney and dysphagia [difficulty in swallowing].

Good

# Is the service caring?

There was a 'resident's information pack' available and on display. This was written in large print and provided people information about the service provided to people and what they could expect whilst residing there.

Bedroom doors and toilets and bathrooms had privacy locks. The stroke unit had four single bedrooms and four shared bedrooms. All shared bedrooms in the stroke unit and the main part of the building had privacy curtains. There were also lockable facilities in each bedroom for people to secure personal items. We saw there was a small therapy room in the part of the service used as a stroke unit. This room had screens for the windows to maintain privacy during therapy sessions.

There was a room available for relatives to make themselves a hot drink. We also noted there was an area in the garden for people who used the service or their relatives to smoke.

We saw the nursing staff had a separate office to make phone calls or to see people in private. This helped to maintain confidentiality when speaking about personal or health related issues. We saw that people's care files and staff's training and personnel records were held securely. The computers were password protected to help ensure information was secure.

Requires improvement

# Is the service responsive?

## Our findings

People told us they received care that was responsive to their needs and they participated in activities. They also told us they felt able to complain if required. Comments included, "I keep busy all day. I sometimes join in the activities. I like bingo and karaoke" and "They showed some slide show of old Hull I really enjoyed that."

One person told us they had their own telephone line installed. This has enabled them to keep in contact with friends in Scotland. They said, "It's been great, I've been able to catch up with everyone and have a good gossip; I'm not one for joining in, I like to read but this phone has been great." They also expressed pleasure that the activities coordinator had altered some trousers for them and wouldn't take any payment for the task.

One person told us they enjoyed using technology gadgets and they had a selection in their bedroom. They told us staff supported them into the community twice a week so they have the opportunity to take photographs and make videos.

One visitor told us they had written their relative's care plan which was used to enable the staff to better understand the person's needs. They said, "This place is fit for purpose and it's really meeting his needs; he talks more and is happy."

We saw, in the main unit, that people had their needs assessed and plans of care were written in a person-centred way in order to guide staff in how to meet their needs. For example, one care plan described how the person's religion and beliefs could impact on their health care needs and was very clear about their wishes. We saw care plans included documents that described what was important to the person and how staff were to support them and ensure these issues were attended to. We saw lots of information about how people's personal care and mobility needs were to be met. One care plan described in detail how the person's nutritional needs were to be met. For example, how they received their nutrition through a tube directly into their stomach, the position the person should be in when receiving their nutrition and what risks were involved. It also detailed how staff were to monitor the person, what action to take if they were nauseous or vomited, how to maintain hygiene and patency of the tube and what dietician input was provided. We saw people admitted to the main unit also had assessments and care plans provided by the local authority.

For people using the stroke unit, we saw the care plans were mostly generic and could be individualised further. This was mentioned to the registered manager to address. However, there were care plans written by occupational therapists [OTs] situated by people's beds; the outcomes for OT interventions were measured and the team used a 'Stroke Impact Scale' to measure them. We saw there were separate notes for nursing and therapy interventions. Nursing staff on the stroke unit were unable to access the therapy notes, as they were recorded on a separate system. The multi-disciplinary team [MDT] notes of meetings were also stored at a different location which meant they were not accessible to the whole team. We have given a recommendation about this below.

We saw how staff responded to people's needs. For example, on the stroke unit, one person had their bed moved to ensure it was in the correct position in line with their bed at home; this was to help facilitate their discharge. People had home visits to assess their skills prior to discharge. The service had a number of bathrooms in different styles which provided people with a range of options for bathing and showering. However, our specialist professional advisor [SPA] felt that twice weekly observations for people admitted with a stroke may not enable staff to detect deterioration in a timely manner. This was mentioned to the nurse in charge of the stroke unit to address.

During discussions with the nurse in charge of the stroke unit, and review of people's care records, we saw there was inadequate handover from the Acute Trust regarding information about the health and care needs of people who had been admitted with a stroke. There was no SBAR [Situation – Background – Assessment – Recommendation] tool or format used for communication and handover of important information, as would be good practice. The nurse in charge of the stroke unit told us they used to receive medical records of the person's assessments whilst they were in hospital but this no longer happened. This could compromise the person's safety. Staff did say this was improving with physiotherapists providing a verbal handover the day after the person's admission. We saw risk

Requires improvement

# Is the service responsive?

assessments and care planning for people admitted with a stroke commenced on admission to the unit, but important information could be missed or late in getting to the service.

**We recommend the registered manager liaises with the Acute Trust to seek advice on how to improve the transfer of information when people are admitted to the stroke unit from hospital. Also to consider whether integrated nursing, therapy and MDT review notes would enhance records access and management.**

We saw there were some activities for people to participate in and an activities coordinator to organise them. These included art and craft work, baking, gardening, bingo, reminiscence sessions, movement to music, a library book exchange programme, chair-based exercise and sewing. The activity coordinator was able to tell us about people's likes, dislikes and abilities. We saw activities were organised but were flexible and could change depending on people's wishes. The activity coordinator told us people liked to receive visits from pets.

For people who used the stroke service, there was also music therapy and we were told there were plans for psychology to have group sessions for them and their relatives, but no time scales were available for this service yet. There was a rehabilitation kitchen for people to have occupational therapy assessments and to practice activities of daily living skills.

There was a large and well-tended garden and courtyard area for people to use in warm weather. There were tables and chairs, bird feeders and raised beds for people to participate in gardening. The raised beds were mainly for people who used the stroke service but the registered manager told us there were plans to extend these to all people who used the service.

We saw the service had a complaints policy and procedure which included timescales for dealing with them. There was a suggestion box and complaints leaflets in reception. None of the people we spoke with had any complaints or concerns about the service, however they all said they would speak to the registered manager if they had any issues. Staff throughout the service knew how to manage complaints and told us they were dealt with promptly. They said, "There is a procedure to follow and forms to fill in. We encourage people to tell us about niggles so we can sort them out. We don't want niggles turning into big complaints."

Good

# Is the service well-led?

## Our findings

People told us they knew who the registered manager was and they would speak to them if required. Comments included, "She's very professional, helpful and friendly." A relative said, "I get on with her fine; she always has time for a chat when she's walking around."

We spoke with the registered manager about the structure and culture of the organisation. The registered manager showed us a 'resident's information pack'. This detailed one of the objectives as, "To ensure all clients are treated as individuals with respect for choice and privacy." The philosophy included, "To promote trust between clients, relatives and staff – to aid and deliver high quality care." We found these were translated into practice. We saw there was a clear structure to the organisation and input from the registered provider, which included visits to the service, meetings with the registered manager and discussions with staff and people who used the service. The registered manager said this enabled them to discuss issues in the service and plan any action so that the objectives and philosophy of care was promoted. The registered manager said, "We have a very open and honest culture – it's not perfect but we encourage service users and families to tell us if we are not doing something right; we get to know families really well."

The registered manager was clear about their responsibilities. They said, "I'm a 'hands on manager' and like to be a big part of the home by doing shifts; I like to see what's going on." We received notifications about incidents that affected the safety and wellbeing of people who used the service. The registered manager told us about a recent change in administration support which had impacted on their management role and increased their administrative tasks. They said this had resulted in additional pressure which could affect the amount of time they had available for management tasks and overseeing people who used the service. They told us this was to be discussed with the registered provider so they could address it.

We found the nurse in charge of the stroke unit was aware of their responsibilities and demonstrated a clear understanding of people's needs and outlined this clearly in nurse handover meetings.

In discussions, staff confirmed they were supported by the management structure. Comments included, "The manager has an open-door policy" and "The directors [registered provider] visit; we have an internal post system and can leave messages for them. They sort out issues via the manager or speak directly to us; we can phone them if necessary." There were some incentives for staff such as a discount with the company who supplied medicines to the service and remuneration for long service. Staff felt this was a small way for them to feel appreciated.

Staff also told us they provided a good quality service to people. They said, "It's a good home and we look after people well. We always help each other out", "Every member of staff is involved and works hard to maintain our reputation" and "I looked after my mum at home; I would have no hesitation at bringing her here."

We saw the staff within the stroke unit, and staff overall, had developed good working relationships with other health and social care professionals who provided a service to people. There was written information in each person's care file to accompany them should they be admitted to hospital. This gave medical and nursing staff a brief description of their main needs and how these should be met.

There was an annual quality monitoring system that included audits. For example, in January 2015 there was an audit of nutrition and end of life care. Some areas were audited monthly, for example medicines management. We looked at audits for staffing levels, medicines, infection prevention and control, hoist slings and care file recording. When shortfalls were identified, these were addressed.

The registered manager completed an analysis of accidents, falls and incidents so that learning could take place. Accidents and incidents were also discussed during shift handovers. This helped to ensure staff were aware of them and records could be updated.

There were audits and checks completed by external agencies. For example, the local authority completed contract monitoring visits and the supplying pharmacy checked medicines management. We saw when issues were identified, these were addressed.

There were surveys of the views of people who used the service. Twenty surveys had recently been sent to people who used the service and the staff were in the process of analysing the results. In the past there had been changes to practice as a result of survey findings. For example, in November 2014 a survey about activities indicated 20% of

Good

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respondents felt they were not sufficiently varied. This resulted in a new activity co-ordinator and training for staff. The registered manager told us about one person who stated in a survey that they were bored. Staff now supported the person to access the community twice a week to fulfil a specific hobby, which had impacted positively on their mood.

A survey of people who accessed the stroke service and their relatives had been completed. Results of this were displayed in a 'You said, We did' document in the unit. Results of surveys and audit action were not displayed in this format in the main unit. This was discussed with the registered manager to address.

The registered manager had held a series of meetings with staff in 2014 but none in 2015 yet. Staff confirmed they received information in other ways such as thorough shift handovers, discussions with the registered provider, individual meetings with the registered manager, supervision and appraisal sessions and communication books.