Mr & Mrs B Clarke and Mrs C Mills

Threeways Nursing Home

Inspection report

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Ratings

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

Overall summary

Threeways Nursing Home is located in Seaford with parking on site and nearby on the road. The original building has been extended to the side, there are communal rooms on the ground and first floor; lifts enable people to access all parts of the home, and there are large accessible gardens to the rear.

The home provides support and care for up to 45 people with nursing and personal care needs. There were 38 people living at the home at the time of the inspection. Some people had complex needs and required continual nursing care and support, including end of life care. Others needed support with personal care and assistance moving around the home due to physical frailty or medical conditions, and some were living with dementia.

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

This inspection took place on the 11 and 13 August 2015 and was unannounced.

There were systems in place to manage medicines, but guidelines for some medicines were not clear, which meant medicines may not have been given to people in a safe or consistent way.

People were assessed before they moved into the home to ensure staff could meet their needs, and care plans were developed from this information. However, care plans were not focused on each person's preferences and choices, and guidance for staff to follow when planning and providing care was limited. Although staff knew and understood people living in the home and were able to plan their care delivery in line with their choices

People felt staff took a long time to answer the calls bells at times, and this had not been identified by the management as an area for improvement. People also felt there were enough staff working in the home and that staff provided the support and care they needed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but had not followed current guidance to ensure people were protected.

A safeguarding policy was in place and staff had attended safeguarding training. They had an understanding of recognising risks of abuse to people and how to raise concerns if they had any.

Risk assessments had been completed as part of the care planning process, with guidance for staff to follow to reduce the risk of harm.

Recruitment procedures were in place to ensure only suitable people worked at the home. Staff said they were supported to deliver safe and effective care, and demonstrated they knew people well and enabled people to maintain their independence.

New staff were required to complete an induction programme in line with Skills for Care, and the ongoing training programme supported staff to meet people's needs. The registered nurses attended fundamental training and additional training to ensure their nursing competencies were up to date.

People told us the food was very good. Staff asked people what they wanted to eat, choices were available for each meal, and people enjoyed the food provided. People told us they decided what they wanted to do, some joined in activities while others chose to sit quietly in their room or communal areas. One person said, "I know there is an activities programme and I could join in if I wanted to, it is up to us really."

People had access to health professionals as and when they required it. The visits were recorded in the care plans with details of any changes to support provided as guidance for staff to follow when planning care.

A complaints procedure was in place. This was displayed on the notice board near the entrance to the building, and given to people, and relatives, when they moved into the home. People said they did not have anything to complain about, and relatives said they were aware of the procedures and who to complain to, but had not needed to use them.

People, relatives and staff said the management were very approachable, and were involved in decisions about how the service developed with ongoing discussion on a day by day basis and during residents meetings. In addition feedback was sought from people, their relatives and other visitors to the home through satisfaction questionnaires.

The registered manager had quality assurance systems in place to audit the support provided at the home. These included audits of care plans, medicines, menus, accidents and complaints.

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

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?

Requires Improvement

The service was not consistently safe.

Medicines were not managed safely because guidelines in relation to the administration of some medicines were not clear.

The staffing levels had not been reviewed to ensure there were sufficient staff at busy times of the day.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

Risk to people had been assessed and managed as part of the care planning process. There was guidance for staff to follow.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Senior staff had attended training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, when planning care and support for people who did not have capacity decisions were not always appropriate.

Staff had received fundamental training and provided appropriate support. Nurses attended training to ensure they were competent.

People were provided with sufficient food and drink which supported them to maintain a healthy diet.

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not ensure that people's privacy and dignity was protected at all times.

The registered manager and staff approach was to promote independence and encourage people to make their own decisions.

Staff communicated effectively with people and treated them with kindness.

People were encouraged to maintain relationships with relatives and friends. Visitors were made to feel very welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed before they moved into the home, but the care plans were not personalised or based on enabling people to be independent.

Summary of findings

People decided how they spent their time, and a range of activities were provided depending on people's preferences.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were clear lines of accountability and staff were aware of their roles and responsibilities. However, this limited their flexibility and prevented them from taking on other roles.

The service had not notified the Care Quality Commission (CQC) of significant events in line with their legal responsibilities.

People, relatives and staff were encouraged to provide feedback about the support and care provided.

Quality assurance audits were carried out to ensure the safe running of the home.

Threeways 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.

This inspection took place on the 11 and 13 August. It was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events with the service is required to send us by law. We reviewed the provider information return, which is a form that asks the provider to give some key information about the service, what they do well and any improvements they plan to make. We also spoke to the commissioner of care from the local authority before the inspection.

During the inspection 15 people told us about the care they received and we spoke with two visiting relatives and three friends. We spoke with 12 members of staff, which included housekeeping staff, care staff, activity person, registered nurses, the registered manager, personnel manager and provider.

Some people were living with dementia and were unable to communicate their needs. We spent time observing the support and care provided to help us understand their experiences of living in the home.

We observed care and support in the communal areas, the midday and evening meal, medicines being administered and activities, and we looked around the home

We looked at a range of documents. These included assessment records, care plans, medicine records, staff training, recruitment and supervision records, accidents and incidents, quality audits and policies and procedures.

We recommended the provider should take into account the National Institute for Health Care Excellence (NICE) guidance 2014, Managing Medicine in Care Homes.

Requires Improvement

Is the service safe?

Our findings

People told us the staff and registered manager looked after them very well. People said, "I feel quite safe here." "I have nothing to worry about, they make me feel very safe." "You don't have to be frightened of anyone here" and, "The staff help me to get up and come downstairs, which is very nice and they make sure I am safe." Relatives felt people were very well looked after and staff made sure they were safe and comfortable. People said there were enough staff to look after them. One person told us, "The staff are always around if we need them." Relatives felt there were enough staff working in the home. One relative said, "I haven't noticed any delays with staff helping people when they need it."

People told us medicines were administered on time and that supplies didn't run out. One person said, "I live on drugs, yes they're very good at making sure you take them." However, the systems for giving medicines to people were not always safe. The guidelines for the administration of 'as required' medicines (PRN) were not detailed enough. They stated PRN medicines should be given when people asked for them or when the nurse, following the care plan, had assessed they were required. The amount, time they were given and the nurse's signature was recorded on the Medicine Administration Record (MAR) when the medicines had been taken. The guidelines did not require staff to record the reasons why PRN medicines were administered. The nurse said, "Paracetamol is usually given for general pain and we give some medicine when people are anxious", but there were no records to support this. The lack of appropriate recording and monitoring of PRN medicines could mean that people did not receive the medicines they needed, or nurses may not have identified people's changing needs.

Staff told us most people used prescribed skin creams for dry skin or as a barrier cream for protection and this was recorded in the daily records. However, records relating to creams were not accurate and clear. The application of creams was not recorded on the MAR; the body charts included in the MAR folder were blank and there were no specific directions for staff on where to put the creams, in the care plans or records kept in people's rooms. The lack of clarity on the application of prescribed creams meant people may not have received the medicine as required. These areas were discussed with the nurse and registered manager for review and improvement.

We recommend the provider should take into account the National Institute for Health Care Excellence (NICE) guidance 2014, Managing Medicine in Care Homes.

Medicines were administered by a registered nurse. Nurses said their competency was assessed through observation as they administered medicines. Medicines were administered individually from the trolley, which was locked when not in use. A drink was provided and the MAR were signed after people had taken the medicines. Risk assessments had been completed with regard to medicines and some people had been assessed as able to keep their medicines with them, such as inhalers. One person told us, "I look after my own medicines at home, but since I have moved in here to recover I think it is best they look after them until I go home."

Accidents and incidents were recorded, the registered manager monitored these and audited them monthly. Staff said if an accident or incident occurred they would inform the nurse on duty and an accident form would be completed. Information about what happened was recorded and staff discussed what happened and how they could reduce the risk of it happening again. However, although staff were aware of the accidents and incidents, the care plans had not been reviewed and updated to inform staff of any changes in people's support needs. For example, injuries had occurred on one person's legs from bed barriers. The audit had picked this up, but the care plan had not been updated and some staff did not know this person was at risk of injury and appropriate guidance was not in place to protect them. This is an area for improvement.

The registered manager said the staffing levels were based on the needs of people living in the home and were flexible. Although some people felt staff took a long time to answer the call bells and that they should not use their call bell as staff were very busy. We observed most call bells were answered in less than five minutes during the inspection. However, the call log report from the 2 August to 9 August 2015 showed there were times when staff had taken over five minutes to respond and in some instances over 20 minutes, which may mean people were not safe. For

Is the service safe?

example, people who required assistance from staff to walk or transfer safely may attempt to walk to the bathroom if they had to wait a long time for staff, and may be at risk of falls. The registered manager told us the call bell system has only been in place for a few months and had not yet used the call log system to review staff responses to call bells, but planned to do so as part of the review of staffing levels.

People and staff also told us there were enough staff working in the home. One person told us, "There seem to be enough staff to look after people." Another person said, "I don't have to wait too long for staff and if they are busy with someone else they let me know." Staff said they were able to provide the care and support people needed and covered for each other for holidays or sickness. The registered manager said regular agency staff were used to cover for nurses and when people's healthcare needs changed additional staff were provided to ensure there was enough staff to support people on a one to one basis as required. Nurses and care staff confirmed this. One staff member said, "If we need extra staff and we are unable to cover for each other, agency staff are employed, usually ones that have been here before and know the support and care people need."

Recruitment procedures were in place to ensure that only suitable staff worked at the home. We looked at the personnel files for four staff. There were relevant checks on prospective staff's suitability, including completed application forms, two references, interview records, evidence of their residence in the UK. A Disclosure and Barring System (Police) check, which identify if prospective staff had a criminal record or were barred from working with children or adults, had been completed for all staff. The management had taken appropriate action if they identified areas of concern during the recruitment procedures. Such as a poor reference. Systems were in place to check nurses were registered with the Nursing and Midwifery Council (NMC) and therefore able to practice as a registered nurse. This meant they had the qualifications and correct registration to provide nursing care.

As far as possible people were protected from the risk of abuse or harm. Staff had received safeguarding training and understood the different types of abuse and described the action they would take if they had any concerns. Staff had read the whistleblowing policy and stated they would report any concerns to the nurse on duty and the registered manager. If they felt their concerns had not been addressed to their satisfaction they would contact the local authority or CQC. Staff said the contact details for the relevant bodies were available in the office and they could all access these if they needed to. Staff told us they had not seen anything they were concerned about and were confident if they did action would be taken. Relatives said people were supported in a safe way to be as independent as possible and they had not seen anything of concern.

Risk assessments had been completed depending on people's individual needs. These included moving and handling with information about people's mobility, nutrition risk and specific dietary needs, and waterlow assessments for risk of pressure damage. They were specific for each person and included guidance for staff to follow to ensure people's needs were met. Staff felt the assessments identified people's care and support needs and enabled them to respond and reduce the risk to people's health as much as possible.

The home was clean and well maintained with pictures and homely touches throughout. Cleaning schedules showed how often each area of the home was cleaned and checks were completed to ensure these were followed. Records showed equipment was checked regularly including the lighting, hot water, call bells and electrical equipment. The fire alarm system was checked weekly and fire training was provided for all staff and training records showed they had all attended. External contractors maintained the lift, electricity supply and kitchen equipment, and if there were any problems staff were able to access their contact details.

There were systems in place to deal with unforeseen emergencies. Emergency evacuation plans were in place for each person with clear information about how much support people needed and what action staff should take. Staff were aware of the emergency evacuation plans and felt confident they could follow them. Staff told us a senior member of staff was always on call and a number of staff lived nearby and could be available, if they were needed, within a short time of being contacted.

Requires Improvement

Is the service effective?

Our findings

People felt the staff looked after them very well and understood their needs. People said, "They all seem very well trained to me" and, "They are very good and certainly know what they are doing." People felt they had access to GP's and other health professionals if they needed to, "Yes I see the doctor regularly" and, "I've got hospital appointments and they've arranged everything for me." Relatives felt staff had the skills to look after people. One relative said, "You cannot get any better than the staff working here." People said the food was very good. They told us, "It is always very tasty" and, "There is a choice and staff ask us what we want." Relatives said people liked the food provided and join their family member for meals if they wanted to. One relative said, "It always looks appetising."

Senior staff and the registered manager said they had attended training and had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to moving in and outside the home, these have been authorised by the local authority to protect the person from harm. Other staff had a basic understanding of MCA and DoLS and training had been arranged to update all staff. Staff said they always asked people for their consent if they needed assistance and we heard and observed staff doing this.

However, staff had not followed current guidance, when they planned people's care, including people's right to take risks and the necessity to act in people's best interests when required. For example, staff said bed barriers were used to ensure two people were safe when they were in bed. Daily records showed these people had been injured when moving around with bed barriers in place. Another person remained in bed because staff said it was unsafe for them to sit in a chair as they had been restless and at risk of falling out. Staff told us, and this was recorded in the care plans, that these people did not have the capacity to give their consent. There was no evidence that the decision to use bed barriers or to restrict a person to bedrest had been made following best interest meetings; which involve discussions between health and social care professionals, relatives and staff to ensure that the least restrictive measures are in place to protect people. This meant these people's safety and people's rights to take risks had not been taken into account when care and treatment was planned.

The lack of appropriate systems to ensure people's safety and right to take risks is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People felt that staff were competent and skilled in their roles. Staff said the training was very good. They told us, "We do all the usual training, like moving and handling, safeguarding and infection control, and additional training to support people with specific health problems, like dementia." "I have learnt a lot from other staff who have worked here longer, but I think we are here to support people to have the life they would have had if they had stayed at home" and, "I realise how important the training is so that we can provide the care people want."

The training plan showed staff had attended fundamental training including safeguarding, moving and handling, food hygiene, infection control, health and safety, fire safety and equality and diversity. In addition training in dementia awareness, Parkinson's disease and compassion had been attended by some staff. Care staff said they could work towards professional qualifications if they wanted to and were encouraged to do so. Three staff had completed National Vocational Qualifications in Care level 3, two staff at level 2, and two new members of staff had recently started the course. A member of staff said they had completed induction training when they started working as a care worker and records showed that all new staff underwent a formal induction period of training. This was based on the Skills for Life Care Certificate and the policies, procedures and working practices at the home. They said they had worked with more experienced staff until they felt confident and had been assessed as competent by senior staff. Staff said they had a good understanding of people's individual needs and provided care they needed.

Staff told us they had regular one to one supervision with the registered manager and they felt this gave them a chance to sit down and talk about anything, and find out if there were areas where they could improve. The supervision records showed staff attended regularly and appraisals were carried out yearly. Staff said they could talk to their colleagues, including the registered manager, at any time, and they were clear about the disciplinary

Requires Improvement

Is the service effective?

procedures if the registered manager or their colleagues thought they were not providing the care and support people needed. One staff member said, "If we are not doing something right then we need to be told so we can do something about it." This meant that staff were observed and monitored to ensure people received the support and care they needed and wanted.

People had access to healthcare professionals as required. One person said, "We can see the doctor if we need to, but I don't need to at the moment." Appointments were arranged with dentists, opticians and GPs as required, and when necessary the GP visited the home. Another person told us, "I have glaucoma and asthma and see the doctor when I need to." Appointments and any outcomes were recorded in people's care plans, with information about any changes to support.

People were very complementary about the food and most chose to eat their meals in their rooms. Their trays, like the dining table, had placemats, condiments and cutlery appropriate to their specific needs. The cook had an excellent understanding of people's support needs at mealtimes and was aware of people's likes and dislikes. For example, not putting too much on a person's place as too much food put some people off eating, and providing finger foods, soft diet and pureed meals, with plate guards in place to support people to eat independently. The cook used a system for serving the meals that ensured enough staff were available to assist people with their meals when appropriate. All the food was fresh and home cooked. People were chatting with each other and staff as the meals were served. Staff asked people what they wanted although they had already chosen their preference, and alternatives were provided when people changed their minds. People were encouraged to have enough to eat and drink, and if people did not want to eat at the usual times staff kept their meals for when they were ready to eat them. Snacks and drinks were available at any time and people said they had enough to eat and drink. People told us, "The food is like the best hotel." "You get four or more meals and anything you want in between." "I have to watch what I eat the food is a bit too good and I've put on a bit of weight" and, "I used to cook for a nursing home and I'm very critical and I think the foods good."

People's weights were monitored monthly and recorded in the care plans. Staff said they would notice if people were not eating and drinking as much as usual and would report this to the nurse or registered manager. Nurses said they would contact the person's GP if they had any concerns. Relatives said their family members were able to have the food they liked and there were always choices. A relative said, "Everyone I speak to says the food is very good."

Requires Improvement

Is the service caring?

Our findings

People gave us very positive feedback regarding the caring nature of staff. They said, "I couldn't be any better looked after if I was the Queen." "As soon as I saw it here I liked it straight away." "It couldn't get any better than here, they have such nice ways" and, "They're ever so friendly and helpful and my friends say can you get us in here." Relatives and friends thought staff were very helpful and went out of their way to support people. One relative said, "People have the care and support they need." A friend told us, "Staff look after people very well, but also let them make their own decisions, especially if they have dementia."

Staff said they respected people's privacy and dignity. They knocked on each person's door and asked for permission to enter before they walked in. People thought this was very nice and showed how much staff cared about them. However, we observed that staff did not consistently ensure people's privacy and dignity was protected. For example, when staff supported people who were unable to walk and wash independently or when people were restless in bed. We saw one person, who remained in bed, moved around and the bedclothes did not cover them. The staff were aware this happened regularly, but had not ensured the person wore appropriate clothes, consequently people walking past their bedroom door could see the person's bare legs. The registered manager and staff said this was an area of care that needed to be reviewed and improvements made.

Staff regarded information about people as confidential. Staff said they had been given a copy of the confidentiality policy and were clear that they did not discuss people's support needs with other people, relatives or each other in a communal or public area of the home. Staff said, "Any information about residents is completely confidential, we never talk about residents or their needs with anyone else" and, "We do not talk about people's needs in front of other people and if relatives ask we refer them to the nurse or the manager."

People were treated with kindness and compassion. We heard and saw staff were caring, supportive and patient when they asked people if they needed assistance and when they offered support. People felt staff treated them with respect. Interaction was friendly, people were relaxed and comfortable sitting in the lounge area, the dining room or their rooms, and there was considerable laughter and joking when people were doing activities. People said staff understood their needs and provided the care they needed. Staff felt they knew people's preferences and used the map of life in the care plans to understand their lives, interests and hobbies, and people who were important to them. One staff member told us, "We need to know how residents lived their lives so that even when they can't talk to us we have a good idea what might interest them and can offer them the right choices." One person liked to do crosswords and staff supported them to do this, another person preferred to sit quietly in their room with the door closed and this was respected. One staff member said, "We are here to provide the care and support residents need, depending on what they want to do, and all of the support we offer is based on their choices. Like the time they want to get up or go to bed, they all have their own preferences, some earlier than others, and we work around this" and, another staff member felt happy that residents were safe and had been well cared for when they went home at the end of each shift.

Staff demonstrated an understanding of people's care and support needs when they were unable communicate verbally. For example, if they were living with dementia. Staff said people who were unable to tell them what they wanted were encouraged to make choices. They let staff know what they wanted to do through body language and facial expressions. Staff gave examples of people turning their head away when they didn't want a drink and closing their eyes if they did not want to get up at that time. Staff used good eye contact when speaking with people living with dementia. They were patient, the caring was unrushed and staff waited for people to respond before they provided support.

People were supported to make choices about their appearance, they chose the clothes they wore and liked to be smart but comfortable. People agreed that staff always asked them what they wanted to wear and if necessary they assisted people with their clothes and to move around the home safely. The hairdresser visited the home regularly and worked an extra day during the inspection to colour two ladies hair in their bedrooms. The ladies were relaxed and comfortable and one said, "It makes me feel so much better to have my hair done and it is never any trouble for the hairdresser." The hairdresser said they provided their service for everyone living in the home, ladies and

Requires Improvement

Is the service caring?

gentlemen, “They only need to put their name on my list and I am very happy to cut their hair.” Another person told us they had their own hairdresser and they just had to ring her up to come in.

People said they could have visitors at any time and some people chose to use the phones, that were in people's bedrooms. One person said, “I like to ring people when I feel like it and they can ring me when they want to.” Relatives agreed there were no restrictions on visiting and when they contacted the home staff asked if they wanted to talk to their family member. Relatives said, “We are always made to feel very welcome” and, “They offer the best care, you couldn’t get it better anywhere else.” Relatives and friends said staff let them know if people needed anything, such as clothes or toiletries and a friend told us, “I was made to feel very welcome. They asked me if I wanted a drink straight away and we were able to sit quietly in the dining room for a chat.” Staff knew relatives and friends. They welcomed them to the home, asking them how they were and staff let them know where the person they were visiting was in the home.

A health professional felt staff provided appropriate end of life care for people whose needs had changed and they required more support and care. Staff said the management had systems in place to recognise when additional support was needed and the palliative care training had given them a better understanding of how to support people, their relatives, friends and staff. Staff offered relatives the support they needed; with appropriate affection, hugs and best wishes as part of the end of life care provided.

Requires Improvement

Is the service responsive?

Our findings

People felt staff understood their individual needs and provided support and care specifically to meet them. One person said, "We all have different health problems. I am recovering from a stay in hospital and expect to go home, but some people live here and need much more support than me." People were very positive about the activities provided, each person had their own preferences and the activity person supported them to do group and individual activities. People told us they enjoyed the activities and could choose when to join in. One relative told us, "The activities are very good, and people clearly enjoy themselves, otherwise they wouldn't do them." A complaints procedure was in place, people and relatives said they would talk to staff if they were not happy with anything.

People's needs were assessed by the registered manager or senior staff before they moved in to ensure the staff could provide the support and care they needed. One person said, "Someone came to see me and asked questions about my health to check they could look after me, which is very good." Another person said, "My family found this lovely room for me. I was in hospital so not well enough to decide, but I am quite happy with their choice." The information from the assessments was used as the basis for the care plans.

Care plans were informative in terms of an assessment of people's needs with goals or outcomes as guidance for staff to follow when providing support and care. These included pressure relief, mobility, risk of falls, nutritional needs and mental capacity assessments had been completed. The care plans were written and reviewed by the nurses with people or their relatives who signed to show they agreed to them. However, the care plans did not identify how staff supported people to be independent and make choices about the care they received. The care plans did not show that people's views and opinions were central to the decision making process and there was no evidence they included things that mattered to people. For example, in one care plan it stated that the person can 'display challenging behaviour'. There was no specific information about the challenging behaviour, the triggers that might cause it or guidance for staff to follow to reduce or prevent its occurrence. This meant people may not receive the support and care they need. The training manager said record keeping training was required, as staff had not attended this since 2012.

Care plan summaries were kept in people's rooms, with food and fluid charts, turn charts and daily records. These were completed by the care staff and checked by the nurse on each shift. Staff said each person required individualised care, as they had different medical or physical needs, and each care plan recorded a different plan of support. This meant staff could provide people with the care they needed and wanted. Staff recorded the personal care they provided in the daily records. However, they did not include how people had spent their day; how they felt or if staff had supported them to do something they wanted to do. Incidents recorded in the daily records were not always identified as important and transferred to the main care plan by nurses, which meant specific guidance to ensure people's safety was not always in place. For example, one person had injured their legs on the bed barriers as they moved around the bed. The care plan had not been updated and there was no guidance for staff to follow to prevent a reoccurrence and the person injured themselves a second time. The nurse said bumpers had been attached to the bed to prevent this happening again and these were in place. The training records showed three staff had attended training in fluids/diet/documentation in 2015, while the majority or staff had not attended training at all or had done so in 2013. This meant staff were not up to date with record keeping and people may be at risk of harm, because there was no guidance in place to ensure consistency.

The lack of accurate and complete personal records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nurses and care staff were not involved in providing activities. They felt their role was to provide the support and care people needed and that activity staff were responsible for providing activities. Staff said when they assisted people with washing and dressing, moving around the home safely or with meals, they spoke to each person and involved them in decisions about the care provided, and may spend extra time with them if the person was feeling low or wanted to talk. However, care staff did not see the conversations they had or the extra time they spent as an 'activity' and essential to people's well-being. Care

Requires Improvement

Is the service responsive?

staff said they were usually very busy as people's needs had increased and feedback from people was that staff rarely had time to sit and talk to them. This is an area that needs to be reviewed and improvements made to ensure that support and care is based on all aspects of people's needs, including their hobbies and interests.

People were very positive about the activities provided, each person had their own preferences and the activity person supported them to do group and individual activities. An activity programme was in place, although activity staff said this was very flexible and changed as and when people wanted to do something else. A student nurse supported one person to do a crossword, a large group of people sat around the main lounge and played a game on the first day of the inspection, and a group of people played bingo on the second day with personalised boards with larger numbers and handles on discs to enable them to participate. People told us about the variety of activities they could join in if they wished. One person particularly liked the visits from pets, another enjoyed knitting and she was very pleased when staff found plastic sleeves to protect the knitting patterns. People, relatives, friends and staff had recently attended the summer fete held in the home's garden and the money raised was for charity. Other activities included film nights, amateur dramatics and people had enjoyed the curry lunch; the activity person and student nurse had dressed up in sari's, and individual and group games had been organised for people to do after the lunch.

Activity staff said they looked at people's needs on a holistic basis, which meant different activities were planned and arranged depending on people's preferences and choices were always offered. People living with dementia had recently decorated biscuits and photograph frames and a photo of each person had been placed inside. Whilst trips out were rare and depended on the weather and people's health, there were local volunteers with transport if trips were arranged, and trips to the local pub for lunch or to the seafront had been offered as part of the activity programme. People also said they could go out in the garden if they wanted to and one person told us they often sat outside with visitors, "And they always bring you a cup of tea and a nice cake."

A number of people chose to remain in their rooms and time had been allocated on the activity programme for activity staff to spend time with them. Activity staff said they would arrange anything people wanted and one person told us, "I am a committed Christian and I have communion here twice a month." People said, "I might go into the lounge, depends what's on." "There are activities you can go to but I tend to read or watch the telly" and, "I know tomorrow is pet's day."

People told us they did not really have anything to complain about, but felt they were listened to when they did raise issues. People said they were confident about talking to staff if they had any worries. One person told us, "I'd tell someone here if I needed to. It would be fine to do that."

There was a clear complaints procedure which was displayed on the notice board in the entrance. Information about making a complaint was included in the statement of purpose, which was given to people and their relatives when they moved in, and was also available in each person room. The registered manager said complaints were recorded with actions taken to address them and the outcomes of the investigations. Records confirmed that complaints were investigated and resolved in accordance with the home's policy. People found staff approachable and several people said the registered manager was very nice and one person told us, "If I tell them anything I feel they listen to me."

Requires Improvement

Is the service well-led?

Our findings

From our discussions with people, relatives, staff and the management team, and our observations, we found the culture at the home was open and relaxed. People felt Threeways Nursing Home was a well-run home and they were happy with the organisation of the care and support they received. People said they were comfortable living at the home, one person said they were happy in their room and got a good night's sleep. People told us the registered manager and nurses were always available and they could talk to them at any time. Relatives said the management of the home was very good, they could talk to the registered manager when they needed to and staff were always very helpful. One relative said, "The home is very well managed. People are safe and supported to enjoy their lives and make decisions about the care and support they have." Staff said the management supported them to provide the care people needed and they were able to talk to them at any time.

There was a clear management structure at the home and staff were aware of the lines of accountability. This meant staff understood their individual roles and responsibilities and had a good understanding of the support and guidance they provided in their role. However, because the management structure and lines of accountability were so well defined staff did not work flexibly, such as assisting a colleague who had different responsibilities. This was evident when care staff said they did not support people with activities. They felt this was the responsibility of the activity staff, this meant there were no activities on Sunday when the activity staff were not working. The allocation of staff to certain areas of the home also meant staff may only work in those areas, staff said they were not allocated to a certain room when we asked for assistance. The provider and registered manager said staff should be working together as part of the team of people employed at the home. This was identified as an area for review and improvement.

There were systems in place to inform the CQC of any changes in the home through notifications, which they are required to send us by law. We had received a number of notifications regarding deaths and issues about the home, however safeguarding referrals had been made to the local authority and CQC had not been informed of this by the home's management. The deputy manager said they sent information about any issues to CQC and were sure they had done this. They checked their records and were unable to find these notifications and said it was an oversight on their part and would review their system to ensure it was not repeated.

All of the staff said they enjoyed working at Threeways. One staff member said, "I wouldn't want to work anywhere else, I have worked in other places, I really like working here." Staff told us they had regular meetings, although they felt able to discuss any issues and make suggestions at any time. One staff member said, "We can just pop into the office to talk to the nurses or matron when we need to rather than having to wait for a meeting or supervision." There were separate management, nurses and care staff meetings, with the same process of looking at areas where improvements might be made and action plans for staff to follow to bring about change. These meetings were held regularly, the last nurses meeting was in July 2015 and care staff meeting in February 2015. Some issues involved all staff working in the home and were picked up in each action plan. For example, care staff identified there was not enough information in the care plans kept in people's rooms for people who had recently moved into the home. This included moving and handling assessments, weights, food and their medical need such as diabetes. This was picked up at the nurses meeting and action plan to address. The minutes of the meetings referred to people living in the home as patients, and some staff used this term when speaking to us, although they changed it to residents when asked. Staff said it was a term they used sometime, but did not really mean anything. This was discussed with the registered manager as the term patient may give the impression of treatment and hospital care rather than supporting people living in their home, and staff agreed Threeways was their home. This is an area for review and improvement.

People felt involved in discussions about support and care provided. Residents meetings had been held twice yearly, with the activity person and registered manager taking notes and leading the meetings. The last one had been held on 1 May 2015. Positive comments were made about the activities provided, suggestions were put forward for a curry lunch and this had been arranged and people really enjoyed it. Areas for improvement were raised as an action plan and passed on to staff to ensure changes were made.

Requires Improvement

Is the service well-led?

These included specific food to be prepared for one person based on their preferences; a reminder for staff that people can have their doors closed and for staff to check the call bell panel all the time.

The statement of purpose stated the ethos and philosophy of the home was to 'place the rights of residents at the forefront of our philosophy of care' and their 'views and experiences are listened to and influence the way the service operates'. People felt involved in decisions about the care and support they received and staff said they encouraged people to be independent and make choices about the care provided.

A quality assurance system was in place which assessed all aspects of the support and care provided for people living in the home, as well as the equipment used and the maintenance of the building itself. A number of audits were carried out on a regular basis to ensure people were protected from mistakes. These included individual care plan audits, which looked at areas that nurses had not reviewed or completed properly and medicine audits. These looked at the MAR to identify any gaps in recording and the nurse who had not completed the record correctly.

An improvement plan for the building in January 2015 identified changes that were for the benefit of people living in the home, with dates when these had been made. Wi-Fi had been installed in the home in April 2015, this gave people access to the internet if they wanted it, and enabled staff to access on line training. People were aware of this but did not use it, they said they would rather use the phone. A laptop had been purchased in July 2015 for people, staff and relatives to use. Overhead hoist tracking systems had been installed in three bedrooms and a bathroom, to enable staff to support people safely when transferring them to and from bed or chairs. Equipment was reviewed and replaced as required, a stand-aid hoist and shower chair had been purchased in July 2015. The provider had a continual system of improvement, which was based on the needs of people living in the home and enabled staff to support people as their needs changed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not ensuring people were protected against abuse and improper treatment because they were acting in a way that controlled or restrained a person which was not necessary or proportionate to prevent a risk of harm to the person or other people who did not need such control or restraint Regulation 13(4) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People's personal records were not accurate and up to date. The provider did not maintain secure and accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(2) (c).