Barchester Healthcare Homes Limited

Ashford House

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 18 January 2016. This inspection was to follow up on actions we had asked the provider to take to improve the service people received.

Ashford House is registered to provide accommodation with nursing care for up to 54 people. At the time of our visit, there were 38 older people living at the home. The majority of the people who lived at the home were living with dementia, some have complex needs and the home also provided end of life care. The accommodation is provided over two floors that were accessible by stairs and a lift.

The home did not have a registered manager in place. '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.' The provider had arranged temporary management coverage at the home. We have been informed that a new manager for the home had been recruited and they would then submit an application to be registered as manager with Care Quality Commission (CQC).

At our previous inspection on 6 and 7 May 2015 we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to the standards of cleanliness, infection control, management of medicines, dignity and respect, assessing and monitoring the quality of the service provided. Where the regulations were not being met, we took enforcement action. The provider sent us an action plan on 18 August 2015 and provided timescales by which the regulations would be met. The provider also sent us the updates in relation to progress they had made.

The home had also been placed in 'Special measures' by the Care Quality Commission. As this was the second time the home has been rated inadequate for one of the five key questions.

At this inspection we found that some improvements had been made. However, there was still a breach of the regulations. They had not met the requirements regarding the management of medicines.

People were at risk because the arrangements in place to manage medicines were not followed correctly. Medicines administration records (MARs) were not always accurately completed when verified against medicines in stock. The provider was not able to demonstrate when a medicine is correctly administered in line with the instructions provided. People were at risk of not receiving their PRN [to be taken as required] medicines in a consistent way. Documentation was not always completed in line with current legislation.

Staff were up to date with current guidance to support people to make decisions. However where people did not have capacity, not all of the records were completed and did not contain information about who could make certain decisions on their behalf. We made a recommendation that the provider ensures that

the contents of their documentation is in line with current legislation.

Improvements had been made to the systems and arrangements in place to regularly assess and monitor the quality of the home, however they were still not effective enough to minimise risk or correct poor practice.

People's needs were assessed when they entered the home and on a continuous basis to reflect changings in their needs. However there was some discrepancies between information provided by healthcare professionals was not always integrated into practice. We made a recommendation that the provider ensures that the contents of their documentation is in line with people's current care and support needs.

Medicines were stored safely. Any changes to people's medicines were prescribed by the person's GP and administered appropriately.

The standard of cleanliness had improved and staff were following the provider's Infection control policies and procedures.

People were safe at Ashford House. A relative told us, "People are safe because staff are always patient. I have never seen them rush anything or show any irritation." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

There was sufficient numbers of staff deployed who had the necessary skills and knowledge to meet people's needs. Recruitment practices were safe and relevant checks had been completed before staff started work. Staff worked within best practice guidelines to ensure people's care and support promoted well-being and independence.

Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts.

Where people had restrictions placed on them these were done in their best interests using appropriate safeguards. Staff had a clear understanding of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) as well as their responsibilities in respect of this.

The provider ensured staff had the skills and experience which were necessary to carry out their role. Staff had received appropriate support that promoted their development. We found the staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's privacy and dignity were respected and promoted when personal care was undertaken.

People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the home.

People had access to activities that were important and relevant to them. People were protected from social isolation through systems the home had in place. There were a range of activities available within the home and community.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

People's care and welfare was monitored regularly to ensure their needs were met within a safe environment.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the home. Staff told us they would report any concerns to their manager. Staff felt that management were very supportive.

We found a breach 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were at risk because procedures to manage medicines were not followed correctly.

People had risk assessments in place however they were not always related to the person's care and support needs.

Procedures to prevent and control the spread of infection were in place and being followed correctly.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always consistently effective.

Staff understood and knew how to apply legislation that supported people to consent to treatment. However where people did not have capacity, not all of the records were completed and did not contain information about who could make certain decisions on their behalf.

Where restrictions were in place this was in line with appropriate guidelines.

People's care and support promoted a good quality of life based on good practice guidance. People were supported to have access to healthcare services.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion, kindness, dignity and respect. People's privacy were respected and promoted.

Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed when they entered the home and on a continuous basis. However there were some discrepancies between information provided by healthcare professionals which was not always integrated into practice.

The home was organised to meet people's changing needs.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the home and there were different ways for their voices to be heard.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to the systems and arrangements to regularly assess and monitor the quality of the home.

The provider had sought, encouraged and supported people's involvement in the improvement of the home.

People told us the staff were friendly, supportive and management were visible and approachable.

Ashford House

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.

We visited the home on 18 January 2016 and it was an unannounced inspection. The inspection was conducted by two inspectors, a pharmacist, a nurse specialist 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 service.

We spoke to seven people living at the home, seven relatives, 15 staff including nurses, care workers, housekeeping staff, maintenance, activity staff, deputy manager, operations manager and regional director. We also spoke to a healthcare professional visiting the home. We observed care and support in communal areas; looked at 11 bedrooms with the agreement of the relevant people. We reviewed seven care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, complaints records, policies and procedures and external and internal audits. We also reviewed six staff recruitment records, training and supervision records and staff rotas.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This was because we were following up on action taken in regard with the concerns found at the last inspection.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team and the health authority, who had funding responsibility for people using the home. We contacted two social care professionals who were involved with the home to obtain their views.

We also reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. A person told us, "I feel very safe here. They are nice people who are interested in me." A relative told us, "My family member is most definitely safe. [Person] has been here for 10 years so we know." Another relative told us, "Safe and cared for. When I leave I am confident that [person] is well supported." We observed that people were safe and were provided guidance about what to do if they suspected abuse was taking place.

At our last inspection on 6 and 7 May 2015, we identified breaches of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to have effective systems in place to assess the risk, prevent and control the spread of infections. They had also failed to ensure the proper and safe management of medicines.

Where the regulations were not being met, we took enforcement action and issued a warning notice in regard to cleanliness and infection control. We asked the provider to take action to make improvements to their infection control procedures and review the management of medicines. The provider sent us an action plan stating they would make the improvements by 30 September 2015.

At this inspection we found that some improvements had been made. There was adequate systems and arrangements to protect people from the spread of infection. However, we found that the provider had not made all of the improvements to the safe management of medicines.

People were at risk of not receiving their prescribed medicines in a timely manner. We viewed the medicines administration records (MARs) in use at the time of the inspection and found that these were not always accurately completed. We checked a sample of medicines which had been supplied in blister packs against the MARs. The amounts remaining in the blister pack did not always match with what had been recorded as having been given to people. For example, medicine due to be administered at 6pm for Monday to Thursday only the Tuesday dose was gone from the blister pack. The MAR stated that the medicine had been given on all of the above days.

Accurate records were not always made of the time medicines were given to people. For example, a medicine which should be given before any food, drink or other medicines was recorded as being given at the same time as other medicines. It is important these medicines are given before other medicines or food to permit the correct absorption of the drug. Staff told us that this was not the case and that this medicine was administered appropriately but it was not possible to observe this. The provider was unable to demonstrate when a medicine was correctly administered in line with the instructions provided.

People were at risk of not receiving their 'as required' (PRN) medicines in a consistent way. PRN record sheets did not always contain minimal dosing intervals. For example, one person's PRN sheet for Lorazepam stated PRN for agitation/restlessness. However, the box printed 'How often can the dose be repeated?' was left blank. Another example was found for a person taking paracetamol, the information stated the dosage but not how long staff should wait for the next medicines to be administered. This would provide staff with

accurate guidance and information on the safe time intervals between each dosage of medicines, such as paracetamol, so that people were given safe dosages of medicines over a 24 hour period.

People were at risk of harm as records of transdermal patch sites were intermittently missing from a person's record. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. This is an important record as the site of patches must be rotated to avoid people developing skin damage.

People were at risk as some staff were not working in line with current policies or best practices. Staff were not completing documentation in line with the requirements of The Misuse of Drugs Regulations 2001. Registers were in place to record the handling of Control Drugs (CD). However, we found that one CD register was not always completed correctly. For example, there were crossings out on entries in the CD register. Additionally, some pages of the register did not have the full details of the medicines and preparation as required by current legislation.

Staff did not always have access to current guidelines or procedures regarding the management of medicines. For example, policies on medicines administration and storage were issued in September 2007 and due for review in September 2010. Upon speaking to the operations manager, they were able to obtain up to date policies which had an expiry date of September 2016. This demonstrated that people were at risk as some staff were not working in line with current policies or best practices.

Due to concerns raised at the previous inspection and notifications received, we wanted to review any incidents of medicines errors. However we were not able to view records on medicines administration errors as there was a lack of error reports completed. The provider was unable to demonstrate that was any learning obtained from previous adverse events or that practice had improved as a result. There were no audits on this of any kind.

People were at risk of receiving inappropriate medicines. A bottle of mixed waste liquid medicine was stored in one of the medicines trolley. This was stored next to other medicines in the trolley and not emptied regularly, meaning there was a small risk this could be given to a person in error.

Failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (1) and (2), (b) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were kept safely and stored securely. We found that controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring) were stored securely. Registers were in place to record the handling of CDs. CDs were disposed of appropriately and we viewed records which demonstrated this was the case. Medicines requiring cold storage were also stored appropriately and records were in place. Any changes to people's medicines were verified and prescribed by the person's GP.

During our previous inspection, we found that documentation had not been correctly completed for people medicines administered covertly. During this inspection we found that appropriate processes had been followed and correct documentation was in place for people who had medicines administered covertly. The administration of covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it.

A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. A photograph of each person was on their MAR to ensure that staff were giving the medicine to the correct person. All medicines coming into the home were recorded and

medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

Only staff who had attended training in the safe management of medicines were authorised to administer medicines. Staff attended regular refresher training in this area and after completing this training, the deputy manager observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. We observed staff waited patiently until the person had taken their medicines.

People were no longer at risk as adequate systems and arrangements to protect people from the spread of infection were in place. Appropriate standards of cleanliness were now being maintained. During the inspection we saw staff wearing personal protective equipment (PPE), however there was one incident where staff were not wearing PPE. When questioned, staff immediately realised their error and put on the equipment. Staff were also following the provider's Infection control policies and procedures. Although we identified some concerns about some bedding, mattresses and wheelchairs, there was a vast improvement in the standards of cleanliness throughout the home.

We were informed that the management of the home had overall accountability for infection control with nurses on each unit and shift taking lead responsibility. The operations manager explained, "Everyone is responsible including management. Everyone is aware they have to check everything, mattresses, and air cushions. We have replaced alot. We have cleaning schedules and audits for monitoring. As a result of the audits we found we did not have enough slings so have ordered more and are using the ones from empty rooms at the moment." This demonstrated that arrangements were in place to monitor and manage infection control and prevention.

There were three housekeeping staff employed who undertook a mixture of cleaning and laundry duties seven days a week. Records confirmed that housekeeping staff were allocated to specific areas of the home and to undertake laundry duties. Staff had been provided with infection control training. The head housekeeper told us, "My main role is to make sure all the jobs are done properly and I also fill in whenever necessary if we are short. I am responsible for laundry, rotas, and keeping the schedules up to date. I do monthly audits. I don't pick which room is audited; this is chosen at random by a care assistant. I check the cleanliness of ensuite, bedrooms, lounges, stair wells on both floors. I make sure the cleaning schedule includes deep cleaning. We have a resident of the day and their room is deep cleaned and this includes bed frames and mattresses."

Infection control audits were completed to ensure safe standards of cleanliness were maintained. Those we sampled demonstrated that improvements had been made at the home. For example, as a result of the November 2015 audit arrangements had been made to replace shower screens, fans had been cleaned and slide sheets had been washed and labelled. A slide sheet is a special fabric sheet designed to assist with moving or turning a person in bed. Staff confirmed that improvements had been made in relation to cleanliness and infection control. A member of staff told us, "We are now cleaning properly, especially the beds. The manager is doing her best to change things and replace items." Infection control audits were completed to ensure safe standards of cleanliness were maintained.
Other improvements that had taken place since our last inspection included the reviewing of housekeeping shifts with start and finish times adjusted so that cover during the afternoon was increased. The provider had given regional support to the new head housekeeper to ensure that good infection control practices are embedded. Random checks of cleaning records in addition to formal audits and visual checks of equipment and the premises had been completed. Some carpets, bedding, mattresses and bed linen have been

replaced and arrangements were in place for others to be replaced in due course.

Safety arrangements for people were in place in the event of an emergency. Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts. The provider had identified alternative locations which would be utilised if the home was unable to be used. There was information displayed regarding the Fire Evacuation plan. We saw in people's care plan a 'personal emergency evacuation plan' had been completed. This demonstrated that staff had information on how to support people in the event of an evacuation.

Staff had undertaken adult safeguarding training and were able to explain the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult services safeguarding team should be made, in line with the provider's policy. A staff member told us, "I must protect and look after people. If I see abuse I must report to the manager. If the manager did not do anything I would speak to the regional director and go higher."

The home had the most recent Surrey County Council (SCC) multi-agency safeguarding policy. This provided staff with guidance about what to do in the event of suspected abuse. We saw incidents and safeguarding had been raised and dealt with and notifications had been sent to CQC in a timely manner.

Risk assessments and any healthcare issues that arose were discussed with the involvement of a relative, social or health care professionals such as psychiatrist, community psychiatric nurse, GP or speech and language therapist. Staff were knowledgeable about people's needs, and what techniques to use when people were distressed or at risk of harm. Risk assessments had detailed the support needs, views, wishes, likes, dislikes and routines of people, however they were not always person centred. For example where a person had an eating disorder or Parkinson's disease, there was no information recorded about how to keep them safe. Risk assessments and protocols identified the level of concern, risks and how to manage the risks.

Individual records were in place for accidents and incidents. There was also an electronic log that was monitored centrally by the provider. In addition the electronic monitoring system included a link to statutory notifications which the operations manager explained helped ensure all appropriate agencies were informed of important matters.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques. Staff supported people to move safely from wheelchairs to armchairs using a hoist. They explained the process to people, telling them what was happening and provided reassurance. Records were in place that confirmed that hoists and slings were checked on a regular basis along with a system to report if equipment was faulty.

Robust recruitment checks were completed to ensure staff were safe to support people living at the home. Staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. They also included checks on eligibility to work in the United Kingdom (UK) and confirmation that nurses were registered to practice with the National Midwifery Council.

There were sufficient numbers of staff deployed to keep people safe. A person told us, "I can get help when I need it. Not waiting about too long." A relative told us, "Carers always popping in and out. Never far away." The consistent staff team were able to build up a rapport with people who lived at the home. This enabled

staff to acquire an understanding of people's care and support needs. The staffing rotas were based on the individual needs of people. We saw that additional staff had been recruited. We reviewed the staffing rota and saw that additional duties had been added. This included, supporting people to attend appointments and activities in the local community.

We noted on the day of our visit, that people's needs were met promptly and they were given one to one support when required. At times the home used agency and bank staff to ensure sufficient staff levels. The regional director explained, "We have used nurses and care assistants over last few weeks and using staff from our other homes. We have preferred agencies and bank staff on standby. Wherever possible we use regular staff for consistency."

Requires Improvement

Is the service effective?

Our findings

Relatives and residents spoke highly of the staff working at the home. They felt that they were well trained and had sufficient knowledge to keep people safe. A relative told us, "[Person] has been here a long time. They are well cared for. Lately staff are trying different things with her to try and stimulate her mind."

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. We saw some assessments had been completed where people were unable to make decisions for themselves and who was able to make decisions on their behalf, made in their best interests. However there were some records that did not contain this information.

We recommend the provider ensures that the contents of their documentation are in line with current legislation.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We noted that the manager had completed and submitted DoLS applications in line with the latest Supreme Court judgement to the local authority for people living at the home.

During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff asked people for consent before assisting them to move, to eat, and before giving them medicines. Staff that we spoke with had received Mental Capacity Act training and were able to explain how they supported people to make decisions. A member of staff told us, "Some residents can't make decisions by themselves and need our help. We have training about this and have a booklet to refer to." The member of staff then produced a small booklet titled 'What is MCA'. A second member of staff told us, "It's all about giving choices and good quality care. Some people can't make their own choices so we have to make decisions in their best interest. It's important to read care plans and to talk to them."

There was sufficient qualified, skilled and experienced staff to meet people's needs. The provider ensured staff had the skills and experience which were necessary to carry out their responsibilities through regular training and supervision. All new staff attended induction training that followed nationally recognised standards and shadowed an experienced member of staff until they were competent to carry out their role.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. Staff confirmed they were fully supported by management. A member of staff told us, "We get supervision and nurses help us and show us better ways of doing things." Monitoring systems were in place to ensure that staff received consistent support throughout the year. A member of staff told us, "I get help from other staff, the deputy

and the manager plus you can go and ask. I get good support."

Staff told us they were happy with the training provided and it was relevant to their job role. A member of staff told us, "I have done moving and handling, infection control, fire and dementia. At the moment we are doing further dementia training that is more in-depth and looks at the whole person." A second member of staff told us, "We have regular training on fire safety, dementia and health and safety. We have been having new training about experiencing what residents are feeling." A third member of staff told us, "Training is provided all the time and we get updates posted on the bulletin board." Staff were trained in areas that included fire safety, first aid, food hygiene, infection control, moving and handling, safeguarding and health and safety. A training programme was in place that included courses that were relevant to the needs of people who lived at Ashford. These included dementia care and wound care. The operations manager informed us that further training had been arranged for nurses in relation to catheterisation (a procedure used to drain the bladder and collect urine, through a flexible tube called a catheter), venepuncture (the procedure of inserting a needle into a vein) and management of pressure areas.

People had their needs assessed and care plans had been developed in relation to their individual needs. For example, where people had specific dietary needs relating to their condition, guidelines were in place to monitor and review their needs. Staff monitored people throughout the day to ensure that people's physical and mental health needs were supported. The operations manager informed us that work had been undertaken to improve the management of people's weight. They explained, "We have done quite a lot of work and this seems to have stabilised. We leave more snacks out at night and finger foods and fortified meals." The deputy manager explained that a form is now used to inform kitchen staff of people who may be at risk of losing weight.

People told us about the food at the home. A person told us, "It is very nice food. Very good breakfasts. Plenty of it." Another person told us, "The food is marvellous no worries about getting thin." A relative told us, "[Person] eats a normal diet. They eat very slowly so I come in to help. [Person] likes their puddings. The food is very good." The chef prepared and cooked all of the meals in the home. People were offered a choice of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; an alternative option was available if people did not like what was on offer. Care plans confirmed that a dietician was involved with people who had special dietary requirements.

Lunchtime was observed as a social occasion. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, communal lounges or in their room. People were supported to have their nutrition and hydration needs met. Detailed information about people's food likes and dislikes and preferences such as religious or cultural needs was available.

We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were unable to eat independently were supported by a member of staff. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated.

People had access to healthcare professionals such as GP, district nurse, occupational therapist, dietician, physiotherapist, speech and language therapist and social care professionals. A relative told us, "[Person] has visits from the Multiple Sclerosis nurse and the Occupational Therapist." Healthcare professional visiting the home told us, "Staff call us if a resident requires it and they have not had any problems." They went onto say that they had no other issues with the home and that they thought the staff were delivering excellent care. Outcomes of people's visits to healthcare professionals were recorded in their care records. Staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

People's bedrooms were personalised with pictures, photographs or items of personal interest. Large windows provided natural daylight and provided people living at the home with views of their courtyard, and the garden. Efforts were being made to ensure the design and decoration of the home was suitable for people who lived with dementia. We were informed that a programme of redecoration was in the process of starting that would include decorating the corridors and doors within the home so that they were more visible to people who lived with dementia. There were also plans for themed areas of the premises to be put in place along with objects of reference.

Good

Is the service caring?

Our findings

At our last inspection we identified a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to treat people with dignity and respect.

At this inspection we found that the provider had made all of the improvements required to meet the requirements of the regulations.

Staff were kind and caring. The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. People were happy and laughing whilst enjoying being in the company of staff. A person told us, "The girls are very kind." A relative told us, "We are very happy with the care. We wouldn't find anywhere better."

Staff understood the importance of promoting independence and choice. A person told us, "I still shave myself. I want to do this for myself for as long as possible." A member of staff told us, "We show two items for example clothes so people can make a choice. Some people can't make choices even when we do this so we have to make it on their behalf based on what families tell us." They went onto say "Information is in care plans that we read. It's important to respect people's choices and the decisions they make." A second member of staff told us, "It's important to know peoples likes and dislikes and routines. To understand about their past. Do they like sugar in their tea? If they are agitated it could be that you gave a cup of tea without sugar and they can't explain this to you. It's important to read care plans as some people can't tell you about their routines and past."

A person told us, "I can get up and go to bed when I want to." People are able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations.

Staff knew about the people they supported. A relative told us, "[Person] has a programme devised by health professionals. As part of this they need to stand upright from time to time. Staff have taken this on board and during handling and moving, using a chair to stand and lift, they ensure that [person] spends a short time standing in a near vertical position. The occupational therapist has come in because [person] has problems with his hands so she has come up with exercises which the activity staff oversees."

Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. There was detailed information in care records that highlighted people's personal preferences, and also what constituted as a good or bad day for people, so that staff would know what people needed from them. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. During the inspection we observed people's behaviour and how staff

responded to help them calm down. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them. Care records were reviewed on a regular basis or when care needs changed.

Information about people's care and support was also provided if a person require hospitalisation. This enabled hospital staff to know important things about people's medicines, allergies, medical history, mental and physical needs and how to keep them safe.

Staff approached people with kindness and compassion. A person told us, "The girls look after me very good." We saw that staff treated people with dignity and respect. For example a person was sitting in a chair and their clothes were in disarray as a result of fidgeting. As soon as a member of staff became aware the person was attended to, reassured and asked if they would like a blanket. The person stated that they didn't and her wish was respected.

Personal care was provided in private and staff placed a sign on people's doors stating 'not to be disturbed as personal care being given.' Staff called people by their preferred names. Staff interacted with people throughout the day. For example when attending activities in the home, helping them eat and drink, listening to music and watching television, at each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

Staff understood the importance of respecting people's privacy and dignity and treating people with respect. Staff were seen to discreetly advise people when they required attention to their personal care and this was always provided in private. We observed that staff knocked on people's doors before entering. During lunch staff ensured people's mouths were wiped which helped promote their dignity. A member of staff explained, "I look at people like they are part of my family. So give kind care and hug if needed." A second member of staff told us, "When helping to bath make sure the door is closed and cover as much as possible when giving personal care."

People were involved in making decisions about their care. A relative told us, "I am always kept informed about [person]. Staff will let us know straight away if anything happened. I always chat to the nurse when I come in." We observed that when staff asked people questions, they were given time to respond. For example, when being offered a drink staff did not rush people for a response, nor did they make the choice for the person. Relatives, health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were protected from social isolation with the activities, interests and hobbies they were involved with. Relatives and friends were encouraged to visit and maintain relationships with people. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We also saw that religious services were held in the home and these were open to those who wished to attend. This demonstrated that care and support was provided with due regard for people's religious persuasion.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information about people were kept in a secure office. This ensured that visitors and other people who were involved in people's care could not gain access to their private information without staff being present.

Requires Improvement

Is the service responsive?

Our findings

A person told us, "The staff are very responsive and open to suggestions. I only have to mention something and the carers will take it on board." A relative told us, "I am pleased that there is more for [person] to do." There were examples of how staff knew and responded to people's needs. For example, one person with very limited capacity for speech liked to listen to music. Staff know that they did not like crowded spaces and noise so staff have set up a quiet lounge as a music room where this person could spend their time listening to classical music.

People were at risk of not receiving the appropriate treatment in line with healthcare professional guidance. Information provided by healthcare professionals was not always integrated into practice. For example where a person had a pressure sore, it was documented that a dry dressing was being regularly applied. However this was not the advice given by the Tissue Viability Nurse. There was no evidence in the records, of the clinical rationale for not following the specialist advice given. Another example, the documentation stated that the resident "prefers liquidised meals" and "likes finger soft meals." There was no information about the type of textured food they should have which is in line with the National Texture Modified Diet Classifications. This identifies different types of textured food including a description. The reason for texture modified diets is to reduce a person's risk of choking. The chef confirmed that the Speech and Language Therapy (SaLT) team were involved with people who had special dietary requirements.

We recommend the provider ensures that the contents of their documentation are in line with people's current care and support needs.

Care records outlined individual's care and support. For example, personal hygiene, medicine, health, dietary needs, sleep patterns, safety and environmental issues, emotional and behavioural issues and mobility. Any changes to people's care was updated in their care record and ensured that staff had up to date information.

Care given was based on individual's care and support needs. Pre-admission and admission assessments provided information about people's needs and support. Where people displayed behaviour that was challenging, guidelines were provided to staff to minimise risk, whilst ensuring the person was safe. Staff were quick to respond to people's needs. They told us by having a consistent staff team they were able to build up a rapport with people and staff knew people well and understood their needs.

Needs assessments recorded individual's personal details and whether they had capacity to make decisions for themselves were reviewed on a regular basis. Details of health and social care professionals, information about any medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were documented. This information was reviewed before a care plan was developed and care and support given. Staff were able to build a picture of the person's support needs based on the information provided.

Staff told us that they completed a handover sheet after each shift which outlined changes to people's

needs. We looked at these sheets and saw that the information related to a change in people's medicine, healthcare appointments and messages to staff. Daily records were also completed to record each person's daily activities, personal care given, what went well and what did not and any action taken. The staff had up to date information relating to people's care needs.

We saw there was a call bell system in place; the system was easy to use. We saw that the information displayed on the call unit indicated in which room the call button had been activated. We observed there were call bells in communal areas as well as in people's bedrooms. We observed that the call bells or requests for help were responded to quickly.

People confirmed that they took part in the activities in the home and outside in their community. Activities included skittles, quizzes and one to one activities, external entertainers/ singers, music for health, trips, and events such as garden parties, and a Burns Night celebration. We saw photographs of outings or events people had attended. Items were placed throughout the home which created sensations that could assist relaxation, or stimulate people's senses. For example, staff informed us of a person who suffers from epilepsy spends a long time in a darkened room in case their condition was triggered by photosensitivity. They went on to say they had obtained guidance from the GP who stated that staff should try a range of things including light therapy. Staff informed us they had started light therapy and the person was responding.

Those who were cared for in bed were offered one to one time with the activities co-ordinator. There was an activities programme which was displayed throughout the home and each person received a copy of the activity programme, in a format which supported their needs to identify relevant activities they were interested in.

People were provided with the necessary equipment, care and support to assist with their care and support needs. For example, pressure relieving mattresses and cushions, wheelchairs, and hoists. Information regarding people's individual needs and treatment was recorded in their care records; and staff were knowledgeable about their needs.

People were supported to raise concerns and complaints without fear of reprisal. A relative told us, "The management is very responsive. If I have any complaints I go to the nurse then to the manager if necessary." Another relative told us, "'No complaints at all. Very happy all is well. If there was anything I knew that it would be dealt with." There was various ways that someone could voice their opinion about the home. For example discussing the issue with staff, the manager or at the relatives or residents meetings. People had their comments and complaints listened to and acted upon. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms.

Staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The home maintained a complaints log and these were dealt with in a timely manner, in accordance to their complaint policy. A record was in place of complaints received that included a record of actions taken to investigate the complaint and outcome. We noted that responses to the complaints contained action to be taken and offers of apology. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, and Local Government Ombudsman.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we identified a breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have effective arrangements in place to protect people by regularly assessing and monitoring the quality of the service provided and identifying, assessing and managing risks.

At this inspection we found that the provider had made the improvements required to meet the requirements of the regulations.

The home did not have a registered manager in place. An operations manager employed by the registered provider had been based at the home since 22 May 2015 2015 on a full time basis. The regional director explained that the operations manager had undertaken all duties expected of a registered manager. They informed us that a manager had been recruited and was due to commence employment at the end of January. They would complete two weeks induction before coming to the home to commence work in February. We were informed they would then submit an application to be registered as manager with CQC.

We noted that there were some inconsistencies in how each floor was managed. Each floor had a designated nurse who was in charge of the shift. For example, the downstairs unit appeared to be much more well run that the upstairs unit. The nurse who was in charged downstairs was able to produce handover sheets and monitoring charts. Whereas the nurse upstairs was not aware there was a handover sheet in place.

The operations manager understood the importance of creating and promoting a positive culture at the home. She explained, "I go and talk to staff every day. When I first got here moral was really low and staff were leaving. It's a lot more positive now. They are now getting more support and regular supervision." Staff that we spoke with and examination of records confirmed that the frequency of staff meetings had increased. A member of staff told us, "At staff meetings we are now asked what we think about the home and what we need." A second member of staff told us, "We have staff meetings and they ask us what we think is best for the home."

People and relatives referred to the manager as being open, approachable and responsive. People told us they all knew the manager and the deputy manager and that they were always around on the floor. Staff informed us that the operations manager was approachable. A staff member told us, "You know you can go to them with problems." Another told us, "Management keeps on changing and that has caused problems. I like (operations manager) she listens to our opinions." A third told us, "Since working here I have had four managers. It can be confusing, as each change things. The manager is helping me to go another level."
Services are required to display the rating of their service to people and visitors. We saw this had been displayed in the lobby of the home.
The operations manager also understood the importance of obtaining the views of people and their representatives. She explained, "I have an open door policy and from 10am till 8pm on Wednesdays keep my time free so I can give dedicated time to anyone who wants to speak to me." Resident and relatives

meetings were also used as a forum for obtaining people's views.

Surveys were sent to people and their representatives in order that their views could be used to drive improvements at the home. The latest surveys were sent to people during November 2015. There was no action plan in place yet as the findings from these were in the process of being collated at the provider's central office at the time of our inspection.

The operations manager explained how she monitored the quality of service provided to people. She told us, "First thing I do each day is walk around, check staffing, look for any problems. Check some rooms, beds, charts and deal with them as I go around. I record this on a daily management report. Then I do 11 o'clock stand up. This is a meeting with all of the heads of nursing, caring, HR, maintenance staff. They then cascade information to staff. This 11 o'clock meeting is recorded. We also have a quarterly quality first audit by Barchester quality assurance team. Also have monthly audits for medicines and infection control and may have others identified centrally. We also have clinical governance monthly. Audits are monitored via an electronic system centrally. They monitor that actions are taken timely and involve the right people."

A range of quality assurance audits were completed by the operations manager and representatives of the provider that helped ensure quality standards were maintained and legislation complied with. These included audits of medicines, accidents and incidents, health and safety, care and staffing and infection control. The audit system had been reviewed and was linked to the fundamental standards and the domains of safe, effective, caring, responsive and well -led. The findings from the audits were collated and an overall action place was in place that monitored that timely actions were taken to drive improvements. For example old carpets, bedding and flooring have been replaced.

The provider had a system to manage and report incidents, accidents and safeguarding. Members of staff told us they would report concerns to the manager. We saw incidents and safeguarding had been raised and dealt with where relevant notifications had been received by the Care Quality Commission. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents occurring in the future. We saw accident records were kept. Each accident had an accident form completed, which included immediate action taken.

The operations manager explained that since being in post at the home she had reviewed the systems in place at the home and introduced a number of changes. For instance, a nutritional log of people who were at risk or who had lost weight. They compiled a DoLS log and made contact with the DoLS team to verify applications they had received and also introduced additional audits for medicines and infection control. Records were in place that confirmed all of this. Staff also confirmed that improvements had taken place at the home. A member of staff told us, "Activities and decoration has got a lot better. I think having permanent activity staff has made all the difference." The activity co-ordinator informed us it was identified that the sensory room was not effective for people who were social isolated, so staff now use the equipment from the room in communal areas and in people's room which they respond and benefit from.

The operations manager explained, "We just had a [external pharmacy] audit last week. They gave initial feedback and I did an action plan so we could start work straight away and I told nurses to cascade to staff." We reviewed the audit from the external pharmacy and the action plan. We also reviewed that an action plan that was in place that collated the findings from all of the audits completed at the home. The regional director monitored progress on a regular basis.

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and

other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. This demonstrated that the provider understood their responsibility and was working within the current regulations.

The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The regional director explained that she had received training in relation to duty of candour and cascaded this to staff. She explained that she then checked staffs understanding when she carried out quality assurance visits to the home. The majority of staff that we spoke with were able to describe its relevance and application. The operations manager and regional director demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated their knowledge regarding these policies and procedures. The policies and procedures were reviewed on a regular basis. This ensured that people continued to receive care and support safely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1)(2) (b) and (g)