Health & Care Services (UK) Limited

Ashfield Lodge

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**

Summary of findings

Overall summary

The inspection took place on 7 and 8 November 2017 and was unannounced.

Ashfield Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashfield Lodge accommodates 20 people who require nursing care in a purpose build single story building. Most of the people living at Ashfield Lodge were living with dementia. There were 20 people living at the home on the day of our inspection.

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.

This is the third consecutive time the service has been rated Requires Improvement.

At the last inspection we found the provider was in breach of regulations 9, 11,12,14,17 and 18. We found that the provider had not always engaged people in developing their care so care was not meeting their needs. Consent was not always gained by staff before providing care and people's rights under the mental capacity act were not respected. Medicines were not properly managed and risks to people were not always identified. People did not receive adequate support in relation to food and drink. Staffing levels did not support safe care and staff did not receive adequate training and support. The systems to monitor the quality of care provided were not effective at identifying and rectifying concerns.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to at least good.

At this inspection we found the manager had made improvements in all but one of the areas where we had concerns. The management of medicines was still not adequate to ensure people's medicines were stored safely and available when needed. You can see what action we have told the provider to take at the back of the full version of this report.

Audits to identify areas for concern or improvement were effective in most areas but had failed to identify the issues with medicines management. The environment was in need of decoration and did not support people living with dementia to be independent and there was an unpleasant odour of urine in the home. People were not supported to manage their continence which impacted on their privacy and dignity.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind and caring and were enough staff to meet people's needs. Staff were provided with appropriate training and support which reflected current guidance and legislation. Staff worked well together and received appropriate management so that they understood their roles and responsibilities. Regular quality meetings supported the registered manager to continually drive improvements in the home and to implement changes to reflect best practice. Recruitment processes ensured staff were safe to work with people living at the home.

Risks to people were identified and action was taken to keep people safe. Incidents were reported and action was taken to reduce the risk of the same incident reoccurring. Incidents were monitored at the home and at provider level to ensure lessons learnt in all the provider's homes were shared to keep people safe. Staff knew how to keep people safe from the risk of infection, however there was an unpleasant odour in the parts of the home.

People were offered choices about their everyday lives. They were supported to access a choice of food and drink which they were able to consume safely and with appropriate support from staff when needed. However, we did find the lunchtime period was chaotic and care was not always person centred. Activities provided appropriate entertainment for people.

People had been involved in making decisions about their care and were happy with the care and support they received. The registered manager and staff worked closely with other healthcare agencies to ensure that people received all of the support available to them. People wishes for the end of their lives had been discussed and recorded and action was taken to keep people as comfortable as possible for the final stages of their lives.

People living at the home, relatives and staff all spoke highly of the registered manager and were confident in their abilities to manage the home. People's views of the care they received were used to drive improvements in the home.

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 had not always been managed in line with good practice.

Risks to people had been identified and action had been taken to keep people safe.

Staffing levels supported people to receive safe timely care and appropriate checks were completed to ensure staff were safe to work with people living at the home.

Staff knew how to keep people safe from the risks of infection.

The registered manager ensured that changes were made to the care provided after accidents and incidents to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment was in need of decorations and did not support people with dementia to maximise their independence.

People's ability to maintain a healthy weight and eat safely was monitored and appropriate action was taken to support people when concerns were identified. However, more individualised care around mealtimes was needed.

Staff received training and support which enabled them to provide safe care for people. In addition all the staff worked as a team to support people's needs.

The provider had systems in place to ensure that the training was updated to reflect changes in legislation and best practice. In addition changes in guidance were regularly shared with staff.

People's rights under the Mental Capacity Act 2005 were protected.

People were supported to access healthcare when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always supported.

Staff were kind and caring.

People were offered choices about their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's continence was not always supported.

People were involved in planning their own care needs.

The registered manager ensured that the care people received at the end of their lives met their needs.

There were a variety of activities available to support people.

Complaints were investigated and resolved in line with the provider's policies.

Is the service well-led?

Requires Improvement

The service was well led.

Audits had been effective in identifying most concerns around the home. However, more work was needed to support the home to be complaint with medicines management.

People living at the home, relatives and staff were all happy to raising issues with the registered manager and were confident that action would be taken.

The views of people living at the home were taken into account and used to drive continuous improvement in the home.

Ashfield Lodge

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 7 and 8 November 2017 and was unannounced. On the first day our team consisted of an inspector 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. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home. This included the action plan completed by the provider following our last inspection. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy manager, the activities coordinator, a nurse, a member of the care staff, the housekeeper and the cook. We also spoke with three people living at the home and five relatives of people who lived at the home.

We looked at a range of documents and written records including four people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

When we inspected on 30 January 2017 we found that care was not delivered in a way to minimise the risks to people and that the management of medicines was not always safe. This was a breach of regulation 112 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. Following our inspection the provider wrote to us and told us they would review people's care plans around their risks and the way medicines were managed in the home.

At this inspection we found medicines had not always been stored safely. Some people's liquid medicines had not been dated to show when they had been opened. This is important as some medicines have a limited lifespan once opened. the provider's policy stated, "When opening a new packet or bottle of medication a note of the date of opening should be made on the bottle or packet, an expiry date calculated and recorded." By checking the administered dates we found one of the bottles was past the 90 day lifespan it had once opened. There was no impact on the patient as they had not requested any of this pain medicine recently. Staff had also stored some creams in the trolley which should have been stored in the refrigerator. This meant effectiveness of the medicine may have reduced and the medicine may not have worked so well as . The nurse told us they would order replacement medicines immediately.

The stock checks of medicines were not always accurate. For example, totals for paracetamol and cocodamol did not match the numbers available in the medicines trolley. In addition, we saw that some medicines had not been removed from the trolley when they had stopped being prescribed for people.

Medicines were administered by the nurse. They spent time with people to ensure that they took their medicines safely. For example, by encouraging them to sit up so that they could swallow safely. However, we saw that they did not follow the provider's medicines policy which stated, "The medication trolley should be taken as close to the resident as possible." Instead they dispensed all the medicines in the medicine room and took them to the person. This increased the risk that medicine may be dropped or spoilt.

The home monitored people's needs around medicines. For example, they had asked for one person's medicines to be reviewed as they were making them too sleepy and it was impacting on their ability to eat and maintain a healthy weight. Staff had also requested the timing of some people's medicines be reviewed. An example of this was one person who was often tired in the mornings and would refuse to take their medicine, in discussion with the GP the medicines had been moved to lunchtime as the person was more inclined to take medicines at that time of day.

Some medicines were administered to people by being crushed or hidden in their food. Staff had taken advice from the doctor and the pharmacy on whether this would impact of the benefit people received from taking the medicine. Any special instructions given by the doctor or the pharmacist was followed.

The deputy manager had put in place protocols for homely remedies such as cough mixture to ensure that they were offered to people safely when needed. They had checked with people's GP's which homely remedies it was appropriate to offer people to ensure that they did not interact with people's prescribed

medicines.

The written protocols in place did not always support people to receive their as required medicines as care had not been taken when putting them in place. For example, we saw three people's protocols for paracetamol which stated that it should be taken for diarrhoea instead of pain. We discussed this with the nurse who confirmed that this was an error. Records showed people had received their pain medicine when needed. Where people were given medicines on an as required basis, the outcome of the administration was not recorded. This meant that healthcare professionals would not have been able you review how effective the medicine was and if the person may need it on a more routine basis.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment in relation to how medicines were managed.

Care plans also contained information so that medicines used to help people manage their emotions were used as a last resort. Staff were required to try and redirect the person to an activity they enjoyed. The staff monitored people after any medicine change to see if it had a positive effect on their welfare. If they had any concerns they would ask for the medicine to be reviewed. For example, staff had noticed that one person was drowsy after their medicine change and this impacted on their appetite and ability to walk safely. A healthcare professional had reviewed the medicines and suggested changes to help the person stay safe and healthy.

Risks to people had been assessed and care had been put into place to keep people safe and well. Staff were aware of the care people needed to help them prevent pressure ulcers. For example, support in repositioning on a regular basis. In addition, for one person who was frail and who had a high risk of developing pressure ulcers an individual risk assessment had been completed and the provider had obtained a special air cushion for them. Their relative told us, "[Name] has had no sores or anything and has a vibrating cushion and equipment to relieve pressure."

However, care plans did not detail the type of cushion which was most suitable for each person to use and staff were not clear on the need for people to have their own named pressure cushion. As no one in the home had any pressure sores there had been no impact of not following best practice on people. We raised this as a concern with the registered manager. Following our inspection they contacted the NHS tissue viability nurse for advice and assured us that they would be following the best practice guidelines going forwards.

Staff had received training in supporting people to move safely. Where equipment such as hoists were used to support people to move there was guidance available for staff on the correct sling to use and each person had their own sling to use to reduce the risk of cross infection. Staff supported people to move safely and offered reassurance to the person to help them stay calm and relaxed.

Health and safety risk assessments had been completed and systems were in place to keep people safe. For example, all visitors were escorted out to the building to ensure that no one living at the home left without a member of staff being aware. This meant people who would be unable to look after themselves in the community were kept safe. Risk assessments had also been completed around people's ability to evacuate the home in an emergency and the support they would need to remain safe.

When we inspected on 30 January 2017 we found that there were not enough staff available to meet people's needs in a safe and timely fashion. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. Following our inspection the provider wrote to us

and told us they would review staffing levels in line with people's needs and ensure that the lounge area was constantly monitored.

At this inspection we found people's needs were assessed and this information was used to set the staffing levels for the home. The registered manager had been recruiting and had nearly a full complement of staff. Records showed that the registered manager ensured that there were enough staff available to meet people's needs. A relative told us, "I think the staff are wonderful and I am really pleased mum is here. I can't imagine her being anywhere else."

A healthcare professional told us how there was always a member of staff in the main lounge and so they were confident that people were safe and that they could redirect people if they became distressed.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw staff had completed application forms and the registered manager had completed structured interviews. Any gaps in staff's employment history had been identified and investigated. Nurse's qualifications were checked with the nursing and midwifery council. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

The provider was now meeting the regulation in relation to ensuring there was enough staff to meet people's needs

Staff had received training in keeping people safe from abuse and knew how to raise concerns both with the registered manager and external agencies. In addition, staff had received training on how to keep themselves and others safe should a person living at the home become distressed and aggressive.

All the relatives we spoke with said they felt their loved ones were safe living at Ashfield Lodge and that the staff handled their relatives in a safe manner. One relative told us, "They care really well here for my husband and I know he is well cared for and safe. They always respond to his needs." Another relative said, "I have never had any problems since my husband has been in this care home and I know he is safe."

Staff had completed training in infection prevention and control and knew how to work to minimise the risk of infection by using protective equipment such as gloves and aprons. In addition, the registered manager supported staff by discussing best practice in staff supervisions. For example, a recent group supervision meeting with all staff discussed the importance of good hand washing in reducing the risk of cross infection.

There were systems in place to keep the home clean and infection clean. The housekeeper told us that there was a cleaning schedule in place to ensure that all areas were cleaned on a regular basis. Records showed that the cleaning schedule had been followed. They also confirmed that they had appropriate access to equipment and products to keep the home clean and reduce the risk of infection. In addition, checks were completed by staff to ensure people were protected from the risk of infection. For example, people's mattresses were checked weekly to ensure that they were clean and fit for purpose. However, there was an unpleasant odour in the home in particular near the entrance and main lounge area. The sluice room was near to the main entrance where there was an unpleasant odour. Staff told us that used pads were disposed of in the bins in this room. They said that they thought the odour was because pads were not always bagged before being disposed of and the bin was not emptied in a timely fashion. One of the nurses was designated as the infection control lead and attended the infection control link meetings, where changes in best practice were discussed along with actions staff would take to keep people safe.

All incidents were recorded on the computer system and the providers quality improvement leads reviewed the incidents at each home and contact the registered manager if they have any particular concerns. Accidents and incidents records showed what action had been taken to keep people safe. In addition, they had been analysed to identify trends. The figures showed that there had been a large number of falls in the lounge area. The registered manager had required a member of staff to be in the lounge at all times. This action had reduced the number of falls from eight in April 2017 to two in October 2017.

Requires Improvement

Is the service effective?

Our findings

When we inspected on 30 January 2017 we found that people were not always supported to access food and drink. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. Following our inspection the provider wrote to us and told us they would increase the amount of times people were offered food and drink and monitor people's intake.

At this inspection we found that the monitoring around people's nutritional and fluid intake had been increased. Nutrition audits to monitor people's progress and to identify when people lost weight were in place. In addition, the registered manager checked food and fluid charts daily to ensure that they were fully completed. One relative told us, ""I know they weigh my husband regularly and they have got his weight back up again now."

Staff had recorded people's dietary needs in their care plans. For example, if people needed a soft diet to help them eat safely or if they needed a low sugar diet due to diabetes. Where needed people had been referred to be assessed for their ability to eat and drink safely and staff had followed the advice of healthcare professionals. One person living at the home and a tube into their stomach as they were unable to eat safely. Their care plan recorded all the relevant information to assist staff in meeting their nutritional needs. All the staff had received training in how to support this person with their nutrition.

The provider was now meeting the regulation in relation to ensuring that people's nutritional needs were met.

Staff told us that they knew people who were cared for in bed needed to be sat up to eat and to remain upright for half an hour after eating. However, while administering medicines the nurse found a person had been laid flat. Their face was red and hot. The nurse supported them to move to a more comfortable safe position.

One person had not sat down to eat their lunch we saw that they were walking around the lounge area with little awareness of other people in the room. We saw a member of staff was supporting them to eat. We saw that every so often the member of staff would put a spoon of food in the person's mouth. They did this without engaging with the person or prompting them about what was to happen. We saw that they had not followed the best practice of providing a calm quiet environment for this person. Staff made no effort to engage the person with their food. We raised this as a concern with the registered manager was it was not an appropriate way to ensure that the person was eating well.

We saw that other care staff made little effort to support people in a person centred way. There was little interaction between staff and the people they were supporting and they did not discuss the content of the meal with people. The dessert of rice pudding was served to people and they complained that it was too hot. One person said, "Oh that's far too hot. I'll have to wait to eat it else it will burn my mouth." Another person after trying the dessert said, "It's much too hot." It is important to serve food at a safe temperature as

people with dementia may not be able to recognise heat and may burn themselves.

The home was in need of decoration. The doors and skirting boards were chipped and walls were marked. The environment was not dementia friendly, both corridors of the home were painted the same colour so that people may become confused about which corridor they lived down. There was some dementia friendly signage on bathroom and toilet doors in communal area, but toilet doors were not painted a different colour to make them easier to identify. In addition, en-suite toilets were not labelled or painted a different colour making it harder for people with dementia to identify them.

Staff told us that at present they had a lot of people with a high level of needs and that the main lounge people chose to use was not always big enough.

When we inspected on 30 January 2017 we found that staff had not been supported with appropriate training and support to provide effective care to people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. Following our inspection the provider wrote to us and told us they would ensure staff received regular supervision and that training would be available to all staff in the key areas needed to provide safe care.

At this inspection we found that relatives were complementary about the staff's skills. One relative told us they were happy with the care provided by the care staff and they thought the staff were competent and trained. Mandatory training had been set by head office. The registered manager did a weekly review of staff's training needs and had plans to make the home a training site for the company. The posted lists of the outstanding training to remind staff what needed to be completed. Records showed that 88 % of staff training was up to date. The provider liked each home to be above 90 % and training levels was discussed between the registered manager and the operations director on a regular basis.

The register manager had a clear process in place to follow up outstanding training with staff. This consisted of a phone call followed by a letter. If training was still not completed then at this stage the member of staff would be removed from the rota until their training was up to date.

The registered manager had a structured induction in place for new staff. This included e-learning in key areas and shadowing an experienced member of staff. If needed the number of shadow shifts could be extended until the new member of staff was confident.

Records showed that staff were having regular supervisions with their line manager. One member of staff told us that they had been having more regular supervisions since the new registered manager was in place. In addition, they had been supported to access training to develop their skills and had registered to complete the care certificate. The care certificate is a set of national standards to ensure staff have the basic skills to care for people safely.

The provider was now meeting the regulation in relation to ensuring that staff received appropriate training and support.

There was a regular quality meeting in the home and any changes in best practice were disseminated through this meeting. This ensured all staff were aware of any changes needed. In addition, training was changed to reflect best practice. The minutes from the quality meeting were sent to the operations director for them to monitor the quality of care provided. The e-learning is regularly reviewed by the provider and updated to reflect any changes in best practice.

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

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

When we inspected on 30 January 2017 we found that people's rights under the mental capacity act had not been respected. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent. Following our inspection the provider wrote to us and told us they would monitor DoLS applications and their need for renewal and support staff to understand the need to gain consent before providing care.

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People's ability to consent to living at the home had been assessed when they moved in. If needed a formal capacity assessment had been completed to see if people were able to consent to being in the home and receiving personal care. Where they were unable to consent a best interest decision had been made to decide if moving into the home was in the person's best interest and an application for a DoLS had been completed. No one who was subject to a DoLS had any conditions on their DoLS. The registered manager had a DoLS tracker in place to monitor when applications for re assessments needed to be submitted.

The registered manager and deputy manager had both completed courses which meant they were able to provide training in the MCA. Staff had understood people's rights and supported them to make choices and consent to care. We saw this understanding was reflected in their care plans with capacity assessments in place for bed rails. Where people had covert medicines there was a mental capacity assessment in place. In addition, there was a best interest decision or an agreement from a representative who had been legally identified as able to make decisions for the person.

Where people had legally arranged for another person to make decisions on their behalf, there were copies of the legal documentation so that staff knew who could support the person in decision making.

The provider was now meeting the regulation in relation to ensuring that people's rights under the MCA were respected.

Staff from the various departments within the home also worked well together to ensure the delivery of effective care and support. For example, the cook worked with the care staff when identifying what people wanted to eat and the housekeeper told us that they would engage with people while cleaning to help keep people engaged and occupied. At the start of each shift the nurse allocated roles for each member of the care team. This meant the care staff were aware of their responsibilities on each shift.

Records showed that staff identified when people were not well and called the doctor for advice. For example, we saw that staff had contacted the doctor as one person had increased sleepiness and had stopped eating so well. The doctor diagnosed a chest infection and medicine to support the person. A relative told us, "They organise physiotherapy appointments and flu jabs and things." A person living at the home said, "If I am not very well the doctor will come, he is very good. The girls are very kind to me."

Requires Improvement

Is the service caring?

Our findings

Staff had completed their training in equality and diversity and told us they knew how to maintain people's dignity. For example, by leaving them alone in the toilet and by making sure people were covered as much as possible when providing personal care. A relative told us that staff, "try to encourage [name] to have a shave and treat him with dignity and respect."

However, staff had not always provided care to support people's dignity. For example, we saw one member of staff shouting down the corridor for support because a person had been incontinent and was walking around the home in wet trousers. While staff immediately took them to help them into dry clothes, there was a lack of understanding that the person would not have wanted the whole home to know about their incident. In addition, a lady had not been happy with the top they were wearing and removed it in the hallway. We saw staff supported their dignity, but did not help them find another top. We saw that the person continued to be unhappy with the top they were wearing. They came to talk to us and indicated that they wanted a different top.

People's need for privacy was not fully supported. Records showed that a number of people living at the home were unable to manage their continence and struggled to access toilet facilities due to their dementia. Staff told us how these people were regularly urinating on carpets in other people's bedroom.

We found the lunchtime dining experience was chaotic and task focussed. The care provided was not person centred and did not support people's dignity or maximise their food intake. We saw one relative assisted their family member with their lunch, we saw they had to ask staff to bring the dessert. In addition, staff had not ensured that the person had a drink to hand and their relative had to get them one. There were no serviettes available in the dining room and the relative had to go to the person's room and fetch some tissues to help the person retain their dignity while eating.

All the relatives we spoke with said they felt the staff were kind, courteous and polite and they treated their family members with respect and dignity. One relative said, "Although he has Parkinson's he is still aware of everything and nothing is too much trouble for the staff. They treat him with the utmost dignity and respect and always knock before entering his room. They always explain to him before doing anything." There was a notice in the home letting relative s know that they welcome to stay and share a meal with their family member if they wished. Staff told us that they got to know people and their behaviours and moods. They said that this enabled them to recognise when people were unwell and to raise concerns with the nurse.

The provider had structured the rotas to help staff be refreshed when they were on shift. There was a rolling staff rota which ensured that care staff had every other weekend off and were suitable recompensed for working over their contracted hours. The registered manager had encouraged staff to take their annual leave entitlement as this supported their well-being.

The registered manager told us that they were aware that the use of agency staff impacted on the quality of care people received as people living with dementia may find new staff unsettling. Therefore they were

trying to fill shifts using overtime and bank staff to support continuity of care for people. Where the use of agency staff could not be avoided the registered manager consistently used the nursing agency and the same two nurses to support people's needs.

A local supermarket gifted the home some flowers on a regular basis. The staff gave priority to placing these flowers in the rooms of people who were unable to get out of bed to give them something cheerful to look at. We saw that in the summer the registered manager had supported a person living at the home to celebrate a significant wedding anniversary with a party at the home to which they could invite their friends and relatives.

People were offered choices about their lives. For example, the cook visited people each morning to see what they wanted to eat for the midday meal, if people chose to eat something differed from the offered menu this as provided. People were also offered choices such as what to wear and where they wished to spend time.

Most people living at the home had relatives who supported them. However, one person received support from an advocate. An advocate can represent a person who is unable to fully communicate their needs and wishes so that their views were heard and taken into account when decisions were being made.

Requires Improvement

Is the service responsive?

Our findings

When we inspected on 30 January 2017 we found that care was not always provided to meet people's needs or planned to minimise people's distress and to help them have a calm happy day. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care. Following our inspection the provider wrote to us and told us they would review the care needs of people and plan more activities to support people's needs.

At this inspection we found people living at the home and their relatives were happy with the care provided. They had been involved in planning the care to meet their individual needs, One relative told us, "I have seen the care plan. They know just how to monitor her care and food and drink and they have a good management plan. Without any shadow of a doubt things have improved." Another relative told us, "It's the best treatment I`ve seen her get here. It's a difficult job to do but she is always well presented and tidy." A third relative commented, "I can't fault it here. They are doing their best. They are so friendly and caring, the staff are gems. They manage to get my husband shaved and tidy."

However, we saw that there were some people living at the home who were unable to manage their own continence and would urinate in their own bedroom, communal areas and other people's bedrooms. The cleaner showed us evidence that they had to clean the carpets in two or three bedroom each day to manage the problem. The registered manager explained how they had requested laminate flooring in two of the bedrooms to support people's needs. While care plans noted people's ability around maintaining continence, they were not effective in managing the continence issues some people had.

The registered manager had worked closely with the local NHS assessment unit to understand people's needs when they assessed them so that they could be sure if the service was able to meet their needs. For example, they assessed one person twice just to be sure that the care they could provide would be appropriate. In addition, the provider was working with people to support them to stay in the home when their condition settled and their needs and funding levels were reassessed. This was better for the person as a move to a new environment may cause a decline in the person's abilities.

A healthcare professional told us that the registered manager and staff had worked hard to be able to support people with challenging behaviour. They said that staff managed these people's needs really well. In addition, they told us that the staff worked hard to reduce the amount of medicines people received so that they could have a better quality of life. For example, they had recently discussed the need to reduce one person's medicines and the care notes provided by staff showed clear evidence of the issues and allowed the healthcare professional to make a decision to reduce the medicines.

Staff monitored people's health to ensure that they were supported to remain as comfortable as possible. For example, records showed one person's muscles were becoming contracted due to a loss of mobility. This had impacted on their ability to sleep. We saw that the staff had contacted the GP to raise the concerns and some medicine had been prescribed to support the person. People's pain levels were assessed and managed with medicines. In addition, the impact of people's medicines was noted. For example, one person

was prescribed two medicines for pain relief. However, their notes showed that they would eat and drink better if one of the medicines was used. Therefore this was their first choice of pain medicine.

Care plans had been reviewed with people or their chosen representative. We saw that when needed action had been taken to update some care plans to reflect people's need for individualised care to meet their needs. For example, one care plan reflected that a more consistent approach was needed from staff to improve a person's nutritional input. Where people had wounds appropriate management was in place and fully documented to support the staff to provide consistent care in line with best practice.

The provider was now meeting the regulation in relation to ensuring that care met people's needs.

The registered manager had assessed people's ability to communicate and where needed had put systems in place to maximise communication options. People's ability to communicate was recorded in their care plan and where people used non-verbal communication this was recorded along with the person's first language. If needed the home liaised with family to help them understand the person's needs and staff had learnt key works in people's first language to help support them. Staff told us how one person while reluctant to communicate verbally would write down what they wanted to say. Another person whose first language was not English had key pieces of information about the home in translated into their own language.

Relatives told us and records showed that people were supported to engage with a variety of activities. One relative said, "He does like the quizzes and takes part in them when he can." Another relative said, "I know they do pamper sessions, snakes and ladders and things and they had a special event called My Golden Wedding. They are always doing something." A third relative commented on how people were encouraged to engage with activities and said, "The television is very rarely on which is good because none of them are really able to watch it." During our visit we saw that staff were with people encouraging them to make Christmas decorations. Another staff member sat with a person and discussed the daily newspaper.

People had end of life care plans in place. This included information on whether they wished to be resuscitated, and who they wanted to handle their funeral arrangements. People's preferred place to die was recorded. When people were at the end of their lives the registered manager engaged with external agencies such as the community nurses, local hospice and the Marie Currie nurses to ensure they were all aware of the situation and support was available if needed. In addition, the nurses monitored people to identify when they neared the end of their lives and put preventative care in place to keep people comfortable. For example, One person who was at the end of life had their legs dressed to prevent pressure sores.

People told us that they knew how to raise concerns and complaints and where happy with the response from the registered manager. One person said, "If there's been any issues, like there was one when they kept missing out his thickener, I just went to the new manager. It was quickly sorted as he called a meeting with all the staff and told them where to look and it was all written down. That was a while ago now though. Things have improved so much these past months." Another person told us, "If I had any worries I would go see the manager but he keeps us well informed now, so I don't ever feel the need to. He is very approachable and hands on though."

A leaflet on how to raise a complaint was on display in the main entrance to the home; however the writing was small and may not have been accessible for everyone. Two complaints had been received since our last inspection and both had been resolved in line with the provider's complaints policy. Action had been taken to stop the same complaint arising again in the future.

Requires Improvement

Is the service well-led?

Our findings

When we inspected on 30 January 2017 we found that systems to monitor the quality of care provided were ineffective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. Following our inspection the provider wrote to us and told us they would employ a new manager for the home and review audits to ensure they identified concerns.

At this inspection we found that the provider had employed a new manager for the home and they had applied for and become a registered manager under the Health and Social Care Act 2008 Registration Regulations (2009). Relatives were now confident that the service was well led. They all said that there had been much improvement in the home over the past few months since the management had changed. One relative told us, "Everywhere is much cleaner too and little things like putting bins in the toilets, and replacing my husband`s toilet seat, things like that matter. I think it's well led now." Another relative said, "This manager is great. Things are happening at last. He keeps us well informed. He needed time and things are starting to come to fruition."

The registered manager had a suite of audits in place to monitor the quality of care provided. We found that they were effective in identifying most concerns and that the registered manager had developed action plans to ensure that all issues identified had been rectified. The one area where audits had not been effective at monitoring compliance with best practice was medicines. We discussed our concerns with the registered manager who said they would relook at the audits around medicines to ensure that they covered the areas we identified for improvement. The registered manager told us that they received a good level of support from the provider and that the operations director had been very supportive.

The provider was now meeting the regulation in relation to ensuring that the quality of care was effectively monitored.

All the relatives we spoke with were complementary about the new registered manager and found them approachable and willing to listen to concerns. They told us that the staff attitude had also changed and that staff were now approachable and focused on providing a good standard of care.

The company had a set of values which focus around putting people first and striving for excellence. The registered manager used these values in staff supervisions to improve the quality of care for people. For example, recent supervisions focused on privacy and dignity for people. One relative said, "Since this manager came there's been a big improvement. Staff are now sitting and talking to residents and are always present in the lounge. It doesn't matter if you come at weekends, or weekdays, it's the same. It's very good to see now."

Systems were also in place to ensure effective external communication with people's relatives and professionals involved in their care. For example, a visiting healthcare professional told us that the manager had worked collaboratively with them to evaluate people's needs which helped them place people with a high level of needs at the home. They told us, "Things have improved tremendously since the new manager

came and he has been brilliant." They also commented that the staff team had adapted to the changes made and had improved the quality of support provided to people.

Staff were also positive about the new registered manager and told us they were approachable and would respond to concerns and ideas. This supported the staff to be involved in improving the quality of care provided. One member of staff said, "He is a nice boss. He is very supportive and we can talk to him about anything and if there is any trouble at work he will listen." Another member of staff said, "We are able to suggest things and so long as there is a valid reason the manager is willing to trial things." For example, they had asked if the activities person could come in an hour earlier to help with breakfast and this had worked well. In addition, staff were supported to keep up to date with changes in the home through regular staff meetings.

The registered manager and his team were committed to the ongoing improvement and development of the home and, as described elsewhere in this report, had worked hard to address the shortfalls identified at our last inspection. To assist in this process of continuous improvement, the provider conducted regular surveys of people, their relatives and visiting professionals to measure satisfaction with the service provided. For example, a meeting was planned with people and their relatives to discuss any changes to the menu.

In addition, to the surveys the registered manager monitored the trade publications and the internet to identify any changes in best practice of methods of improving the care provided. For example, the registered manager was aware of the changes we had made in the way we inspected.

The provider was aware of the need to notify CQC or other agencies of any untoward incidents or events within the home. The report and rating from our previous inspection was on display in the home, as required by the law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated medicines Regulation 12 (2) (g)