Ashton Manor Care Home Ltd

Ashton Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 25 July 2017 and was unannounced.

Ashton Manor Nursing Home is a nursing home that provides nursing and personal care to up to 39 adults. People living at the home had physical disabilities and long term health conditions. The majority of people at the home were living with dementia. At the time of our inspection there were 33 people living at the home.

There was a registered manager in post. 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.

At this inspection, we identified a breach of Regulation 12 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 the report.

People's care was not always delivered safely. We identified potentially hazardous substances not being stored securely. Some equipment was shared between people without actions in place to reduce the risk of infection spreading. We also observed unsafe practice by staff when administering medicines. Following the inspection the provider had addressed these individual concerns. However, we will require action taken to ensure future risks are identified and managed more proactively.

People were cared for by sufficient numbers of staff. We did identify that staff appeared stretched at busy times. The provider was already taking steps to address this at the time of inspection. Appropriate checks were carried out when recruiting staff to ensure that they were suitable for their roles.

Risks to people's safety were assessed and managed. Measures were in place to keep people safe, whilst still promoting people's independence. Staff had a good understanding of how to support people to be more independent. People's care plans were person-centred and reflected what was important to them, as well as their needs and goals. Regular reviews were undertaken and where people's needs changed, measures were put in place to address this. The provider took steps to ensure that people were kept safe in the event of an emergency.

People were supported by kind and caring staff who knew them well. Relatives told us that staff encouraged visits from them and maintained good communication with them. Staff communicated with people in a way that demonstrated understanding of their needs. We did note one instance in which staff did not communicate with one person effectively. We recommended that the provider reviews their systems for ensuring staff communicate with people with more complex needs.

Apart from the unsafe practice observed from one staff member when administering medicine to one person, people's medicines were managed safely. Important information about people's healthcare needs and medicines were recorded in their care plans. Staff worked alongside healthcare professionals to meet people's health needs. Where any accidents, incidents or infections occurred, staff took appropriate action in response to them. People told us that staff were respectful and staff understood how to promote people's privacy and dignity when providing care.

People were provided with food that matched their preferences and ensured any dietary needs were met. Staff routinely offered people choices and involved them in their care. People's legal rights were protected because staff worked in accordance with the Mental Capacity Act (2005). People had access to a range of activities that suited their needs and their interests.

The provider created a positive culture by giving staff lead roles and delegating to senior staff appropriately. Staff felt valued and supported and there were a variety of systems and schemes in place to ensure this. Staff received training appropriate to their roles and the provider's values. Staff benefitted from regular supervision and appraisals.

Regular audits and checks were carried out to ensure the quality of the care that people received. Apart from where we found safety concerns, audits were regular and robust. We did recommend that the provider reviews their systems for auditing medicines storage. The provider routinely involved people, relatives and staff in decisions about the home. People knew how to raise a complaint and where complaints were raised, they were responded to appropriately.

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.

We identified risks with regards to thickener, equipment and medicines that were not managed.

Personalised risks to people were assessed with plans in place to manage them.

Where accidents or incidents occurred, the provider took appropriate actions to prevent them from reoccurring. People were supported by staff who understood their roles in safeguarding them from abuse.

People's medicines were stored and managed safely.

There were sufficient staff present to safely meet people's needs. The provider carried out checks to ensure staff were suitable for their roles.

Plans were in place to keep people safe in the event of an emergency.

Is the service effective?

Good

The service was effective.

People were happy with the food on offer and it matched their preferences and dietary requirements.

Staff followed the guidance of healthcare professionals to meet people's needs.

People's legal rights were protected because staff worked in accordance with the Mental Capacity Act (2005).

Staff received appropriate training and supervision for their roles.

Is the service caring?

Good

The service was caring.

We observed positive caring interactions between people and staff.

Staff communicated with people effectively. However, we did note one instance where communication methods had not been followed for one person. We recommended that the provider reviews their system for updating staff on people's communication needs.

People were supported by staff that knew them well.

Staff promoted people's independence when supporting them.

People's privacy and dignity was maintained whilst being provided care.

Is the service responsive?

Good

The service was responsive.

People knew how to raise a complaint and where complaints were raised, appropriate actions were taken in response.

People had access to a range of activities that suited their needs and interests.

Care plans were person-centred and reflected people's needs and preferences.

People's needs were regularly reviewed and any changes in need were addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor the quality of the care that people received. However, they were not always effective as we identified concerns that had not been picked up by audits.

People got on well with the registered manager.

There was appropriate delegation of leadership at the home which created a positive culture amongst staff.

Staff told us that they felt supported and values and there were schemes in place to reward and support staff.

The provider had a set of values and systems were in place to

ensure staff embodied them.

Ashton Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. We also received further concerns about the care that another person received.

The information shared with CQC about the incident indicated potential concerns about the management of risk of falls and incidents. This inspection examined those risks.

This inspection took place on 25 July 2017 and was unannounced.

The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider did not complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As the inspection was brought forward, no PIR was sent to the provider before our visit.

As part of our inspection we spoke with six people, five relatives and two visiting healthcare professionals. We also observed caring interactions for three people who were not able to provide verbal feedback to us. We spoke with the registered manager, the deputy manager, a nurse and three care staff. We read care plans for eight people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at four staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff, people and relatives.

Our last inspection was in August 2016 in which we found no concerns and gave the home a 'Good' rating.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person told us, "Yes I do feel safe, someone is around the whole time. They're always here for you." A relative told us, "I've worked in the care industry and have never seen anything here which concerns me."

Despite these comments we identified some concerns with the safety of the care that people received. During the inspection we observed thickener being stored in people's rooms and where people could access it in communal areas. Thickener is a powder prescribed to people who need their drinks thickened to reduce the risk of choking. Thickener was also kept in the clinical rooms, which were locked. In February 2015, NHS England sent out a patient safety alert regarding thickener. This was following cases in which people had died as a result of ingesting the powder. The guidance stated that thickener should be kept securely, especially where people living with dementia could access it and potentially ingest it.

At the home, people living with dementia were able to reach thickeners, both in their rooms and communal areas. This could have had fatal consequences. The nurse was not aware of the guidance when we asked about the storage of thickener. When we showed the registered manager the safety alert, they had not seen it before and were not aware of these risks. Following the inspection, the registered manager checked all thickener and ensured that it was stored safely. However, there had been a lack of awareness of this risk, and a lack of measures in place to manage it.

Staff did not always assure the safety of the equipment used to support people. Where people required the assistance of hoisting equipment to move, the provider had limited numbers of slings. Slings are attached to hoists and used to support people when using this equipment. Staff told us they regularly moved slings between people, even if they have been used to take someone to the toilet. One of the slings, specifically for helping people go to the toilet, was shared by three people. The slings were cleaned at the end of each day, but no cleaning took place between people using the slings to go to the toilet. We observed one person being supported to move with a sling specifically for toileting, in the lounge area. We then observed staff take the same hoist and sling to someone else's room in order to support them to get out of bed.

We made the registered manager aware of this and they confirmed to us they did have limited number of slings. An audit in February had identified that more slings were required and a plan was already underway to purchase slings. When we told the registered manager about our concerns they acknowledged them and following the inspection submitted evidence to show that the numbers of slings had been increased. We did note that we had no concerns with the overall cleanliness of the home and effective cleaning practices were in place. However, people had been living in an environment in which the risk of infections spreading was increased due to the sharing of slings.

People's medicines were not always administered safely. The provider had an electronic system in place for medicines. This system was precise and had safeguards in place to ensure that medicines were administered safely. For example, where people had PRN (as required) medicines, these have strict dosage instructions to ensure they are not administered too frequently. The electronic system calculated the time

between doses of PRN medicines to ensure they were administered as prescribed. When observing medicines being administered, we witnessed the nurse supporting one person who was prescribed PRN pain killing medicine. The system alerted the nurse that the person should not be given the medicine for another 19 minutes. The nurse then started to override the system and administer the medicine anyway. It was only when we asked if this was appropriate that the nurse reflected and did not administer the medicine. We informed the registered manager immediately and following the inspection, they took action to ensure people's safety. The registered manager also spoke to all staff and reviewed medicines records to establish if this had been a common practice. They told us that they found no evidence to suggest this had been something that staff had done before. However, prior to the inspection there was a risk that people's medicines had not been administered safely.

Whilst we did see areas of good practice that we will evidence below, the number of risks to people identified on the day of inspection showed shortfalls in the safety of the care delivered. We acknowledge the robust action taken in response to our concerns. However, we will require further actions to be taken to ensure the provider has systems in place to proactively identify and manage these types of risks on an ongoing basis.

The lack of awareness of risks relating to thickeners, the risks to people from the sharing of slings and the observed unsafe administration of medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's personal risks were assessed and plans were in place to manage them. People's care records contained risk assessments and detailed plans on how staff should reduce risks. One person spent a lot of time in bed due to their mobility. A risk assessment identified that they were at high risk of pressure sores as a result of this. To manage the risk, the person had a pressure relieving mattress for when they were in bed and a pressure relieving cushion for when seated. Staff repositioned the person every two hours and a chart was kept to document this. Staff applied prescribed creams to the person's skin each day to reduce the risk further. The plan also stated that the person should maintain a nutritious diet to improve their skin integrity. Food and fluid charts showed this was taking place. Staff reported any concerns with the person's skin to the nurse in charge who could make a referral for further treatment if required.

Where accidents or incidents occurred, appropriate actions were taken to prevent them from reoccurring. The provider kept a log of all accidents and incidents that recorded details of what happened, as well as what actions were taken. The records showed that the actions taken in response to incidents were focused on preventing them reoccurring and keeping people safe. For example, one person was found on the floor by staff. Staff supported them up safely. As the person did not have a history of falls a referral was made to the GP to identify any potential underlying causes. The person's care plan was updated to include additional checks from staff. The person also had a sensor mat placed in their room to alert staff if they got up so that they could be supported safely.

People were supported by staff that understood their roles in safeguarding people from abuse. Staff had undergone training in safeguarding and it was discussed in supervisions and in team meetings. Staff were able to tell us the signs of potential abuse and what they would do if they had concerns. Where staff had safeguarding concerns, records showed that they had raised these and the provider had informed the local authority and notified CQC.

People's medicines were managed safely. Although we had identified concerns with how people's medicines were administered, the provider had systems in place to safely manage and store people's medicines. People's medicine administration records (MARs) were completed electronically and these were

all up to date. People had PRN protocols in place that described the medicines they were on and when staff should administer them. Medicines were kept securely and systems were in place to regularly count medicines to keep track of stock. Where people were prescribed controlled drugs, appropriate systems were in place to manage these securely.
When used correctly, the electronic system helped ensure people's medicines were administered safely. Staff checked who they were prescribing medicines to and what medicines they were administering and the system also did this. People's records contained a picture of them, so staff could be sure they were administering medicines to the right person. People's allergies were listed both in the records and on the electronic system, which flagged these up if required. Nurses administered medicines and they told us that they had been trained and had their competency assessed. Where care staff supported with managing medicines, they had also been trained and had their competency assessed before working in this area.

There were sufficient staff present to meet people's needs safely, however we observed that staff were rushed at times. The feedback from people and relatives was mixed. One person told us, "Yes they're always about." However, another person said, "They do very well but sometimes I think they feel rushed. Sometimes you think they need a couple of more staff." We observed on the day that staff were able to respond to people within a reasonable amount of time. Call bells were answered promptly and where people needed support in communal areas staff were able to support them. Call bell audits showed that bells were always answered in less than three minutes and mostly within two minutes.

Our inspection was prompted, in part, by concerns raised about staffing levels. Our findings on the day were that people were kept safe by sufficient staff. Ratios of staff to people had been increased since our last inspection. The provider had a tool in place to calculate staffing numbers and staffing rotas showed that these numbers had been maintained. However we did note that staff were stretched and busy at certain times of day. For example, we noted that at lunchtime staff were rushed. This meant staff could not always stop to spend time with people and we observed instances where this did impact on people's care. For example, when one person dropped their fork on the floor whilst eating their meal, a staff member came to pick it up and get them a new one. This took some time and another staff member then came and took the person's meal away before the new fork arrived. If staff had more time, it could have been spent establishing why the person was not eating and let them continue their meal with the new fork.
We told the registered manager about this at the end of the inspection and they took action to address the problem. They changed the way that staff were deployed at lunchtime and a new 'care companion' role was already being introduced. One of these roles had already been recruited to and the provider was in the process of recruiting another. These were roles specifically to support at lunch time and during activities. We will review the impact of these changes at our next inspection.

People were kept safe from being cared for by inappropriate staff because the provider carried out checks on all new staff that they recruited. Staff files contained evidence of work history, references, health declarations, right to work in the UK and a DBS check. DBS is the disclosure barring service. Where nursing staff were employed, the saw evidence of checks being carried out with the Nursing and Midwifery Council (NMC). Nurses had an up to date PIN number and checks were carried out to ensure that these were in date. Staff told us that they had undergone checks as well as an application process and interview before starting work.

People were kept safe in the event of an emergency. People had personal emergency evacuation plans (PEEPs) in place. These reflected people's needs and provided staff with information on how to best support them in the event of an emergency. The home had assessed risks such as fire risk and all equipment for use in the event of an emergency was regularly serviced. The home had a plan for what to do in the event of an emergency to ensure that people were kept safe and their care needs could be met.

Good

Is the service effective?

Our findings

People told us that they liked the food that was prepared for them. One person told us, "I'm terribly fussy with my food but on the whole it's good." Another person said, "I have my drinks thickened and a pureed meal as I have a swallowing problem but the food is fine." Another person told us, "Very nice. We're usually asked what we want."

People were served food that matched their preferences. People's records contained information about foods that they enjoyed and records showed they were served these. One person liked to eat lots of fruit, this was clear in their care plan and we observed that they had access to fruit throughout the day. Another person's care plan said that they liked apple juice and we saw them being offered this during the inspection. We observed people being offered a choice at mealtimes and when choosing drinks. People's feedback on food was regularly taken at residents meetings and at reviews and their preferences were noted. Feedback that we saw showed people were happy with the food they were served and this matched what people told us. The kitchen had information on people's allergies, preferences and any dietary requirements.

People's dietary needs were met. Care records contained important information about people's dietary needs and how best to meet them. One person told us, "I have to use a thickener due to a swallowing problem. The speech therapist came in the other day." Care records contained input from healthcare professionals and any recommendations made were in people's care plans. One person had problems swallowing and had been seen by a speech and language therapist (SALT). To reduce the risk of choking, the SALT recommended pureed food and thickened fluids. This information was displayed clearly in the person's care plan and we observed staff providing them with food that matched these requirements. Another person had diabetes and their care plan detailed the types of food they could have. The kitchen prepared alternatives for dessert that were suitable for people living with diabetes.

People's weights were taken regularly and recorded. Where changes in weights were identified, these were responded to. One person had recently lost weight so in response staff informed their GP and they were given a diet of fortified foods. The person's weight had stabilised as a result of this. People's food and fluid intake was monitored and we observed staff recording these on the day of inspection. Records contained detailed charts of what people had eaten each day as well as what fluids had been consumed.

Staff worked alongside healthcare professionals to meet people's needs. People's records contained evidence of staff working collaboratively with visiting professionals. One person had a long- term condition that affected their mobility. They had regular visits from the physiotherapist in order to maintain their strength and dexterity. This information was in the care plan and visits from the physiotherapist were documented in their records. Staff took important observations, such as blood pressure and weight, that were used to inform the decisions of healthcare professionals. A visiting healthcare professional told us, "The staff are quite helpful with knowing people's medicines and any updates. They are good if they need to do dressings or follow a treatment regime."

People had access to a GP and we saw evidence of staff reporting any concerns that they had. One person

told us, "They (staff) ring the doctor and he decides if he needs to come." We saw examples of staff liaising with the GP. For example, one person had lost their appetite and appeared unwell. Staff noticed this and made a referral to the GP who visited the person and was able to provide treatment. People's records contained evidence of visits from chiropodists, opticians and specialist nurses such as the diabetes nurse. Before the inspection, we had received concerns about one person's healthcare needs not being met effectively at the home. We did not find any evidence that people's healthcare needs were not met during our inspection.

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 people 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).

People's legal rights were protected because staff followed the guidance of the MCA. Records contained evidence of specific mental capacity assessments where people were unable to make decisions themselves. Where people lacked capacity to make a decision, a best interest decision was documented. Best interest decisions were made in consultation with people's relatives, healthcare professionals and staff. Where restrictions were to be placed upon people in order to keep them safe, an application was made to the local authority DoLS team.

People were supported by staff that were trained to meet their needs. One person told us, "Yes they (staff) are all trained. When new staff come they all get training." Staff told us that they completed an induction when they started work which involved spending time shadowing and being linked to a 'mentor', who was a more experienced member of staff. Staff said they completed a selection of mandatory training courses when they started, such as health and safety, infection control, safeguarding and first aid. Training was also delivered that was specific to people's needs. For example, staff supported a number of people living with dementia. Staff had completed training in dementia. We observed staff providing care to people living with dementia in a way that was considerate of their needs. Training records also showed that staff had attended training in various health conditions and these were appropriate to the needs of the people they looked after.

The provider kept a list of all training courses attended and was able to identify when training needed refreshing. Records showed that staff training was up to date. A staff member told us, "We do all kinds of training. I'm doing my NVQ and I go to college." NVQ is a National Vocational Qualification in adult social care. Nursing staff received regular clinical supervision and records showed that they discussed different health needs and procedures that they may need to undertake. One nursing staff member told us, "I need supervision. I have it every month, it's supportive." They told us they had completed training recently in venepuncture and catheter care. Venepuncture is the process of obtaining intravenous access for the purpose of intravenous therapy or for blood tests.

Staff had regular one to one supervision. Records showed that these sessions were used to discuss people's needs as well as staff learning and development. The registered manager showed us how supervision and the appraisal process linked staff performance and development to the service's values and expected competencies. Records of discussions showed that these were detailed. The provider kept a tracker for

supervisions and appraisals that showed that staff had regular meetings and were up to date.

Good

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person told us, "They (staff) are very helpful and good." Another person said, "Every member of staff is fantastic, wonderful." Another person told us, "They (staff) are great, we have a good laugh. It's a nice place to be."

During the inspection we observed kind and pleasant interactions between people and staff. We saw one person living with dementia who held a doll for comfort. We observed staff talking to the person about the doll which the person was enjoying. Wherever care was provided to people, staff offered explanations and reassurance. One person was supported to move using a hoist. Staff talked them through the process with prompts. Afterwards staff asked the person if they wanted a drink which they went to get.

Staff used effective communication methods with people. We observed that staff got down to people's eye level when speaking to them and used a caring and reassuring tone of voice. One person who was living with dementia, responded to simple words and phrases. This was clear in their care plan and we observed staff using this technique. Where one person had complex needs relating to their communication, we saw evidence of the provider working with relatives and healthcare professionals to try to find appropriate communication aides to support the person.

People were supported by staff that knew them well. People's care records contained detailed information about their backgrounds that included life stories and things that were important to them. One person's records contained information about their family and where they grew up. It also recorded that they used to enjoy surfing. A member of staff was able to tell us this information about this person. Another person enjoyed singing and sung a particular song with staff. Staff told us this information, which was also in the person's care plan. The person sang this song on the day of inspection. Staff told us that they had all the information they needed to get to know people well. They also told us that they were encouraged to do so. One staff member told us, "On my induction, the first thing we did was meet all the residents. During breaks I check care plans, we have a sheet that has all their important information." People's records contained a page that described brief information about people's preferences and important facts about them. There was also a screen on display in the hall which showed pictures of staff with a couple of facts about them, to help people get to know staff. Staff that we spoke to throughout the day had an understanding of people's needs. We observed staff chatting to people about things that interested them.

Staff understood people's strengths and encouraged people to be independent. Staff cared for people who, in some cases, had complex needs which meant that they were reliant on support. People's care plans reflected what they were able to do and what their goals were. One person was living with dementia and had other long term conditions. In their care plan, one of their goals was, 'I wish to maintain my personal care with minimum support'. The person was able to complete a lot of personal care tasks themselves, and these were listed in their care plan. Staff were able to tell us how they supported this person and it involved them prompting and encouraging them to complete tasks themselves, as these were important to the person. One staff member told us, "We encourage lots of people, even if it is only with washing their own face and brushing their teeth. With meals lots of people can support themselves." We observed people, who

were able to, eating independently at lunch time. People also had access to drinks stations and we saw people preparing themselves drinks during the inspection.

People were involved in their care. Throughout the day we observed staff asking people what they wished to do and offering them choice. One person said, "I have wine and beer. It's not that I want it all the time but it's good to know I can have it when I want." People's preferences were recorded and people told us that staff routinely offered them choices. People had access to regular meetings where they had been involved in decisions about their home and what they did there.

Staff promoted people's privacy and dignity when supporting them. People told us that staff were respectful and knocked on their doors before entering. We observed staff waiting for permission to enter before going into people's rooms. Where people needed support with personal care, staff provided this discreetly with doors closed. Staff were careful not to talk about people's medical conditions where they could be heard. Staff were able to demonstrate to us how they promoted people's privacy and dignity whilst supporting them. One staff member told us, "I always wait until people give me permission. I pull the curtains and make sure that the door is closed."

Relatives told us that they were made to feel welcome when they visited and that staff maintained good communication with them. People told us that staff contacted relatives on their behalf when requested. People's records contained evidence of relatives having attended reviews and regular meetings took place at the home which relatives attended.

People's cultural and religious beliefs were taken seriously by staff. At admission assessments, people were asked about their religious beliefs and any cultural needs that they had. This information was then put into people's care plans. The home arranged visits from local church groups. Staff training included equality and diversity courses and records showed these had been attended by all staff.

Good

Is the service responsive?

Our findings

People told us that they knew how to complain and when they did raise a complaint, it was taken seriously by staff. One person told us, "I'd speak to the care staff and then the manager. I did have a problem, in the end we rang the manager and it was sorted."

The provider kept a log of complaints and recorded what actions had been taken in response. There had been four complaints since the last inspection and records showed when they were received and responded to. A relative had recently complained because they had overheard staff talking about people's needs in public. This was addressed with the staff member and a response was sent to the relative to apologise. Records showed that responses were made within the timescales of the provider's policy. Following complaints, the registered manager contacted complainants to ensure they were satisfied with the response.

People had access to a range of activities. One person said, "I like the exercises." A relative told us, "(Person) likes to join in the exercises, she likes to be doing things." There was variety of activities going on at the home with a timetable on display to inform people of when and where they were happening. The timetable showed that activities included exercises, quizzes, visiting entertainers and arts and crafts. The home had an activity co-ordinator who planned activities and worked with people to identify any activities they wished to do. Where people were cared for in bed, staff spent time with them one to one. Staff kept a record of activities and these showed people had regular time engaging in activities.

We observed an activity taking place in the morning and people were engaged and enjoying it. People were taking part in an exercise game where they had to catch a ball and name an animal. People were joining in and smiling whilst naming animals. People joked with each other and staff about the activity. People also had access to boxes that contained different materials and textures to touch. These were particularly good for people who were living with dementia and found structured activities harder to engage with. We observed staff supporting people to enjoy the tactile sensations of the materials within the boxes. In the afternoon, some birds of prey visited the home which was very well attended. Staff told us that this had been arranged as a number of people at the home liked animals and they responded really well to a recent visit from a local farm.

People's care plans were person centred and reflected their needs and preferences. The provider had an electronic care plan system which clearly listed people's needs and also contained important information about people's routines and their likes and dislikes. One person liked to read a particular newspaper each day. Their care plan listed this clearly and we saw they had a copy of that day's edition in their room when we visited. Their care plan also stated that they may sometimes refuse care. The guidance was clear that staff were to leave them and give them time, then come back to ask them later. When asked, staff told us that this was how they supported this person.

People received a thorough assessment before coming to live at the home. The assessment captured important information about people's needs and backgrounds. This information was added to care plans

and reviewed monthly. The electronic care planning system documented people's goals and where these changed, the care plan was updated accordingly. For example, where one person's behaviour had changed a review was carried out to update the care plan. Staff carried out increased checks on the person and changes were made to the way they received their personal care. The person was referred to the community mental health team who visited to identify ways of supporting the person when they displayed aggressive behaviour.

Requires Improvement

Is the service well-led?

Our findings

People told us that they got along with the registered manager. One person told us, "The manager is very good and comes and talks to you."

During the inspection we observed the registered manager interacting with people. People responded warmly and it was evident that they got along well with them. The registered manager worked alongside staff to meet people's needs and kept an open door to their office. People, relatives and staff told us that they could easily access management and our observations confirmed this. The provider found creative ways to involve staff, people and relatives in the running of the home. For example, the registered manager told us that they had recently sent more experienced staff on the induction again. This was because the induction course involved a relative coming to speak to the staff about their experiences and expectations of care. The course also involved staff discussing good practice and communication. The registered manager told us that after doing this, they had seen improvements in the way staff worked together and solved problems.

The provider fostered a positive culture amongst staff. The registered manager encouraged leadership amongst senior staff which increased management support. This enabled effective delegation of tasks. Senior care staff attended leadership and management training each month. They developed skills in how to provide leadership, support and encouragement to staff. Staff also took on a number of lead roles in areas such as moving and handling, infection control and dignity. Staff in these lead roles were given additional training and cascaded their knowledge to the rest of the staff through meetings, training, shadowing and one to ones. Staff told us that they benefitted from opportunities to shadow and work with experienced staff.

Staff told us that they felt supported and valued in their roles. One staff member told us, "The support is one hundred percent. They've helped me a lot and I can ask for anything." Staff had regular contact with management through supervisions and team meetings. Staff were encouraged to provide feedback and suggestions on ways they could improve the running of the home. The registered manager had also set up an 'employee forum' where staff discussed their roles and how they could work better. At the last meeting staff had discussed the creation of a wellbeing programme.
The provider took staff wellbeing seriously and had recently introduced breakfasts for staff. Staff already received a daily lunch if they wanted it. At the time of inspection, a programme was being rolled out giving staff access to a dietician and a psychologist to further promote their health. A recognition scheme was also in place that rewarded staff who had worked particularly hard that month, staff received a certificate and a reward. The registered manager told us that following this, staff retention had improved and absences had gone down.

Staff also had regular team meetings that were used to discuss how people's needs were met and the running of the home. Meetings took place monthly and minutes were recorded. Minutes of meetings showed that they were used as an opportunity to identify ways of improving the quality of the care that people received. A recent meeting had been used to discuss safeguarding and ideas for a summer event to put on

for people. Staff had also discussed the morning routines and gave suggestions for ways in which routines and communication could be developed to work more efficiently.

The home had a clear set of values and systems were in place to embed them at the home. The five key values were, 'teamwork, communication, self-sufficiency, personal management and commitment to quality'. The registered manager told us that they recruited staff to these values and they showed us the toolkit that was in place to ensure prospective staff embodied these values. Applications and interviews were checked against values when making recruitment decisions. Once employed, staff supervisions and appraisals were linked to the home's values as well as competencies. Staff were able to tell us what the home's values were and they told us that they had robust appraisal discussions that related to them.

Systems were in place to regularly check and assure the quality of the care that people received. The registered manager carried out frequent audits within the home. Audits covered areas such as health and safety, care plans, food, call bell response times, unexplained bruises and medicines. Where improvements were identified, these were actioned by staff. A recent health and safety audit had noted that there was no personal emergency evacuation plan (PEEP) in one person's records. This was addressed and an up to date PEEP was put in place for the person. There were also regular monthly audits of people's clinical needs and we saw evidence of audits of people's weights, falls and any infections. Where patterns were identified, appropriate actions were taken to address these. The provider also carried out a monthly audit that focused on one area of the home and a further visit twice a year that covered all aspects of people's care. Where improvements were identified these were added to the home's ongoing action plan.

Whilst we noted that the audits in place were regular and proactive, we did note instances where improvements had not been identified. The issues relating to thickener, that we described in Safe, had not been considered in audits. Audits had identified that more slings were needed for equipment. However, this had not yet been addressed five months after the provider identified it. The issues with staff deployment at lunchtime that we described had not also not been identified through audits. The provider will need to provide us with a plan for how they will ensure that best practice is maintained in the future, therefore this domain will not achieve a 'Good' rating until the provider can demonstrate this.

We also noted that audits of medicines did not cover all areas of storage. Medicines that required refrigeration were kept in a fridge and staff audited the temperature daily. However, we did note that the temperature of the clinical room, used to store medicines, was not routinely audited and there was no temperature control system in there. This meant that the temperature could go above the recommended storage temperature for medicines and staff would not be aware. The provider had already identified this in their audits and were in the process of introducing systems to control and audit storage temperatures.

The provider involved people and their relatives in the running of the home. Regular meetings took place in which people and relatives were kept updated on any changes at the home, as well as given opportunities to provide feedback or suggestions. Minutes showed that actions were taken following meetings. For example, people and relatives had discussed improving tea and coffee making facilities for people to prepare their own drinks independently. By the time of our inspection, stations were in place with equipment for people to prepare both hot and cold drinks. People were also asked for feedback on food and activities. The last meeting had also been used to discuss surveys. The provider carried out annual surveys of people and relatives to get their views on the quality of the care that they received and to identify any areas for improvement. At the time of our inspection, the latest survey was in the process of being sent out and completed.

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 The provider failed to ensure that hazardous substances were kept securely. Equipment was shared between people, which increased the risk of infection spreading. We observed unsafe practice when staff administered medicines.