Ashley Down Care Home Limited

Ashley Down Nursing Home

Inspection report

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Tel: 01474363638

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 December 2018. The inspection was unannounced.

Ashley Down Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashley Down Nursing Home provides accommodation and support for up to 19 older people. There were 13 people living at the service at the time of our inspection. People had varying care needs. Some people were living with dementia, some people had diabetes or were recovering from a stroke, people required support with their mobility around the home, no one was able to walk around independently.

Although a manager was in post, they were not a registered manager. 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 our last inspection, on 20 and 21 February 2018, the service was rated as 'requires improvement'. At this inspection, the service continues to be rated requires improvement. Since two previous 'inadequate' ratings, this is the second consecutive time the service has been rated requires improvement. However, improvements have been made in many areas.

At the last inspection we found breaches of Regulations 12, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to, medicines administration processes were not managed safely; robust recruitment processes were not used to make sure only suitable staff were employed; Registered nurses and staff did not receive the appropriate training to carry out their role.

The provider and registered manager sent action plans dated 27 April 2018 stating they had already made the improvements to make sure regulations 12 and 19 were met. They said they would meet regulation 18 by 18 May 2018. At this inspection, the provider and registered manager had made improvements in most areas. People's prescribed medicines were now being managed and administered safely. Robust recruitment processes were now being followed to make sure only suitable staff were employed.

Although improvements had been made to the training of nurses and staff, there were still areas that needed to improve. The manager did not have access to staff training records and registered nurses had not completed professional development training.

Although the provider had a means of assessing people's needs to determine the numbers of staff needed each week, staff did not always have the time available to sit and chat with people. Staff numbers at night were low, meaning there was a risk people's needs might not be met. We have made a recommendation about this.

Although the food looked appetising and there were no complaints about food, people were not given suitable choices on the menu at meal times. Accessible formats of the menu were not available to help people to make choices. We have made a recommendation about this.

We received very positive feedback about the new manager, their knowledge and their approachability. This was their first position as a manager, having previously held the role as senior nurse at the service. The new manager had not received the support, training and access to local networks to help them to succeed in their role. We have made a recommendation about this.

Although the manager had been in post since August 2018, they had not applied to register with the Care Quality Commission. It is the provider's legal responsibility to ensure a registered manager is in post.

Staff felt supported and confirmed they could speak with the manager at any time if they needed to. They were confident any concerns they had would be acted on quickly.

Quality audits, to monitor the safety and good quality of the service were effective in identifying where improvements were needed and action was taken to quickly remedy areas of concern.

At the last inspection, we found the support of people's rights within the basic principles of the Mental Capacity Act 2005 needed to be improved. People's capacity to make decisions was now appropriately assessed and any decisions were made in their best interests.

People's privacy and dignity was not always respected at the last inspection. The provider had taken action to rectify the concern and people were now able to sit in the lounge area with their privacy respected. Many bedrooms were not made personal and homely at the last inspection. This had much improved and people had their personal belongings and mementoes around them.

People were supported to maintain their independence to help to keep them active. Relatives and friends were welcomed when visiting at any time.

Access to activities and interests was more available since the last inspection. An activities coordinator spent most of their time with people individually as this met the needs of people living in the service, although people were encouraged to join in together where they could.

The manager carried out an assessment of people's needs before they agreed people could be admitted, to make sure nurses and staff could provide the care and support needed. Care plans were person centred and detailed the individual support people needed. People's preferences and likes and dislikes were recorded. Risks were identified and management plans were in place to keep people safe and prevent harm.

Staff knew their responsibilities in keeping people safe from abuse. Procedures were in place for staff to follow. The provider and manager had worked with the local safeguarding teams when concerns had been raised.

Registered nurses, including the manager, were able to provide nursing care to people. Health care professionals were referred to when people needed further support with their health needs. People were supported at the end of their life and their final wishes were recorded.

The service was clean and odour free and infection control practices were being used to good effect.

All essential maintenance and servicing had been carried out at the appropriate times, including fire equipment and alarms.

The provider had displayed the ratings from the last inspection, in February 2018, in a prominent place so that people and their visitors were able to see them.

During this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although staffing numbers had improved, some further work needed to be done to provide a more holistic approach.

The assessment of individual risk had been considered and recorded to prevent harm. The practices used when administering medicines provided a safe service.

Accidents and incidents were recorded by staff and monitored by the manager.

Staff followed safe procedures to control the risk of infection. Robust recruitment practices were now followed.

The manager and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Fire safety measures were in place to keep people safe. Servicing of equipment was carried out as appropriate.

Is the service effective?

Requires Improvement

The service was not always effective.

Nurses and staff did not always receive the training they required to make sure they had the knowledge to provide the care and support people were assessed as needing. Staff had the opportunity to have one to one supervision meetings with the manager.

More consideration needed to be given to meal and menu choices. People were supported to eat a balanced diet.

The basic principles in relation to the Mental Capacity Act 2005 were followed to make sure people's rights were upheld.

People's needs were assessed before moving in to the service and care plans developed accordingly.

Nursing care was given by registered nurses. People had access to advice and guidance from specialist health care professionals when needed.

Is the service caring?

Good

The service was caring.

People thought the staff were kind and caring in their approach and staff knew people well.

People were supported to maintain their independence. Staff were aware of people's privacy and dignity and respected this.

People could receive visitors when they wanted. Visitors were made to feel welcome.

Is the service responsive?

Good

The service was responsive.

Care plans that reflected a person centred approach were in place,

Complaints were listened and responded to, following the provider's complaints procedure.

People were encouraged to make plans for the end of their life. Their cultural and spiritual needs were addressed.

People were given the opportunity to take part in activities when they could. People had one to one support to try to do things that interested them.

Is the service well-led?

Requires Improvement

The service was not always well led.

The new manager was not given the opportunities to enhance their personal development and seek appropriate support. Links with other agencies were not developed.

The manager had not applied to register with the Care Quality Commission.

People, their relatives and staff were very positive about the management and approachability of the manager. Staff felt listed to and supported, they understood what was expected of them.

Opportunities were taken to make improvements through the quality audit and monitoring process.	

Ashley Down Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 December 2018. The inspection was unannounced. The inspection was carried out by two inspectors and one 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 looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection. We did not receive an up to date Provider Information Return before the inspection took place as this inspection was carried out earlier than planned. 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 also looked at the last inspection report and the provider's action plans to help inform the inspection.

We spoke with two people who lived at the service and five relatives, to gain their views and experience of the service provided. We also spoke to the manager and four staff. We contacted three health and social care professionals and local authority commissioners for their feedback about the service. This confirmed the service had made improvements. We also contacted the local Healthwatch but they told us they had not visited the service or received any comments or concerns since the last inspection.

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 spent time observing the care provided in communal areas and the interaction between staff and people. We looked at four people's care files and medicine administration records. We also looked at six staff records including recruitment and supervision, as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures,

auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, on the 20 and 21 February 2018 we found breaches of Regulations 12, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The administration of people's medicines were not managed safely and monitoring processes were not effective to ensure ongoing safe management. Processes were not in place to ensure suitable numbers of staff were planned and available to meet people's assessed needs. All the necessary recruitment checks had not been carried out to make sure new staff were suitable to care for people living in the service.

The provider sent an action plan on 27 April 2018, following the inspection, detailing what they planned to do to meet Regulation 18 by 18 May 2018 and confirming they were now compliant with Regulations 12 and 19. At this inspection, medicines management had improved and now safe so Regulation 12 is now met. Recruitment processes had improved so Regulation 19 is now met. Regulation 18 is now met, however, some further improvement was needed to staffing.

The provider and manager told us that they continued to have some staff vacancies and that recruiting new registered nurses and staff had been difficult. However, new nurses and staff had recently started in post and the service now used very little agency staff. The provider had a new dependency assessment tool to determine the level of need of each person living in the service; high, medium or low. The manager was able to use the tool as a guide to calculate the numbers of staff needed to meet the needs of all the people living in the service each week. Although the use of the new tool now gave a better indication of staffing levels needed, we found that staff were not always available to spend time just sitting chatting with people. Although staff were very friendly and engaged well with people, they were not able to fully meet their emotional and social needs. In the morning, once people were up and sitting in the lounge, a member of staff spent time in the lounge also so they could attend to their needs. When the activities coordinator arrived on duty, they spent their time in the lounge engaging well with people so the member of staff was able to carry on with their duties. However, this left the activities coordinator little time to spend time with people in their rooms, and staff time was spent providing personal care tasks. Two staff provided the night time care and support. One registered nurse and one care assistant. The complex and high level of need of some people would make it difficult for staff to always be available through the night. For instance, one person regularly did not sleep well and was unsettled at night, climbing out of bed. Other people were very frail and needed attention throughout the night. Bedrooms were upstairs as well as downstairs. This meant that when both staff were attending to one person or if the nurse was administering medicines, leaving one staff member available, people could be left waiting for assistance.

We recommend the provider seeks advice and guidance from a reputable source regarding the suitable deployment of staff, taking a holistic view of people's needs.

Most people living at Ashley Down Nursing Home were not able to tell us verbally if they felt safe. However, one person did tell us, "Yes, I feel safe. It's because there are always people around." Other people nodded their head when we asked if they felt safe. The relatives visiting all thought their loved ones were safe living in the service. One relative said, "Yes, he is very safe. It is the room he is in, the bed that he is in, that make

him safe. Staff are always checking on him" and another relative told us, "Yes, she is safe; the staff are always on the ball."

At the last inspection, on 20 and 21 February 2018, robust recruitment processes were not in place. At this inspection, safe recruitment practices were now followed to ensure that staff were suitable to support people living in the service. The provider checked written references and their employment history, employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

People's prescribed medicines were managed and administered safely. Procedures and auditing processes had improved since the last inspection. Guidance was now in place for staff to follow when people were prescribed 'as and when necessary' (PRN) medicines. This gave the information needed for nurses giving people their medicines to know what the PRN medicine was prescribed for, when to offer it and how often the person could safely take the medicine. Much closer monitoring; daily, weekly and monthly, was carried out by nurses and the manager to check and count the medicines in stock and the medicines administration records (MAR). A safer system and storage box was now used for medicines that needed to be returned to the pharmacy. A member of staff told us, "The manager checks all the medication regularly, and also checks the nurses competence to administer medication, (The manager) is very thorough."

We audited a sample of the medicines kept in the medicines trolley against the records and found they tallied. People's MAR's were neat and had all the information needed for staff to administer their medicines safely. No gaps in recording were evident and staff had signed to say they had checked the stock of medicines when they had arrived to make sure they were correct.

A care plan was in place giving a personal record of how people preferred to take their medicines and the support they needed. One person often refused to take their medicines. The person had been assessed as not having the capacity to make the decision to not take their medicines. Some medicines were important to their continued health. A best interest's decision making process had been followed with the involvement of relatives and the GP. The decision made, to ensure the person's health and well being, was to give them their medicines covertly. This meant they took their medicines disguised within their food. The process was fully recorded and showed the person's best interests had been taken fully into account.

People were protected from harm. Individual risk assessments had been completed to mitigate the risks associated with people's specific needs. People's care plans included a range of risk assessments dependant on their individual circumstances. One person climbed out of bed when unsettled and so was at risk of falls. Their risk assessment described the measures in place to prevent them harming themselves, such as their bed lowered near the floor and a crash mattress beside the bed to lessen any impact when they lowered themselves to the floor. We saw the arrangements in place as described in the care plan when we arrived at the beginning of the inspection visit. Staff were advised through the care plan to respond quickly if the person called out as they would become anxious if they needed to wait for assistance and would try to stand or move themselves. This would increase their risk of falling. Staff told us this when describing the person's care.

People who were at risk of developing pressure sores due to their frail health and lack of movement had a comprehensive risk assessment describing the person's individual circumstances. Management plans advised staff how to provide the person's care to control the risk and prevent a deterioration in their skin integrity.

Some people had behaviour that challenged others at times, for example, due to the progression of dementia. Detailed care plans were in place to make sure people were supported in a positive way by staff, to reduce their anxieties as quickly as possible. Step by step guidance described, what was likely to trigger an episode of anxiety and challenges; what the early warning signs were for the person; how to distract them; what action to take, such as, sit with, chat to, hold their hand, are they in pain; a note for staff, such as, stay calm and relaxed, don't take the behaviour personally, show you understand, call for assistance. This gave staff, including new and agency staff, the guidance needed to make sure they could support people with their individual needs in a positive and consistent way to reduce people's anxieties and help them to feel secure and safe. The manager had arranged a full review of the medicines one person was taking, with healthcare professionals. They were seeking advice to see if reducing some of their medicines, or adding something different could have a more beneficial effect. People were supported with a positive and consistent approach to reduce anxieties and help to manage their behaviour.

Staff had a good understanding of their responsibility to protect people from abuse. Guidance and advice for staff about how to report a concern was available through a safeguarding procedure. Staff described how they would raise any worries they had with the manager, who they were confident would act quickly on their concerns. They were also aware of who to contact outside of the organisation if they needed to.

Accidents and incidents were recorded by staff. Post fall observations had been carried out by staff when no obvious injury that required a visit to the hospital or call to the GP was found. Body maps were completed if small injuries such as skin tears, or bruises were apparent, to monitor the healing process.

All areas were clean and there were no odours present throughout the day. A visiting relative commented, "I cannot fault the cleanliness." Domestic staff were employed to take responsibility for the cleaning tasks around the service. They followed a cleaning schedule which was kept up to date. Personal protective equipment such as disposable gloves and aprons were available and being used by staff when providing personal care. This helped to prevent the spread of infection within the service.

The premises were well maintained. Each person had a personal emergency evacuation plan to support their safe evacuation in the event of an emergency. Fire alarm tests were carried out regularly and fire evacuation drills had been practiced and recorded. All essential works and servicing were carried out at suitable intervals by the appropriate professional services including, fire alarms and equipment; gas safety; electrical safety; lifting equipment; portable appliance testing; legionella testing.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, on the 20 and 21 February 2018 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Evidence was not available to show staff had received the training they needed to carry out their role providing care and support to people living in the service. Registered nurses had not had the opportunity to undertake specific training to ensure their continued professional development.

The provider sent an action plan on 27 April 2018, following the inspection, detailing what they planned to do to meet Regulation 18 by 18 May 2018. At this inspection, improvements had been made and staff were receiving more suitable training to carry out their role, however, some further improvement was needed to make sure staff kept up to date with the training requirements.

Although some improvements had been made to staff training and staff now had the opportunity to do online training, the manager was not able to access individual staff training records. To check if staff had completed the required training, the manager had to ask the staff if they had completed it and then ask them to print off their certificates. This was time consuming and not effective. Although the manager had completed a training schedule to try to keep track of staff training, this was not up to date because of these issues. We found, on looking at the training schedule and going through it with the manager that some staff were not up to date with their training, these included; dementia training, challenging behaviour training and fire training. Registered nurses were still completing the same training as the care staff, they were not given the opportunity to undertake training specific to their professional registration. The manager was not sure if all nurses had completed the mandatory training due to the issues. There was no evidence to show that nurses had completed training to support their registration validation since the last inspection. The manager did not have that information available to them.

The minutes of a staff meeting, in August 2018, showed the provider had told staff they would not pay for their time to undertake the required training courses. This may discourage staff from spending the necessary time on their online training to be able to understand the information to provide them with the skills to carry out their role.

The failure to provide the training necessary to enable staff to develop the skills to fulfil their role is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Although most people were not able to verbally tell us if staff knew how to support them, one person told us, "Yes, generally, I think they understand me." Relatives were confident that staff were competent in their role. The comments we received from relatives included, "I think they understand her needs well. She arrived a few months ago, and has never had any bedsores; they turn her frequently" and "I have never visited to find that he has not been clean. They check on him all the time. He has never had any bedsores. They call the GP when required."

Although a menu was available for people to make choices from at mealtimes, the options did not give

people a real choice. People had the option of a hot meal or a salad on most days, even during the winter months. Six people were frail and needed their food to be pureed or softened, which meant they only had one option as a salad could not be pureed. The manager told us one person was fed through a tube, one person was on a weight loss programme so ate mainly salad and another person ate a very restricted diet by choice. This meant four people ate a normal diet and if they did not want to eat salad they also only had one other choice. The manager told us if people did not want what was on the menu they could ask for something else. However, the planned menu did not give suitable choices. One day when two hot meals were on the menu, they were both chicken dishes which gave no options if people did not want to eat chicken. The manager said they would speak to the provider and the cook to improve the menu to provide a better meal experience. Although photographs were available of some meals, these were small and not clear enough to recognise the menu choices easily. People living with dementia may not understand the choices they were making when asked, without more accessible formats for menus.

A number of people living in the service were living with dementia. During lunchtime, when staff brought people their meals, they did not remind them what they had ordered and checked to see if they were still happy with the choice made earlier in the day. People were not given the opportunity to change their minds by being reminded of their choice, to help with the enjoyment of their meal.

We recommend the provider seeks advice and guidance from a reputable source to increase the choice and enhance the meal experience for people living in the service.

At the last inspection we made a recommendation to the provider and registered manager as a universally recognised malnutrition scoring tool was not used to its full advantage. At this inspection, the manager had made sure nurses knew how to complete the assessment fully and it was now used appropriately to measure the risk of malnutrition. Individually detailed care plans were in place to make sure people were supported where needed with eating and drinking. Their likes and dislikes around food and drinks were included, for example if they liked milk and sugar in their hot drinks and which foods were their favourites. This meant staff were able to give people their preferences if they were not able to communicate their wishes. Some people needed to have their food and fluid intake recorded as they were at risk of malnutrition or dehydration. Food and fluid records were accurate and well maintained by staff. The staff we spoke with were aware of their responsibilities in making sure people had the right amounts of nutrition and hydration to maintain their health. The nurses and manager monitored people's weights and kept accurate records. Advice was sought from healthcare professionals such as dieticians if they had concerns about loss of weight.

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.

At the last inspection, further improvement was needed to make sure people were supported appropriately to make and consent to decisions. At this inspection, improvements had been made and people were supported to maintain their rights within the principles of the Act.

Capacity assessments were carried out to determine if people understood and could retain the information to make particular decisions. Where people were found to lack capacity, a best interest's decision making process was taken to agree the right decision for the person. Their family members and others relevant to the decision making were included where appropriate.

Some people had asked a family member or friend to act as Lasting Power of Attorney (LPA) to act on their behalf if they lost the capacity to make particular decisions. The manager had requested copies of a person's LPA where this was relevant to verify the agreement and protect people's rights.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met. The provider and manager had made DoLS applications to the local authority as necessary and once authorised, kept them under review.

At the last inspection we made a recommendation to the provider as a consistent approach was not used when monitoring the blood glucose readings of people with diabetes. At this inspection, the manager had changed the blood glucose recording times so they were at approximately the same times each week, which was more beneficial for monitoring purposes.

The manager carried out a detailed assessment with people before they moved in to the service so their care could be planned. The assessment covered the person's needs in relation to their; mobility, washing bathing and dressing, skin condition, mouth care, foot care, diet, continence, sleep, psychological wellbeing, communication, risk of falls and family and social. This enabled the manager to make an informed decision whether the registered nurses and staff team had the skills and experience necessary to support people with their needs and wishes. Where people moved from another care home or a hospital, a transfer of care was completed by the manager to make sure they had the information they needed about people for a smooth transition to their new home.

People's healthcare and nursing needs were looked after well by the manager, who was a registered nurse, and the nursing team. Where necessary, referrals had been made to other healthcare professionals to make sure people were fully supported to maintain their health and manage their health conditions. Records were made of visits and telephone calls by the GP and visits by the dietician, specialist hospice nurses, community mental health teams or district nurses.

The manager had introduced 'champion' roles for the staff team, although this was still a work in progress. Some staff had been given these roles in various subjects so they could support good practice and be a role model for the staff team. Staff received extra training and coaching in their champion role to increase their knowledge and confidence. Lead roles included, infection control, moving and handling and end of life care. The manager was planning to introduce more champion roles when staff were ready to take these on.

Staff had received one to one supervision with the manager to support them in their role and to plan their personal development. Staff were also observed carrying out their everyday practice such as carrying out personal care and administering medicines; these checks had been incorporated into the personal one to one meetings, held as part of the supervision process. The manager had asked the provider to provide supervision training for nurses so they could take on the supervision of care staff. This would enable the manager to spend time on other areas within their management role and support the personal and professional development of nurses. A member of staff said, "I like working here, the team work well together and we all support each other."
The environment was well presented and homely. Suitable adaptations had been made to meet the needs of people living in the service. Staff had the space available to use the mobility equipment people needed

safely.

Good

Is the service caring?

Our findings

The people who were able to tell us about their care were positive about the care they received from staff. One person told us, "They look after me very well" and another person said "They do their best. I would not get anything better anywhere else." People's relatives were overwhelmingly positive about the care their loved ones received and the staff approach. The comments we received from relatives included, "The staff laugh and joke. They are fantastic. Nothing is too much trouble"; "We are more than happy with the care here" and "The service has been excellent. Second to none. They have been really excellent with (loved one) care."

At the last inspection, people's privacy and dignity was not always respected as one person sitting near a ground floor lounge window pulled their clothes up as they wanted to wipe their face regularly. The window did not have coverings so the person may have been seen by people walking by outside. At this inspection, net curtains had been put up at the lounge windows to give people added privacy. Staff knocked on people's doors before entering and addressed them with respect.

At the last inspection, some people's bedrooms were bare and did not present a homely atmosphere. At this inspection, people's rooms were more personalised where appropriate, for example photographs were displayed and personal items were on show. Some rooms had Christmas decorations up where people had asked for them.

Staff were patient and caring towards people. A member of staff stayed in the lounge with people to make sure they could respond if they needed attention. One person was confused and often repeated themselves, unsure of the time and place they were in. The member of staff responded consistently to them to put them at their ease and prevent anxiety. Even though the person was unsure of where they were at times, they clearly had a good bond with staff and responded warmly to any staff entering the lounge, pleased to see them.

When there was a spillage of tea, a member of staff quickly reassured the person who spilt the drink and asked the domestic cleaner to help by clearing up quickly. The two members of staff worked well as a team, reassuring the person and making sure they were comfortable again quickly and efficiently.

Staff were happy in their work, showing a friendly and happy demeanour. Staff knew people well and were able to describe how they preferred to be supported and their likes and dislikes. We saw many caring exchanges between staff and people.

Staff told us how they supported people to maintain their independence, by gaining their trust and then giving gentle encouragement. One staff member gave an example of a person who could use a walking aid to get around. They would prefer staff pushed them in a wheelchair. Staff supported the person to walk as much as possible to help them to remain active and therefore more independent.

People were supported to maintain as much contact with their friends and family as they wanted. Staff said

that they take care of not only the people living in the service, but also the family, who were encouraged to visit at any time. Visiting relatives confirmed they were made to feel welcome at any time they visited.

Information about people was treated confidentially. The provider and manager were aware of the new General Data Protection Regulation (GDPR); this is the new law regulating how companies protect people's personal information. People's care records and files containing information about staff were held securely in locked cabinets or offices. The computer used by the manager was password protected.

The provider had a comprehensive service guide which set out all the information people and their relatives would need before moving into the service. Information such as how to make a complaint and what services people could expect to find which helped to answer any questions they may have.

Good

Is the service responsive?

Our findings

At the last inspection, although improvements had been made to the care planning, a person centred approach was not always evident. It was not clear that people and their relatives were involved in developing and reviewing their care plans. People's cultural and spiritual needs were not clearly addressed and some people were encouraged to go to bed early in the afternoon. People did not always have the opportunity to take part in activities that interested them individually. At this inspection, improvements had been made in all areas and a new activity coordinator was in post.

People's relatives knew the activities coordinator and were positive about their input. One relative said, "The activities coordinator sits with him and always makes sure he has got his favourite things to hand, and keeps on talking to him even if he does not respond which is nice" and another commented, "The coordinator goes into her room and talks to her."

A new activities coordinator had been employed since the last inspection who worked five days a week. They had a range of activities they encouraged people to take part in. The activities coordinator often worked on an individual basis with people as most stayed in their rooms, either because they were too frail to go downstairs into the lounge or chose not to. Some people sat in the lounge on some days and not others, dependant on their health or by choice. On the day of the inspection visit three to four people were sitting in the lounge. The activities coordinator clearly knew people well and people were very pleased to see them when they arrived on duty. The activities coordinator mainly spent time with people individually as most people were not able to join in group activities, however, they did encourage people and tried to include them. One person was asked if they wanted to play a game of cards and they said no. The activities coordinator waited for a while then brought a pack of cards over and asked if the person was going to join in and they did, thoroughly enjoying the card games they played.

A Christmas party had been held the weekend before the inspection visit. The people who were able to tell us about it, relatives and staff were all still talking about what a success it had been. One relative said, "The party was fantastic. It was a lovely day. They made it really special for the residents."

The activities coordinator had started to gather more information about each person's life history to enhance the information in their care plans. They told us they had been speaking to relatives to try to get to know people better. They kept a record of the individual activities they encouraged people to join in with, either in their room or in the communal lounge area. The records commented on whether people enjoyed the activity or if a different approach was needed.

Care plans were person centred and provided staff with important and personal details of people to enable them to provide care and support in the way people wanted. During the inspection visit we could see how staff responded to people in the way it was described in their care plan. One person was expecting to see family members who had passed away. This could make them anxious and low in mood when their loved ones did not appear. Their care plan described the best approach and we saw staff consistently responding in the way described.

The personal history of people was included in their care plan, including where they had lived, their family members, their employment and what their interests were. Who the important people in their lives was recorded so staff were able to talk about them. One person's close family members were very important to them and we heard staff talking about them by name when the person became anxious and this helped to calm them. It was recorded in the person's care plan that they did not like to be woken or asked by staff to get out of bed early, often wishing to stay in bed until late morning or later. The manager told us this was important to the person when we arrived for the inspection visit. Staff were also able to tell us this and spoke about the person's preference with respect and fondness.

People's cultural and spiritual needs were included in their care plans. People were described either as Christian or did not practice a faith. One person was described as Roman Catholic and had requested that a Priest visit them regularly. Their records showed a Priest visited each week.

Care plans were reviewed regularly, every two weeks, and updates made when necessary if there was a change in care needs, or healthcare advice was given. The manager made sure people's care plans reflected their up to date assessed needs so staff were able to give the correct care and support. People were involved in the development and review of their care plans where they could. Where people needed close family members to help them to understand, or to add to their care plan on their behalf, it was clear this had happened and loved ones had signed to confirm their involvement.

Some people were receiving end of life care. The local hospice community team visited the service regularly reviewing the ongoing needs of people. Their visits had a greater emphasis though in monitoring the care and pain management of four people who were nearing the end of their life. People had a care plan to set out theirs and their family's wishes when they were nearing and reached the end of their life. Each care plan was respectful and recorded people's individual wishes, where appropriate. The care plan clearly stated the aim was to make sure people were supported to be peaceful and pain free at the end of their life.

The provider had a complaints policy which was displayed in the hallway for people and visitors to access. The policy set out how to make a complaint and the external agencies people could go to if they were not happy with the response to their complaint. A relative told us, "We very rarely have concerns, but if we do, they are addressed very quickly." Two complaints had been made since the last inspection. Both had been responded to appropriately as described in the complaints policy. One complaint, from a family member, led to a safeguarding alert raised by the provider and a full investigation. The family member had not known all the names of the staff on duty at the time of the concern. As a result, in addition to the other actions taken following the investigation, staff now wore name badges so people and visitors knew who they were talking to. This meant the provider had responded to, and learned lessons from, complaints made.

Requires Improvement

Is the service well-led?

Our findings

The relatives we spoke with were overwhelmingly complimentary about the new manager. The comments we received included, "The current manager is definitely approachable. (The manager) has time for everyone. If (Loved one) has a cold, they always ring me. When I first walked in here, I thought what a lovely atmosphere. I am so happy that my relative is here"; "The manager always keeps us informed. (The manager) is lovely, very approachable" and "They always tell me what is going on. Overall, I am really satisfied. The manager is very good. Nothing gets past (The manager). Whatever question I have, (The manager) always has an answer. Quite often they come into the room when I am visiting, and discuss with me my relative's condition, and ideas as to how the home can provide further support."

One person's relatives told us they were aware of the ratings of previous inspections as they had seen this on the CQC website. However, they were impressed when they viewed the service and met the manager, before they considered it for their loved one. They said, "We could not have wished for better since (Loved one) has been here. The staff are consistent and know (Loved one) well. The manager is really open and friendly."

At the last inspection, a new manager was in post and had made many improvements. They had introduced new systems to monitor the quality and safety of the service. The systems were new and had recently been commenced so time was needed to make sure action taken to make improvements were continued.

The manager who was in position at the last inspection successfully registered with CQC but was asked to leave by the provider in July 2018. The manager in post at this inspection had previously been the senior nurse in the service and had worked there for some time. They started their new position as manager in August 2018, however they had not yet made an application to register with the Care Quality Commission. It is the provider's legal responsibility to make sure a registered manager is in post as soon as possible after a registered manager leaves. This is an area for improvement.

The new manager was very well thought of amongst the staff team and people and relatives. They had a sound and thorough knowledge of every person living in the service. The manager had not had previous experience of managing a service and felt they would benefit from further training and support. Due to having to spend time getting to understand their new position they had not had the opportunity to start a management qualification or to start to network with other organisations or managers. This placed them at a disadvantage as they were working in isolation without the connections and training to succeed in their new role. Although the provider was aware of the new manager's situation, they had not put measures in place to provide the appropriate support.

The manager worked in partnership with health and social care agencies to provide people with a joined-up delivery of care. For example, the local GP, hospice care team and dieticians, who visited the service. Contact was maintained with commissioners who funded some peoples' care. However, the provider did not attend any local forums to gather information and meet staff from other agencies and services. They had not passed the opportunity for networking and sharing good practice on to the new manager to be able to develop partnerships beneficial to the care provided to people.

We recommend the provider seeks advice and guidance from a reputable source to offer the manager a suitable support and training network and to develop beneficial partnerships.

Following previous inspections, we had made it a condition of the provider's registration to provide CQC with a monthly report of their progress in making improvements and to seek permission before admitting or readmitting people to the service. The provider had fully complied with the conditions, keeping CQC fully informed.

The nursing team, together with the manager, were responsible for writing and reviewing care plans and risk assessments. Care plans were comprehensive and responsive to people's changing needs, so up to date. Only one computer was available, in the manager's office and only accessible when they were on duty. As a computer was not available for nurses and staff to use, care plans were all handwritten. Staff told us this was a very time consuming exercise as they were regularly having to re-write a whole care plan when there were only a few small changes to make. They felt a computer would cut this part of their workload down significantly. Staff felt it was manageable at that time as they did not have the full complement of people living in the service. However, they were concerned they would struggle to keep up with changes once the service was full. We spoke to the provider about this who agreed they would look into the possibility of providing a computer or electronic device to add benefit and maximise the time available to nurses and staff.

Staff were positive about the manager and said they were approachable. One member of staff described the manager as, 'transparent and open' and said they expected good quality care to be provided and all staff knew this. Staff told us the manager kept them well-informed and listened to what they had to say, and was always open with people, visitors and staff.

Staff meetings were held regularly and with different staff groups to focus discussions. The manager met with the nursing team, the care staff team and kitchen staff. Notes of the meetings showed the manager clearly tackling areas for improvement among the staff and in the service, with the emphasis on the quality of care provided. The manager also used staff meetings as an opportunity for coaching and development in subjects they had found staff needed more information and training. For example, recording in people's daily records and how to carry out various tasks.

The provider had a range of monthly audits to monitor the safety and quality of the service provided. These had all been in place since the last inspection and were now embedded by the new manager. These included, a 'manager's walkabout'; medicines audit; care plans audit; accidents and incidents; falls; infection control; complaints; cleaning; safeguarding; environmental checklist. Areas for improvement had been identified and action taken either by the manager, or the nurse or member of staff the action was delegated to. The manager completed all audits but said they planned to delegate to nurses and staff once they had coached them to make sure they were competent and confident.

The manager carried out the manager's walkabout two or three times a week, at different times throughout the day, walking around the service, checking for example that, people looked well cared for; were not waiting for support; health and safety hazards; fire safety; infection control concerns; staff were presentable. Where concerns were found, the manager took action straight away and recorded this. For example, the manager noted a smell in the sluice room and asked the housekeeper to do a deep clean and this was completed straight away. Care plans were audited every month and the manager regularly identified areas to improve. The relevant nurses were actioned with making the improvements, when the manager checked again to make sure the standard was as requested. For example, on 30 October 2018, the manager had requested a number of care plans be rewritten to make sure a more person centre approach was taken. At

our inspection, we found the care plans had an emphasis on person centred care.

The provider asked for people's and their relatives views of the service through an annual survey, resident meetings and relatives meetings. The most recent survey was undertaken in August 2018 and the feedback was positive from all who responded. Only two people were able to respond, both were very satisfied with their care. There were six responses from relatives, which included the comment, 'Great place for our (Loved one), everyone is perfect.'

As many people were not able to attend a meeting in the communal areas, the manager went around to each individual in their room and asked their views as part of the residents meetings. People gave their views on, if they were happy with the staff, what activities they would like and the food. They were also updated on other items of interest, such as information about CQC inspection visits and findings. Relatives were able to raise any concerns they had and were provided with updates regarding the service such as the change in manager and improvements made as a result of CQC inspection reports.

The provider and the manager understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly and without delay.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the front door lobby area of the service.

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	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff had the necessary training to develop the skills to fulfil their role. Regulation 18 (1)(2)