Archmore Care Services Ltd

Ashdown Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Ashdown Nursing Home on 3 May 2016. Following the inspection we received some information of concern and as a result we returned for a second day of inspection on 13 May 2016. We previously carried out a comprehensive inspection at Ashdown Nursing Home on 6 and 8 January 2016. Breaches of legal requirements were found and we took enforcement action against the provider in relation to safe care and treatment, staffing, nutrition and hydration and dignity and respect. The overall rating of the home was 'Inadequate' and Ashdown Nursing Home was placed into 'special measures'.

The purpose of special measures is to provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. Services placed in special measures will be re-inspected again within six months. If sufficient improvements have been made, the service can come out of special measures and the overall rating can be revised. You can read the report from our previous inspection, by selecting the 'all reports' link for (Ashdown Nursing Home) on our website at www.cqc.org.uk

We undertook this unannounced comprehensive inspection to look at all aspects of the home and to ensure that the required actions had been taken to address the concerns, and to see if the required improvements had been made. We found improvements had been made in the majority of areas. The overall rating for Ashdown Nursing Home has been revised to 'Requires Improvement', the home has also come out of 'Special Measures'. However, the legal requirements in relation to safe care and treatment, need for consent and dignity and respect had not been fully met. Areas for improvement were identified in order to further improve some practices in relation to staffing levels, medicines, communication and interaction and providing choice.

Ashdown Nursing Home is located in Worthing. It is registered to accommodate a maximum of forty people, as some of the rooms were large enough for dual occupancy. However rooms had been converted and were single occupancy, therefore the provider was only able to accommodate a maximum of thirty-one people. At the time of our inspection there were twenty-three people living in the home. The home is for people living with dementia, some of whom have complex health needs and who may require nursing support. The home itself is a large detached property spread over two floors. People had their own rooms and had access to shared, communal bathrooms. There was a lounge and a dining area. There was a garden that was in the process of being landscaped with a summer house that people could use during the summer months.

The service had not had a registered manager for seven months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The providers had been responsible for the day to day management of the home and people's care. A new manager had been in post for one month and was undertaking the process of registration.
Observations of some care practices and feedback from some people and their relatives raised concerns

over people's safety when they were supported with moving and positioning. Risk assessments recognised the potential risk to people and provided guidance to staff in relation to how to support people in a safe manner. However, staff did not always adhere to this guidance and were observed undertaking unsafe moving and handling practices. One person told us "They often knock and bang my legs when they hoist me, but they can't help it". This was raised with the providers who took immediate action. Meetings were held with the members of staff concerned and they undertook refresher training.

The provider had taken some measures to ensure that people were asked for their consent and were not deprived of their liberty unlawfully. However, for people who required the use of bed rails and who needed to have their medicines administered covertly, measures hadn't been taken to ensure that relevant people were consulted to give lawful consent for their use. This was addressed with the provider who was aware that this required further improvement, there were plans in place to improve this but these had yet to be implemented. This was an area of concern.

People, relatives and staff told us that the staffing levels were sufficient, and our observations confirmed this. However, we were unable to determine whether the current service provision, in relation to staffing levels, had been fully embedded and could be sustained over time, should the number of people living at the service increase.

Most staff communicated with people, explained their actions and demonstrated positive interactions. However, some staff provided little interaction or communication with people, particularly when people were being supported to eat and drink and to have their medicines. People were supported to have their medicines by registered nurses and had their medicines on time. However, there were concerns regarding people's privacy and dignity when being supported with their medicines. This was an area of concern.

Guidelines were in place for people who required medicines on an 'as and when required' basis, however these lacked detail and there was a potential risk that this could lead to a lack of consistency in approach by staff. However despite these areas that required further improvement, the provider had made significant improvements to the standard of care people received.

Staff had received induction training and had access to on-going training to ensure their knowledge was current and that they had the relevant skills to meet people's needs. People were safeguarded from harm. Staff had received training in safeguarding adults at risk, they were aware of the policies and procedures in place in relation to safeguarding and knew how to raise concerns.

Risk assessments had been undertaken and were regularly reviewed. They considered people's physical, health and cognitive needs as well as hazards in the environment and provided guidance to staff. People were encouraged and enabled to take positive risks. People's independence was not restricted through risk assessments. Observations of people assessed as being at risk of falls showed them to be independently walking around the home. There were low incidences of accidents and incidents, those that had occurred had been recorded and were used to inform practice.

People were supported to maintain their nutrition and hydration and now had a positive dining experience. People felt that they had enough food and drink and observations confirmed that drinks and snacks were offered throughout the day. Most people were content with the food. One person told us "The foods not bad". Another person told us "It's quite good". For people at risk of malnutrition, appropriate measures had been implemented to ensure they received drink supplements. Foods were fortified with double cream and full fat milk to increase their calorie intake. As a result people's weights had increased.

People had access to relevant healthcare professionals to maintain good health. Records confirmed that external healthcare professionals had been consulted to ensure that they were being provided with safe and effective care. People's clinical needs were assessed and met. People received good health care to maintain their health and well-being.

People were cared for by a majority of staff who knew them and who understood their needs and preferences. The provider had taken appropriate measures to ensure that people, who were at risk of social isolation, had access to interaction and engagement with staff and others. People had access to a wide range of activities and observations showed people partaking in these activities and showing enjoyment.

People were involved in their care and decisions that related to this. People and relatives were asked their preferences when people first moved into the home. They were provided with an opportunity to share their concerns and make comments about the care they received through care plan reviews and relative and resident meetings. Most relatives confirmed that they were involved in their loved ones care, felt welcomed when they visited the home and knew who to go to if they had any concerns. People also confirmed that they knew who to go to if they had any concerns. One person told us "I'd tell her over there (pointing to the provider) she's like the teacher here and makes sure you're alright".

There was a homely, friendly, calm and relaxed atmosphere within the home. People were complimentary about the leadership and management of the home. One person told us "Things have definitely changed for the better". Relatives confirmed this, one relative told us "They've got strong leadership now and I feel there's reliability and safety which is consistent". Staff felt supported by the providers and manager and spoke highly of them. One member of staff told us "The atmosphere has changed. Before, everybody had a long face, not now though, everybody is happy and it's calmer". Another member of staff told us "The manager and providers are very nice, they're polite, they're approachable and listen to us".

There were now rigorous quality assurance processes in place that were carried out by the provider to ensure that the quality of care provided, as well as the environment itself, was meeting people's needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 home was not consistently safe.

There were continued concerns over people's safety when being supported with moving and positioning. Risk assessments had been devised but were not always adhered to.

People received their medicines on time and there were safe systems to store and dispose of medicines. However, people were provided with little interaction or explanation when being supported to take their medicines. There was limited guidance provided to staff in relation to the administration of 'as and when' required medicines.

There were enough skilled and experienced staff to ensure current numbers of people living at the home were safe and cared for. However, we were unable to determine whether the current service provision could be sustained over time, should the number of people increase.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. The home was clean and systems were in place to reduce the spread of infection.

Is the service effective?

Requires Improvement

The home was not consistently effective.

There were continued concerns regarding gaining people's consent. People were not always asked for their consent before being supported. Relevant people were not involved in the decision making process when people lacked the capacity to give their consent.

People were supported to eat and drink to maintain their health and had a positive dining experience. Most people were supported appropriately by staff, and were offered explanations and encouragement. However, for some people there was little interaction or explanation when they were being supported to eat and drink.

People were supported to maintain good health. They had access to healthcare professionals to enable them to receive the necessary care and treatment.

Regular observations of staff practice as well as supervision meetings had ensured that staff's practice had improved. Staff had access to on-going and appropriate training to enable them to carry out their roles.

Is the service caring?

Requires Improvement

The home was not consistently caring.

Most people were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. However, some staff were not always consistent in their approach to maintaining people's privacy or dignity.

People were supported by staff who appeared to know their preferences and needs well. Positive relationships had developed and there was a friendly and warm atmosphere.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People received care that was in accordance with their needs and preferences. However, there were inconsistencies in staff's approach in relation to the choices people were provided with.

There were a variety of activities offered to people. Their interests were taken into consideration when offering support. However, there was mixed feedback from people regarding the activities that were offered.

People were involved in their care. There were mechanisms in place to enable people and their relatives to comment and complain about the care people received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

There was no registered manager. The home had been without a registered manager for seven months. As part of the conditions of the provider's registration they were required to have a registered manager. Since the previous inspection the providers had taken over the day to day management of the home.

People and staff were positive about the management and culture of the home. Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Ashdown 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 took place on 3 and 13 May 2016 and was unannounced, this meant that the providers and staff did not know we were coming. On the first day of inspection, 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. On the second day of the inspection there was one inspector.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with five people, four relatives, six members of staff, one healthcare professional and the providers. We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area and spent time observing the lunchtime experience for people and the administration of medicines.

The home was last inspected in January 2016 when it received an overall rating of 'inadequate' and entered into special measures as enforcement action was taken due to the serious concerns noted.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 6 and 8 January 2016, the provider was in breach of Regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to people's safety in regard to pressure area care, weight loss, unsafe moving and handling, safeguarding people from abuse and improper treatment and staffing. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to these regulations. Improvements had been made in relation to pressure area care, people's weight loss, safeguarding people from abuse and improper treatment and staffing. The provider was meeting the legal requirements of Regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to these. However, we found areas of practice, in relation to moving and handling that required further improvement.

At the previous inspection there were concerns raised regarding staff's practice in relation to moving and positioning people. Observations showed staff undertook unsafe moving and handling practices and therefore placed people at risk of injury. Following the inspection the provider ensured that staff had up to date moving and handling training that provided them with both theoretical and practical knowledge of how to move and position people in a safe manner. The provider had taken measures to ensure that people, who required assistance with moving and positioning, had risk assessments and mobilising care plans in place. These identified the risks to the person, the potential hazards and the goals to be achieved. They provided advice and guidance to staff on the precautions and actions to take to minimise the risks and ensure people's safety.

People told us that they felt safe but that the moving and handling practices of staff needed to improve. One person told us "They often knock and bang my legs when they hoist me but they can't help it". This was confirmed by a relative, who explained that their relative often had bruises on their legs that had been as a result of their legs being knocked when being supported with moving and positioning. They told us that they had raised this with the previous provider and for a period of time this had improved. However, their relative was once again sustaining injuries as a result of the support they received with moving and positioning. They told us "I did speak to the other manager when they were here and for a period of time things got better, then it went back to how it was. It would suggest that things can be done to prevent [my relative's] legs from being knocked if they could do it before". We looked in detail in relation to this matter and found that the provider had appropriate mechanisms in place to recognise the risk to people when being supported with moving and positioning. For example, one person, who due to their cognitive abilities, often displayed behaviours that challenged others, had moving and handling risk assessments and care plans in place. These recognised both the physical and cognitive abilities of the person, the potential hazards and measures to take to mitigate the risks. These included ensuring that staff offered support with moving and positioning when the person was in a calm state and offering reassurance to the person throughout the manoeuvre. The provider had appropriate mechanisms in place to minimise accidental bruising.

Most staff ensured people were supported to move and position in a safe manner when being assisted to use the hoist. Staff had a good knowledge in relation to which people required the use of a hoist and were

observed assisting people in a safe manner when using this. Observations showed most staff supported people to move and position in a safe manner and in accordance with the moving and handling risk assessments and care plans. For example, one person's care plan recommended that they be supported to use a hoist to transfer out of bed and to a wheelchair to travel distances. Observations showed staff adhered to this guidance and they demonstrated good practice in regards to moving and positioning techniques. The person's care plan acknowledged that being supported with moving and positioning could be distressing for them, it advised staff 'Please explain the procedure to me and reassure me throughout the transfer'. Some staff explained their actions to people, communicated to them throughout the manoeuvre and ensured that they were supported in a safe manner. Observations showed that a member of staff explained their actions, reassured the person and acknowledged their anxieties. They were overheard gently saying to the person "Okay, I know you don't like it, but I will help you".

However, despite this some staff were observed undertaking unsafe moving and handling practices. Some staff did not adhere to the guidance in people's moving and handling risk assessments or care plans and they did not explain their actions when they were offering support. Observations of some staff showed that they supported people in an unsafe manner. One person, who was sitting in a wheelchair, slipped in their seat. A member of staff demonstrated good practice and noticed this. They asked another member of staff to assist them to move the person back in the seat of their wheelchair. The member of staff was overheard saying to their colleague "We need a hoist – no"? The first member of staff indicated no and with no explanation or warning of what was about to happen, both members of staff placed their arms underneath the person's armpits and knees and lifted the person back into the seat of their wheelchair, with no acknowledgment of the potential impact on the person. Moving and handling risk assessments and care plan records for the person identified that there was a potential risk of the person slipping out of their wheelchair, it identified that the precautions and actions that were needed to minimise this risk was for staff to undertake moving and positioning training and for the person to be supported to move and position with a hoist with two members of staff.

Further observations showed another two members of staff moved and positioned people in an unsafe manner. One person was sitting in another person's specialised armchair, the person who it belonged to was assisted into the lounge and needed to sit in the chair. Staff were kind and considerate in their explanation to the person and explained that they needed them to move out of the chair to enable the other person to sit there. However they then proceeded to pull the person quite firmly by their upper arms, placing their hands under the person's armpits to move them. This manoeuvre was not good moving and handling practice, nor was it pleasant for the person involved, they showed signs of distress and were clearly unhappy about being moved from the chair. Observations later in the day showed the same two members of staff support another person to transfer from a wheelchair to an armchair in an unsafe way. The members of staff offered no explanation to the person before they placed their arms underneath the person's armpits and moved them quickly, from a sideways sitting position in the wheelchair to the armchair.

These types of manoeuvres are known as 'drag' lifts. The 'drag' lift is any method of handling where the care worker(s) place a hand or arm under the person's armpit. Use of this lift can result to damage of the spine, shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' These unsafe practices were fedback to the provider who immediately addressed the issues with the staff concerned and arranged for refresher training in relation to moving and handling. The provider also planned to implement assessments of staff's competence, in regard to moving and handling, when they completed their training.

Despite the moving and handling risk assessments, care plans, and staff having received training in relation to moving and handling, feedback from people and relatives as well as our observations raised concerns over people's safety. People were not always safe when being supported with moving and positioning. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection there were concerns regarding pressure area care. There was a lack of documented information related to people's pressure area care and therefore the provider had no way of monitoring the deterioration or improvement in a person's wound. People had not been supported to use the recommended pressure relieving equipment or to have the dressings on their wounds changed according to the advice given by the Tissue Viability Nurse (TVN). During this inspection it was evident that the provider had ensured that there were more rigorous systems in place to ensure people were supported, in relation to pressure area care, in an appropriate way.

Following the previous inspection trained staff had undertaken refresher training for tissue viability and wound care. People's skin integrity and their risk of developing pressure ulcers were assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. Assessments were used to identify which people were at risk of developing pressure ulcers. Care plans for people showed that referrals had been made and measures had been taken to liaise with relevant professionals such as GPs, practice and tissue viability nurses. For people who had pressure ulcers, body maps and wound assessment charts were completed that detailed the wound and the treatment plan recommended. Photographs of wounds were taken to monitor their improvement or deterioration. For two people these photographs showed a significant improvement in the condition of their skin due to the treatment and wound management carried out by staff.

There were now robust mechanisms in place to ensure that people at risk of developing pressure ulcers and those with physical disabilities had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushions and mattress that was appropriate as well as the setting that the mattress was required to be. Records showed that daily checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations.

At the previous inspection there were no mechanisms in place to monitor and analyse the food and fluid intake of people who had been assessed as being at risk of malnutrition. As a result people had lost significant amounts of weight and had not been referred to appropriate health care professionals for support with their hydration and nutrition. During this inspection it was evident that the provider had taken appropriate measures to ensure that people had access to sufficient hydration and nutrition and that they had access to healthcare professionals, and as a result most people's weight had increased. People's risk of malnutrition was assessed upon admission and reviewed monthly, using a Malnutrition Universal Screening Tool (MUST) to identify people who were at a significant risk. These people were weighed each week or month, dependent on advice provided by healthcare professionals, to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP and the practice nurse. Advice and guidance provided by these professionals had been followed. For example, for one person who was at risk of malnutrition, they had advised that the person be given a drink supplement and their food be fortified with high calorie products. Observations and discussions with staff confirmed that this was implemented in practice. The provider had taken appropriate action when people's weight had continued to decrease. Care records for one person showed that the person's weight had gradually declined. The provider was monitoring the person's weight, food and fluid intake and providing supplements and increased calorie intake. In addition

to this, the provider had referred the person to the GP and practice nurse to investigate any physical health needs, they had also referred the person to the Living Well with Dementia team (LWWD) to identify if their cognitive needs were contributing to their weight loss.

At the previous inspection the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to insufficient staff during peak periods and the inappropriate deployment of staff. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to staffing. Improvements had been made and the provider was now meeting the legal requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there to be insufficient staff and an inappropriate deployment of staff during peak periods and this had placed people at risk. During this inspection the staffing levels had remained the same, however, the number of people living at the service had reduced from twenty-nine to twenty-three. The provider calculated staffing levels using a dependency tool. This tool looked at each person's level of dependency (care needs) and calculated the required staffing numbers. The information to aid the dependency tool was based on individual care plans and people's assessed level of need. Feedback from people and staff indicated they felt the home had enough staff and our observations confirmed this. One member of staff told us "I think we have enough staff, it's alright, and we have enough". Another member of staff told us "We get enough time now to support people to the toilet as there is enough staff".

People confirmed that staff responded to them if they required assistance. Call bells in people's rooms enabled people that could use them, to call for assistance from staff. People confirmed that staff's responsiveness to call bells had improved, although was sometimes inconsistent, as there were enough staff to ensure their safety. People also told us that the bells themselves were now generally placed within reach. One person told us "They're getting better, I could never reach it before". Another person told us "I couldn't reach mine this morning, I had a sore throat and I had to keep banging to make them come to me". Assessments for people who were unable to use calls bells, due to their cognitive abilities, had been undertaken. One person's assessment recognised that the person would be unable to use their call bell due to their cognitive ability. The assessment identified they were at risk of becoming entangled in the bell cord and there was an increased risk of falling due to the trip hazard this might cause. The provider had introduced measures to ensure that staff undertook regular checks to ensure the person's safety and had advised staff to ensure the person was checked every half an hour throughout the day and at hourly intervals throughout the night. Observations confirmed that staff complied with this guidance.

People, relatives and staff told us that the staffing levels were sufficient and our observations confirmed this. However, we were unable at this inspection to determine whether the current service provision could be sustained over time, should the number of people living at the home increase. When the provider was asked how they would ensure that staffing levels continued to remain sufficient to meet people's needs if the occupancy levels increased, they explained that they would introduce a phased approach to increasing numbers to enable them to have time to identify people's needs and devise and implement their care plans. Whilst it is acknowledged that the current staffing levels improved the safety of people, we cannot at this stage determine an accurate representation of the care delivery if occupancy levels increased. The provider would need to demonstrate appropriate staffing arrangements over a period of time, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this as an area of practice that needs improvement.

People were assisted to take their medicines safely by registered nurses. However, when supporting some people, there was little interaction from the nurse and people were not always advised of what the medicine

was for or advised that they had medicines to take. For example, observations showed that one person was given their medicine, there was no interaction or explanation and the nurse held a glass of squash to the person's mouth. The person didn't want this as they wanted to take their medicine with their tea, the person was then able to take their medicine in their preferred way and with their choice of drink. Observations showed another person being supported to take a sachet of medicine that had been mixed into a drink. There was no interaction or communication with the person, they had the drink put to their lips and were assisted to drink the contents. However, other observations showed people being supported in a more respectful manner. One person was asked for their consent and was provided with explanations about what was about to happen.

Medicine records showed that each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies, these were regularly audited by the provider. These confirmed that medicines were administered appropriately and on time. People and relatives also confirmed this. One relative told us "Yes [person's name] had antibiotics and they've been making sure they get them". For people that required 'as and when' medicines, documentation advised staff of the medicines that could be offered and what these were for. However, the guidance lacked detail in regards to when it could be offered. For example, records for one person advised staff that the medicine could be given if the person showed signs of agitation, shouting or verbal aggression. However, it did not provide staff with guidance in relation to the steps to follow before administering this medicine. This could potentially lead to a lack of consistency in approach by staff. This, as well as ensuring that people are offered an explanation and interaction when being supported to have their medicines, are areas of practice in need of improvement.

At the previous inspection the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to the safeguarding of people from abuse and improper treatment. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to safeguarding people from abuse and improper treatment. Improvements had been made and the provider was now meeting the legal requirements of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection people's human rights were not respected and they were subjected to discrimination due to their vulnerability. People were subjected to neglectful practices and degrading treatment, were being deprived of their liberty unlawfully, were not supported to make decisions such as their choice of clothing or decisions relating to their health and welfare and were not adequately supported to maintain sufficient hydration or nutrition. Observations, during this inspection showed people being treated in such a way that ensured that they were safeguarded from abuse and improper treatment.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS) and their employment history gained. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Staff had an understanding of safeguarding adults, they had undertaken relevant training, or were working towards this, and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. (A

whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace). The provider had demonstrated an awareness of the importance of safeguarding people from abuse and improper treatment and had made a safeguarding referral to the local authority about one person, when they used another service.

Suitable measures had been taken to ensure that people were safe but their freedom was not restricted. Some people were supported to undertake positive risks, we observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Staff confirmed this and told us that one person, who used to have a room on the first floor was asked if they'd like to move to a room on the ground floor as they enjoyed walking through the home using their walking aid. The member of staff explained that the person kept having to wait for staff to support them to use the lift to go to their room, however since moving to a room on the ground floor was able to mobilise independently. Observations confirmed this. Another member of staff told us about another person whose mobility had improved. They told us "Residents can take risks. One person came to us and because of their hip they could not walk. We have got them better and now they walk around the home with their zimmer frame. They're a bit unsteady with it, but they want to walk and go to the toilet by themselves and we want to encourage them".

Accidents and incidents were recorded and monitored. They were used to identify trends and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements and relevant equipment provided. One person, who due to their condition, had often been found sitting beside their bed, unresponsive, on a number of occasions. The provider had taken the appropriate measures and had arranged for the person to see a healthcare professional. They had also installed a low profile bed and a crash mat to minimise the risk of injury to the person should they slip out of the bed in future.

People were protected by the prevention and control of infection. Most staff had undertaken infection control training or were working towards this and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People were supported with their continence needs and to access the toilet facilities regularly, and as a result people were supported in a more dignified way and there was no longer a strong odour within the home. Staff confirmed that infection control had improved. One member of staff told us "The home is nice now and not smelly like it was".

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 6 and 8 January 2016, the provider was in breach of Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to gaining people's consent when supporting them to take their medicines and when they were using bed rails. There were concerns regarding people's hydration and nutrition and they had poor dining experiences. There was a lack of appropriate support, training and supervision for staff to carry out their role to ensure people were safe and well cared for. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to these areas of concern. Improvements had been made and the provider was now meeting the legal requirements of Regulations 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found areas of practice, in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 that required further improvement.

At the previous inspection people were sometimes provided with care and treatment without them, or relevant people, being involved in the decisions related to this. Decisions for some people, regarding the use of bed rails had been made by someone who was unlawfully able to make those decisions. As a result people's movement was restricted. People who lacked capacity to understand the need to take certain medicines had their medicines provided to them covertly. The provider had not consulted the relevant people in relation to this and as a result people were provided with medicines without their consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made DoLS applications for some people, who were unable to leave the home without staff support. Most people were asked for their consent before being supported. Staff told us and records confirmed, that staff had received training for MCA and DoLS. One member of staff told us "I have had plenty of training and done training on the MCA. I know about consent and asking first. Of course I would always ask first".

The provider had undertaken mental capacity assessments and best interest decisions for some people and was aware of DoLS. However, although they had reviewed these documents since the last inspection, they acknowledged that they needed further improvement. Mental capacity assessments should be decision specific and assess a person's ability to understand the information related to the decision being made. The person should be able to retain and weigh up the information and communicate their decision. Records should show how the decision of capacity was reached. Records did not clearly show that this had taken

place and were not always decision specific. For example, mental capacity assessments had been completed that stated they were for 'All aspects of care'.

Observations identified that some people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails can be implemented for people's safety but do restrict movement. Bed rails risk assessments were in place which considered the risk and how to eliminate the risk. The bed rail risk assessment identified that the person, their next of kin or the GP were consulted and had consented to the use of bed rails. However, this was not the case and therefore it was not evident how this was decided in the person's best interest. For people who had been assessed as lacking the capacity to consent to the use of bed rails the registered nurse or provider had undertaken a mental capacity assessment without the consultation or involvement of other professionals or the person's power of attorney or next of kin.

Some people were supported to have their medication given covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example hidden in their food or drink. The National Institute for Health and Care Excellence (NICE) guidance for medicines states that a best interest meeting should take place involving healthcare professionals (including the prescriber and pharmacist) and people's relatives or representatives to discuss and agree if this is the correct option. The person's GP should review their medicines as well as the pharmacist who should then advise the provider of how to administer covert medicines safely. If agreed, a management plan should be made which should contain information on these reviews, the decision taken at the best interest meeting and a date to review the need for continued covert administration of medicines.

There were seven people who were assisted to have their medicines covertly. Best interest decisions had taken place between the provider and the person's representatives and there were signed forms to confirm this. However, a GP had not always been involved with these decisions and there was no involvement from a pharmacist or any documented guidance on how the medicine should be covertly administered in a safe way to avoid altering the structure of the medicines. There was a lack of involvement and guidance from healthcare professionals to ensure that the medicines were being administered in an appropriate way. Reviews to ensure the continued need for covert administration of medicines were not held. The provider had made plans to implement a new form to capture this involvement and agreement, however, these were not yet implemented.

Care and treatment of people must only be provided with the consent of the relevant person. Decisions for some people had been made by someone who was legally unable to make those decisions and best interest decisions had not always involved the relevant people. As a result people's movement was restricted and they were provided with medicines without their consent. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection people were cared for by staff that appeared to have little experience, skills or knowledge to meet their needs. Staff had access to some essential training, however, observations of their practice raised concerns about its effectiveness. Staff did not have access to training to meet people's specialist needs, such as people who were living with dementia, and as a result had little understanding of people's needs and condition. There was a lack of appropriate support to enable staff to carry out their role to ensure that people were safe and well cared for. There was no observed and formal supervision and as a result staff's poor practice had not been recognised or addressed. During this inspection observations showed that staff had the relevant skills and experience to care for people in an effective and safe way. The provider had taken appropriate measures to ensure that staff now had access to relevant training, support and supervision to enable them to understand and carry out their roles.

Most people and relatives felt that staff were good at their jobs and were happy with the care that was provided, however recognised that some new members of staff needed more training. The provider had taken appropriate measures to ensure that staff had received, or were working towards essential training as well as training that was specific to the needs and conditions of people. For example, training to support people who were living with dementia. They recognised that the training of staff needed to improve further but explained that they had concentrated on ensuring that all staff had undertaken essential training and would then look to introduce more specific training for people's needs and abilities. Registered nurses ensured that their practice was current, they undertook relevant training courses and were registered with the Nursing and Midwifery Council (NMC). Staff were complimentary about the changes the provider had made since taking ownership of the home, particularly in relation to their learning and development. One member of staff told us "There have been lots of changes. It has taken a while to get used to everything, but things have got better. There have been lots of changes in staff which has helped, as some staff did not want to work with the new changes the managers made". Another member of staff told us "A lot of staff have left. The new people are good though and we all work well together".

Staff had completed their induction training, or were working towards this. As part of the staff's induction they were asked to complete a twelve week induction programme, during which time they were asked to complete an induction booklet to ensure that they were aware of the provider's policies and procedures. The provider was aware of the changes in induction practices since the Care Act 2014 and informed us that any new staff would be undertaking the Care Certificate induction process. The Care Certificate is a set of standards that social care and health workers should work towards. It is the new minimum standards that should be covered as part of the induction training of new care workers. Staff told us that the induction training was useful and enabled them to feel more confident in their roles. One member of staff told us "My induction explained my role within the home and I looked at all the care plans to get to know the residents. I had support through my induction from the managers and the other staff". Another member of staff told us "All the staff are well trained and the new staff have a good induction". Supervision and appraisal meetings took place and were a chance for staff to be given feedback on their practice, discuss people's needs and identify learning and development opportunities. Staff felt that they were supported well, one staff member told us "I do like working here, I've had two supervisions recently".

At the previous inspection people were not supported sufficiently by staff to eat and drink sufficient amounts to ensure their health and well-being was maintained. People were not provided with a suitable environment that was conducive to a positive dining experience. During this inspection people's dining experience had improved. The provider had taken appropriate action to ensure that people were offered appropriate support and sufficient quantities to eat and drink. Records of a recent staff meeting showed that the provider had advised staff on how they could ensure that the dining experience for people improved. It stated 'Please encourage all people to come down to the dining area for their meals and ensure that the television is turned off'. (As there was music playing). It advised staff to 'Use the new table cloths and napkins and ensure that there is salt and pepper on each table for people to use'.

Feedback from a recent residents meeting showed that most people were content with the food. People confirmed this. One person told us "The foods not bad, it's okay". Another person told us "It's quite good". People appeared to have choice over the food they ate, observations showed staff asking people what they wanted to eat. One member of staff informed people of the main choice and was overheard asking if the choice was okay for people. There was a menu board that provided additional information to people in relation to the choices available. People and staff told us that they could choose alternatives if they wished and our observations confirmed this. Staff told us that the hydration and nutrition for people had improved. One member of staff told us "Food and fluid records are much better, people are gaining weight, they have lovely food".

People told us that they had plenty to eat and drink and that they weren't left feeling thirsty or hungry. One person said that they felt they had too much to eat. They told us "I ask for smaller portions as I've never been a big eater". The person's relative confirmed this and told us "We keep asking but they're still giving [person's name] too much". Observations confirmed that people were offered snacks and drinks throughout the day. For people that required assistance from staff fluid charts indicated that they had access to fluids during the day and night.

People's dining experience had improved. At the previous inspection there were not enough tables and chairs for people to sit at to eat their meals, as a result most people were having their meals sitting in the armchairs that they had spent most of the day in. Since the previous inspection the provider had purchased additional dining tables and chairs and most people were able to sit at the table to eat their meal, this helped aid their digestion and level of independence and had a positive impact on people's dining experience. Observations showed that it assisted people, living with dementia, to orientate and know that it was time for their meal. There was soft music playing and tables were laid with tablecloths, placemats, napkins and condiments and contributed to a pleasant environment for people to have their meal.

At the previous inspection people were sometimes supported to eat and drink by several members of staff, some of whom would stand over people whilst they were eating and drinking, and therefore not providing a relaxing or pleasant experience for people. During this inspection people were supported by staff that were patient and calm. Staff sat alongside people whilst they supported them and monitored their reactions to ensure they were supporting them appropriately. Observations showed positive communication and interactions between some staff and people. One staff member was overheard saying "Come on [person's name], this looks nice, let me give you a hand". Whilst another member of staff was overheard saying "[Person's name, try and have a bit more lunch, let me help you". Most staff offered people explanations about what they were eating and ensured that they were happy with the food provided. However, some staff did not offer explanations or interact with people whilst they were having their meal. This is an area in need of further improvement.

People's communication needs had been assessed when they first moved into the home. People were encouraged to communicate with one another. Observations in the communal lounge and during lunch showed that people enjoyed having conversations within one another. Most staff encouraged this by engaging in conversations with people, contributing to a friendly and relaxed atmosphere. Staff handover meetings provided an opportunity for staff who had been working during the previous shift to provide information about people's needs to staff working during the following shift. Staff told us that these meetings were helpful to them as it provided them with information so that they could ensure that people's care was consistent and effective. One member of staff told us "Handover meetings are very useful, we find out how the residents have been and get up to date with everyone's condition and care".

People had access to health care professionals. People and records confirmed that they had access to GPs, opticians, dentists, tissue viability nurses and chiropodists. The provider had arranged for a practice nurse from the local surgery, to visit the home each week and monitor people who were at risk of pressure sores, malnutrition or who were unwell. Records showed that referrals had been made in a timely manner to ensure that people had access to relevant health professionals, these included referrals to Tissue Viability Nurses (TVN) and Psych geriatricians. This demonstrated that the provider was aware of the importance of making referrals and ensuring that people had access to appropriate healthcare professionals to meet their health needs. One person told us "They call the doctor but it would have to be organised the doctor wouldn't just come out". A relative told us "My relative was assessed as needing dental treatment and they were very good at getting this organised". Staff confirmed that people could see the doctor if they were unwell. One member of staff told us "Some people can't respond, but we recognise when they are not well.

We still speak with them and look for signs like a reduced appetite". The provider had recognised that some people were unable to verbally communicate their needs or inform staff that they were in pain. They had introduced an Abbey Pain Scale. The Abbey Pain Scale is best used for people who are living with dementia or for those with limited verbal communication and provides guidance to staff to assist them in the assessment of pain in people who are unable to clearly articulate their needs.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection on 6 and 8 January 2016, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to dignity and respect. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to dignity and respect. Improvements had been made and the provider was now meeting the legal requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found areas of practice, in relation to dignity and respect that required some further improvement.

At the previous inspection there were concerns related to people not being treated in a respectful manner. There was a lack of communication and interaction between people and staff and a lack of understanding and insight into people's needs. People were not supported in a dignified way to maintain their continence, personal hygiene or appearance and their emotional needs were not met. During this inspection people, relatives and staff told us that the caring nature of staff had improved and our observations confirmed this. One person told us "It's free and easy and they try to help you and they ask how you're feeling". A relative told us "I've stopped feeling the need to write things down and it was after a new member of staff started here, they're amazing and get the best out of everybody, they just have a way about them as does [the provider] too, but it would be great if the others were more like it too". Staff told us that they helped new staff to get to know people, that they offered people a good place to live and looked after them. One member of staff told us "I like to help people and I like what I do". Another member of staff told us "We provide good care here". A third member of staff told us "The staff are very caring and know each individual resident".

The provider had implemented mechanisms to ensure that people's privacy and dignity were maintained. They had implemented a new system where more experienced and skilled staff were given the roles of team leaders. These team leaders were responsible for monitoring staff's performance and providing feedback to them in relation to their practice. In addition to this a sign had been made for each person's door that could be displayed if staff were assisting them with personal care, this advised other people and staff that the person needed privacy. Observations showed staff knocked on people's doors and waited for a reply before entering and privacy was maintained when assisting people with their personal care. Most staff supported people in a discreet and sensitive manner. One person began to lift their clothing, a member of staff immediately, yet discreetly, intervened and assisted the person to the bathroom to assist them to rearrange their clothing. Observations showed another member of staff discreetly asking them if they'd like to use the bathroom. People's right to confidentiality was respected. Records held about them were stored in locked cabinets and offices to ensure that their privacy was maintained.

Most staff were mindful of people's right to privacy and people were treated in a respectful and dignified way. However, observations showed some staff not maintaining people's privacy and dignity. Staff were keen to show how the changes that they had been part of had had positive outcomes for people, but had not considered the potential embarrassment this might cause people. For example, one member of staff pointed at a person and called across the room at an inspector. They said "Do you remember [person's

name] from last time, they just used to sit in the corner, now look at them". The person appeared embarrassed by this, they raised their eyebrows and shook their head. Another person was enjoying conversations with other people, they were sitting at a table having a cup of tea and some sandwiches. The same member of staff approached the person and in a voice loud enough for others to hear, said to the person "Your fingers are all dirty". Another member of staff was called over and the person was taken away from the table, without being asked, to support them to wash their hands.

People's privacy and dignity was not always maintained when they were being supported with their medicines. Observations showed a small group of people sitting at a table having tea and sandwiches. The nurse dispensing the medicines approached the person and with no explanation or interaction pulled down the person's shirt to apply a medicine patch. Another person sitting at the table was very upset by this and said "That's not right, you better leave them alone, their breast is showing, it's wrong, that's wrong, that's wrong". There was no acknowledgment of people's feelings or the distress this had caused.

Most people were treated in a respectful and dignified way and were supported by staff that showed genuine warmth and compassion. People appeared to be at ease in the company of certain members of staff. They were observed holding hands and having reassuring hugs. There was a shared sense of humour, laughter and smiles when there was interaction and engagement. Whilst people appeared to interact with some staff there was a lack of engagement and interaction with a small amount of staff that were not communicative, instead they remained task orientated. People and relatives confirmed this. One relative told us "Some staff talk to my relative and put their arms around them, but some of the others just ignore them". Another relative told us "It would be nice if when my relative holds out a hand that they could just acknowledge them or smile". People and relatives felt that some staff, who used English as their second language, were less communicative and engaging with people and our observations confirmed this. Whilst staff offered some explanations to people there was a lack of conversational and language skills and as a result some staff only communicated using key words. One relative told us "My relative doesn't always feel that they take them into consideration and part of the problem is that their [staff] English isn't all that good". Although people's privacy and dignity had significantly improved, these incidences did not create an environment that respected people's dignity or privacy. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff communicated with people using their preferred name and adapted their approach to meet people's needs and preferences. The Alzheimer's Society advises that time should be taken to listen to people's feelings and that patience and understanding should be shown when supporting people who are experiencing signs of distress or anxiety. Observations of some staff confirmed that they were mindful of this and showed that positive relationships had developed with people. Care records for one person, contained information advising staff of the measures they could take to support the person if they showed signs of distress or apparent anxiety. It advised staff that the person liked staff to talk calmly to them and offer support. Observations showed the person, when they were displaying signs of slight anxiety was supported by staff. A member of staff sat with the person and communicated with them, the person appeared to calm down and was seen to be more settled after this interaction. Another member of staff was observed taking time to speak to each person, asking them how they were and what their weekend had been like. One person, who was sitting in the lounge, advised staff that they were cold. One member of staff responded to the person and advised them that they would get them a blanket once they had finished assisting another person in their chair. The member of staff then placed a blanket around the person's shoulders and across their knees and asked if they felt better. The person confirmed that they did and the member of staff and the person then engaged in conversation. The person appeared to enjoy this interaction and was observed smiling and laughing with the member of staff. Another person gave a member of staff a hug. The member of staff was overheard saying "That's a lovely cuddle, thank you". The member of staff then straightened the

person's jumper, which they appeared pleased about and they smiled and hugged the member of staff again.

People were supported equally and their differences were respected. People were able to choose where they spent their time, some preferring to spend time in the communal lounge, whereas others chose to spend time in their own rooms or walking throughout the home. People's rooms were personalised with their belongings, photographs and ornaments and they were supported to maintain their sense of identity. People were supported to maintain their personal hygiene and appearance. Observations showed people were regularly supported to access toilet facilities and to have their personal hygiene maintained. People appeared well cared for and were able to dress in such a way that respected their individual style and identity. On the day of the inspection people were able to have their hair styled by the visiting hairdresser which they appeared to enjoy.

People were encouraged to maintain relationships with one another as well as family and friends. Observations showed visitors and relatives spending time with people. One person received a telephone call from their relative. Staff were observed asking the person if they'd like to take the call in their room so that they could talk in private. Relatives told us that they were made to feel welcome, that they could visit any time and that communication between the provider and themselves was good. One relative told us "You're always made to feel welcome and I always get tea and cake".

People were supported to be independent, they told us that they were able to spend time where they liked in the home. Observations showed people independently walking around the home and expressing their views to ensure they were involved in making decisions about how they spent their time and how they were supported. Staff explained that they encouraged people to be as independent as possible. One member of staff told us "We encourage people to brush their own hair and wash themselves, if they can". The provider recognised that people may require additional support to be involved in their care and explained that if people required the assistance of an advocate then this would be arranged. (An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.)

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Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 6 and 8 January 2016, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to a lack of person-centred care. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to this area of concern. Improvements had been made and the provider was now meeting the legal requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection people did not receive the care and treatment to meet their assessed needs or reflect their preferences or wishes. This was because there was a lack of personalised care and people were at risk of social isolation. During this inspection people's needs had been assessed and regularly reviewed. Observations and records confirmed that care plans had been implemented. People had access to a varied range of activities and most were complimentary about the improvement this had made to their lives. One person told us "We have a programme so every day we have something different going on". Another person told us "I like to get involved in whatever is going on". A third person told us "I like all the musical things they do".

There was mixed feedback regarding the choice people had within their lives and our observations confirmed this. Observations showed people being asked where they would like to spend their time. For example, a member of staff was overheard saying "Are you happy sitting here? Would you like to go to the lounge or to your room"? And "What would you like to drink"? Other observations showed one person refused to take their medicine. The person had capacity to make this choice and their right was respected. People told us that they were given choice in regards to what time they went to bed, what time they got up in the morning, if they preferred male or female carers or if they preferred a bath or shower. One person told us "I have a bath once a week and that's fine for me but I can have one when I want really". Staff told us that they promoted choice whenever possible. One member of staff told us "We give choices to people about what they want to wear. I hold up a couple of outfits and they point or let me know which one". However, observations showed that people were not consistently offered choice. One member of staff was handing out pieces of fruit alongside people's sandwiches, however there was no interaction or communication with people to determine what type of fruit people wanted. One person was overheard saying "I'd have preferred two pieces of apple instead of the orange, I find them too chewy".

Two people were sitting at the dining table and were asked by the provider if they would like a cup of tea or coffee. They chose coffee and before the provider had organised this another member of staff handed out hot drinks from a trolley. The member of staff placed two cups of tea in front of the people and when they were informed that the people had previously chosen to have coffee the member of staff commented that they usually had tea. The provider had taken measures to ensure that the atmosphere within the home and the environment was more homely. They had installed a music system that played music throughout each of the corridors and in the communal areas. This did create more of a homely atmosphere, however the music was playing constantly and was sometimes quite loud, it didn't appear that there was anywhere where people could go should they prefer a quieter area. One person told us "Sometimes it is a bit

overpowering". Another person told us "I haven't spoken to them yet but sometimes with the background noise and the TV you can't hear yourself think". Although people appeared to be provided with some choice, there was a lack of consistency in staff's approach. This was fedback to the provider.

At the previous inspection the provider was in the process of introducing a new care plan system. During this inspection these care plans had been implemented. People's health, cognitive and physical needs had been assessed and care plans had been devised, these were comprehensive and clearly documented the person's needs and abilities. Staff told us that they found the care plans useful and that they helped them to understand people's needs. Records showed that some relatives had been involved in the development of people's care plans. When relatives had been involved in the development of the care plan it contained more information detailing the person's preferences and life history. Relatives and staff confirmed that some relatives had been involved in the review of care plans, however these had not been recorded and therefore didn't recognise the good practice carried out by staff in regards to involving relatives in the review process. Most care plans had been reviewed monthly by nursing staff to ensure that they reflected the person's current needs. Changes to the care plan had been made if a person's needs had changed. For example, care plan records for one person showed that their weight had increased. As a result their care plan and support was changed and they were weighed once per month instead of each week.

Care plans contained person-centred information. (Person-centred means putting the person at the centre of the planning for their lives.) People's preferences were recorded in relation to what time they liked to get up in the morning and go to bed, as well as their preferences in relation to food was recorded. Staff told us that they knew people's needs. One member of staff told us "I know the residents well, for example there is one person who after any meal always wants to go for a lie down. We make sure their bed is ready for them at the end of the meal. We read the care plans, they explain about the person and their likes and dislikes and all the information about them". However, apart from when relatives had been involved in the development of people's care plans, care plans did not always contain personalised information in relation to people's social needs, their interests or hobbies. As this type of information was not always captured it did not inform the activities that people took part in and as a result the activities that were offered to people did not always meet their interests. Some people confirmed this. One person explained about their love of music and knitting. They told us "I'd like one of those little key board things to practice on or knitting, I mentioned it a while ago and I could manage with those big knitting needles". Another person told us "I'm not interested in all that stuff they do, flower arranging and basket making". Whilst a third person told us "I'm one of the younger ones in here so what they do I'm not keen on".

However, people's social stimulation had improved. An activities coordinator had been recruited and people had access to more activities and stimulation throughout the day. Records showed that some people had been supported to have one to one time, go outside for walks, have hand massages, quizzes, live music, PAT dogs (Pets as Therapy), watch films and reminiscence. One member of staff told us "I take some people out, even if it's only around the block. We will go and get the newspapers together and visit the shops". One member of staff told us about a recent reminiscence activity that had taken place, people were shown flash cards with photographs of certain foods on them as well as a sensory activity to smell and taste different foods. They told us "We reminisce and I have flash cards with foods on. It jogs people's memory about how things taste and helps their reading skills. We all decided to get fish and chips one afternoon after this game". The member of staff went on to explain "Some people have hobbies that we do together, like knitting and playing cards and we did some planting the other day, I am organising and event for Armed Forces day on 25 June 2016. We will have a street party and have a Frank Sinatra and Dame Vera singer. I'm involving one of the people in organising this, as it was their idea".

Observations showed people enjoying various activities, these included having manicures, playing board

games and watching films. There were some positive and heart-warming interactions when people were engaged in activities. One person told a member of staff that they wanted to watch a cowboy film. Several members of staff responded to this and looked for a film. They explained to the person that there wasn't a cowboy film on the television that day but offered an alternative. This then sparked a conversation with another person who informed staff that they had a cowboy film in their room. Staff supported the person to their room where they collected the film and people then enjoyed watching the film together. Some staff demonstrated positive and warm interactions with people. People appeared to really enjoy the interaction with some staff and positive relationships had clearly been developed.

A provider entertained people by playing the keyboard and singing songs. People appeared to really enjoy this and were seen singing, dancing and joining in with percussion instruments. One member of staff sat beside a person and was overheard saying "Guess what, I've brought a drum in for you today, so we can join in with the music". The person smiled and nodded and looked happy. Later, whilst the music was playing, we observed the person playing the drum. We were told by the provider that this person used to play the guitar and enjoyed playing with instruments along with the music. Some people became emotional when hearing and singing some of the songs, staff offered reassurance. One member of staff was observed spending time with one person, talking with them about their feelings, offering a tissue and holding their hand. The member of staff was overheard saying "Look you're just as bad as me, we're both crying. Here's a tissue". The person responded well to this and smiled.

At the previous inspection people who spent time in their rooms, were at risk of social isolation. During this inspection, although two people still spent time in their room by choice, positive improvements had been made. At the previous inspection, some people spent the entire day in their rooms, there was little interaction between people and staff. Observations showed that apart from providing the person with their lunch and drinks there was no interaction between staff and the person. During this inspection, although two people continued to spend time in their rooms, positive improvements had been made. One member of staff told us "I go round to everybody and greet them each day. I ask them what they would like to do. I visit people who stay in their rooms. I read poetry to one person and will read to another. This person lifts themselves up in their chair and I said to them 'Did you used to be a gymnast'? And they replied 'I did gymnastics' I haven't got anything else from them about it though. I try to persuade people to come out of their room, but if they want to stay there that's fine". Observations showed one person, who had previous spent their days in their room with no stimulation or interaction, spending time in the lounge area, listening to music and engaging with staff. Observations showed another person, who continued to spend time in their room, being supported according to their assessed needs. Care plan records for the person stated that they could sometimes feel lonely and would like staff to take time to talk to them. It explained that the person liked one to one time with staff and, due to a visual impairment, liked to be read to. It also stated that the person used to be in the Women's Royal Naval Service (Wrens). Observations showed one member of staff spending time with the person, they sat alongside the person and read a magazine to them, this then led to conversations with the person about their earlier life and the person enjoyed talking about where they had lived and their time in the Wrens. Records confirmed that the person had received regular interaction and engagement with staff.

The provider had a complaints policy, there had been no complaints about the new provider, however, they had investigated an on-going complaint that related to the previous provider. This had been dealt with according to the provider's policy. Records showed that people and relatives were encouraged to make their thoughts and feelings known, they had been invited to attend care plan reviews and resident and relative meetings. People told us that they were able to make their thoughts known during meetings. One person told us "We have a meeting to chat, they might say it's going to be on Wednesday afternoon perhaps". People confirmed that they knew how to make a complaint. One person told us "I'd tell her over there

(pointing to the provider) she's like the teacher here and makes sure you're alright".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 6 and 8 January 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to a lack of good governance. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to this area of concern. Improvements had been made and the provider was now meeting the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection there was a concern regarding the lack of oversight and governance. Staff were not supervised or provided with guidance about their roles, there was a lack of quality assurance processes to monitor the provision of care and identify trends and areas for improvement, and as a result people received care that was inadequate. During this inspection it was apparent that the providers had made significant efforts to improve the standard of care. The home had been without a registered manager for seven months. The providers had been responsible for the day to day management of the home and people's care. A new manager had been in post for one month and was undertaking the process of registration. The management team had a visible presence in the home and it was apparent that they knew people's needs and preferences well. Observations showed them interacting and communicating with people. They provided positive role models for staff. The providers had implemented a new system to ensure that experienced staff were empowered and motivated within their roles. They had implemented team leader roles to enable people to develop and to provide leadership and supervision to other members of care staff. Rigorous quality assurance processes had also been implemented to monitor the standard of care and to identify trends and potential areas for development.

People, relatives and staff were complimentary about the leadership and management and recognised the changes that had been made for the better. One person, when asked how the home had changed, told us "Things have definitely changed for the better". Another person told us "It's a big improvement on the previous administration, much better now". A third person told us "I like it here, I like the staff and the boss". Relatives confirmed this and told us "They've got strong leadership now and I feel there's reliability and safety which is consistent". Another relative told us "You never feel like there's a crisis, it always seems in hand".

Staff were equally as positive and told us "I like working here. The care is much better now. If I didn't like it, I wouldn't work here". Another member of staff told us "Good changes here, they have made things better". Observations further confirmed people's positive feedback. There was a friendly, calm and homely atmosphere within the home. People looked comfortable, content and well cared for. Staff confirmed that the atmosphere in the home had improved. One member of staff told us "The atmosphere has changed. Before, everybody had a long face, not now though, everybody is happy and it's calmer". Another member of staff told us "You have to want to do this work and the managers are good at understanding. They listen to us. We talk to them and they talk to us". A healthcare professional was also complimentary about the leadership and management, they told us "During my involvement with Ashdown, I witnessed strong leadership and management from the providers. There was openness and transparency and I found that

there was clear partnership working and collaboration". In addition to the healthcare professional's comments in relation to the provider being open and transparent. The provider had further demonstrated their awareness of the implementation of the Duty of Candour CQC regulation and records showed that they had informed people's relatives if people's health needs or condition had changed. (The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'.)

The providers ensured that links with the local community were maintained. There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local GP practice and local authority. The provider had plans to arrange for the hospital avoidance team to provide additional training for staff. One member of staff told us that the provider was arranging for them to join a forum where they could meet other people with similar job roles to enable them to share ideas and best practice.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

There were rigorous quality assurance processes in place as well as regular audits to enable the manager to have oversight of the processes in place to identify what was working well, or if there were any trends or areas of improvement required. These included the implementation of audits to monitor people's weights, medicines, care plans, wound care and accidents and incidents. The provider conducted a monthly management report to enable them to monitor the general performance of the home. It included monitoring the frequency of resident, relative and staff meetings, ensuring that audits had been completed, occupancy levels, compliments and complaints, falls, hospital referrals, infections, safeguarding investigations and staffing. Quality assurance surveys were sent to people and their relatives to gain their feedback, a majority of which provided positive feedback, these were analysed by the provider and used to drive change.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not ensured that service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.