

Athena Care Homes (Bretton) Limited

Ashlynn Grange

Inspection report

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Date of inspection visit:

17 May 2018

24 May 2018

Date of publication:

06 July 2018

Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection of Ashlynn Grange took place on 17 and 24 May 2018 and was unannounced.

Ashlynn Grange provides, accommodation, nursing and personal care for up to 156 adults; some of whom have dementia. It is also registered to provide the regulated activity; treatment, disease, disorder and injury. At the time of this inspection there were 78 people living in four areas of the service (called communities), each of which have separate adapted facilities. The communities of Yeoman and Woolsack were housed together in one unit and the communities of Harvester and Hayward were housed in two separate units.

At the last inspection in 10 and 16 August 2017, the service was rated 'Requires Improvement'. At this inspection, we found the service had made the necessary improvements under the questions is the service caring, and responsive; and was now rated as 'Good'. Improvements were still needed for the question of, is the service safe?

Ashlynn Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post at the time of this inspection. During this inspection the general manager had applied with the CQC to become the registered manager and were awaiting their fit and proper person interview. 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.

People were supported by staff who were knowledgeable about safeguarding and its reporting processes. Risk assessments were in place as guidance for staff to support and monitor people's assessed risks. Technology was used to assist the majority of people to receive safe, care and support.

People's confidential records were not always held securely. This put people's personal information at risk.

Systems were in place to promote and maintain good infection prevention and control. Staff had been recruited safely prior to working at the service. A sufficient number of staff were deployed in a way which met people's needs in a timely manner in two out of the four communities (units). We have made recommendations about the provider making sure that the right skills mix of staff are available on shift to support people safely.

Actions were taken to learn any lessons when things did not always go as planned. However, records documenting the incident and any actions taken were not always in situ.

Medicines were administered as prescribed and they were managed safely. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received an effective service that met their assessed needs by staff who had been trained to have the skills they required. People were supported with their eating and drinking to promote their well-being. We have recommended that the provider looks at current guidance to make sure that people with short term memory loss are supported with both visual and verbal prompts to enable them to make food and drink choices.

Staff supported people to access healthcare services when this was required. The manager and staff team worked with other organisations to help ensure that people's care was coordinated and person centred.

People received a caring service as their needs were met in a kind, and considerate way. People's privacy was promoted and maintained by staff and the majority of people's dignity was supported by staff assisting them. People were involved in their care and staff promoted people's independence as far as practicable. Staff knew the people they cared for well.

Activities were in place to support people's interests and well-being. However, there was a lack of organised trips outside of the service for people to enjoy. This limited people's ability to live a meaningful a life as possible. Compliments were received about the service and complaints investigated, responded to and resolved where possible to the complainants' satisfaction. Staff worked well with other external health professionals to make sure that peoples end-of-life care was well managed and this helped ensure people could have a dignified death.

People received that was well-led as the manager led by example and encouraged an open and honest culture within their staff team. Quality assurance, audit and governance systems were in place to drive forward any improvements required. The manager and their staff team worked together with other organisations to ensure people's well-being.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People's confidential records were not always held securely.

There were not always enough staff to fully meet people's needs in a timely manner in two of the communities.

Risks to people were assessed and managed by staff. The majority of accidents and incidents were recorded and appropriate action taken.

People were supported to take their medicines as prescribed and safely.

Staff understood their roles and responsibilities in safeguarding people.

Requires Improvement 

Is the service effective?

The service was effective.

Mental capacity assessments and best interests' decisions had been made for people in line with the legal requirements. This ensured that people did not have illegal restrictions put on them.

Staff were trained and supported to ensure they followed best practice.

People had choice over their meals and were being provided with a specialist diet if required.

People were supported to access the healthcare services they needed.

Good 

Is the service caring?

The service was caring.

People were supported by caring and respectful staff who knew

Good 

each person and their individual needs.

People and their relatives were involved in planning their care and support and staff showed people that they mattered. Visitors were welcomed.

Staff respected people's privacy and encouraged people to be as independent as possible.

Is the service responsive?

Good ●

The service was responsive.

Individual care records were in place for each person as was up-to-date guidance for staff to meet their care and support needs.

Activities were arranged and people benefitted from these by having regular social stimulation.

A complaints procedure was in place and complaints and concerns were investigated and resolved to the complainants' satisfaction where possible.

End-of-life care was planned and provided when required.

Is the service well-led?

Good ●

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Staff were aware of their roles and responsibilities in providing people with the care that they needed.

Quality assurance systems were in place which reviewed the quality and safety of people's care.

Ashlynn Grange

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 17 and 24 May 2018 and was unannounced. The inspection was undertaken by three inspectors, an assistant inspector, a specialist advisor and an expert-by-experience. The specialist advisor was assigned from the CQC medicines team due to concerns received since the last inspection about the safe management of people's medicines. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and people living with dementia.

The inspection was bought forward due to concerns received by the CQC about the service, as such the provider had not been requested 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. We reviewed other information we held about the service to aid with our inspection planning. This included past inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We also contacted other health and social care organisations such as representatives from the local authority commissioning department; quality improvement team and the local safeguarding authority. We also received feedback from the clinical commissioning team and continuing health care team. This was to ask their views about the service provided at Ashlynn Grange. Their views helped us in the planning of our inspection and the judgements we made.

We spoke with nine people living at the service who could give us their views verbally of the care and support they received. We also spoke with six visiting relatives/friends; a GP; a community sister and an assistant practitioner. We also observed staff interaction throughout the 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 spoke with the nominated individual (this is the person who has overall responsibility for supervising the management of the regulated activity and ensuring the quality of the service provided); clinical governance director and general manager. We also spoke with the clinical lead; two-unit (community) managers; three nurses (one a senior nurse); the head chef; two team leaders; seven care assistants; an activities co-ordinator; three house-keepers; a gardener and a laundry assistant.

We looked at care documentation for nine people living at Ashlynn Grange, medicines records, two staff files, staff supervision and training planning records. We also looked at other records relating to the management of the service including audits and action plans; accident and incident records; surveys; recruitment and supervision policies; meeting minutes and complaint and compliment records.

Is the service safe?

Our findings

Improvements had been made since the last inspection on August 2017, we found that there were occasions when accurate records were not held that documented people's safe medication management. We also found that records to monitor people's assessed risks were inaccurate or not a complete record for example; gaps in recording the staff support given. However, although improvements had been made, during this inspection we found there was still some work to improve the service provided under the question, is the service safe?

People's care records and risk assessments were computerised records that were password protected and held securely. Within the Hayward and Harvester community, peoples' paper based monitoring records and information were stored securely within people's rooms. However, on both inspection days we found that on the Yeoman and Woolsack communities, some of these paper records were stored in the communal corridor. This meant that there was an increased risk that personalised information could be looked at by others.

A fire safety officer had visited the service in April 2017; they found that the service was broadly compliant with some minor deficiencies relating to the fire doors. People also had emergency evacuation risk assessments in place to assist them to evacuate safely in the event of an emergency such as a fire. A staff member confirmed to us that, "We have had basic fire training, the fire doors are checked regularly." Training records showed that the majority of staff had completed training in fire safety, however, some staff said that, even with the training they would not be confident to know what to do in the event of a fire. We fed this back to the manager and clinical governance director during the inspection.

During this inspection we found that staffing levels were inconsistent across the service. The manager used a dependency tool to establish staffing levels based on people's care and support needs. People and their relatives spoken with had positive opinions over the number of staff available and whether they met their, their family member's needs. A person said, "If I haven't been spoken to for a while [staff] come to me and offer a drink and have a chat." Observations during this inspection on the Harvester and Hayward communities showed that there was enough staff to meet people's needs and care call bells were answered promptly. However, on the Yeoman and Woolsack communities during this inspection, we found, and visiting health professionals told us that they sometimes had to wait for assistance from staff, to let them into the building, as staff were busy supporting people using the service. A person told us, "The call bell [response from staff] is normally good if they are not busy." However, a visiting health professional said about Yeoman community, "Sometimes there is not enough staff but it is getting better."

The registered manager did not always ensure that staff had the right mix of skills to make sure that practice is safe. A staff member told us, "A new staff member was added to the numbers when they hadn't done any shadowing [shadowing a more experienced staff member until competent and confident]. [Named staff member] gave them a full 12-hour shift as the fourth care [staff] on 15 May 2018." Rotas we looked for this date corroborated this concern. We fed back this information about staffing levels on Yeoman and Woolsack communities to the manager and the clinical governance director who said that they would consider these

concerns.

We recommend that the provider seeks advice and guidance to ensure that the right skills mix of staff are available to support people using the service safely.

Records showed that the majority of incident or accidents that occurred, were recorded in with outcomes documented in people's care plan to reflect any changes that were made or needed. To make sure all staff were aware of these changes, these were discussed at staff meetings and at a daily handover and then people's care records were updated. These meetings helped to inform all staff of any learning from the incident/accidents and to reduce the potential for any further risk in the future. The clinical lead said, "We are looking at learning lessons and having better outcome next time. For example, not being complacent for ambulance wait times. Taking action and being transparent [with our findings]." However, during our random check of people's care records on Yeoman community we were made aware that there was no incident form completed for a person who had recently experienced an injury following a fall. This meant that there was an increased risk that the documentation of incidents and accidents were not always completed in a timely manner as guidance for staff.

People and visitors of people who used the service confirmed to us that they, their family member/friend, felt safe living at the service. This, they told us, was because of the care and assistance provided by the members of staff. One person said, "Yes, I'm safe. [Staff] are first class, champion." Another person told us they felt safe because, "I'm checked on [by staff] regularly."

The service had effective safeguarding systems, policies and procedures that were fully embedded and understood by staff. Staff had completed training on how to safeguard people from harm and poor care. They demonstrated a good understanding of their responsibilities. Staff explained to us that they would report poor care and suspicions of harm both internally to management and to external agencies such as the local authority, police and CQC. Staff were also aware of how to whistle-blow. This is a process where staff are provided a safe arena to report any poor standards of care they may witness. Information about how to report concerns was available for people, their visitors and staff, to refer to if needed. A relative confirmed to us that they felt their family member was, "Safe and looked after very well." A person confirmed to us that, "I never hear any shouting, [staff] are so patient."

Technology was used to assist people to receive safe, care and support. We saw that there were care call bells and sensor mats in place for people to summon or alert staff when needed. A sensor mat is alarmed and alerts staff of movement; they are used where people are at risk of falls. One person said, "I have one of these great big wheelchairs. Electronic, you can do all sorts of moves. It is so comfortable."

Information within people's risk assessments had improved since our last inspection. They gave clear and detailed guidance for staff to follow to reduce risk to people's health and welfare and deliver safe care. Staff reviewed risk assessments following any deterioration in people's needs and to find any new risks. Monitoring records had also improved to show staff carried out required care to minimise risk and support people's health and wellbeing, for example repositioning to relieve pressure and prevent skin breakdown.

The majority of people and their relatives spoken were unable to tell us whether they were aware of their, their family members risk assessments. However, we were told that communication was good and one relative said that they were, "Confident with the care," their family member received.

Recruitment systems were robust and made sure that the right staff were recruited to the role. Required checks were carried out on new staff members by the manager to confirm that they were appropriate to work with people and of good character. Staff told us that these checks were in place before they could start

work unsupervised at the service. One staff member said, "[My] previous job references were in place before [the manager] allowed me to start my training."

Since our last inspection the provider had made improvements to the medicine management systems. Accurate records of people's medicine management were now held. People and their relatives were satisfied with how medicines were managed by staff. One person told us, "Staff always stay while I take my tablets." A relative said, "[Family member] is looked after. They have a specific health condition and sometimes need the nebuliser urgently. They have permission to use the emergency bell instead of the normal bell so staff know that [family member] needs help quickly." Staff administering medication had received appropriate training to do so and their competency had been reviewed by senior staff. People were told what their medication was for by staff and were asked if they wanted any pain relief medication. This was done by staff in a patient manner.

Medication was stored securely, maintained at the correct temperature and disposed of safely. Medication administration records (MARs) showed that medication was administered as prescribed. Any medication errors were reported and escalated and the family of the person involved and their GP were also made aware. Shared learning took place regarding any errors or near misses to reduce the risk of recurrence.

The service managed the control and prevention of infection well. The service was clean with no lingering malodours. One person said, "I've settled in nicely. I get checked regularly. Everything is kept nice and clean, my room, my clothes are always folded nicely." We saw that soap, hot water and hand gel were available for staff, people and their visitors to use to clean their hands. Staff were knowledgeable about their role in preventing the spread of infection. A member of staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use and that this equipment was for single use only. They talked us through how they cleaned different areas of the building using different cloths, and different colour mops and buckets to control and prevent the spread of infection.

Is the service effective?

Our findings

People's assessed needs continued to be met by staff who were trained and had been given the skills to support people to be as independent as practicable. Guidance from various social and healthcare organisations were used to support staff to provide people with care based upon current practice. For example, the implementation of RESPECT guidance. This guidance is a recommended summary plan for staff around the emergency care and treatment to support people at the end of their life.

Staff were supported with supervisions and appraisals to support them in their day-to-day role and to help identify and discuss any learning requirements. They were also supported to maintain their current skills with regular training on mandatory core subject areas relevant to their role. This included training during staffs' induction, to help them understand how to support people living with dementia. The clinical governance director told us that staff were now confident to request to the management team training they would like to undertake. Some staff had asked to develop their skills and knowledge further by undertaking more specialist training including that for, diabetes and safe moving and handling practices for people with a fracture. The clinical lead told us that this area for improvement had already been identified by the service and action taken. They said, "We are looking at doing training [for staff] regarding diabetes. There is a basic knowledge [documented guidance in place for staff] but [currently] no training." The manager and clinical governance director talked us through the introduction of CHAP's (Care Home Advanced Practitioner) training. This they told us would train senior staff to develop their clinical and management skills and help support staff to meet people's care and health needs.

People had a choice of freshly sourced and prepared food and drinks. High calorie and fortified foods were given to people identified at risk of malnutrition, these foods provided additional nourishment to people and helped to promote or maintain weight. Mealtimes were a positive experience which people clearly enjoyed. This was evidenced by positive comments from people including one person who told us, "The food is good. I can have it in my room or in the lounge. It's always hot and nice." Another person said, "I only eat beef, fish or jacket potatoes. Even if these aren't the choices staff will always willingly do me a jacket spud or salmon fillet." A relative told us, "The food is fantastic. Scrambled eggs are great. Staff will always do an alternative if [family member] does not like the days choices."

Our observations showed that people were assisted or encouraged to eat and drink independently. Support from staff was carried out in a patient and unhurried manner. One relative said, "[Family member] needs help eating and it's always done well." However, in the Hayward and Harvester communities there were some missed opportunities by some staff to support people with short term memory loss, by presenting them with the choices of menu in a visual format (plated up).

We recommend that the provider seeks advice and guidance from a reputable source, about ensuring that people with short term memory loss are given appropriate prompts to help them with their decision making.

Staff enabled and continued to support people to access external healthcare services such as a GP, dentist or optician. The manager and staff team worked with external organisations such as speech and language therapist teams, community nurses and health practitioners. This was to promote people's well-being. A

relative told us, "[Family member] has had a pressure sore since [their] last time in hospital. The staff keep a close check on it. If I spot any problems I raise it with the nurse and it's always sorted very quickly." Another relative said, "[Staff] keep us updated if a GP is needed." Healthcare professionals we spoke with had varied experiences about how staff worked and communicated with them. Some feedback was very positive but others felt communication, engagement and attention to detail needed improvement with some staff to improve working relationship and outcomes for people.

Adaptations to the building such as hand rails and wheelchair access enabled people to mobilise more easily and access the gardens and other areas independently.

Memory boxes and signage were used in the communities supporting people with dementia to provide an enabling environment. The other communities used signage to again help people with sensory needs with their orientation and recognition. The decoration in Yeoman and Harvester communities was looking tired and carpet in the communal areas was marked. This had already been identified by the and actions were to be taken to make the necessary improvement.

The 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The service was continuing to work within the principles of the MCA. Principles of DoLS had been considered for people living in the service and applications to relevant authority were made where required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. For example, we saw that people had free access to all areas of the service and choices of when they would like to get up.

Is the service caring?

Our findings

Improvements had been made since the last inspection on August 2017, where we found that improvement was needed to ensure people's privacy and dignity was maintained. During this inspection we found that the provider had made improvements.

Prior to this inspection the CQC received concerns about how people were supported by staff. During this inspection we found that people's care and support needs were met by staff who understood their role and responsibilities. People and their relatives spoken with were all complimentary about the care and support they, their family member received from staff. One person told us, "I can't praise them enough, so willing to help, nothing is too much trouble." Another person said, "The staff are nice." A relative told us, "It is excellent care, so kind and considerate. I'm 100% confident." A third person confirmed to us that staff were kind by, "Just seeing if I am alright. If I haven't been spoken to for a while they come to offer me a drink and have a chat...Staff are thoughtful. Always join me, bring me a cup of coffee if I am under the weather. They cheer me up with a chat and a drink." Observations showed that staff knew the people they supported well. For example, we saw how staff members dealt with people's increased anxiety that could result in behaviour that challenged themselves and others. Staff were patient and kind and took time to reassure people and offer distractions, such as activities that helped reduce the persons fears.

Observations showed that the majority of people's dignity was promoted and maintained by the staff supporting them. Staff knocked on the door of people's rooms before entering them and personal care was carried out behind closed doors to support people's privacy. We also saw that staff knelt or bent down beside people who were sat, so that they could communicate and engage with the person at eye level. Staff were also observed taking people's hands to reassure them and talked calmly to them about subjects that would distract their anxiety. People recognised staff, interacted with them and often rewarded them with a smile. One person said, "I'm checked regularly [by staff] and they give me a good wash every day." Another person told us, "Some staff are exceptional, they go out of their way to do a little kindness." A relative said, "The level of care is very good, this is the best place [family member] can be." However, although the majority of staff interactions with people were positive; we observed two separate incidents where staff, with their verbal responses, did not promote people's dignity fully. Although, fortunately these incidents were observed to not have a negative impact on people. We raised these concerns with the unit manager and clinical lead during the inspection, who told us that the staff members involved had been spoken with at the time and reminded of their responsibilities.

People and their relatives spoken with told us that they were encouraged to express their views and were involved in the decisions about their, their family members care. One relative told us, "I get proactive updates, I never have to go hunting for information about [family member]." Another relative confirmed to us, "I know about the care plan, I think it was reviewed last [named date]."

Meetings were held to engage people and their relatives with updates about the service provided. These meetings were also a forum where people could make any suggestions or raise any concerns they may have had. A relative said, "I know about the residents' meetings but I don't go. If I have any concerns or questions

then I go to [named unit manager]. I have complimented the staff to [them] several times for their general behaviour and the way they cope with difficult residents." However, another relative told us, "I do go to the meetings and I've seen notes being taken but I never get anything [minutes of the meeting] afterwards." A third relative said, "I know about the residents' meetings but I don't go and I never see any outcomes." This meant that there was a missed opportunity for the management to feedback to people and their relatives any items discussed or actions taken because of these meetings.

Advocacy was provided for people in the form of relatives with a lasting power of attorney to make decisions about their loved one's care needs such as with health and welfare. This was as well as the provider having policies and procedures and information available around advocacy services should people or relatives need this information and advice. Advocates are people who are independent and support people to make and communicate their views and wishes.

Our observations showed that although busy, staff supported people in an unrushed manner and at the persons preferred pace which they set. Staff explained to people what they were going to do before helping them. For example, when guiding a person to a seat or assisting a person with their meals. We saw that people could be independent such as with going out into the garden with staff support or mobilising around the service using walking aids. This was as well as support from staff to promote people's independence including with eating, drinking and daily activities. During our inspection, people's visitors were seen coming and going from the service. Relatives we spoke with told us that they were always welcomed by the staff at any time of the day.

Is the service responsive?

Our findings

Improvements had been made since the last inspection on August 2017 where we found that people were not always given an update of any actions taken because of their complaint or concern. People also told us and we observed that there were a lack of activities to stimulate people. During this inspection we found that people who raised concerns or complaints were responded to and that the number and quality of activities provided had improved.

The service had a complaints process in place that was easy and accessible for people to use. Information on how to raise a complaint was provided in the residents' guide booklet.

People and their relatives spoken with told us that they felt comfortable about raising a complaint or making a suggestion if they needed to. One person confirmed they had raised a complaint and this had been resolved to their satisfaction. A relative told us, "We're listened to and responded to. We're treated like a friend... [family member] likes fresh fruit every day. I spoke to the manager about this and now they make sure they have two different fruits every day." Another relative told us that they had in the past raised concerns about staffing levels in the Harvester community. They were concerned that the communal lounge was sometimes left unattended by staff. The manager had listened to these concerns and the relative confirmed to us that, "More was now done to ensure at least one [staff member] is always present."

Compliments had been received about the service provided since our last inspection. Compliments included, "You are an amazing team. Thank you so much for your patience, kindness and support with [named person]. We think you do a very challenging job – much needed." And, "Thank you so much for looking after [named person] so well for all the years [named person] have been under your care."

The service had received three complaints since January 2018. Records showed the complaints were handled effectively in line with the providers complaints policy and resolved in most cases to the complainants' satisfaction. They included a timely response, explanation of outcome, action taken to make the necessary improvement and an apology.

Improvements had been made since the last inspection about the number and variety of activities provided at the service for people to take part in should they wish. The majority of people and their relatives, had positive opinions about the activities provided. One relative told us, "[Family member] really enjoys flower arranging and making decorations. It really helps to keep [them] calm. [Family member] has always enjoyed opera. They had an opera singer in a short while ago and [they] really loved it." Although, a person told us that on occasion they found that they were bored.

During the first day of our inspection we saw a visiting hairdresser offering haircuts to people, a gardening activity taking place, with the bedding up of strawberry plants and strawberry tasting, the baking and decoration of cup-cakes and an exercise activity. We saw that these were attended by people from the different communities, including people living with dementia. We observed that the activities including the gardening activity and cake decoration engaged and stimulated people who chose to take part. This was

because these activities helped support people with interests they had prior to them moving into the service. One person who took part confirmed to us that they enjoyed these activities because, "I don't like games."

There was information in each of the communities that advertised a daily activity programme. People told us staff asked them if they wanted to take part in activities but could choose not to do so. People and relatives spoken with said that they would like to see more trips outside of the service organised. One person told us, "I enjoy music but don't like bingo or exercises. I've asked for trips out but nothing happens." A relative said, "They don't do trips out and I know a lot of the residents would like them to." We fed this back to the manager and clinical governance director, who told us they would look at making the necessary improvements.

People's needs were assessed prior to them moving into the service, this was to ensure the staff were able to meet people's care and support requirements. People and their families were involved in the development of care records. Care records contained life history information and provided information so that staff could get to know the people they supported and meet people's needs. Observations demonstrated to us that staff knew people well and that guidance for staff within people's records, for example, of what to do when a person became anxious was seen in practice during this inspection. Daily notes, were completed by staff who were providing people's care each day as a record of how people had spent their day. These records as well as the handover at the start of each shift, provided staff coming on duty with a satisfactory overview of any changes in people's needs and their general well-being.

Improvements had been made to the service because of learning, following an incident prior to the inspection, around a person end-of-life wishes not being followed. Where people had been prepared to discuss their future wishes in the event of deteriorating health, these wishes had been clearly identified in their care records within their end-of-life care plan. The information included how and where they wished to be cared for and any arrangements to be made following their death. We saw that Do Not Attempt Resuscitation (DNAR) forms were in place for people who had chosen not to be resuscitated. This helped to make sure staff knew about people's wishes in advance. Although not all staff had not received specific end-of-life training, unit managers told us that they worked with external health care professionals' guidance and advice when it became clear that people's health conditions had changed or deteriorated. A nurse told us, "I did grief bereavement counselling...I've just been speaking with a MacMillan nurse about anticipatory medication. (Medication a person may need to manage symptoms likely to occur in the last days of their life). I had to get correct confirmation of pain relief...We follow RESPECT guidance. (Recommended summary plan for emergency care and treatment). We have two care staff talking with the person making sure they are comfortable and dignified to the end." This enabled staff to support people to have the most comfortable, dignified, and pain-free a death as possible.

Is the service well-led?

Our findings

Prior to our inspection the service had been without a registered manager since 16 February 2018. At the time of our inspection there was a manager in place who was going through the process to become a registered manager. Shortly after this inspection the Commission approved their application.

The manager and staff demonstrated a good understanding and knowledge of people's care and support needs. Staff were clear about the expectation to provide good quality service that met and supported people's individual needs. One staff member told us, "You should treat everyone as an individual, value each other and the [named service]." Another staff member said, "Care to be given like you are at home." A third staff member told us, "I love the residents, I get team support, feels like a family, we work really well together."

The majority of staff spoken with told us that they felt supported by the management of the service. One staff member said, "The manager is the best home manager that we have had in a long time." Another staff member told us, "The manager is approachable, always pops their head around, has time for people, comes and chats and see how we are doing." A third staff member said, "The manager and unit manager are approachable." There was an opportunity for staff, who had been recognised as going above and beyond at work, to be rewarded for their efforts by being nominated for 'star performer' at the providers celebration awards ball. One staff member nominated for this award and then a national award told us how proud this had made them feel and that this had made them feel valued.

The organisation promoted equality and inclusion within its workforce. A staff member confirmed to us that they felt, "Supported immediately [with their equality and diversity needs]," by the management. They also told us the management put provisions in place to support staff who were 'fasting' (not eating or drinking during daylight hours).

People and their relatives spoken with were complimentary about the service provided, and how the service was run. A relative said, "The service has changed for the better since Athena took over...the general manager is very visible. They will talk at any time and acts on what is said."

Records showed that a 'resident and relatives' survey had been carried out since the last inspection to gain feedback on the quality of the service provided. The feedback was mainly positive with actions to improve the service, including a request for more live entertainment, actioned or on-going.

The management of the service made checks to monitor the quality and safety of the service provided. Recent changes to data protection meant that information and how it was shared and held was updated and reflected within the service. A staff member confirmed to us that, "Privacy protection is the new training [General Data Protection Regulation] GDPR on line." Governance of the service also included the monitoring of, accidents and incidents, complaints, the safe management of people's medicine, people's care records, meal-time experience audits, infection control audits, and health and safety. For any areas of improvement found, actions were taken to reduce the risk of recurrence. These improvements included work with the

computer software provider to improve the quality of information that could be held within people's computerised care records. For example, staff being able to remove a medication prescribed to a person from these records once the course (for example a short course of antibiotics) had been completed. These improvements meant that the persons care records would be a complete and accurate record for staff. This showed us that the service looked to continuously improve the quality of service provided.

Records the Care Quality Commission (CQC) held about the service and reviewed during the inspection, confirmed that the provider had sent notifications to the CQC as legally required. A notification is information about important events that the provider is required by law to notify us about such as safeguarding concerns, deaths at the service and serious incidents. In addition, the provider was correctly displaying their previous inspection rating conspicuously.

Staff at the service worked in partnership and shared information with other key organisations and agencies to provide joined up care to people who used the service. This included working with a variety of health and social care providers such as the JET team (Joint Emergency Team) to help prevent hospital admissions where possible.