Scofil Limited

Ashley Arnewood Manor

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Ashley Arnewood Manor on 8 and 14 December 2015 to check the provider had made improvements to meet the breaches of regulations we had identified during our previous inspection. This was an unannounced inspection and we found improvements had been made but there was still work to do.

We had inspected Ashley Arnewood Manor on 24, 25 and 31 March 2015. This was an unannounced inspection to check they had made improvements to comply with the breaches of regulations we had identified at our inspection on 26 June 2014. At the inspection in March 2015, the provider had not improved the safety and quality of care people received. The provider had appointed two people to jointly manage the service. They had given appropriate support and guidance to the new managers and as they had not attended the home regularly had not been able to assure themselves that people were safe and the home was being managed appropriately.

Following the inspection in March 2015, the provider kept us informed of actions they were taking, including appointing an interim manager whilst recruiting a new manager to oversee the improvement and development of the home.

At this inspection (December 2015) we found improvements had been made. However, there were areas that needed further improvement and some areas that remained in breach of regulation since our inspection in June 2015.

Ashley Arnewood Manor is a small home in New Milton and provides care and support for up to 20 older people, some of whom are living with dementia. Each person has their own room which is personalised with their own belongings and furnishings.

The home does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always sufficient numbers of staff deployed at all times. Staff recruitment procedures were robust and ensured only those considered suitable to work in social care settings were employed.

Staff received training, supervision and appraisal to support them in their role. New staff received an induction when they started work and received regular training to enable them to carry out their duties safely. However, the manager and some staff did not fully understand the Mental Capacity Act 2005 or when to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation.

Staff understood their responsibilities to report any concerns of possible abuse. People's medicines were managed safely although we identified some issues in relation to the administration of medicines. Infection

control procedures within the home had improved, although there was still work to be done.

People were treated with respect and compassion. Observations showed staff knew people very well and considered their emotional wellbeing, choices and wishes and promoted their independence. People's hobbies and interests were documented and staff encouraged people to take part in activities.

Care plans and risk assessments had been reviewed regularly. Although some care plans did not accurately reflect people's support needs. Referrals to health care professionals were made quickly when people felt unwell and advice was acted upon, although some on-going conditions required closer monitoring.

Surveys were in place to gain feedback from people and relatives, who told us they felt able to voice their opinions about the quality of care provided and any concerns they might have.

Systems were in place to monitor the quality of the service. Health and safety checks were completed to ensure the environment was maintained to a safe standard. Records relating to the management of the home, such as policies required updating and improving.

We found two breaches of the Health and Social Care Act 2008 Regulations (Regulated Activities) 2014. You can see the action we have asked the provide to take in the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were not always sufficient numbers of staff deployed at all times.

Medicines were stored and managed safely. People received their medicines appropriately.

People felt safe. The provider had systems in place to recognise and respond to allegations of abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Staff received training to ensure they had the skills and knowledge to meet people's individual needs. However, the manager and some staff did not fully understand the Mental Capacity Act and DoLS.

Staff understood their responsibility in obtaining consent before providing care and support.

People's dietary needs were assessed and taken into account when providing them with meals.

Is the service caring?

Good

The service was caring. Staff treated people with dignity and respect.

Care records contained personalised information about people's backgrounds, likes and dislikes and preferred daily routines.

Staff knew people well and understood their individual care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans did not always reflect people's individual support needs.

People were supported to manage their daily health care needs and access healthcare professionals when required, although

some on-going conditions required closer monitoring.

People said they would talk to staff if they had a concern and staff knew how to respond to any complaints that were raised.

Is the service well-led?

Requires Improvement

The service was not always well-led. The new manager lacked experience in dementia care but was taking steps to increase their knowledge. Records were not always accurate and up to date.

The staff regularly sought the views of relatives and people living at the home. Quality assurance monitoring systems had improved within the home.

People and relatives said there was a welcoming and approachable culture within the home.

Ashley Arnewood Manor

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.

We inspected Ashley Arnewood Manor on 8 and 14 December 2015 to check the provider had made improvements to meet the breaches of regulations we had identified during our previous inspection. This was an unannounced inspection and we found improvements had been made but there was still work to do.

Following the inspection in March 2015, the provider kept us informed of actions they were taking, including appointing an interim manager to oversee the improvement and development of the home whilst recruiting a new permanent manager.

At this inspection (December 2015) we found improvements had been made. However, there were areas that needed further improvement and some areas that remained in breach of regulation since our inspection in June 2015.

The inspection was conducted by an inspector, a specialist adviser with clinical expertise of caring for people living with dementia, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed 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 the information included in the PIR along with information we held about the service such as previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During our visit we spoke with five people, and a friend and a relative who were visiting. We observed interactions throughout the day between people and care staff. We spoke with six care staff and the new manager. We also spoke with a visiting care professional. We looked at seven people's care records and

pathway tracked four people using the service. This is when we follow a person's experience through the service and view their care records to gain an understanding of the actions staff have taken to ensure safe and effective care is provided. We looked at each person's medicines administration records (MAR), five staff recruitment and training files and other records relating to the management of the home such as health and safety records and quality assurance systems.

We last inspected the home on 31 March 2015 when we identified a number of concerns and seven breaches of regulations of the Health and Social Care Act 2008. The provider sent us an action plan telling us how they would make the improvements required, some of which would be an on-going programme of refurbishment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Ashley Arnewood Manor. One person told us they felt "Very safe because we're all looked after very well." Another person said, in relation to fire safety, "We've all got alarms on the ceiling" which would alert people in the event of a fire. People told us they had call bells in their bedrooms which were within reach if they needed to summon help. People we spoke with were happy with the way their medicines were managed. One person said "I have sleeping tablets. I'm always ready for them." Another person told us "I have lots of pills and tablets. If I ask what they're for they will tell me."

Improvements had been made to the management and administration of medicines since our last inspection. However, further improvement was required.

We checked a number of topical creams in people's bedrooms and found that all but one of these did not have dates written on them of when they were opened. There were often two identical creams in use at the same time. This meant there was a risk that creams would be used after their expiry date. The topical creams records in people's rooms were not always completed so staff could not be sure people had had their creams applied appropriately.

People received their medicines appropriately. The specialist adviser accompanied a senior carer as they undertook a medicines round. The medicines trolley was tidy and well organised and we saw a carer brought two jugs, one of water and one of orange squash to give people a (limited) choice about what to take their medicine with. They did not hurry people and knew each person by name. They also had knowledge about their preferences in terms of drinks and how people liked to take their medication. However, we did note that they did not specifically ask for people's consent when they gave people their medicines. The carer approached people in a friendly manner but in the place of seeking consent they said "here are your tablets" or "it is time for your tablets". They did assist people to take their medicines and waited until they had swallowed them and was thorough and systematic.

There were not always sufficient numbers of staff deployed. Four people commented on how busy the staff were. One person said "It needs a bit more of staff talking to you. They don't have time." Other comments included "They [staff] are under pressure, especially in the evening. They are tired" and "Staff are very tired in the evening" and "I need to walk more but I never get the chance." One person said they liked to eat in the dining room but staff could not always support with this because of pressure of time. Staff rotas confirmed there were some shifts when there were only 2 care staff on duty during the day. This was mainly due to sickness or holidays. We asked staff about this and they confirmed there were days when this happened. On the first day of our inspection, we observed part of the day when this was the case and the cook, who was also a carer, helped to support people with their care.

Rotas were unclear and did not always record if cover had been arranged as there were a number of shifts still to be allocated. For example, on 1 December 2015 there were only two staff on each shift and the shift requiring cover had not been allocated. On 7 December 2015 there were only two staff on a twelve hour shift from 8am to 8pm. There was an 8am to 8pm shift requiring cover but this had not been allocated. We spoke

to the new manager at lunchtime on 14 December 2015 about the waking night shift that had not been allocated on the rota and still needed covering that night. They told us they would cover it themselves which meant they would also be working the day shift beforehand.

The new manager told us they were in the process of recruiting more staff and this was on-going, although they did not have a process in place to assess staffing levels. They told us they would do this through observation and see if staff were being rushed. Following the previous inspection, staffing levels had been increased to three care staff in the afternoon, but the two supper assistant roles had been removed. Night staffing had been increased to provide two waking night care staff. The new manager currently worked from lunchtime on Mondays through to lunchtime on Thursdays and as they lived on site during that time, they regularly worked in the evenings. The two deputy managers provided management cover at all other times but were often on the rota as the second and third member of the care team.

Staff recruitment was robust and followed policies and procedures that ensured only those considered suitable to work in adult social care were employed. Application forms had been completed which recorded the applicant's full employment history. References had been obtained and a criminal records check completed for staff before they started work.

People were protected from the risk of abuse because staff had a good knowledge of how to recognise and respond to allegations or incidents of abuse. They understood the process for reporting concerns within the home and reporting them to outside agencies if needed. Staff said they would raise any concerns with the new manager, deputy managers or registered provider. They also said they would feel confident in raising concerns with other relevant agencies such as the CQC or local authority. Staff told us the home had a whistleblowing policy and they would use it if they had to. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

The process of updating systems to monitor and manage infection control had begun immediately after our previous inspection and this was on-going. Infection control audits were now completed regularly and actions taken. For example, some bathrooms had been updated and one had been replaced with a wet room. Other concerns had been addressed by the deputy managers following our previous inspection. For example, the old damaged commodes had been replaced with new ones and new toilet seats had been purchased. We found a few minor issues but overall the home was clean and the risk of the spread of infection was well controlled.

There were regular checks of health and safety arrangements within the home, such as on the fire detection system and emergency lighting to make sure it was in good working order. A new fire risk assessment had been carried out and actions taken. Each person had a personal emergency evacuation plan which guided staff in how to support them during an emergency, including any specialist equipment they would need. The home had an emergency contingency plan to ensure people could be safely cared for in the event the home could not function following, for example, a fire or flood. The plan included contact details of staff and other emergency contacts such as utilities companies, the police and the local authority.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the staff were well trained and gave them the care they needed. One person said "Everybody's looked after well." Another person told us "I'm pretty sure they do [know what they're doing]. They're skilled and attentive." A relative told us "The home is absolutely the best." People commented that on the whole they were happy with the food they were served. One person said "Everything I've had I've enjoyed." Other comments included "There is enough food" and "On the whole I like it" and "I don't like eggs. They remember that well." However, one person told us they only had one sausage with their lunch the previous day and would have liked more.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The home was not working within the principles of the MCA. The new manager and some staff did not fully understand the requirements of the Mental Capacity Act 2005 (MCA). MCA assessments had been completed for a range of decisions such as washing, showering and nutrition. However, assessments for capacity to make the decision to live at the home had not been completed for people, even though the new manager had applied for DoLS authorisations for everyone who lived at the home. They told us this was because the home had a keypad on the front door. DoLS can only apply to people who lack the capacity to make the specific decision in question and who are under constant supervision and having their freedom restricted. Some of the DoLS applications were inappropriate, as some people at the home had capacity to make the decision to live there. We spoke to the new manager and provider about our concerns and they told us they had sought advice from the local authority safeguarding team, who had told them to submit a DoLS application for everyone.

We followed this up and spoke with the local authority DoLS team who confirmed a DoLS application would only be appropriate for people who lacked capacity to make the specific decision to live at the home and met the other relevant criteria. We confirmed this with new manager who said they may have misunderstood the advice and would review the applications and would arrange further training in the MCA.

Four people had 'Do not resuscitate' forms that either they had signed when they had the capacity to do so or they had been signed by relatives who had Power of Attorney (POA) for finance but with no evidence of POA for health and welfare. We spoke with the new manager who said they would address this.

People told us staff asked for their consent before providing any care or support and we saw staff doing so

throughout our inspection. Consent forms had been completed and signed by people or relatives to confirm their consent to their care plan, to receive medication, to be weighed and to have their photo taken.

Most people were able to eat independently and mealtimes were relaxed and sociable. People sat at tables in the dining room and chatted to each other but said they could eat in their rooms or the lounge if they wanted to. We observed staff supporting people to eat their meals and they were patient and attentive to people throughout the experience. Staff spoke with people about the food and they explained what the food was and asked pertinent questions about how it tasted. Those we observed seemed to have good experiences of staff support at mealtimes.

Main meals were planned in advance and menus were written up on the notice board outside the dining room. People were asked in the morning what they would like for lunch from that day's menu, which was a choice of lamb chops, omelette or salad. Staff were knowledgeable about people's food likes, dislikes and allergies and these were recorded in the kitchen for staff to refer to. Water jugs were available in the lounge and drinks were served regularly throughout the day. Two people commented they would like more fresh fruit and the new manager said they would put a fruit bowl in the lounge for people to help themselves.

People's health care needs were met and monitored. They had access to a range of health professionals including GPs, psychiatrists, opticians, speech and language therapists, community nurses, chiropodists and dentists to make sure they received effective healthcare and treatment. People spoke of attending health appointments. They told us they saw a doctor when they were unwell or concerned about their health or well-being. People' needs were discussed and recorded during staff shift handover meetings. Staff told us there was very good communication among the staff team about each person's needs, so they were up to date with people's progress and knew how to provide people with the care and support they needed.

The manager provided us with a copy of the training matrix. Staff training was up to date and relevant to meet the needs of the people who lived in the home. For example, safeguarding adults, moving and handling and equality and diversity training. Training was mainly completed through workbooks that were sent away to the training company to be marked. The new manager told us staff would re-do the course if they did not reach the required mark. Staff confirmed they had completed a range of training courses in this way, although this method was not always thought to be the most effective. We spoke to the new manager about training methods, as people learn in different ways. They told us they would look in to this.

Staff received regular supervision meetings with the deputy managers or the new manager to discuss performance, training or other relevant issues. Records of staff supervision meetings confirmed this. Some staff had received an annual appraisal although the new manager told us that all annual appraisals would take place during February and March 2016 so that they would then all be due around the same time in future. Staff meetings had taken place in May 2015 and August 2015 and minutes showed that staff discussed a wide range of issues. For example, minutes from the May meeting confirmed the deputy managers had shared feedback from our previous inspection with staff and the action that needed to be taken.

Good

Is the service caring?

Our findings

People told us the staff were caring and treated them with respect. They said "[The staff] are very kind" and "I see the same [staff] and get to know them." Another person said "I'm happy with everything. They are all pretty patient." A relative told us "If I want something done for [my relative] it is done straight away and it is done cheerfully. Everyone is so friendly."

The home was informal, calm and relaxed. Staff interacted positively with people and we observed that staff clearly cared about them and how they were feeling. They were sensitive to people's emotional ups and downs and responded confidently and with reassurance and kindness. Staff were observant and noticed when people needed help. During lunch, a member of staff noticed the sun was in one person's eyes. They quickly moved to the window and closed the curtain to make it more comfortable for them. When supporting a person to sit down in a chair, staff talked to them throughout the process, offering encouragement, guidance and reassurance.

In the afternoon an external professional arrived at the home and gave people a hand massage and manicure. During this we observed they spoke with people in a warm and affectionate manner. People responded in a friendly way and there were lots of smiles and laughter.

Staff respected people's privacy and dignity. When people required personal care the staff spoke with them quietly and then supported them to their rooms. We saw one person had been incontinent which was quickly noticed by a member of staff. They spoke with them and then escorted them discretely to a shower room which meant the care they required was provided in a way that protected their privacy and dignity.

People's records contained information about what was important to them. People's preferences on how they wished to receive their daily care and support were written in their care plans and their likes, dislikes and preferences had also been recorded. Most staff had been at the home for a long time and knew people very well. They were able to tell us about people's life histories, current health conditions and how they wanted to receive their care. Terms of endearment were used regularly but people's chosen names were also used. "Sweetheart", "Honey" and "Darling" seemed to be the most commonly used but when staff used them they did so in a smiling and friendly manner. As a consequence it appeared to be affectionate and not belittling.

People's bedrooms were personalised and contained things that were important to them, such as family photos, pictures and ornaments. Each person's bedroom door had a photo of them and a picture that they could relate to that would help them to recognise their room. People told us they could spend time in their room if they wanted to or could sit in the communal areas and chat to people or watch television.

Friends and relatives were welcome to visit at any time and staff made sure people had privacy and space to entertain their guests. For example, some people chose to meet with friends and relatives in their rooms. Others were happy to chat in the communal rooms. There was a quiet room which was available for people to use if they wished.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed and staff responded to their concerns. One person said "I used to have an uncomfortable mattress. They got me a mattress which was higher at the bottom; for my legs." Another person told us "They look in [at night] to see if I'm alright." Some people told us they felt fully involved in their care. However one person said "They just come and tell me what my needs are." A relative told us "The staff work their socks off night and day" and went on to say "They [staff] keep me informed."

We looked at the records of people and found that compared to our previous inspection there had been improvements in the structure and content of people's care plans. These were, on the whole, more person centred, although we found a number of issues and there were still improvements to be made. For example, people did not have care plans to guide staff in when and how to administer 'as and when necessary' (PRN) medicines, such as medicines to take if they became constipated. Some people had been prescribed pain relief for their conditions. However, there were no pain assessments or pain care plans in their records which would have guided staff in how to support people to manage their pain.

One person's MAR showed they had been prescribed a medication primarily used to treat epilepsy in order to prevent seizures. There was brief guidance about what the staff should do in the event of a seizure which focused on the removal of harmful objects and calling the emergency services. However the person's care records did not contain a care plan to guide staff in how to support them with their epilepsy. There are clear protocols available on the internet created by Epilepsy UK and other specialist epilepsy organisations which provide evidence based guidelines for staff to follow. The new manager told us "They have not had a seizure for a very long time". The purpose of the epilepsy medication is to prevent seizures and the fact the person had not had a seizure for ten years may indicate that it had been successful in its purpose. However, this does not mean that the person may not have further seizures if other conditions apply, for example, an infection may be the trigger for a seizure even after a prolonged period.

Another person had sustained a number of falls. We looked at their records because we noted they had a large dressing on their right forehead. They had sustained six falls in a six month period and two of these had required attention via paramedics at the local hospital. The records did not contain a clear falls prevention plan or a protocol in the event that they had another fall. There had been no recent referral to the Falls Service which would have assessed the person for additional advice and support. We spoke to the new manager about this who told us they had identified the falls usually happened in their bedroom. They had moved the person to a smaller room and had arranged the furniture so they could use it to steady themselves and this seemed to be working as they had not had any recent falls. Whilst this seemed to have addressed the issue in their room, there was still a risk the person would be prone to falls elsewhere in the home.

When people had end of life care plans there were sections that had not been completed and those what were related to the person's funeral arrangements rather than the quality of their experiences during their final days and hours. This meant staff would not know what people's wishes were in relation to how they

would want to receive care at the end of their life.

Some improvements had been made to people's nutrition risk and need based care plans since our last inspection. However, further work was needed to ensure they provided clear guidance for staff. Three of the plans we looked at were either very similar or they were identical so there was a risk that these may not have met people's individual nutritional needs. For example, two people's risk and care plans were word for word the same as a third person's, with the exception of a reference to insulin. This person's risk was stated as "I would be at risk of a hyper or hypo if I was to continue to eat all the wrong food that contained lots of sugars." This use of language was not appropriate and the information did not give sufficient guidance to staff in how to support the person to manage their condition or how a hypoglycaemic attack could affect them.

On the first day of our inspection we observed a staff member guiding a person to put salt on their cooked lunch. They reminded them that they should not have too much salt due to their health condition. The staff member dealt with the issue sensitively and acknowledged the person's wish to have salt, and shook a little salt into the person's hand and they then sprinkled it on their meal. The person went along with this approach but had become quite agitated because they wanted the salt cellar to do this themselves. We spoke to the staff member who told us the person would empty the entire salt cellar on their food if they weren't supported with this. We later heard that a new member of staff had given the salt cellar to the person during another mealtime and they had "ruined" their meal with salt. We checked the person's nutrition care plan but found there was no reference to salt or why they should not have too much, and no guidance for staff in relation to the approach they should take if the person became agitated because of this during mealtimes.

This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We raised the above issues with the new manager who amended the person's nutition care plan and said they would make the other necessary amendments. Other care plans had been written clearly and in the first person and had corresponding risk assessments in place. For example, people's 'personal care' care plans had information about their current strengths, abilities, objectives and actions, risk and preventative measures.

Initial assessments had been carried out which included, for example, people's personal information, medical history, medication, dietary requirements and any mobility issues. This provided information for the new manager to make a decision about whether they could meet people's needs before they moved in to the home.

New daily reports had been implemented in which staff documented the care people received. These were up to date and included information on the person's well-being, diet, and professional interventions carried out that day.

The provider had improved the range of activities available to people and we observed that people engaged in these. On one day we observed people who had the dexterity and had good visual abilities in the lounge taking part in a throwing game. This was a large inflatable target set on the floor and people threw beanbags from their seats into it. The member of staff facilitating kept a running score and said who scored the most points at each round. They adjusted the distance for each person and those who had more limited movement were enthusiastically encouraged. Everyone enjoyed the activity and it created laughter and

discussion. The others were not excluded by the staff member because they continually asked for their views and discussed what was going on with them. This ensured as much engagement by as many people who were in the lounge as possible.

Most people told us they felt activities were good. One person said "We have quite a lot of entertainment." Other people told us "A man came yesterday and he was singing. He's always good" and "If I want to I can go to the entertainment" and "People come in. We have exercises and singing." A mulled wine evening had been arranged and people told us they were looking forward to it.

People and relatives told us they knew how to complain. People told us they would speak with the new manager or a member of staff if they had a concern but told us they had no complaints. Staff told us they knew how to report a complaint if they received one, although they had not received any. The complaints procedure informing people of how to make a compliant was pinned to the notice board outside of the office, although this was not very visible.

Requires Improvement

Is the service well-led?

Our findings

People told us the new manager was "Very nice" and "It's early days but I think she'll be alright." People said they felt able to talk to the new manager and said she "Helps out where needed." One person told us they were happy on the whole, saying "I'd like to say 100% but not quite. It's satisfactory." A visitor told us they would recommend the home telling us "My friend seems reasonably happy and their room looks very nice." A relative told us "If anything needs doing it is actioned straight away by the manager and staff."

There had been a number of improvements since our last inspection in March 2015. Prior to the new manager coming in to post, the two deputy managers had started to implement an action plan. An interim part time manager, who the provider had brought in from another of their homes, had supported them to continue the process of improvements alongside the provider, who had been more involved and visible at the home. We had received action plans and updates from them throughout this time informing us of the progress they were making. The action plan and service development plan which had been on-going since July 2015 was a work in progress. A range of audits and quality monitoring processes had been put in place and a programme of refurbishment was underway. The provider had arranged for a 'mock inspection' which had taken place two weeks before our inspection. This had highlighted areas for improvement in line with the Health and Social Care Act 2008 (HSCA) regulations.

The new manager had been in post since August 2015 and had continued to implement the action plan. This was their first management post in a home caring for people with dementia. During the inspection they made reference to similarities between dementia and brain injury, as this was their background. We discussed this with them as the conditions are very different, and people with dementia are unique as individuals but with dementia having some common traits. The home had a policies and procedure manual in which we found a policy relating to dementia. Behind the policy was a guide containing information about numerous age related and dementia organisations. We showed this to the new manager so they could see the range of resources available to support their learning and increase their knowledge.

Following the issues identified with medicines at the previous inspection, the new manager had implemented medicines checks so all medicines (that were not in blister packs) were now counted at each medicines round. This was time consuming for staff but the new manager told us "I am determined that we did not make the same kind of mistakes that were picked up before and counting the medicines each time is the way we ensure it". The new manager told us "I have worked night and day to get the records right but I know there is a bit more to do, it is training the staff as much as anything so that they are up to speed".

However, not all audits were effective as we found a number of concerns in relation to people's records which we discussed with the new manager. We identified some concerns on four people's Medicine Administration Records (MARs) which included errors in tablet counts and conflicting instructions for staff. For example, two people's MAR charts stated the medicine should be taken "At least 30 minutes before the first food/drink or medicine of the day". However, a dosage time of 11.30am had been hand written on the MAR and highlighted in pink. This discrepancy had not been picked up by the new manager. When we brought it to their attention, they telephoned the GP for advice. They told us the GP was happy for the

medicine to be given at 11.30 before lunch but had not recognised the discrepancy between the two instructions. We asked the new manager to arrange for the instructions to be changed on the MAR as this was conflicting information for staff.

The senior carer detected an error in the count of iron tablets on the first Medicines Administration Records (MARs) they came to. They counted the tablets a number of times. According to the MAR, the person was short of one iron tablet which had been counted as correct up until and including the previous night's medicines round. The senior carer spoke to the new manager who phoned the GP and the pharmacy and completed a near-miss medicines error form.

A second missing medicine was not picked up by the senior carer and which we pointed out to the new manager. The dose from the previous evening had not been signed for although it had been counted as given. In addition there were some changes to a record the previous day that had been scored through so it was not possible to read what had been written. We showed this to the new manager who told us "That is not right, I thought the staff know they should not do this, it is not clear, I will raise it with them also".

One person's records contained concerning information which had been recorded by a member of staff following a discussion with the person. There was no record of how this had been followed up and no investigation or outcome had been recorded. We asked the new manager about this as it could have been an allegation of abuse. They told us they had spoken to the person and were confident it was not a safeguarding concern. However, they had not recorded this in the person's record.

Other audits had been carried out and actions had been identified, such as fire safety checks which had found that door closures were not working on two doors. However, records were incomplete. It had been recorded that staff had contacted the contractor about the issues but there was no record of what the outcome had been or whether the door closures had been fixed. A problem with the nurse call system had also been identified. It had been recorded that the engineer had been contacted but there was no record of what had been done. When we spoke to the new manager they confirmed these had been rectified, and said they would record the outcomes in future.

Inaccurate record keeping was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Good Governance.

On the first day of our inspection the home felt cold because the heating had broken down. The manager explained the heating engineer had been called and would be attending the home later that day. Staff had provided people with blankets in the meantime, and small portable heaters had been brought out to try warm up the main rooms. These were hot to touch and very unstable. On one occasion in the lounge, we observed a person lean against it to steady themselves and immediately withdrew their hand because it was hot. We spoke to the new manager and provider about this as we thought the heaters were a risk to people. They told us they didn't usually use them but had to resort to it because of the heating failure. However, they had not thought to position these out of the way or behind furniture, for example, to minimise the risks to people which we found to be poor risk management. The following day the new manager informed us they had purchased a number of convector heaters as a more appropriate standby.

We found the new manager to be responsive to our feedback throughout the inspection. Where we identified issues, they were keen to put things right and did so immediately where possible. Staff told us the new manager was trying to make further improvements to the home, such as new paperwork systems including daily records, night checks, and handover notes, but said the new manager's limited time in the home meant they still reported to the deputies who provided management cover four days a week.

The management team had an 'open door' policy which provided the opportunity for people, their relatives and members of staff to discuss any issues or concerns with them at any time. Discussion with members of staff confirmed that policies and procedures for reporting poor practice, known as 'whistleblowing' were in place.

People and relatives said there was a welcoming and approachable culture within the home. Feedback was received from people informally on an on-going basis. The new manager told us they sat in the lounge in the evenings with people and chatted to them. They had started to record the feedback people gave them. Feedback from relatives was received through questionnaires and on an ad hoc basis when they visited. A comments book in the reception showed people were satisfied with the care their loved ones received.

Accidents and incidents were recorded and investigated appropriately. A new recording system had been put in place to log falls and these were now recorded and linked to hourly checks at night to ensure people were monitored appropriately following a fall. These were analysed regularly to identify and trends or patterns in falls. The new manager told us they had identified a pattern in one person's falls and as a result had changed their environment to minimise the risk of further falls.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care and treatment was always designed and planned to meet their needs. Regulation 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not maintained accurate, complete and contemporaneous records relating to the care and treatment of service users, and other records relating to the management of the home. Regulation 17(2)(c)(d)