Resicare Homes Limited

Ashton Lodge

Inspection report

Ashton Road
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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 Ashton Lodge in January 2019 and this inspection was unannounced. Ashton Lodge provides care for to up to 54 adults. Accommodation is provided over two floors.

Ashton Lodge 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.

We inspected Ashton Lodge in June 2016 and rated the home as 'Requires Improvement' overall. At the following inspection in September 2017 we rated the home as 'Inadequate' overall with breaches of the legal requirements. In April 2018 improvements had been made so the home was rated 'Requires Improvement' overall with Inadequate in well led.

At this inspection in January 2019 improvements had been made resulting in an overall rating of 'Requires Improvement' with Good in caring. At the previous inspection there had been three breaches of the legal requirements. In dignity and respect, person centred care and in the governance of the home. At this latest inspection there were no breaches of the legal requirements.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

There was a registered manager in place when we inspected the home. 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.

We found some issues which had the potential to put some people at risk of harm. A person's oxygen was not being stored safely. The use and storage of the oxygen had not been risk assessed and was not being fully monitored to ensure the person using the oxygen and others were safe.

People who needed to be supported to be transferred using a hoist were at risk of becoming ill through cross contamination of the slings used in this process, as people did not have their own slings. We found staining on one of these slings and they were bunched together. We also found some recent errors with people's medication. Some people had not received their medicines as prescribed. Some medicines were also not stored safely and some which were being used were out of date.

When we raised these issues with the registered manager they took swift action to start addressing them.

People had risk assessments in place and care plans to advise staff about how to meet people's needs. However, we did find that improvements were needed in how the service managed and risk assessed people who were at risk of self-neglect. Systems and plans were not in place to manage these situations.

Staff recruitment checks helped ensure people were safe around new staff. However, staff did not have a full employment history in place despite this being brought to the provider's attention at previous inspections.

Various safety checks were being completed of the equipment used and of the building to check people were safe. This included a recent fire safety inspection from the fire service.

Staff knowledge about what abuse could potentially look like was limited at times. Also, staff were not clear on how to report concerns outside of the home. We made a recommendation about improving staff knowledge in this area.

The management team completed various competency checks on staff when they started at the home and during their working life at the home. This was to ensure staff were performing well in their work and promote the knowledge of staff.

People were given enough to eat and drink. The service responded quickly when people were not eating enough and were losing weight. Some initiatives were in place to promote weight gain and sustain people's weight who were at risk in this area. Records supported these actions. We did however suggest the service reviewed their approach to supporting people who were high in weight. People were not very critical of the food, but they were not very positive either.

People's dining experience had improved, staff were more responsive to people in this way. People told us that they had choice with food. Although there were still areas where the service could promote people's dining experiences.

Health professionals were contacted quickly when people became unwell or when there were signs they needed involvement from a health professional. One of these professionals spoke positively about the home and the actions of staff in keeping people healthy.

Staff offered people choices and understood the importance of supporting people to make decisions about the care they received. However, the management team's knowledge needed to be improved upon when a deprivation of liberty was taking place and when to assess people's capacity.

Staff were consistently caring, thoughtful, and considerate towards the people who lived at Ashton Lodge. People's privacy and dignity was promoted. People appeared to enjoy the company of staff.

The management team captured people's physical needs and interests in their assessments. Activities took place and events and trips had happened. Plans were being made for trips out for later this year. However, staff did not spend time chatting and engaging with people. Some people were left alone with limited stimulation for most of the day. Improvements had been made in this area, but further progress was still needed to promote people's social experiences and their well-being at the home.

The issues found during the inspection reflected on the effectiveness of the management and provider

audits taking place at the home. These issues had not been identified by audits undertaken by the provider and registered manager. However, some improvements had been made in this area. The provider now completed detailed audits of the service. The management team were completing more checks to assess people's experiences of living at the home.

People spoke positively about the registered manager and the deputy manager. There was a positive culture at the home. Improvements were taking place and we had assurances that this would continue.

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.

Oxygen cylinders were not stored or managed safely.

People did not always receive their medicines as prescribed. Some of these were not stored safely.

Infection control was not always managed safely.

Risk assessments and plans for people who self-neglected were not in place.

Other risk assessments and care plans were in place.

Equipment and fire safety checks were in place and up to date.

Is the service effective?

Requires Improvement

The service was effective.

People's dining experiences needed improving.

The service needed to respond to how they supported people who were at risk of being over-weight.

External professional support was not sought for one person.

Staff competency checks were in place. Staff received regular training.

Action was taken in a timely and preventative way for people who were at risk of being at a low weight.

People were supported to maintain and improve their health.

Staff promoted inclusion and encouraged people to make their own decisions.

Is the service caring?

Good

The service was caring.

People were treated consistently in a kind and caring way.

Staff promoted people's privacy and dignity.

People's confidential information was protected.

Relatives felt welcomed at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People di not have meaningful reviews of their care and experiences

Staff did not spend time chatting and engaging with people.

Some people were left without any real stimulation.

Limited activities were taking place.

People had care records and care plans in place identifying people's needs and interests.

Events and trips had taken place and plans were being made to plan for new trips.

People had end of life plans in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Certain shortfalls in people's safety and the planning of their care was identified at this inspection which the management of the home had not identified.

People's experiences of daily life could still be improved upon.

There were shortfalls in some audits completed at the home.

There was a registered manager in place which people spoke positively of.

The service was developing how they involved people in the development of the home. There were growing links with the community.

Ashton Lodge

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 site visit took place on 9 January 2019. The inspection was unannounced. The inspection team consisted of two inspectors, and an Expert by Experience. An Expert by Experience is someone who has experience of this type of service.

Before the inspection we contacted the local authority contracts team. We asked them for their views on the service and we took these into account when we inspected the service. We looked at the notifications that the registered manager and previous managers had sent us over the last six months. Notifications are about important events that the provider must tell us about.

During the inspection we spoke with 11 people who lived at the home. We spoke with four people's relatives and five members of care staff, the registered manager and the deputy manager. We also spoke with two visiting professionals. We looked at the care records of five people, including the medicines and dietary records of six people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

We inspected Ashton Lodge in June 2016, September 2017 and April 2018 and found that it was not always safe. People's risk assessments were not all up to date. The provider was not able to demonstrate if they had responded to all the issues raised in their previous fire safety assessment. Records regarding people's creams did not state where this had been applied.

At this inspection in January 2019 we found issues with the safety of the home. However, these were different issues to those identified previously and improvements had been made to the previous issues identified in this area.

A person was receiving additional oxygen as a medicine. We found that these cylinders were not being stored safely at the home. There were four cylinders stored against a warm radiator. These were not connected to a wall to prevent them from falling. Senior staff were monitoring the flow of the oxygen weekly but there was no risk assessment regarding the storage or use of these cylinders. Best practice had not been sought from a professional or the manufacturer to ensure these were being used and stored in a safe way. We spoke with the registered manager about this. They contacted an oxygen supplier on the day we had raised this issue. The supplier visited the next day and the registered manager took initial advice over the telephone the day we inspected. Measures were put in place to start responding to this risk before we completed our inspection. We received confirmation of what action had taken place the day after our inspection to correct this issue.

We completed a check on people's medicines to see if people had received their medicines as prescribed. For two people there were more medicines left in the boxes than the records evidenced. This meant that staff had signed for the medicines indicating they had administered them, however these were left in the box. Some medicines we could not reconcile as staff had not recorded the opening date for the box and the amount they carried forward form one month to another.

The service had changed back to a long-standing medication system three days before our inspection. However, systems were not in place to check staff were still competent in this area.

We found eye drops for four people in the medicine trolley which should have been discarded on 31 December 2018 after four weeks from opening, however staff were still using them although they had received a new supply from the pharmacy. For one person the eye drops kept in the medicine trolley should have been kept in the fridge according to the instructions printed on the box and the label.

During our inspection we also found two prescribed creams which were opened without an open date on them. These medicines were not out of date, but it is safe practice to record the open date to help guide staff when these types of medicines should be discarded. The registered manager told us that they had spoken with staff to remind them of this.

Staff were cutting one medicine as directed by the GP and pharmacy. However, staff confirmed that this meant this person did not always receive the full half of the medicine. This issue had not been raised with the management team by staff to see if there was a solution to this. We raised this with the registered manager who sought professional advice about how the improve this situation.

As a result of these issues the registered manager completed a full medication audit of the remaining medication trollies. They also introduced a more robust system to monitor the administration of medication to address shortfalls quickly.

Some people in the home were transferred from one position to another in slings and a hoist. These people did not have their own slings. This could be an infection control risk. We found one sling had brown matter on it. Slings were also bunched together. This could also increase the risk of spreading infection. We spoke with the registered manager about this. They put a new system in place on the same day as our visit to rectify these issues, which meant people had their own slings stored in their bedrooms.

From our observations we found that there were sufficient levels of staff. However, we found that in certain areas of the home, the deployment of staff was not always effective in meeting people's needs. One lounge had seven people in it and was set away from the main part of the home. Staff visited to check people were okay, but people were not able to access assistance if they needed to. We spoke with the registered manager about this who told us that one person would press the alarm button if another person needed help. We found this was not an adequate system, as this person also needed support.

When we visited this room, a person was sleeping in their chair with their head in an awkward position. People's walking frames had been moved away from them. We concluded that the deployment of staff was poor in this area in order to meet people's needs. The registered manager also had no system to monitor how often staff visited this room. We spoke with the registered manager about these concerns. They told us that they would review the use of staff in this lounge.

We checked to see that staff were safely recruited. We found that most measures were in place to give the registered manager assurances that people were safe around staff. However, the service was not requesting a full employment history of their staff. One out of the three staff files we looked at did not have a full employment history with gaps explained. The other two did but this was likely to be because these members of staff had not had a long employment history due to their ages. The application form did not ask for a complete history. This has been an issue before. The registered manager said they would correct this issue.

During our inspection we spoke with staff about their understanding of how to protect people from harm or abuse. Some staff struggled to tell us what abuse could look like. They knew if they had concerns they needed to report it straight away to their senior or a manager. Staff were aware there were outside agencies they could report concerns to. However, they were not all clear who these were. Staff were aware there were telephone numbers for an outside agency in the building, but they did not know where these were located. It is important staff are knowledgeable and clear about how to identify and report suspected abuse.

At this inspection we made a recommendation to seek robust training in this area. Also for more effective systems to be put in place to check and promote staff understanding of this important area of caring for people.

Staff knowledge of how to protect people from discrimination was limited. However, throughout our inspection we observed staff treating everyone respectfully and promoting inclusion into the home. We

spoke with the registered manager about this who made suggestions about how to improve staff's knowledge and confidence in this area.

People had risk assessments in place which identified the risks they faced. There were plans for staff to follow to try and reduce these risks. However, the service did not have a robust plan in place when responding to people who refused care and were vulnerable to experiencing self-neglect. We spoke with the registered manager about this. They told us that they would review this area of people's care planning.

We found that accidents and incidents were analysed clearly to see what had happened, and what lessons could be learnt from these events. These reports also recorded what actions were being taken to try and prevent a repeat of these types of events. We also noted that there were no patterns of people having repeated injuries or accidents.

Various safety checks were taking place on the equipment used at the home to check it was safe to use. The registered manager had arranged for a recent fire inspection to take place. We saw that they found the management team were taking appropriate measures to promote fire safety at the home.

Requires Improvement

Is the service effective?

Our findings

We inspected Ashton Lodge in September 2017 and found the service was not effective. When we inspected in April 2018 some improvements had been made but further improvements were still needed. This was in relation to people's dining experiences, safe moving and handling techniques and how staff competency was evidenced.

At this inspection in January 2019 improvements had been made but there were still areas which needed further work.

The management team assessed the competency of staff and recorded this in an effective way, to show how they had reached the judgement that individual staff members were competent in their work. However, staff competency had not been checked regarding the administration of medicines when the home returned to the previous medicine system. We also found shortfalls in regard to staff knowledge in safeguarding processes.

Staff received regular training and spoke positively about the training they received. Staff gave examples of why they felt the training was effective. We could also see that staff received training relevant to the needs of the people who lived at the home.

We asked people about their views on the food. We had a mixed response. One person said, "It's debateable. It's not as good as it used to be. There's a good variety." Another person said, "It's good, I can't complain. Some meals are hard to eat; they [staff] bring something different then. I get a choice." A relative told us, "The food looks alright. [Relative's name] has put weight on; half a stone lately."

People were supported to have enough to eat and drink. We saw that people were given various choices about what they could have to eat. Staff asked people in the morning what they would like for lunch and supper from the daily menu. We saw that there were choices on this menu. At lunch time one person asked for something different to what they had requested earlier, this was made for them. However, we noted that people who lived with dementia or memory issues were not asked again what they wanted to eat. Best practice in terms of supporting these people to have an informed choice or give them the option of changing their mind was not being followed. We spoke to the registered manager about this who said they would make these changes in this area.

We observed the dining experience. Staff were calm and thoughtful when supporting people with their food. Those who needed support with eating and drinking were supported at their own pace. Most staff spoke with these people and checked they were happy with what they were eating and drinking. However, two people were being supported to eat by a member of staff who stood and at times bent over each person as they assisted them with eating. They did not try and have a conversation with these people. We spoke with the registered manager about this, who said they would monitor this and speak with staff about this practice.

During the lunch time we considered people's dining experience. We could see that the management team were also monitoring this. We noted that with the exception of one lounge people were not asked if they wanted to move and sit at the table. Most people were not given this option. Where the home had dining tables they were not laid out in a way to promote people's dining experience. Some people told us that they missed this part of their daily life, to sit at a table to eat a meal. One person told us that, "Sometimes if I've had my hair done and I'm in the wheelchair I'll have it at the table. If there's enough of us they'll put a cloth on the big table." We spoke with the registered manager about this, they talked to us about how they would address this issue in the future.

People`s weight was monitored monthly and when people were found to be losing weight they were referred to the GP. We found that the GP prescribed build up drinks for these people. The cook also made high calorie smoothies for everyone at the home. Risk assessments or nutritional care plans listed what people`s likes and dislikes were in regard to meals, and how staff had to encourage people to have good nutritional intake. Food and fluids were monitored for people who were at risk of malnutrition. Staff were quick in seeking professional advice when people lost weight and this had a positive impact on people`s health as their weight stabilised.

We did however find that a high number of people gained weight and they were classed as overweight or obese. The registered manager told us they discussed this with people and suggested healthier meal options, however they had not discussed with people the involvement of health professionals to discuss this issue. We suggested that information on how health care professionals like dieticians and GPs could help people maintain a healthy weight, were shared with these people. Other ways to promote a healthy life style was not being promoted at the home. For example, staff did not encourage people to move about.

There was evidence of regular GP visits. We saw evidence of dietician and district nurse involvement in people`s care. One visiting health care professional told us, "I find staff being very responsive they [staff] call us every time anyone has an issue. Because they [staff] call us straight away when they notice something, people don't need a lot of input. I have no concerns with this home at all. People are well looked after."

Despite this there was one person who was not in receipt of the professional support they needed. During this inspection we had identified one person who was at risk of a breakdown to their physical health and mental well-being. This person had expressed challenging behaviour towards others, they had refused to socialise, and was losing weight. This person could make their own decisions and it was accepted by the management team that the decisions they were taking were unwise. However, there was no evidence of discussions with the person about what the potential impact of their behaviour was having towards their physical and mental health. The management team had not promoted a review of their needs by the appropriate professionals. We spoke with the registered manager about this. We later were told that they had referred this person for a professional to review.

The environment was clean and welcoming. We noted that some parts of the home were recently decorated and the registered manager told us they had further plans to improve the environment people lived in. Due to the lack of storage space equipment like hoists and wheelchairs had to be kept in the lounge corners and this at time created a cluttered feel. However, the registered manager told us they had plans to extend the home and a storage place would be built so that equipment could be stored appropriately.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We saw that staff offered people choice throughout our time at the home. Staff told us how they encouraged people to make their own choices. These members of staff told us how important this was in order to promote people's quality of life.

When DoLS authorisations were in place the service was adhering to these authorisations. When we spoke with staff they understood how they were to promote a person's freedoms, especially their freedom of movement. However, the management team had not understood when a DoLS assessment was needed and when a capacity assessment was needed in relation to people who were at risk of self-neglecting. When some people refused care the management team made a DoLS referral to the local authority. However, these people were considered to have capacity. Therefore, a DoLS was not appropriate. The management team should have been checking these individuals still had capacity to refuse care.

Good

Is the service caring?

Our findings

When we inspected Ashton Lodge in June 2016, September 2017 and April 2018 we found that the service and staff were not always caring towards the people it looked after. We saw some actions from staff which were not kind, thoughtful, or respectful. This led to a breach in the Health and Social Care Act 2008 in relation to Dignity and Respect.

At this inspection in January 2019 we found that improvements had been made in this area.

One person told us, "Everyone's so kind and helpful, always. There's enough staff. They don't rush you." Another person said, "They [staff] are patient and gentle." A person's relative said, "There have been lots of changes. It's a lot better now. They look after [relative] well; never unkind or sharp. The staff are always nice. They are kind and caring."

People were treated in a kind and thoughtful way. Staff were gentle towards people. For example, we saw one member of staff gently wake a person who was living with dementia, as lunch was being served. They asked in a low voice if they wanted lunch, this person nodded and the member of staff gently stroked their hair, this person smiled.

At times we saw staff talking with people in relation to the support or assistance they needed. We also saw staff giving reassurance to people when they were distressed or when they passed them in the corridors, staff stopped and asked people if they were OK. Staff used people's names and spoke with them at their eye level. People responded positively when staff spoke with them.

When we saw staff engaging in light banter with a person this was respectful and the person was fully involved in this conversation as an equal.

Staff knew the people they supported. Staff told us about certain individuals likes, preferences and about their families who visited them.

Staff promoted people's dignity. When people were supported to transfer from one position to another, this was carried out in a respectful way. Small blankets were placed over people's laps when they were placed in a wheelchair after being hoisted. Incontinence products were discreetly stored. When people needed to use the bathroom or requested this help, staff managed these situations in a discreet way.

One person told us how staff promoted their privacy. "Yes, (staff are polite and respectful), and they close the door and the curtains (for privacy)." We spoke with a person's relative about this, they said, "Yes, it's good." We also saw that staff knocked on people's doors and waited to enter.

People's private information was protected. Information relating to people's medical and personal histories was kept secure.

When we spoke with people's relatives they told us that they felt comfortable visiting when their relative wanted them to. They told us that they were made to feel welcome by the staff.

Requires Improvement

Is the service responsive?

Our findings

When we visited Ashton Lodge in June 2016 improvements were needed in how the service responded to people's needs. In September 2017 we rated the home inadequate in terms of being responsive to people's needs. In April 2018 improvements had taken place and the service was rated requires improvement in this area. However, we found that care plans and reviews were not person centred, people's emotional and social needs were not always met who spent all their time in their room. We also found that staff did not spend real time with people chatting and passing the time of day. This led to a breach in the Health and Social Care Act 2008 in Person Centred Care.

At this inspection in January 2019 we found that improvements had been made but there was still further development needed in this area.

People's care assessments and care plans had improved. These were detailed records outlining what people's physical care needs were. People's interests were identified and explored in these documents. We could also see that people's backgrounds and their personal histories were also recorded here. However, this information was not being realised in people's daily experiences. For example, in the planned activities provided.

Reviews of people's needs and experiences were taking place on a regular basis. We saw that in one person's review how the staff had tried to involve them with some of their identified interests. However, review records did not always show if people or their relatives had been involved in the review of their care. These records did not show us that these reviews had been fully person centred and had always involved the person.

We also discussed with the registered manager that care plans could have been further improved to give a clear description for staff in how to help people and meet their needs. For example, a care plan detailed that staff should encourage a person to participate in activities, however there was little detail of how staff should do this.

We asked people if they felt there was enough social opportunities taking place at the home. One person said, "I watch telly, do my reading. I can't read a lot because the light reflects in here. We've got a good activities team, they're really good. They do dominoes, games on the floor; big cards, rolling things, card making at Christmas, quite a lot." Another person said, "Oh, yes. I just think. I don't feel lonely. Staff do come and chat." A further person said, "Children come to sing."

At this inspection we saw that activities had been taking place. We were shown the home's social media page which some people and their relatives had agreed to be part of. These showed various events taking place during the build up to Christmas. The registered manager told us about a relationship the home had with a local school. People told us and we saw pictures of children from this school spending time with people at the home. From looking at these images people looked very happy. One person was supported on

a regular basis to go back to their home and spend time there with the support of a member of staff.

The registered manager told us about a trip which had taken place at the local theatre last year. They also told us about cinema nights when vintage films were projected onto a wall at the home. At this inspection we saw the registered manager giving people handouts about an upcoming play and a musical at this local theatre and asking people's views on this.

We reflected back to the registered manager that this was positive and improvements had been made in this area. However, when we inspected there were little activities taking place. There were two lounges which staff visited to check people were okay but they did not spend any real time with people who were in these lounges. In these spaces the TV was left on with the sound on low. Staff did not engage with people in an activity, or chat to people. In another lounge some staff did try and chat to people, but again the TV was on low, no one was asked what they wanted to watch, and most people could not see the TV. Staff deployment in these areas was poor. We discussed this with the registered manager, about how people's interests needed to be realised in the activities they provided.

In conclusion we found that the management team had made improvements in this area of people's lives. Further work was needed.

Some people told us that they felt comfortable speaking with the registered manager and raising issues about their care and experiences of the home. One person said, "If I told the manager I was concerned about something, [manager] would listen and do something. I complained about the heat in here in the summer. The key to the patio door was missing and it couldn't be opened. It was put right straight away."

There were also meetings being advertised about the home. This was to support some people to share their views of the service. Some people spoke positively about this. One person said, "Now it's all recently changed. Look at the notices and you're invited once a month to complain. I haven't been yet, the first one is on 31st January. I think it's good."

When we reviewed people's care records we could see that people had end of life plans in place. These are to ensure the staff capture how people would like to be cared for at this important part of their life. These plans also contained personal details and requests. We could see that these plans were revisited on a regular basis to check they still reflected people's wishes. However, these reviews did not show if the person had been involved and asked if they wanted to add further information. The assessor had also not tried to progress the plan when there was information missing.

Requires Improvement

Is the service well-led?

Our findings

We inspected Ashton Lodge in September 2017 and rated the service inadequate overall and in well led. In April 2018 improvements had been made but these were not sufficient to change the rating in this area. The provider was not completing audits. There was no registered manager, audits were not always effective. This resulted in a breach of the Health and Social Care Act 2008 Well Led.

At this inspection in January 2019 improvements had been made and sustained, however, some further improvements were still required.

Despite the fact we could see that some improvements had taken place, we still found some issues at the home. A person's oxygen was not stored correctly or in a safe way. This risk had not been assessed with a plan in place to follow. Some medicines were not stored correctly and some people had not received their medicines as prescribed or medicines which were in date. There was no robust system in place to monitor the recent change to the medication system.

The management team's knowledge of DoLS was not complete. They did not have a robust way of managing situations of when people refused care and were at risk of self-neglect, despite a recent concern in this area in one of the provider's other homes. Infection control risks when people were transferred in a sling and hoist had not been identified. The management team still did not gain full employment histories for staff despite this being brought to their attention at previous inspections.

Two people's needs had not been met and attempts were not made to promote their rights and wishes. This included a person who had brown matter under their nails and their nails were long. The registered manager said that the person often refused care in this way. However, this was not detailed in their assessment or review. There was no plan in place to support staff to manage this need. We also found that care plans did not tell staff how to manage other challenging situations.

We also identified that some people's experiences of living at the home were not being reviewed to see if they could be improved upon. The dining experience was limited. Some people had said they would like to sit at the table, and that this did not happen. We found that some lounges were left without any staff spending any real time in these rooms with people. The TV or radio was left on as background noise. Some people were left in a lounge with their walking frames moved away from them. Staff did not spend real time with people chatting and engaging with them or gave people this option.

Some people made references to an occasional change in the attitude or behaviour of some members of staff. For example, one person said, "Some [staff] are bang, bang, bang. It depends on the time of day; evenings and that." Another person told us that, "Staff can get a bit niggly if they've been short staffed and they've done double shifts like 7am to 9pm three days in a row." A further person said, "They say [night staff] do you really want something, I've had to come right from the top." The staff we spoke with said they chose to work long hours and they had breaks. However, one member of staff said they did not always have the

opportunity to take their breaks. We spoke with the registered manager about this. We concluded that further work was needed in this area for the registered manager to know if these shift patterns were for the benefit of the people living at the home.

Improvements had been made in relation to people's assessments, risk management, people having more activities and opportunities to enjoy life. However, further improvements were needed in these individual areas.

As a result of finding these issues it questioned some of the governance systems used at the home by the management team. Other quality checks completed sometimes fell short of a robust check. For example, an audit of the meal experience was completed but people were not asked what they thought about the food. Or how the dining experience could be improved upon. Staff were also not involved in this. An audit of the activities took place but these records did not show how the audit took place or how the assessor reached their conclusion. Often audits did not consider if improvements could be made.

At this inspection we could see that the provider visited the home and completed audits of various elements of the home. We looked at the most recent audit in full and found this was detailed. However, the report did not always evidence how they reached their conclusions. Examples and evidence were not given to support their conclusions.

Despite these shortfalls, improvements had been made and had been sustained. The management team and the provider had made positive changes. The culture of the home had improved. Staff were consistently thoughtful and kind to people at the home. The management team monitored and evidenced staff competency, to continually check this. The registered manager responded to the issues which we raised in a timely way. We had assurances that other positive changes would be made as the home progressed further.

There was a registered manager in post. People we spoke with spoke positively about the registered manager and the deputy manager. One person said, "The deputy manager changes things, they look at things differently." A relative told us, "[Registered manager] is brilliant. Any concerns [registered manager] deals with it." Other people told us that they had confidence in the registered manager and the management team.

People were beginning to be more involved in the running and development of the service. We were told by the registered manager that some people were involved in the recruitment process of new staff by looking at application forms and partaking in the interview process. We saw this happening during our inspection. Meetings for people and staff to talk about their experiences were also planned to take place.

There were links with the community. We were told of Christian denominational groups who visited the home regularly. A new connection with the local school had recently been formed. The registered manager told us about plans they were making with the school to develop this further.