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Ashley Manor Nursing Home - Southampton

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

Ashley Manor Nursing Home provides accommodation and nursing care for up to 45 older people. The service is in a rural location near Shedfield, and provides accommodation over three floors in a converted residential dwelling. At the time of our inspection 13 people were using the service.

The inspection took place on 22, 23 and 25 of November 2016 and was unannounced. This was a comprehensive inspection that was carried out to check on the provider's progress in meeting the requirements required as a result of our inspection on 28 and 29 June 2016, when continuing breaches of legal requirements were found in relation to consent, staffing and clinical governance. The provider was served with a warning notice in relation to clinical governance that they were required to meet by 21 November 2016. Following the inspection the provider sent us an action plan detailing how and by when they would meet the regulatory requirements.

At this inspection we found requirements in relation to consent had been met, requirements relating to clinical governance had been met in relation to record keeping but not fully in relation to clinical governance. This is the process whereby a provider assesses the standards, safety and effectiveness of care delivered to people. Requirements in relation to care staffs induction, nurse's supervision, appraisal and training had not been met. We found a new breach in relation to staff recruitment.

Ashley Manor Nursing Home did not have a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited a home manager who had submitted an application to the Care Quality Commission to become the registered manager for the service.

The review of accidents and incidents process was not sufficiently developed to drive service improvement for people. Audits of the service were completed; however, overall they lacked action plans to drive improvement for people. Actions required had not always been addressed for people to ensure their safety. For example, the lack of colour coded knives placed people at potential risk from cross-contamination. Where actions had been completed there was not always written evidence to demonstrate this. The processes for identifying potential risks to people and auditing were not always in place or sufficiently developed to consistently drive service improvement for people.

The provider had completed some recruitment checks in relation to staff. However, they had not always ensured that applicants had provided a full employment history. They had not always assured themselves of applicants conduct in their previous role or the reasons for leaving their previous employment. There was the potential that people might have been placed at risk from the recruitment of staff as the provider had not fully assured themselves of their suitability for their role.

The provider had introduced an induction booklet for staff; however there was not a process for ensuring staff completed this to enable them to demonstrate their competence in caring for people. Care staff had received supervision of their work. There was not a robust process in place to ensure the nurses received clinical supervision of their practice with people as required. Staff had not had an annual appraisal of their work, to ensure they were supported in their work with people. Records showed not all staff had completed the providers training; this created a risk staff might not have the required skills to provide people's care. There was a lack of a structured training plan for the year to ensure staff would be able to book onto training as needed, to ensure their skills in providing peoples' care remained up to date.

Staff were able to demonstrate their understanding of the risks to people and understood the importance of maintaining complete records in relation to people's care. Risks to people's safety had been assessed using screening tools. Processes were in place to identify what records needed to be maintained in relation to the provision of peoples' daily care. Records reviewed showed care staff were completing peoples' records as required, relevant actions were being taken for people where needed.

The provider has been required to undertake work to ensure peoples' safety in relation to the risks from fire. Time is required to ensure the required works are completed.

There was sufficient staffing in the service for the people accommodated. The provider used a staff calculation tool based on people's needs to assess the staffing level required for the service. This will need to be reviewed as new people are accommodated.

Staff we spoke with were able to describe the types and signs of abuse and who they would report any concerns to. Arrangements were in hand to ensure all staff had the opportunity to complete or update their safeguarding knowledge. The provider told us they were working with a local service, to update their safeguarding policy to ensure staff had access to up to date safeguarding information for people. Staff were not all aware of their right to speak in confidence about any concerns they wished to report and how to do this. Therefore there was a potential risk they might not be aware of how to whistleblow for people in the event they needed to. Incidents were recorded, reported and reviewed by the manager to identify if any action needed to be taken for people.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely. Medicines were stored securely within their recommended temperatures by staff. Records of medicines administration including creams were kept at the service. Information to support the safe administration of people's medicines was available.

Infection control processes were in place to keep people safe. The majority of staff had undergone or were due to undertake infection control training. Arrangements still needed to be made for a small number of staff to complete this training to ensure they had the knowledge to protect people from acquiring an infection.

Staff had either completed training on the Mental Capacity Act 2005 or arrangements had been made for them to attend this training; to ensure they had the required knowledge to support people appropriately. People's records demonstrated their consent had been sought for the provision of their care. Staff met legal requirements where people lacked the capacity to consent to their care.

People provided positive feedback about the meals they received. People's care plans and charts provided staff with information about the type of diet the person required. People's preferences about their meals were taken into account. There had been no negative feedback about the meals. However, the provider was

in the process of exploring the options for the future provision of people's meals with an external provider of chilled meals. They have assured us any changes to meal provision will only be made with people's agreement.

Records showed people were able to see health care professionals as required.

People and visitors told us they liked the service and found staff to be caring. Staff were kind and supportive to people. Staff were observed to show concern for peoples' welfare.

People's care plans provided staff with guidance about how people communicated. Staff understood what people liked. People's care records demonstrated staff had listened to people and respected their wishes. Staff spoke with people politely and treated them respectfully.

The manager had completed regular checks upon the night staff following feedback received at the last inspection in order to observe what they were doing and whether they treated people with dignity and respect at night; they had not identified any further issues. We did not receive any negative feedback about the conduct of the night staff.

The information gathered through people's pre-admission assessments had been used to determine what actions the service needed to take to meet their needs.

Reviews of peoples' care were taking place; however, there was a lack of evidence to demonstrate that people and their relatives had been invited. Following the inspection the manager sent us written evidence that they had written to peoples' relatives to invite them to attend a review. The care plans for people living with dementia would benefit from greater detail to ensure staff had access to individualised information about people's care needs in this area. The service needed to ensure nursing staff were able to respond to changes in peoples' care needs, where this resulted in the need to use a syringe driver. Staff did not feel confident in their ability to meet this need for people if required. People were provided with social stimulation but there was scope for increasing the opportunities available for people to ensure their social care needs were fully met.

There was a process in place for people to make a complaint and these were responded to appropriately. The provider had missed the opportunity to collate the results of the June 2016 survey. People were asked for their views through the resident's meetings and one to one contact with the provider. In order to make the providers contact with people more meaningful, there needed to be a more structured record of the contact and evidence of any actions taken for people.

Regular management and staff changes had been a cause for concern for people and visitors. Staff perceived the new manager as available, approachable and willing to help them. The provider is still lacking a permanent clinical lead and is not yet able to demonstrate the service is proactively led by a stable, complete and consistent leadership team for people. Support has been provided by external agencies to enable the provider to meet all of the requirements of the regulations; however, the provider has not been consistently proactive in fully addressing issues for people.

Staff were not explicitly aware of the provider's aims and objectives for the service, which focused on the provision of a therapeutic environment, people's well-being and independence, openness and respect and caring for people. However, staff were observed to be caring to people, to treat them with respect and to show concern for their well-being. There had been an increase in the level of communication between the management team and staff. People were cared for in an environment where staff felt improvements to the

culture had occurred.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There was a potential risk to people as not all staff had undergone the required recruitment checks to demonstrate their suitability to work with people.

Risks to people's health and safety had been identified and staff knew how to manage these. Processes had been implemented to ensure care staff completed records of people's care as required.

There was sufficient staffing for people's current needs.

Processes were in place to safeguard people from the risk of abuse. Some staff still needed to complete or update their training to ensure people were robustly safeguarded from the risk of abuse.

Improvements had been made to ensure people received their medicines safely. However, these needed to be embedded and sustained over time.

Infection control processes were in place to keep people safe. Some staff required training in protecting people from the risk of acquiring an infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff had not received the required support through induction, supervision, training and appraisal to ensure they were competent and skilled to undertake their role.

People's records demonstrated their consent had been sought for the provision of their care. Staff had met legal requirements where people lacked the capacity to consent to their care.

People were offered a balanced diet which they enjoyed and received enough to eat and drink to meet their needs.

People were supported to access health practitioners when

needed.

Is the service caring?

Good

The service was caring.

People experienced caring relationships with staff.

People were supported to express their wishes about their care.

People were treated with dignity and respect by staff. The manager had introduced spot checks on the night staff to enable them to monitor how people were treated following feedback at the last inspection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs had been assessed.

The service needed to ensure nursing staff were able to respond to changes in peoples' care needs, where this resulted in the need to use a syringe driver. Staff did not feel confident in their ability to meet this need for people if required.

People were provided with opportunities for social stimulation, but there was scope for increasing this for people in the mornings and at weekends.

People's views were sought and listened to. Further improvements were required to ensure these were fully documented to enable the provider to be able to demonstrate how this feedback was used and any resulting actions taken for people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's audit and monitoring systems had led to improvements in some areas of the service but had not yet been fully effective in driving the required improvements across the service as a whole.

The provider is still lacking a permanent clinical lead and is not yet able to demonstrate the service is proactively led by a stable, complete and consistent leadership team for people.

The provider has not yet been able to demonstrate that the service is sufficiently well managed to be self-sufficient without the support of external agencies in order to be in a position to safely accommodate the number of people they are registered to accommodate or people with more complex needs.

Improvements had taken place with regards to the culture of the service. Staff were caring to people, treated them with respect and showed concern for their well-being.

Ashley Manor Nursing Home - Southampton

Detailed findings

Background to this inspection

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

The inspection took place on 22, 23 and 25 of November 2016 and was unannounced. The inspection team included two inspectors, a pharmacist 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. The expert by experience had experience of caring for older people.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We did not request 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 gathered this information on the day.

Prior to the inspection we spoke with two nurses from the Clinical Commissioning Group and a GP. We also received written feedback on the service from a Social Services Team Manager and a Safeguarding Officer.

During the inspection we spoke with six people, four visitors and a physiotherapist. As some people experienced dementia and could not speak with us, we used the Short Observational Framework for Inspection (SOFI) to understand their experience of the care provided. We spoke with four care day staff, two night care staff, two day nurses and one night nurse, the activities co-ordinator, one domestic staff, the chef, the acting clinical lead, the manager and the provider.

We reviewed records which included four people's care plans, five staff recruitment and supervision records, staffing rotas for the period 13 October to 16 November 2016, medicine records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2016 we found the provider had not maintained an accurate and complete record for each person. In the providers action plan dated 7 September 2016 they informed us the required actions had been completed. At this inspection we found relevant actions had been taken to ensure there was an accurate, complete and contemporaneous record for each person. We found a new breach in relation to staff recruitment.

Most people spoken with felt the service was safe. One person commented "I feel very secure here I am well looked after. I would have concerns if I needed more regular nursing care as by my own observation things are not good enough." Another person told us "Staff are very good and helpful, medication is given to me twice a day." A relative commented "I think (the person) is well cared for, her room is clean and the staff look after her, so far so good."

The provider did not have an up to date recruitment policy; they told us they were working with a nearby service to put a policy and procedure in place. Staff had undergone some recruitment checks. These included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There was evidence the registration numbers of nursing staff had been checked to assure the provider they were all still registered to practice with the Nursing and Midwifery Council (NMC). One nurse did not have: photographic proof of their identity, a reference from their previous employer nor had they provided reasons for leaving their previous posts. The provider had not obtained all of the information required in order to satisfy themselves of this staff member's satisfactory conduct in their previous employment. A member of the care staff had not provided a full employment history, in order for the provider to satisfy themselves of the reasons for any gaps in their employment. A second member of the care staff had not provided a full employment history, once the manager was aware of this; we saw this information was provided by the second day of the inspection. This same staff member's references were both provided by current staff at Ashley Manor and were not from a previous employer in order to evidence their conduct at their previous employment. Another nurse's references were both provided by current staff at Ashley Manor and they also lacked a full employment history. A third nurse's recruitment information lacked a full employment history. Not all relevant checks had been completed as required to ensure staffs suitability to work with people.

The provider's failure to ensure that all of the required information was available in relation to each staff member employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to demonstrate their understanding of risks to people and understood the importance of maintaining complete records. A care staff member said "We are a lot more focused on residents. Checks are rigorous so we notice things we may not have before. Care of people who are bed bound is a lot better we regularly monitor fluids every one or two hours maximum, regular turning, pad changes and our charts are checked so problems are picked up quickly." A night nurse confirmed they were aware of their

responsibilities to check monitoring records had been completed for people to provide an accurate record of the care provided.

People were assessed monthly using a screening tool for the risk of them developing pressure ulcers. Care plans showed where people had been identified as at risk, arrangements had been made to prevent their skin from deteriorating. People were prescribed topical creams to hydrate and protect their skin in order to minimise their risk of developing pressure ulcers. People who could not change their position independently to relieve the pressure on their skin were supported to reposition regularly to protect their skin from pressure damage. People's records provided guidance for staff about what to be aware of when checking peoples' skin for damage and described how often they were to be re-positioned. This information was replicated on their daily re-positioning records to ensure it was readily available to staff. People's repositioning was recorded by staff on people's charts in accordance with good practice to show people had been repositioned at the required frequency. A night care staff said "We have turning charts and body maps and these help us to record if anything has happened to their skin so we can indicate this and hand it over." People's records documented the pressure relieving equipment to be provided to manage the risk of them developing pressure ulcers and this was provided. Time is required for the provider to demonstrate these processes have been fully embedded in staff practice.

People who were at risk of de-hydration were monitored to ensure they had sufficient to drink. Records informed staff of the amount each person had to drink daily to ensure they remained hydrated. The charts showed people's individual daily fluid requirements had been totalled daily in accordance with good practice. Processes were in place to ensure these records were completed. Where people did not drink sufficient for their needs, staff identified this at the staff shift handover and how they would manage this risk for people. For example, by encouraging them to drink more and ensuring drinks were in reach; staff were observed to follow this guidance.

People's diabetes care plans contained guidance so staff would know how to recognise when people's blood glucose levels were to become dangerously low or high and the action they needed to take to ensure the person's safety.

People's Malnutrition Universal Screening Tool (MUST) was calculated on a monthly basis. MUST is used to assess people's risk of malnutrition. Peoples' care records documented if they needed to be weighed weekly to monitor the risk of them losing weight and staff knew who required weighing weekly. We saw that overall people had been weighed weekly as required. We saw for one person there were two occasions over the course of a nine week period when their weight was not taken, although they had gained weight. The manager provided a valid explanation for why the person's weight was not taken and has advised that the reason for any omissions from weighing the person weekly will be documented in future to ensure a clear record is maintained.

People's moving and transferring needs had been assessed. It was noted how many staff were required to support people to transfer safely. Records also showed the equipment needed to move people safely, for example, where people were hoisted the size of sling was noted. The risk of people falling had been assessed using a screening tool. This identified the risk to the person, the action required and the control measures in place. A care staff member described how they supported a person at risk of falls. They commented "I check she has her Zimmer frame and make sure I am there with her at all times. If she is in bed I check hourly to make sure she is OK." Risks to people related to their mobility and falls were managed safely.

The provider told us and records confirmed the service had been inspected by the county fire and rescue

service on 28 October 2016 and a number of fire safety breaches were identified which the provider was required to rectify by 1 March 2017. The provider was able to demonstrate they had established contact with a fire safety provider to support them in meeting the requirements of the fire safety order to ensure peoples' safety in relation to the risks from fire. Time is required to ensure the required works are completed for peoples' safety.

Records showed that other required checks in relation to gas, electrical and water safety had been completed. However, not all doors required to be kept locked were. For example, doors to; a cupboard with electrical cabling and a storage room with equipment on the first floor and the boiler room on the top floor were signed as requiring to be kept locked but were open. These contained hazards such as electrical equipment and hot surfaces that could present risks to people if they were accessed. Staff needed to ensure these areas are kept secure at all times.

There was sufficient staffing in the service. The provider used a staff calculation tool based on people's needs to assess the staffing level required for the service. The provider told us they added 50% to the total to ensure there was adequate staffing available and this would be adjusted for new people admitted. We saw the records of this calculation which was current for the 12 people accommodated. There was some anxiety from staff about the future staffing levels if the number of people increased. The provider had assessed people's current staffing level requirements; this will require review if new people are accommodated.

There were two nurses in the morning, one nurse in the afternoon and three care staff each day. The interim clinical lead who started their role on 7 November 2016 was included in the nurse rota and did not currently have any supernumary time allocated to carry out their clinical lead duties for people, although this had been offered and they currently felt able to complete their responsibilities. At night there was one nurse and two care staff. There was one chef and three cleaners daily and an activities worker Monday to Friday. Absences and vacant posts were covered by existing staff, the provider's own bank staff or agency staff. Generally staff described the staffing levels as sufficient to meet people's needs.

Staff were able to describe the types and signs of abuse and who they would report any concerns to. A staff member said "I would document and report to the nurse and to the manager." Records showed 23 of the 28 staff were up to date with their annual safeguarding training. Following the inspection the manager provided evidence that safeguarding training had been booked for four staff on 12 September 2016 and that they had also attended safeguarding training. Staff understood how to protect people from abuse and had either attended training or arrangements had been made for them to do so.

Staff had access to relevant telephone numbers in the event they needed to make a safeguarding referral. The provider's safeguarding policy was not up to date and the provider accepted it was not user friendly for staff and did not have clear procedures to follow. The provider told us they were working with a local service to update their safeguarding policy to ensure staff had access to up to date safeguarding information for people.

The provider had a whistleblowing policy. Whistleblowing is when staff report concerns in confidence and their disclosure is protected in law. The policy directed staff to talk to the provider about their concerns and if they remained dissatisfied to speak to the Care Quality Commission (CQC). Staff spoken with were not clear on the purpose of whistleblowing did not see it as distinct to safeguarding; for example, they saw it as reporting concerns and did not appreciate they could raise issues in confidence. Staff should be aware of their right to speak in confidence about any concerns they wish to report and be instructed on how to do this; to ensure people's safety.

At the date of the inspection the provider had not yet completed a referral to the NMC regarding the concerns about the fitness to practice of a nurse previously employed. Following the inspection the manager provided evidence this referral had been completed. The provider had taken the correct action to report their concerns for them to be investigated to ensure people's safety.

Incidents were recorded and included a description of the incident and the immediate and any secondary action taken for people's safety. Records showed these reports were reviewed by the manager to check the appropriate action had been taken. Incidents we reviewed included; falls, skin injuries and refusal of medicines. When people had fallen a falls register was kept to monitor the frequency of falls for the person. A falls protocol was in place to ensure that when a person experienced a fall nurses carried out post fall observations to monitor their progress and any further actions required. Nurses confirmed they understood the incident and post falls observations reporting procedures. We saw examples completed by nurses and care staff. Processes were in place to ensure incidents were recorded, reported and reviewed by the manager to identify if any action needed to be taken for people.

Body maps were used to document any injuries to people at admission and during their residence. People's records demonstrated that one body map had been used to document all of the injuries the person had over a number of years which is not good practice. However, the interim clinical lead told us these were old body maps and that now staff used a separate body map for each injury. We reviewed the records for a person who had several wounds and saw there was a separate body map for each wound and a photograph of the injury sustained as required. This ensured there was a clear record of the person's wounds to enable staff to monitor progress in the healing of their skin. Staff now understood the requirement to separately document each injury a person experienced on a separate body map to provide a clear record of any injuries.

Staff stored medicines securely. We saw that controlled drugs, which are medicines that require a higher level of security, were now stored in a cupboard that complied with the legislation. Temperature records were kept for medicines, including those requiring refrigeration. These records indicated medicines were stored within their recommended temperature ranges. An in-use insulin pen, stored outside of a fridge was now labelled with the date they were removed from the fridge. This ensured that medicines were suitable and safe for use.

People's medicines administration record (MAR) or care plan contained information supporting information about medicines, for example; any allergies, when they were required, and how they liked to take their medicines. The, care plans for medicines people took 'as required' additionally detailed a person's ability to communicate their need or alternate methods, if they were unable to verbalise their need for medicines.

We reviewed the care plans and records for two people prescribed medicines that required their blood to be monitored due to the risks associated with their medicines. These records contained test results, subsequent scheduled tests, the exact dose to administer and how to escalate their care if the person showed signs of an adverse reaction. This ensured staff responded appropriately if an adverse reaction to the medicine occurred.

Staff used MARs to record when medicines were administered. A care worker explained how they applied creams to people as part of their personal care. We viewed cream administration records for three people with a care worker. These records indicated the name of the product, where and when the creams were to be applied. Staff signed when creams had been applied to people.

Staff told us they had undertaken medicines training. Medicine training certificates were not available for

two of the nurses at the time of the inspection. Following the inspection these staff underwent refresher training in medicines to enable them to provide evidence of their up to date training.

Infection control information was displayed around the service. There were hand sanitizers and handwashing instructions displayed. There were plentiful supplies of personal protective equipment and we observed staff wearing these during the inspection. The service was clean and odour free. The infection control lead selected areas and people's bedrooms to audit monthly; records showed action was taken in response to the findings. For example, action had been taken to improve the cleanliness of the kitchenette and areas where cleanliness was noted for action such as dusty windows. Night care staff were able to tell us about their role and responsibilities in relation to infection control. Infection control processes were in place to keep people safe.

The clinical lead attended infection control training on 23 November 2016. Records showed 16 of the 28 staff were up to date with their infection control training. A further six staff were due to attend infection control training on 12 December 2016 and the manager was in the process of re-arranging their own infection control training. Arrangements needed to be made for the remaining five staff to complete or update this training to ensure they had up to date infection control knowledge for people's' safety. Although the manager wrote to us on 28 November 2016 to say the outstanding staff would be rescheduled on the next session there was a lack of evidence to demonstrate this had yet been booked as part of a planned schedule of on-going training.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in June 2016 we found staff had not all received the supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. In the providers action plan dated 7 September 2016 they informed us a programme of training had been booked for the nurses to attend. The clinical lead was in charge of all staff supervision and they were in the process of implementing a new induction programme for care staff. At this inspection we found some but not all of the actions required had been completed.

Staff received a provider's induction to the service. There was an induction workbook based on the requirements of the Care Certificate. This is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. Records showed that eight of the care staff had been issued with these workbooks at intervals since the 1 October 2016. None of the staff issued with workbooks had so far completed them. We spoke to two care staff who confirmed they had received it. One told us "(The provider) gave it to me and said he will tell us what to do with it later." Another said they had received it on 12 October 2016 and confirmed they had not completed the book and it had not been explained to them." The provider had planned for the clinical lead to assess staff; however they have since left the service. At the time of the inspection there was a lack of evidence to demonstrate what progress staff had made in meeting the standards or that any assessments of their practice in relation to the requirements had been completed. The provider had introduced an induction booklet; however there had been a lack of progress in ensuring care staff progressed through the requirements to enable them to be able to demonstrate their competence in caring for people.

A supervision and appraisal policy was in place dated April 2016; it did not describe the frequency of supervisions for staff. Supervision of all care staff day and night had taken place in either October or November 2016. Supervisions addressed; workload, concerns or issues, training and development and any actions to be taken. Achievements since the last session were also covered. Arrangements were in place to ensure care staff had received supervision of their work.

There were six nurses employed of these one had received supervision in August 2016. Two nurses had carried out a peer to peer supervision session with each other in November 2016. One of these nurses had just accepted the interim clinical lead role so was receiving peer supervision from a nurse whose practice they were responsible for. The notes from this did not include any discussion or reference to clinical care. This arrangement was not a sufficiently robust process for providing nurses with clinical supervision. Three nurses had not received clinical supervision since April 2016. A nurse said "We tend to support each otherwise there is no other support." An effective system of appropriate clinical supervision was not available to enable the nursing staff to carry out the duties they were employed to perform for people.

The interim clinical lead told us the nurses' supervisions had not proceeded as the service had been advised that they needed to undertake the required training before doing this. We checked and found the service had been advised by Social Services that they had concerns about the quality of clinical supervision and that it was not being carried out effectively. As the manager was not qualified to offer clinical supervision to

the nurses arrangements were required for their supervision. It is generally the role of a clinical lead in a service to supervise nurses. At the management meeting with the Clinical Commissioning Group on 10 November 2016 it was agreed that a priority was the supervision of the nurses. There was no evidence to demonstrate this had commenced by the time of the inspection. There was a lack of a robust process in place to provide clinical supervision of nurse's practice to ensure people received effective care.

The supervision policy covered staff appraisals and stated 'Annual performance appraisal and development review is a fundamental part of good people management.' Fifteen of the 27 staff employed by the provider had worked at the home for over one year. However, staff told us they did not know what was meant by appraisal and appraisals had not taken place. Records did not evidence that any annual appraisals had taken place. Staff had not had the opportunity to review their performance over the past year or to identify with the provider their objectives for the coming year to ensure they were supported in their role with people as required.

A range of training had been booked and attended by some staff. A night care staff said "We have really improved and been empowered by training. Yesterday we did palliative care. We have been refreshed and as a result we make residents more comfortable, they are happier now." There was evidence training was booked for nurses on the vital signs and escalation of deteriorating people, palliative care, tissue viability, communication and assessing capacity.

Records showed that most staff had completed training in fire safety awareness, moving and handling and safeguarding. However, records showed not all staff had completed all of the providers required training. Only four staff had completed a practical competency check in moving and handling. Twenty-five staff needed to complete or update their food hygiene training. Seventeen staff had not completed dementia awareness training. There was a potential risk that staff might not have all of the skills they required in the above areas to meet peoples' needs.

A training matrix was in place to record when staff had last completed training and when they required an update. Although some training was booked; this did not include training in all of the areas where there were shortfalls as listed above. The provider told us they planned to work with a local service to share training and after the inspection the manager provided evidence of a joint training session covering safeguarding, moving and handling and infection control for some staff had been arranged for 12 December 2016. However, there was a lack of a structured training plan for the year to ensure existing and new staff would be able to book onto training as required, to ensure their skills remained up to date to provide peoples' care.

Staff had not all received supervision, an appraisal and all of the training necessary to enable them to carry out the duties they were employed to perform. This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our previous inspection in June 2016 we found more time was needed for staff to embed learning into practice to ensure mental capacity assessments and associated best interest decisions would always be completed in accordance with current best practice guidance. In the providers action plan dated 7 September 2016 they informed us the use of bedrails had been reviewed to ensure MCA 2005 legal requirements had been met. Staff were involving people in MCA decisions and their relatives involved in best interest decisions. At this inspection we found the requirements of this regulation had been met.

One staff member told us "I can't force people to do anything." They did not understand what was meant by DoLS and had not completed MCA training. They told us they were due to undertake this training. However, other care staff had a basic knowledge of the MCA and were able to describe how they used the principles of this in people's day to day care. For example; by offering choice and respecting people's decisions. A care staff member said "You need to be patient with people and ensure they understand you. I ask people what they like and give people choices". Another staff member said "You have to think of what is best whilst trying to give people as much say as possible within their safety and reason."

The interim clinical lead told us they had undergone MCA training. They were able to demonstrate their understanding of the act and DoLS. Records showed 16 of the 28 staff had either not completed MCA/DoLS training or needed to update this training. Following the inspection the manager provided written evidence they themselves had undertaken this training. They also provided evidence that 13 staff were due to attend this training on 9 December 2016. Staff had either completed MCA training or arrangements had been made for them to attend this training to ensure they had the required knowledge to support people appropriately.

People's records demonstrated their consent had been sought for the provision of their care. Staff had documented that they had sought people's consent to provide their personal care. There was evidence that since the last inspection MCA assessments and best interest decisions had been completed for people, for example; in relation to them being able to consent to receiving care and treatment at the service, the use of bed rails, and the need to share information. Two people were currently subject to DoLS authorisations. Staff had met legal requirements where people lacked the capacity to consent to their care.

We observed lunch in the dining area and in people's rooms. People told us the food was "Always good" a person said "There is a choice and you can always ask for something else and they will give it to you."

People's care plans and charts provided staff with information about the type of diet the person required, for example, if they needed pureed foods or if they had any special dietary requirements. They also documented any equipment people required to drink safely such as a beaker. People at increased risk of choking were referred to the Speech and Language Therapist (SALT) for an assessment when needed. The guidance provided by the SALT was reflected in peoples' care plans. For example, whether they required their drinks to be thickened, a pureed diet or a fork mashable diet. There was guidance for staff about how to position people to ensure they could eat safely which they were observed to follow. Risks to people from choking had been identified and assessed.

The kitchen was clean and well organised and the chef had accessible information about people's nutritional needs. Each person's preferences and needs were recorded. Other details noted included where a person was a 'slow eater' and their preferred portion size, any allergies and foods they should avoid to support their health needs. A person had expressed their preference for their main meal in the evening and this was known and catered for by staff. We saw the person was offered sandwiches and fruit at lunch. Another person liked their food 'piping hot' we observed the chef checking their chips were "extra hot" as they plated their lunch in the kitchen. The person confirmed their food was always served hot. The chef told us about another person who liked spicy foods and they catered for this separately. The chef had been

provided with relevant information about people's needs in relation to their meals.

The lunch time service was observed to be quiet due to the small number of people who chose to eat in the dining room but pleasant for people. There were two tables laid up for lunch with tablecloths, napkins, menus and condiments. People chose where to sit and who to sit with. People in the dining room were served by one member of staff who was supported on the two days of the inspection by a volunteer. Both the staff member and the volunteer chatted with people as they served and supported them.

The provider told us they had organised a tasting session with a provider of frozen meals for people and their relatives to try with a view to introducing these meals to the service. The advantage they felt was the range of food options that could be offered to people. People's feedback on the meals had recently been sought at the residents meeting held on 16 November 2016. Those who attended said they were all enjoying the food at the moment. They did not know what had changed but they liked it. One person expressed concern about the tasting session as they wanted traditional home cooked foods. The provider informed us the system would not be introduced if people and their relatives did not provide positive feedback following the food tasting session. The provider was in the process of exploring the options for the future provision of people's meals. However, this was not due to any negative feedback from people regarding the current meal provision which people appeared to enjoy.

Staff told us they reported any concerns they had about people's health. A night care staff told us about a person's health needs and how they were monitoring them because they had been "poorly" recently. A nurse told us there was a resource file with the contact information for healthcare and equipment services. Another nurse said that families and others were now involved more in decisions and told us about a multi-disciplinary meeting held to discuss a person's healthcare needs. They said "Parkinson's nurse, CPN, GP and the person I got them all together to organise the response to her needs". They said we would involve families if needs be or if they wanted.

Records showed people were routinely able to see a number of health care professionals including, a chiropodist, dietician and dentist as required. The physiotherapist visited a person during the inspection and a local GP visited the home weekly in order to treat anyone who was unwell and made extra visits if there was an emergency. People had also been seen by their social worker where required. People were supported to access specialist health practitioners when needed.

Some people required blood tests to be taken periodically. Two nurses had undertaken training on 15 November 2016 on how to take people's bloods and were planning to start taking the required bloods for people the week after the inspection. Nurses had undergone relevant training to enable them to take people's bloods for them, this work was due to commence imminently.

Good

Is the service caring?

Our findings

Several visitors spoke to us highly of the service and the staff. A relative told us they were "Happy with (their loved ones) care so far." Another commented that staff were good and caring towards their loved one. A person told us they liked the home and staff.

We observed kind and caring interactions between staff and people during meal times. We saw that a person did not want their lunch; staff bent down to communicate with the person and gently coaxed them to try their meal. We observed people eating lunch in their rooms. These people required assistance from staff with eating. We noted staff were attentive to people whilst assisting them. For example, we observed a care staff member make a person comfortable with pillows to ensure a safe position for eating. The staff member chatted with the person and checked with them they were alright and ready for each mouthful. We observed another staff member explaining the person's lunch to them. They encouraged the person to eat and drink and provided patient and attentive assistance. If staff were supporting people to eat in their bedroom and the television was on, we noted that staff remained attentive to the person rather than watching the television. Staff were kind and supportive to people when assisting them with their lunch.

Staff were observed assisting a person into the lounge. The care staff gently guided the person by placing their hand on their back. They spoke in a kindly manner, providing reassurance. Once the person was seated the care staff ensured their comfort. Staff were observed to show concern for peoples' welfare.

People's care plans provided staff with guidance about how people communicated. For example, a person was able to hold basic conversations. Staff were instructed to listen carefully to the person and to explain to them what they were doing and to encourage the person to join in conversation. There was guidance for staff in people's records about how to speak with them. The records for a person with a hearing impairment stated 'Speak in a slow and friendly manner. Always maintain eye contact during interaction.' People's records demonstrated that although a person experienced dementia they were able to make their needs known. Staff had written guidance to instruct them about peoples' communication needs.

There was guidance for staff about what a person enjoyed, for example, for staff to sit with them and how to manage the persons' symptoms of distress. Staff had documented in people's records their interactions with people in addition to the care provided. For example, in a person's records staff had noted 'Had a nice chat about books.' The activities worker had been out to buy people Christmas presents; they had chosen personal gifts for people such as a glass nail file, because a person particularly liked these. Staff understood what people liked.

A member of the care staff told us "I give people support to make choices." We saw people were asked their choice of food. People's preferences about their personal appearance was documented for example, whether they liked to wear make-up or jewellery. They also documented their preferred time of going to bed or when they did not have one staff were instructed that the person would let them know when they were ready. A person's radio had been turned off by staff at the person's request. People's care records demonstrated staff had listened to and respected their wishes.

Staff were heard to speak with people politely and to treat them respectfully. People's records detailed how staff should ensure they maintained people's' privacy and dignity during the provision of personal care. Staff were observed to knock on people's bedroom doors before they entered.
Staff ensured that when they had to provide people with personal care including re-positioning them this was conducted in private to ensure the person's privacy and dignity were upheld. A member of the care staff described how they supported people with their privacy and dignity. They said "I support people to make their own choices; I close doors for personal care and always ask if they need help." Another staff member told us "When I do care I close the door and curtains I ask people to wait if they come to the door. I use a towel to cover people who are undressed so they are not cold and are less embarrassed. If they tell me a confidence I don't tell other people unless the information would affect their health and security." Staff treated people with dignity and respect.

At the last inspection some people felt improvements were needed to ensure all of the night staff showed people care and respect. At this inspection no-one provided any negative feedback about the caring attitude of the night staff. The interim clinical lead told us the manager did spot checks on the night staff. The manager confirmed this, telling us that as they were located on site it was easy for them to meet with staff during the night shift. They provided written evidence that they had completed six spot checks on night staff during October 2016 and nine checks on night staff during November 2016. They had not identified any concerns during their checks. The manager had completed regular checks upon the night staff in order to observe what they were doing and whether they were treating people with dignity and respect at night.

People's friends and relatives were observed to visit them as they wished and to be made welcome within the service. Records documented who people maintained regular contact with and how. People were encouraged to have regular contact with people who were important to them.

Requires Improvement

Is the service responsive?

Our findings

A person had been recently assessed for admission to the service; their needs had been assessed to ensure staff were able to meet them. The interim clinical lead told us the number of care staff in the morning were to be increased when the person moved in, this was to ensure they could meet this person's needs and that they would monitor whether extra staff were required in the afternoon. Where people were admitted to the service staff had obtained relevant documentation such as their previous care records from other services to inform the care planning process. The information gathered through this person's pre-admission assessment had been used by staff to determine what actions they needed to take to meet their needs.

Handover meetings took place at the change of each staff shift to ensure staff were up to date with people's care needs. Nurses had a handover sheet and care staff had a separate one. This ensured staff received the information relevant to their role.

Where people were able to they had signed their care plans to demonstrate their involvement in their care planning. There was evidence staff regularly spoke to people's families about their care and updated them regards any changes. People's care plans had then been reviewed monthly by the nurses and updated more frequently where there were changes to people's care. We saw that although people's care plans had been reviewed by staff, there was little written evidence that people and their relatives had been involved in planned reviews of their care. People might not have had the opportunity to give their feedback on the care provided and any changes required without a review of their care. The interim clinical lead and the provider told us they had approached people's' relatives and asked them to be involved in reviews, although there was no written record to demonstrate this. They told us people's relatives were happy with the care but were reluctant to attend formal reviews. Following the inspection the manager provided written evidence that letters had since been sent to people's relatives to invite them to a review of their loved ones care; it will take time to embed this new practice.

People's care pans reflected their care needs and highlighted to staff what they could do for themselves. A staff member told us how they supported people to retain their independence. They commented "I always offer (person) their walking frame and walk with her. I put food on the table and see if they are able to help themselves." In people's records there was evidence staff had documented what people had achieved for themselves. For example, a person's daily care records noted 'Hair done herself.' A person was observed to go out of the service independently to visit the grounds as they wished during the inspection. People were supported by staff to retain their independence.

Where people experienced dementia they either had a dementia care plan in place or their needs in relation to their dementia such as their communication needs were incorporated into their other care plans. We saw a person's records contained an 'About me' document which provided information and pictures about their background which staff could use to initiate conversation with them. There was basic information about people's needs in their care plans in relation to their dementia, in terms of their communication needs and interests. These care plans would benefit from being developed further to provide a more thorough, detailed and therefore more individualised care plan in relation to people's dementia care needs. This would provide

staff with a greater level of insight into the needs of each person in relation to their dementia.

The manager told us they had recently purchased a new syringe driver. These help reduce symptoms at the end of peoples' life by delivering a steady flow of injected medication continuously under the skin. However, nursing staff felt they required face to face training in its use rather than the on-line training provided with the equipment. The manager was making attempts to source this training as a matter of priority but to date had only been able to find a course in the New Year. This created a potential risk that if a person actually required this equipment nursing staff currently lacked the confidence to use it for them. In this instance the manager informed us they would request nurses from the GP service provide the required training. The service had an item of equipment that nursing staff were not confident to use in the event it was actually needed. There was a plan to address for people but the service would have to reply on support from the GP service to be able to be able to respond immediately if a person had an urgent need for this equipment.

The service had one activities staff member who worked full-time Monday to Friday. They were also supported in the week by a volunteer who was observed to spend time talking with people including those living with dementia which they enjoyed. The provider told us they were in the process of recruiting a second activities co-ordinator to cover the weekends. In the morning the activities staff member read the "Daily Sparkle" with people. This is a reminiscence newspaper that provides information about past events to prompt memories and discussion with people. It also includes some quizzes for people to complete. They told us this was a useful aid to engage people in conversation. We saw a person engaged in conversation using the Daily Sparkle. They also took round the morning coffee to people in their rooms which provided them with an opportunity to visit everyone. The activities staff member provided one to one interaction for those who required this level of support.

Activities included; pamper afternoons, cards, quizzes and lounge games. The activities worker said people usually enjoyed the pamper sessions but it could be a struggle to get people to participate in other group activities. On the first day of the inspection we observed that no group activities ran due to all staff receiving training at 14:00 which was when the activities co-ordinator ran the group activities. On the second day the co-ordinator ran an activity in the afternoon, card bingo. People had requested prizes for games and we saw prizes were provided. It can be difficult to run group activities with small numbers of people. A person commented "When this place was full it was much livelier, I like it like that." The activities worker had been able to take a couple of people out for a coffee or a trip to Marwell Zoo which they said people had enjoyed. People were provided with stimulation but there was scope for increasing the amount of social stimulation available for people in the mornings and at weekends to ensure their needs were fully met.

Care staff told us they would report people's complaints and concerns to the nurse. One care staff member said "I would make sure I went into their room with a witness (if they had complained)." The provider had a complaints procedure, since the last inspection one written complaint had been received. Records demonstrated this had been investigated for the person. There was a process in place for people to make a complaint and these were responded to appropriately.

Records showed a quality assurance survey was completed in June 2016, 10 responses were received. Most of the feedback received was positive. Where one person had raised an issue there was evidence this was being addressed for them. The results had not been collated or analysed to enable the provider and people to review the outcome of the feedback and to identify any trends or themes. We spoke to the manager who was not aware of what action had been taken in relation to the survey results. People's views had been sought but an opportunity to analyse the results and to provide people with feedback had been missed.

The provider told us they were now speaking with people on a one to one basis to canvas their views instead

of using surveys. There was written evidence the provider had visited and spoken with people on four occasions in September 2016, three occasions in October 2016 and twice in November 2016. People had been provided with the opportunity to speak with the provider. However, there was a lack of evidence to demonstrate what the provider spoke with people about, what their feedback was, whether they raised any issues they wanted addressed and if they did what action was taken. In order to make the providers contact with people more meaningful, there needed to be a structured record of the contact and evidence of any actions taken for people.

Records showed the last residents meeting had been held on 16 November 2016 this was attended by four people; and one person's relative. People were asked for their feedback on what Christmas activities they would like. They were consulted about whether they wanted to undertake a monthly exercise class. It was also planned that a singer should be booked to attend the service. People were provided with the opportunity through the residents meetings to give their views.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2016 we found not all systems had been effective at identifying and driving improvements in the service. In the provider's action plan dated 7 September 2016 they informed us processes were in place to address these issues. At this inspection we found systems were still not always in existence, effective or sufficiently developed to consistently keep people safe and to drive continuous improvement.

The manager wrote and told us on 28 November 2016 that there was no separate medication competency assessment for nurses. There was no process as per the National Institute of Clinical Excellence (NICE) guidance on 'Managing medicines in care homes' 2014, to ensure that designated staff (including nurses) administered medicines only when they had been assessed as competent. Nor were arrangements in place for an on-going annual review of nurses' medicines competency as required. There was no process to assess nurses' initial and on-going competence to administer medicines to people safely within the service.

The provider had introduced an audit schedule encompassing weekly, monthly and annual audits. Despite the schedule there was a lack of evidence to demonstrate the provider was consistently following it in relation to what they audited and when. Some audits such as skin integrity were on the schedule as a monthly audit but then the audit proforma stated skin integrity was to be audited weekly. The provider informed us this was actually a monthly audit; this information needed to be reflected on the audit proforma for clarity and to ensure it was completed at the required frequency. Other audits such as a weekly information sheet only appeared to have been completed once on 28 October 2016. Although it was supposed to be a weekly audit there was no written evidence to demonstrate that it had either been completed weekly or if discontinued the reason why. The provider told us they recognised the lack of consistency and that this had occurred due to the changes in management. There was a lack of consistency in determining what was to be audited and when to drive improvement for people.

On 21 October 2016 a monthly record of accidents and incidents had been completed; one incident and two accidents were recorded. There was no analysis of the cause of these or the identification of any trends which might require action for people. The weekly information sheet of 28 October 2016 reviewed: the number of admissions, health and safety, falls, pressure sores, infections, accidents, incidents, safeguarding, complaints, staffing, supervisions and residents meetings. It was noted that four people had experienced an infection that week, the type of infection was noted but there was no analysis of the cause of these infections or any trends which might require action. These reviews were not sufficiently developed to drive service improvement for people.

One staff file audit was completed on 14 November 2016. This identified that there was no proof of photographic identity for the staff member, it stated there were no employment gaps but then went on to say there was a gap from 2010. There was no evidence that their induction checklist had been completed nor their supervision arranged. There was no action plan to demonstrate who was to take responsibility for addressing each action and by when. We had ourselves checked this file on 22 November 2016 and brought to the provider's attention to the lack of photographic evidence and the lack of a full employment history.

When we re-checked the file on 23 November 2016 these items had been supplied. However, completion of these actions had been due to us speaking to the provider rather than a planned action. The audit had failed to identify the other issues we found such as both of the references being provided by two current employees of Ashley Manor. This staff file audit had not been fully effective in identifying all of the issues or addressing them for people's safety.

The audits we reviewed apart from one lacked an action plan to demonstrate who was to take responsibility for addressing each action and by when. Nor was there always written evidence to demonstrate actions had been completed. For example, the provider's pharmacist audited their medicines on 18 October 2016. They noted that the room temperature where medicines were stored was not consistently below 25C as required. This work had been noted as underway in our June 2016 report but had not been addressed by the time of the pharmacist's audit of 18 October 2016. The provider had not taken prompt action to address this for people. It was noted staff were not recording the expiry dates on medicines and recording these. The medicines policy did not reflect NICE guidelines. Medicines training certificates were not available for all staff who were involved in medicines management, which remained the case at the time of the inspection. There was no action plan attached to demonstrate who was to take responsibility for addressing each action and by when. Nor was there any written evidence to demonstrate the actions had been completed. The provider was able to demonstrate they had obtained a cooling unit for the medicines room which was being fitted. We saw action was taken to address the recording of expiry dates with staff. There was evidence the provider was currently in the process of reviewing the medicines policy. The two nurses underwent refresher training in medicines following the inspection. The provider had taken most of the required actions but had not kept a written record to demonstrate the actions taken or to enable them to monitor progress, such as ensuring the two nurses provided evidence of their medicines training for peoples' safety.

A kitchen audit was completed on 7 November 2016. This noted that there was no fridge cleaning schedule and that the kitchen knives were not colour coded. There was no action plan or any written evidence to demonstrate the required actions had been completed. When we spoke with the provider about this they provided evidence the fridge cleaning schedule was in place. The issue in relation to the colour coded knives had not been addressed; the provider told us they could not obtain them. Following the inspection we checked the availability of these products and found them to be readily available. Not using the correctly colour coded knives placed people at potential risk of cross-contamination from foods. The provider had not taken the required action to address an issue they had identified for people and which was readily rectifiable.

Records showed an audit of call bell frequencies and response times had been completed for the period 7 November to 14 November 2016. This identified that a person was using the call bell repeatedly and following the audit a referral was made to the relevant services to source support for the person. There was no written analysis of the average response time to calls to enable the provider to assess how long people had to wait for assistance. This would have been useful in assessing whether call bells were being responded to promptly for people.

Further improvements were needed to ensure all governance systems across the service became and remained effective. The provider did not operate effective quality assurance systems to assess, monitor and improve the quality and risks related to the service. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some visitors told us they felt left out of the current situation regarding the issues at the service, as raised by the CQC reports, and felt unclear what management were doing. Regular management and staff changes had been a cause for concern for many people and visitors.

Since the last inspection there had been further changes to the management team with a new manager commencing their role on 6 September 2016 and the clinical lead having left the service on 28 October 2016. A nurse was acting as an interim clinical lead whilst the provider sought a new clinical lead to support the manager with the clinical expertise required to run a nursing home. These changes have again disrupted progress in implementing all of the required improvements to the service. The interim clinical lead told us "Things are moving forward. We need more time to get things done." The service has not been able to demonstrate stability within the management team over time in order to complete and sustain the required service improvements.

Whilst the new manager had a background in mental health care, they were not a qualified nurse nor did they have experience in managing nursing homes. Neither the new manager nor the service provider had obtained a copy of CQC's guidance for providers on meeting the regulations to ensure they were familiar with the requirements of each regulation. The new manager was not aware of nurses' medicine competency requirements. The new manager was not aware of the requirements of Schedule 3 of The Health and Social Care Act Regulations which outlines what information a service should ensure staff provide to demonstrate their suitability to work with vulnerable people. Without a good knowledge of the regulations and requirements it will be difficult for the management team to develop the service. The new manager appreciated there were gaps in their knowledge and had enrolled themselves on a social care management course to further develop their knowledge and skills. The new manager and the provider were not currently sufficiently familiar with the relevant regulations to enable them to identify for themselves what actions they need to take to fully meet regulatory requirements for people.

The provider told us that there had been challenges to them moving forward with the required improvements. They said that following the original inspection of August 2015 they were complacent in believing they had the right staff in place. The provider told us that since September 2016 they had become much more involved in the running of the service and 'Hands on.' They now feel that they and the manager are working as a team.

Staff feedback about the new manager was positive overall. Their comments included ""I think the manager would listen if I turned to them they would help." "He has shown an interest in what is going on. He is keen to learn. Yes, he is becoming a good manager." "He looks at solutions. He is a good problem solver. He is always out on the floor." A member of staff gave an example of how the manager had intervened promptly to address an issue they had raised. Staff perceived the new manager as available, approachable and willing to help them.

The service has been receiving a considerable amount of support, input and guidance from both the local authority and the local clinical commissioning group (CCG) in order to enable them to meet regulatory requirements and to improve standards for people. Feedback from these agencies was that the service was slow, reactive and there was a lack of appreciation of the depth of the issues; although it was acknowledged that improvements had been made by the new manager. There were concerns about whether the new manager would remain in post and whether a suitable clinical lead would be appointed to ensure the rest of the required changes took place and became embedded into practice in order to improve the service.

For example, the issue of staff not all receiving regular supervision or an appraisal had been identified at the August 2015, January 2016, June 2016 inspections and at this inspection. The provider in their action plan following the August 2015 inspection told CQC that staff supervisions and appraisals would be in place by 9 October 2015. At this inspection we found nurses still had not received clinical supervision and staff appraisals had not taken place. Although considerable help has been provided by external agencies to enable the provider to meet all of the requirements of the regulations the provider has not been consistently

proactive in addressing all issues.

The manager acknowledged that to take more people in "We need to cement the improvements we have made." There needs to be a stable management team; with the correct mix of management and clinical skills to lead the service forward. This will enable the service to complete and embed the actions required to fully meet all regulatory requirements. It will also enable the management team to become fully self-sufficient in running the service and competent at identifying areas for improvement and knowing where to source guidance. At this point the provider is still lacking a permanent clinical lead and is not yet able to demonstrate the service is proactively led by a stable, complete and consistent leadership team for people.

The manager and the provider told us they had been to visit local services to enable them to network with other providers and to see examples of good practice they could apply to the service. Plans were in place for joint training sessions to be held with staff from one of these services. This would enable training to be delivered more cost effectively and for staff to network with staff from other services. People will benefit as staff develop their knowledge and ideas.

The provider's statement of purpose outlined the provider's aims and objectives. These focused on the provision of a therapeutic environment, people's well-being and independence, openness and respect and caring for people. Although staff were not explicitly aware of the provider's aims and objectives for the service they were observed to be caring to people, to treat them with respect and to show concern for their well-being.

Since 7 September 2016 staff meetings have been held on a weekly basis, prior to this the last staff meeting was held on 15 July 2016. At these meetings staff were provided with information about what was expected of them, for example, in relation to the completion of fluid charts; this ensured staff were provided with clear guidance. There have been tensions in the service. Records demonstrated that at the staff meeting held on 12 October 2016 there were tensions between staff and the management team as staff did not feel they had been consulted about changes in their working hours. The manager confirmed to us there were tensions with the staff at that time who were not sure what was happening. They told us they felt these tensions had reduced with the introduction of the weekly meetings. There had been an increase in the level of communication between the management team and staff to ensure people received a smooth service.

Staff reported there had been changes in the culture of the service. One told us "Generally the whole place has improved for me and the residents. Management is 'workable' there is less tension now than before it feels homely to work here now". Another said "I see a nicer change that is of benefit to people here, staff are checking them more regularly, answering call bells quickly and giving fluids." People were cared for in an environment where staff felt improvements to the culture had occurred.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems and processes to assess, monitor and improve the quality and risks related to the service. This was a continuing breach of Regulation 17 (1) (2) (a) (b) (c), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider's failure to ensure there was evidence that all of the required information was available in relation to each staff member employed was a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the provider did not always receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform was a continuing breach of Regulation 18 (2) (a).