

# Bupa Care Homes (CFChomes) Limited

## Ashley Lodge Care Home

### Inspection report

Golden Hill, Ashley Lane  
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New Milton  
Hampshire  
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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	<b>Requires Improvement</b> ●
Is the service effective?	<b>Requires Improvement</b> ●
Is the service caring?	<b>Good</b> ●
Is the service responsive?	<b>Good</b> ●
Is the service well-led?	<b>Requires Improvement</b> ●

# Summary of findings

## Overall summary

About the service: Ashley Lodge Care Home is a care home providing accommodation for up to 77 people. The service provides respite and long-term care for people requiring residential, nursing, and end of life care. At the time of the inspection there were 35 people living at the home, some of who were living with dementia. The accommodation is arranged across two self-contained buildings. Following our last inspection one of these buildings, Oakview, was closed by the Provider. There are no plans to reopen this unit at this time. The Willow and Maple units are based in the main building. Maple Unit is on the first floor and provides a secure environment for people living with dementia or other cognitive impairments.

People's experience of using this service: A range of quality assurance checks continued to be in place. However, further work was needed to ensure that these were being fully effective at driving and sustaining improvements, and at identifying compliance with the Regulations.

Further improvements were needed to ensure that the systems and processes supporting the management of medicines were safe. Some risks associated with people's care continued to not be managed safely. There was evidence of learning from incidents and accidents but also areas where this could have been demonstrated more clearly. We have asked the provider to take some further action with regards to this.

Overall, improvements had been made to the staffing arrangements but these needed to be further embedded to ensure that people were consistently having their needs met in a timely manner.

A team of housekeeping staff were now employed seven days a week to help maintain the cleanliness of the service and they were seen to work effectively to maintain this.

Improvements had been made which ensured that people were treated with dignity and respect and staff were mindful of their privacy.

Further improvements were needed to ensure that planned care was being delivered and that staff consistently escalated concerns about people's clinical needs.

Overall improvements had been made to ensure people's capacity to consent to their care had been appropriately assessed.

Whilst there were still some aspects of the dining experience that could improve further, overall, where people needed support to eat and drink, this was provided in a way that was dignified and respectful of the individual.

Improvements had been made to ensure that staff were adequately supported and had received an induction and ongoing training and supervision.

Staff had a good understanding of how to recognise and report potential abuse.

People were supported to access other health professionals when needed.

Staff were kind and caring and had good relationships with people. They understood people's needs and preferences and provided personalised care. There were increasing opportunities for people to engage in a range of activities.

The premises were generally suitable to people's needs, although we have recommended that the provider continue to explore evidence based practice guidance on how environments can be designed to effectively meet the needs of people living with dementia.

People and their relatives were positive about the improvements made at the service and were confident in the registered manager's ability to continue to embed positive changes.

Rating at last inspection: Inadequate (Report published 28 August 2018).

Why we inspected: At our last inspection in May 2018, we rated the service as 'Inadequate' and placed them in special measures. This inspection was carried out as part of our enforcement process to check for improvements and to review the ratings. We found the provider had made improvements although there remained a breach of the Regulations in relation to risk and medicines management. There were also other areas requiring improvement noted. This meant the service was not yet consistently providing good care.

Follow up: We will meet with the provider to discuss the findings of this report and will continue to monitor the service closely to ensure the provider sustains the improvements already made and improves the rating to at least Good.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective

Details are in our Effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring

Details are in our Caring findings below.

**Good** ●

### Is the service responsive?

The service was responsive

Details are in our Caring findings below.

**Good** ●

### Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

**Requires Improvement** ●

# Ashley Lodge Care Home

## Detailed findings

### Background to this inspection

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

The service has been in special measures since our last inspection which took place in May 2018 when we rated the service as 'Inadequate' in the areas of Safe and Well Led due to widespread breaches of Regulations. Services in special measures are inspected again within a six-month timeframe, when they are expected to have made the required improvements and no longer be rated Inadequate in any key questions. This inspection was carried out to check for improvements.

Inspection team: The inspection team included a lead inspector and a second inspector. On the first day of our inspection, the team also included a pharmacist specialist advisor, a registered nurse specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of care service.

Service and service type: Ashley Lodge Care Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: 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 tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is information we request on at least an annual basis about what the service does well and improvements they plan to make. We sought feedback on the service from the Local

Authority and the Clinical Commissioning Group. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with six people who used the service and 11 relatives. We received written feedback from a further eight people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager and clinical services manager, two regional directors, four registered nurses, two of whom were agency nurses, four care workers, an activities coordinator, a member of the maintenance team, a chef and two housekeeping staff. We also spoke with two visiting health care professionals. We reviewed the care records of eight people. We also looked at the records for two staff that had been recruited since our last inspection and other records relating to the management of the service such as medicines administration records, audits, policies and staff rotas. Following the inspection, we received feedback from a further two health and social care professionals.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- Our last inspection in May 2018 found that risks associated with people's care had not always been identified and actions taken to mitigate these risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We took enforcement action requiring the provider to have made the necessary improvements by the 28 September 2018.
- Whilst improvements were noted, this inspection also found some ongoing concerns with regards to risk management that could impact on people's safety.
- We observed, and a registered nurse confirmed, that one person was being assisted to eat their lunch in a position that was not sufficiently upright. The person had a dysphagia care plan provided by a Speech and Language Therapist (SALT) dated the 14.2.2019 which stated that the person had 'Swallowing problems' and should be 'sitting fully upright'. This SALT guidance was not reflected in the person's eating and drinking care plans.
- The person's eating and drinking care plan noted that the person was not able to chew normal food or a soft diet and so had been provided with a pureed diet for comfort. Whilst this was primarily felt necessary by the home to promote greater intake, a SALT has confirmed to us that the known risk of oral dysphagia, which is an inability to use the mouth and tongue to chew food, does place the person at risk of choking and that therefore they should always be sat fully upright to eat.
- A second person's care records were also found to not fully reflect SALT guidance about their dietary needs and risks.
- Information available in the kitchen about who was losing weight and who was diabetic conflicted with that documented in records used by care staff during mealtimes.
- The nursing handover sheet contained some good information but was also noted to have omissions which would have been useful prompts to support safe care. For instance, there was no mention that one person was experiencing weight loss and their 'do not resuscitate status' was listed as 'None Known'.
- One person was observed to have a table left on top of crash mat next to their bed which could have been injurious to them were they to fall from their bed.
- The service had not demonstrated that it was consistently providing safe care. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- Other risks were being well managed.
- A range of assessment tools and care plans were being used to assess and mitigate risk. These included,

risk assessments regarding the use of bed rails, falls and skin care. One person had a suitable seizure care plan in place to help manage the risks of living with this condition.

- Clinical risk meetings took place weekly and the new clinical services manager undertook daily walk arounds to assist in identifying new or emerging risks.
- The maintenance of the environment and equipment within it continued to be well managed by the maintenance team. Regular checks took place of the fire systems and to protect against risks associated with legionella for example.
- Our concerns about the security of the premises had largely been addressed.
- Visitors were no longer able to access the home without being let in by a member of staff.
- Additional reception staff had been employed to provide cover seven days a week.
- The main entrance was still able to be opened from the inside meaning that people on Willow unit, some of whom had been assessed as being at risk were they to leave the building without an escort, might be able to leave the premises without staffs' knowledge, compromising their safety.
- We discussed this with the registered manager. They were confident that none of the people currently being cared for on Willow unit would be able to leave the premises independently due to their wider needs. We have asked, however, that this be risk assessed on an individual basis so that remedial actions can be taken should any risks be identified.
- People felt safe and their relatives confirmed this. For example, one relative said, "I have no concerns over my mum's care at all now and feel happy she is in safe hands". Another relative said, "I certainly feel that my [family member] is safe, there are measures taken to ensure [person] cannot wander at night nor leave the premises without the staff being made aware".

#### Using medicines safely

- Our last inspection in May 2018 found that people did not always receive their medicines safely and as prescribed. Medicines rounds were lengthy and regularly interrupted. Medicines related incidents were not adequately investigated or analysed for cause or to promote learning. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We took enforcement action requiring the provider to have made the necessary improvements by the 28 September 2018.
- This inspection found that some improvements had been made. The number of medicines errors had significantly reduced. Prescribed agents used to thicken drinks for people with swallowing problems were now being stored safely.
- However, we continued to find other concerns with regards to the management of people's medicines.
- The management of insulin was not always safe. The insulin dose on a medicines administration record (MAR) had been amended and not signed by another member of staff. We were unable to find any documentation which supported the alteration to the insulin dose. The site for administration was not documented. Action has now been taken to obtain this information and this has been placed with the MARs.
- Blood glucose monitoring was not documented appropriately. It was noted that one person often refused for their blood glucose levels to be tested. The persons care plan stated that their GP was happy for insulin to be administered in the absence of a blood glucose result but only if there were no signs of hypoglycaemia (low blood glucose levels). However, there was no record of this being checked before the administration of insulin. The clinical services manager confirmed they would expect this check to be documented.
- The medicines systems were not based on current best practice. The arrangements in place for checking that all the medicines required for the current medicines cycle had been prescribed and supplied correctly were not always effective. The provider had already identified that this was an area where improvements were needed and had arranged a meeting with the pharmacy supplying the medicines to discuss this.
- Records were kept when medicines were administered, however we found that one person's medicines



records contained conflicting information about their allergies. This had not been identified and clarified with a relevant healthcare professional. Where people were prescribed 'as and when required' medicines there were not always protocols to assist staff to understand when to administer such medicines.

- Medicines were not always stored or disposed of safely. There was no awareness of the fire risk associated with emollient creams. Insulin pens were not labelled and did not have an amended expiry date when in use. Devices used to support administration of medicine were not clean.

- The systems and procedures in place did not always support the safe management of medicines. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

## Staffing and recruitment

- At our last inspection in May 2018 the service was in breach of the Regulation regarding the deployment of staff. This was because planned staffing levels were often not being met, people at high risk of falls were, at times, being left unsupervised in the communal areas and people were not able to consistently exercise choice in when they got up for example, due to staffing levels.

- This inspection found that, overall, sufficient improvements had been made and the provider was no longer in breach of this Regulation.

- Neither our observations, or the feedback from people and their relatives, indicated similar concerns, or level of negative impact on people, found in our last inspection in May 2018.

- Throughout the inspection, we did not hear call bells ringing for excessive periods of time and whilst the lunch time service was slow, overall, we observed that people were getting the support they needed to eat and drink.

- Weekly rotas showed that planned staffing levels were being maintained, albeit through the regular use of agency staff.

- Allocation sheets were used daily to help ensure that staff were deployed effectively and were aware of their responsibilities.

- Feedback from staff was generally positive. "One staff member said, "There are definitely the right number of staff on duty, the nurse will always help with personal care and meals". Another staff member told us they had enough time to perform the tasks allocated to them. They said people had choice about when they wanted to have a bath for example. One staff member felt more staff would be helpful, they told us, "Some mornings we are rushed off our feet".

- Feedback from people and their relatives about the staffing levels remained mixed. One person told us, "The levels of staff needs to be improved. There are too many agency staff, especially at the weekends" and another said, "You can wait an age for your call bell to be answered".

- A relative said, "Staffing levels could be improved" and another said, "During the week there are enough staff. However, at weekends there are enough staff on duty but not always permanent staff who know how, what, when [family member] likes to be assisted".

- Other feedback was more positive. Two people told us staff were always there to help when they needed it. And a relative said, "In the last nine months it has improved beyond all recognition, [family member] is really happy, there was so many agency staff, it is improving". Another relative said, "There is definitely improvements at Ashley lodge the main reason of my original concern was the lack of staff which no longer seems an issue".

- However, these improvements needed to be further embedded. Whilst the need for call bells to be answered promptly was being regularly discussed at the daily 'Take Ten' meetings, call bell records showed that people were not yet consistently having their needs met in a timely manner. We were told that it was the providers policy that call bells be answered within nine minutes. Between the 3 and 13 February 2019, there were 57 call bells which took longer than this to answer. Twenty of these had taken longer than 15

minutes and three longer than 30 minutes. We recommend that this requires careful ongoing review to ensure that the numbers of staff deployed remains appropriate to meet people's needs.

- The registered manager advised that recruitment remained a high priority for the service and by April 2019, the service would be fully staffed with regards to day-time nursing team. Additional care hours had also recently recruited to.
- Both the registered manager and provider were confident that the current staffing levels were safe. As further new admissions took place, the registered manager was aware of the need to continue to review staffing levels, taking into account people's changing dependency and the lay out of the building. We were satisfied, therefore, that the registered manager was taking the necessary action to keep staffing levels under review to ensure these remained appropriate.
- Records confirmed that the provider carried out a range of recruitment checks to ensure that staff were suitable to work with people.

### Preventing and controlling infection

- Our last inspection in May 2018 found that there had been a failure to follow effective infection prevention and control procedures. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We took enforcement action requiring the provider to have made the necessary improvements by the 28 September 2018.
- This inspection found that improvements had been made and that the provider was no longer in breach of this part of the Regulation.
- Willow and Maple units were visibly clean throughout including the communal bathrooms and toilets. There were no lasting malodours noted.
- A team of housekeeping staff were now employed seven days a week to help maintain the cleanliness of the service and were seen to work effectively to maintain this.
- Feedback about cleanliness was positive. One relative told us, "Yes its clean and odour free, there is never a single time my nose has never told me anything else" and another said, "Standards of cleanliness have improved markedly over the last six months especially in the bedrooms".

### Learning lessons when things go wrong

- Our last inspection in May 2018 found that there had been a failure to demonstrate learning from incidents and accidents that had occurred within the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This inspection found that overall, sufficient improvements had been made and the provider was no longer in breach of this part of the Regulation.
- Staff understood their responsibility to raise concerns and report safety incidents.
- Accidents and incidents were clearly documented and had been responded to in a number of ways to try and mitigate any further risks. For example, there was evidence of referrals being made to specialist healthcare professionals and equipment being put in place to monitor people's mobility.
- New or emerging risks were discussed at the daily 'Take Ten' meetings and clinical risk meetings.
- Complaint investigations included a section on lessons learnt.
- Where audits of the dining experience had indicated that staff could be working in a more person-centred way, we saw evidence that this was discussed with them as part of their one to one supervision.
- Meetings were already planned to share the findings of our inspection with the staff team to facilitate learning and improvement.
- We did note some areas where the arrangements for reviewing and investigating safety related incidents could be have been developed further. For example, a number of skin tears had occurred within the service between December 2018 and February 2019 without a clear known cause. We have asked the provider to

complete a root cause analysis into this. We also recommend that more detailed analysis of call bell data is undertaken. This should include an investigation into the nature of the call for assistance and the impact of the wait on the person involved. This is to help improve safety and quality of care across the service.

#### Systems and processes to safeguard people from the risk of abuse

- The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.
- The registered manager had been working effectively with the local authority to investigate and learn from safeguarding concerns.
- Staff received training in safeguarding adults from harm and had a positive attitude to reporting concerns. They were confident that these would be acted upon by the registered manager to ensure people's safety.
- Information on the importance of speaking up about poor practice was readily available for staff.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Supporting people to eat and drink enough to maintain a balanced diet

- Our last inspection in May 2018 had found that staff had failed to ensure that people received person-centred support at mealtimes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- This inspection found that, overall, sufficient improvements had been made and the provider was no longer in breach of this Regulation.
- The majority of people we spoke with stated that they enjoyed their meals.
- Relatives were also positive about the food and assistance provided. One relative said, "[family member] has put on a stone in weight, she feeds herself, gets choices, the food is lovely, like homemade food". Another relative told us, "Lunch time meals are relaxed and choices of meals offered. Before it was chaos & noisy".
- Food and drinks were mostly found to be readily available throughout the day and we observed staff supporting people in a patient manner to drink.
- The menu offered two choices for lunch each day. Show plates were also used to facilitate people's choices. Alternatives such as a jacket potato and sandwiches were also available.
- The meals for people requiring pureed food were presented attractively and people were seen to receive food in line with their dietary requirements.
- One person who was often reluctant to sit and eat a meal had been provided with finger foods, placed in their walking aid, for them to graze on throughout the day as they wished.
- There were some areas where further improvements could be made to the lunchtime experience. Whilst most people were being assisted to eat in a patient and kind manner, we noted a small number of less positive or neutral interactions. One person was shown sausages only to be told he couldn't have them. One person was seen to be assisted with their meal by two different staff. A care worker removed one person's plate without asking them and said over their head, 'Do you want pudding, hot or cold'. The person nodded. The care worker placed the dessert in front of them and walked away.
- There was some evidence that staff missed opportunities to offer people cared for in their rooms additional drinks. For example, records for one person indicated that staff supported them with repositioning or personal care tasks on a regular basis, but they did not use this intervention as an opportunity to offer fluids also.
- We have reported in our safe domain on some concerns regarding the safety with which one person was being supported to eat and with regards to the clarity and consistency of some records relating to nutrition which need to be improved.

## Ensuring consent to care and treatment in line with law and guidance

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 checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met."

- Our last inspection in May 2018 had found that staff had failed to ensure that consent was sought in line with the Mental Capacity Act 2005 and its Code of Practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- This inspection found that, overall, sufficient improvements had been made and the provider was no longer in breach of this Regulation.
- Staff had received training in the MCA 2005.
- Where there was doubt about people's ability to make significant decisions about their care, we saw examples where mental capacity assessments had been completed. For example, people had mental capacity assessments regarding the use of sensor mats and living within a secure unit.
- Consultations with relevant people had been undertaken and documented to show how a shared decision had been reached about what was in the person's best interests.
- However, it was not clear that the use of covert medicines (Giving medicines to people without their knowledge) was always taking place in the context of existing legal and good practice frameworks including the Mental Capacity Act 2005.
- We still found examples where documentation had been signed by a third party without it being evident that they had legal authority to do so.
- These are areas for improvement.
- Discussions with the manager demonstrated that they recognised when people were being potentially deprived of their liberty.
- They had been involved in best interest's meetings to discuss how care could be provided in the least restrictive way.
- Applications for DoLS had been submitted where appropriate. We recommend that a monitoring system is implemented to show how conditions attached to people's DoLS are being met.

People needs had been assessed and care plans developed which helped to ensure that staff were able to meet people's needs effectively.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The care plans covered a broad range of needs. For example, people had plans in relation to communication, personal care, mobility, eating and drinking. People had care plans which described how living with dementia impacted upon their needs and safety. Diabetic care plans described the symptoms which might indicate people were experiencing low blood glucose levels.
- Three people had catheters. Two of the three had suitable care plans in place which were in line with best

practice guidance issued by NICE. The third was incomplete but updated following the inspection. The daily care of people's catheters was not clearly logged. Action has been taken to address this.

- One person who had been admitted since our last inspection in May 2018 had had their needs appropriately assessed which helped to ensure that the service would be able to meet them effectively.
- There were areas where people's care plans and supplementary records could be more detailed. One person had been diagnosed as suffering from depression but there was no plan of care which set out how staff might provide support to manage the symptoms of this mental illness.
- Further improvements were needed to ensure that planned care was being consistently delivered and that staff consistently escalated concerns about people's clinical needs.
- The eating and drinking care plan for one person dated 2 January 2019 recorded that fluid balance charts were to be used. This had not been actioned. We saw two other examples where requests for aspects of people's care to be monitored using specific charts had not been actioned.
- Where people had been assessed as needing hourly checks, the records did not always indicate that this was happening.
- Concerns about people's wellbeing had not always been escalated to the nurse in charge. For example, staff had noted that one person's heels were showing some redness, but this had not been shared with the nurse.
- In the case of a second person, there were many recent entries stating that the person was refusing care. There are no documented discussions addressing the impact of this, and of efforts made in response, or of escalation to nurse in charge.
- Although policy, baseline clinical observations were not consistently being undertaken. The registered manager told us there were plans in place to implement RESTORE2. This is designed to support homes to recognise when a resident may be deteriorating and supports them escalating any concerns quickly to health care professionals.
- The provider operated a 'Resident of the Day' system but we found that there was no clear understanding amongst staff of what this should involve. Resident of the day is an initiative that helps care home staff to really understand what is important to each person and to review in depth all aspects of their care within the home.

#### Staff support: induction, training, skills and experience

- Our last inspection in May 2018 had found that staff had not always received appropriate training, supervision and appraisals to support them in their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- Sufficient improvements had been made and the provider was no longer in breach of this Regulation.
- We reviewed the records of two staff who had started at the service since our last inspection. Both had received a suitable induction which had covered a range of essential skills and knowledge such as health and safety, equality and diversity and working in a person-centred way.
- Staff received a range of training deemed mandatory by the provider. This included food hygiene, safeguarding, health and safety, information security and fire training. This training was refreshed periodically and completion rates were currently at 95.6%.
- In addition to the mandatory training, a new annual competency framework was being introduced, during which an in-house assessor evaluated the ongoing knowledge and skills of each staff member in areas such as moving and handling, infection control, dignity and privacy skin integrity, the Mental Capacity Act 2005, dementia and managing challenging behaviour, care planning and person-centred care.
- Staff were positive about the training provided. A registered nurse told us "We have done a lot of training since [registered manager] started, there are a lot of opportunities, I'm doing level five [health and social care qualification] which is helping me to work with our partners.... there is a general approach to upskilling

staff in all areas".

- Where shortfalls were identified in a staff members skills or knowledge, the registered manager acted to address this. For example, group supervisions had been held to remind staff of how to correctly position people when helping them to eat or drink.
- Staff told us they felt well supported and a system of supervision and appraisal continued to be embedded.

Staff working with other agencies to provide consistent, effective, timely care.

Supporting people to live healthier lives, access healthcare services and support

- There was evidence that staff worked effectively with a range of other healthcare professionals to ensure that people's healthcare needs were met. This included GP's and speech and language therapists, diabetes and heart failure specialist nurses. One person had recently been referred to the frailty team and undergone a thorough assessment.
- People were also supported to attend dental and optician appointments and a chiropodist visited the home on a regular basis.
- A relative told us, "The home seeks medical advice whenever required and updates me after doctors' visits".
- A health care professional said, "[Staff] refer in a timely way, [registered nurse] is very good about contractures and getting us in quickly. There are no problems with them following guidelines".
- Another health care professional was positive about the how well the permanent nurses led the twice weekly 'ward rounds'.

Adapting service, design, decoration to meet people's needs

- Overall the design and layout of the home was appropriate for people's needs.
- Each person had their own ensuite room which they were encouraged to make homely with their own personal belongings.
- On each floor there was a small communal lounge and spacious dining room. In addition, on Willow unit there was a dedicated activities room and a hairdressing salon.
- On Maple unit, there were plans to develop the second lounge into a family room, where people could have additional space to spend private time with their relatives or to use for family celebrations.
- There was evidence that the provider continued to invest and update the premises. There was an ongoing programme of redecoration of people's rooms and there was evidence that people's individual preferences about colour, for example, were acted upon.
- The garden had been tidied and new outdoor furniture purchased, although we did note that the garden was not currently secure and recommend that this be reviewed.
- 'First Impressions' audits continued to be undertaken regularly to monitor that the premises were being well maintained.
- There was some evidence that technology was used to support people's care, for example, equipment such as alarm mats were used to monitor people's safety. An upgrade to the call bell system was also planned.
- Personalised memory boxes were located outside each person's room on Maple unit to assist them in recognising their room and there was some limited accessible signage directing people to toilets for example. To develop this further we recommend that the provider explore evidence based guidance on how environments can be designed effectively to meet the needs of people living with dementia.



# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: ☐ People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence

- Our last inspection in May 2018 found that there had been a failure to treat people in a dignified manner and to respect their privacy. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We took enforcement action requiring the provider to have made the necessary improvements by the 28 September 2018.
- This inspection found that overall the required improvements had been made.
- We observed that care was provided in an appropriate manner and people were being treated in a dignified manner. For example, we saw one care worker say to a person discreetly, "Here you are [person], here is a serviette to protect that lovely top".
- Relatives told us staff were mindful of people's privacy and dignity. For example, one relative said "There are some lovely members of staff that are very caring. ... In particular [Staff member] always seems to go the extra mile with making sure my mum always looks clean and tidy in every detail and always makes sure my mums teeth are cleaned properly. Which means a lot to me and my mum even though she can't express that".
- Another relative said, "[Family member] is shown a lot of dignity...she is important, they don't just speak over her".
- A third relative said, "When I have entered [family members] bed sitting room if he is being assisted the door is closed and also the bathroom where he is having personal care".
- We did note a small number of interactions which could have been more person centred, but the feedback we received indicated that the overall culture within the service was one of treating people with respect and that this was role modelled by the registered manager and senior team who were observed to be interacting with people in a dignified manner.

Ensuring people are well treated and supported; equality and diversity

- People told us staff were kind and caring. One person said, "It's not like being at home, but staff are kind and caring" and another said, "The attitudes of most staff are friendly, caring and kind, I find".
- Relatives also commented on the kind and caring nature of the staff. One said, "The staff have shown compassion and understanding". This was a reference to staff managing the persons challenging behaviour and sometimes verbal abuse toward staff.
- Another relative said, "Yes I do feel they are caring. I arrived quite early one morning to find one of the staff helping [family member] to brush her teeth and her hair. She was so caring and wanted [family member] to feel that her hair was right she also called her Mother which [family member] loved. All of this was without the knowledge that I was stood in the door of her room quietly watching so it was not put on for me to see".



- A compliment had been sent to the registered manager thanking staff for celebrating one person's birthday with a cake and there were many other similar compliments.

Supporting people to express their views and be involved in making decisions about their care

- People had plans which described the help they needed to make choices and decisions and we saw that staff involved people in decisions such as which meal they would like to eat and where they would like to sit.
- Relatives were encouraged to take an active part in their family members care and we observed them helping people with their meals and taking part in the activities.
- Relatives told us they were made to feel welcome and able to visit at any time. We observed that they too had a good relationship with staff and the registered manager. One relative said, "I feel really welcomed, including by the laundry and cleaning staff and the maintenance chap".
- Relatives told us their family members independence was promoted. For example, one said "[family member] has had some mobility issues recently, but they are trying hard to keep her walking".

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Improving care quality in response to complaints or concerns

Our last inspection in May 2018 found that there had been a failure to respond appropriately to people's concerns or complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- This inspection found that improvements had been made and that this Regulation was now being met.
- Relatives told us they knew how to make a complaint and would be happy doing so. One said, "Obviously issues can occur but I know the management team will listen and take steps to investigate and improve if I notice anything". Another relative told us issues or concerns were "Dealt with on the spot".
- Some of the people we spoke with were less confident about who they should speak with, but all bar one said they had no reason to complain. The registered manager was aware of the concerns of one person and we could see that action had been taken to address these.
- Complaints received had been investigated and responded to although one had not been responded to in line with the providers time frames.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Our last inspection in May 2018 found that there had been a failure to provide personalised care that was responsive to people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- This inspection found that, overall, improvements had been made and that this Regulation was now being met.
- Most, but not all, relatives told us they had been involved in reviews of family members care. For example, one relative said, "[Registered nurse] does a monthly review and looks at any changes, we had one on Sunday". Another told us they had had some 'Really good discussions' with staff and came away "Feeling confident [family member] was really well cared for".
- There was less evidence that people had been involved in these monthly reviews and this is an area which could be further developed.
- Many of the concerns at our last inspection in May 2018, regarding, access to, and the accuracy of, records related to the Oakview Unit which was no longer open.
- On Willow and Maple units, overall, care plans provided a person-centred record of people's preferences and current needs.
- Each person had a 'My Day, My Life, My Story' document in their rooms. This provided key information about their life before coming to live at the home including their jobs, close friends, pets and hobbies. Alongside this there was a summary of the person's key needs. This information was readily available to staff.

- Our observations and discussions indicated that the permanent staff knew people well and knew how to meet their needs. They knew how and where people liked to spend their time and the things that were important to them. For example, staff made a point of putting one person's handbag on the back of her chair at lunchtime, knowing that this was important to them. We observed one care worker speaking to a person about the job they used to do and what this had been like.
- Relatives felt that the permanent staff also knew their family members well and were responsive to their needs. For example, one relative said, "The knowledge and ability of the staff certainly seems to have improved and when I ring, the staff generally can give me an update".
- Our last inspection had recommended that the activities provision be reviewed to ensure this was meaningful and in line with people's interests, hobbies, likes and preferences.
- This inspection found that some improvements had been made and continued to be embedded. There were now planned activities seven days a week and one of the lounges had been made into a dedicated activities room.
- In the morning there was a focus on providing one to one time, with planned group events usually taking place in the afternoon.
- We saw staff doing jigsaws with people and reading poetry to them. Staff had noted that doll therapy helped one person, living with dementia, and a crib had been set up in their room, all of which was proving effective at supporting the person to have periods when they were less anxious or distressed.
- Plans were being made to assist another person access a local hydro pool and to visit a local steam train.
- The planned activities included magic shows, pamper hours, move and groove sessions, knit and natter groups, external performers and visits from a local church. Movie afternoons were also held.
- Records showed that people cared for in their rooms were getting regular visits from the activities staff, although it was not recorded how long they spent with each person and we have recommended that this be done moving forward to assist the management team with auditing the quality of these interactions not just the frequency.
- Other improvements included the provision of trips out to local places of interest twice a month on the local community mini bus.
- Some people told us they were unaware of the planned activities, although, we did see that these were advertised in communal areas and saw that people had been sent a print out of the week's events.
- Relatives were positive about the improvements to the activities. One said, "We had alpacas last Friday and there is a singalong this afternoon, I can't believe the change". A second relative told us, "In the last week or so they have even managed to get [family member] into her wheelchair and encourage her to take part in some activities. A third relative, whose family member was unable to verbally communicate, told us how staff had asked what his wife liked. They had explained that she liked flowers. On their next visit, they found the activities staff spending time with their family member looking at pictures of flowers.

## End of life care and support

- There was some evidence that people and their relatives were supported to discuss their preferences for their care at the end of their lives. 'My Day, My Life, My Future' care plans were in place to record these wishes, although there was scope to develop these further.
- Feedback from healthcare professionals was that staff worked effectively with them to help people have a pain free and dignified death, remaining at the home if this was their wish.
- A relative of a person being cared for on an end of life pathway told us, "The RGN's and senior care staff have been very diligent and professional in their care of [family member], and above all, have shown kindness and empathy with me and my family, and have kept us continually informed of her condition. I feel secure in the knowledge that, when I leave [family member] after a visit, she is being well cared for and in good hands". A second relative had written to the service thanking them for 'Exemplary' end of life care

provided by the nursing team.

- The numbers of staff currently trained in end of life care were low but there were plans in place to deliver this training across the staff team by the end of April 2019.
- The registered manager was also planning a medium-term goal of enrolling key staff on a programme that would support them to become champions or experts with access to current national and local information needed to develop their knowledge and skills and then share this with and educate staff within the service.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care.

- Our last inspection in May 2018 found that there had been a failure to have effective systems in place to assess and mitigate risks to the quality of care provided and to drive improvements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- We took enforcement action requiring the provider to have made the necessary improvements by the 28 September 2018.
- This inspection found that overall sufficient improvements had been made.
- The provider had made arrangements for a team of senior management to support the registered manager implement a programme of improvement at the home.
- A comprehensive range of quality audits and checks were being carried out regularly.
- A monthly 'Quality Metrics' report was produced allowing the registered manager and provider to have oversight of a number of clinical quality indicators. A review of the most recent report showed that the prevalence of medicines errors, falls and weight loss had all reduced over the last six months.
- Any actions identified as a result of audits or checks were added to a quality improvement plan managed by the regional director and registered manager. This listed all the areas where improvements were planned or needed, and the timescales for these to be achieved. Whilst this still highlighted a number of areas for improvement we were also able to see that a large number of tasks had been completed. For example, a relatives committee had been formed and activities and housekeeping staff were now in post seven days a week.
- The new clinical services manager had only been in post for three weeks when we inspected, but had already gained a good understanding of the areas where improvements were needed to support the delivery of good clinical care. This was being embedded using weekly clinical meetings.
- Following our inspection, we were sent an action plan which highlighted some of the immediate actions that were being taken to address our findings. This demonstrated that the provider was receptive to feedback and committed to making improvements.
- However, there was evidence that the systems in place had not been consistently effective in assessing, monitoring and improving the quality and safety of the service.
- For example, a number of the concerns this inspection identified in relation to medicines management had been identified previously by both external and internal audits but this had not resulted in effective change or improvements.

- Care plan reviews and audits were undertaken but had not been fully effective at identifying shortfalls within the care plans and other documentation described throughout this report.
- The registered manager recognised that there was still further progress to be made. They told us that a minimum of six months was still needed to embed changes so that person centred care and undertaking key tasks became second nature for all staff.
- At our last inspection in May 2018 the service was in breach of Regulation 13. They had failed to notify the local authority of a number of medicines errors and failed to notify the Care Quality Commission of another safeguarding event as they are required to do. At this inspection we found the provider had made the required improvements and was no longer in breach of this Regulation.
- The registered manager had, overall, a good understanding of their responsibility to notify the Care Quality Commission of significant events which had occurred within the service

#### Planning and promoting person-centred, high-quality care and support;

- Relatives were very positive about the improvements which had taken place since our last inspection in May 2018. Many felt this was down to the efforts of the registered manager and her commitment to drive improvements.
- One relative said, "I feel it is a happier environment for all. If staff are happy then the home is happy and the needs of the residents are in good hands".
- Another relative told us, "In the last nine months, the improvement is beyond recognition...I can't believe the change.... everything all round has come up... [registered manager] has been very active, initially I was knocking on her door every day, but it was dealt with there and then...she is very transparent, quite brave, she challenges staff, has put in a lot of hours...she really cares about the residents individually".
- Whilst the results from a survey undertaken in September 2018 indicated some dissatisfaction amongst the staff group, the staff we spoke with were positive about the registered manager and told us they felt well supported. One staff member said, "[The registered manager] is a supportive manager, you could go to her for anything".
- Staff told us morale and teamwork had improved. For example, one staff member told us, "Staff were stronger", and had "learned to work well together".
- All of the staff we spoke with told us there had been improvements and that the registered manager had made a positive impact. One said, "It's a totally different place, everyone has worked so hard, I love working here.... [registered manager] is fantastic". Another said, "[The registered manager is committed, she will never say no, if you call her even if she is on a day off she will help you. She will deal with things if she sees it. We can see the difference now".
- To address the areas where staff feedback was less positive, an action plan had been developed which included weekly 'open office' sessions with the manager and 'listen up' sessions facilitated by the provider.

#### Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were being encouraged to give their feedback about the quality of the service through residents and relatives meetings and satisfaction surveys.
- A 'You said, we did' culture was beginning to be embedded within the home. For example, there was a notice board which showed that people had asked for trips out in the mini bus. This was now happening. A committee had been set up to plan improvements to the garden area which were already underway.
- Staff meetings were also held during which staff were asked for their ideas about how practice and care might be improved.
- A staff reward scheme was in place to thank staff for their hard work and staff sickness had reduced by half

since July 2018 indicating a more engaged workforce resulting in better continuity of care for people using the service.

- The registered manager had plans to further promote the dementia café held at the service to members of the local community, providing a safe space allowing caregivers and people living with dementia to get together and provide a support mechanism.

#### Working in partnership with others

- Since our last inspection, the service had been working in partnership with the local authority, safeguarding teams and local Clinical Commissioning Group under a quality improvement framework. The local authority was satisfied with the progress that had been made and a decision had been reached to remove the service from this framework.
- To ensure that people received better joined up care when they transferred in or out of the service, the registered manager was embedding the use of the 'Red Bag Scheme'. This requires staff to pack a dedicated red bag that includes the person's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. It facilitates a smoother handover of care between the care home and ambulance or hospital staff.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The service had not demonstrated that it was consistently managing risks to people's safety and wellbeing.</p> <p>The systems and procedures in place did not always support the safe management of medicines.</p> <p>This was a continuing breach of Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.</p>