Mimosa Healthcare (13) Limited (In administration)

White Ash Brook

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out an inspection of White Ash Brook on the 17, 18 and 19 November 2014. The first day was unannounced. We last inspected White Ash Brook on 5 February 2014 and found there was a breach of Regulation 9. This was because the planning and delivery of care did not fully protect people from receiving inappropriate or unsafe care.

The service provides nursing and personal care for up to 53 people. Accommodation is provided in single en-suite rooms. At the time of our visit there were 44 people accommodated in the home.

The home was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they were cared for very well and they felt safe. They said they had never had any concerns about how they or other people were treated. Staff were described as being 'very good', 'helpful' and 'nice'. Routines were seen to be flexible to accommodate people's varying needs and there were no institutional practices observed. People identified as having some difficulty making choices or expressing their needs were supported. People who would act in their best interests were named, for example a relative.

People were cared for by staff that had been recruited safely and were both trained and receiving training to support them in their duties. As a result of quality monitoring an improved approach to staff selection was taken to make sure staff selected were considered to have the right qualities and characteristics to provide person centred care. Staff had relevant training to support them in their role and in response to people's changing needs, although new staff had not completed all required training. This was in progress. Staff were kept up to date with changes in people's needs and circumstances and new staff were mentored by senior staff.

Staff were confident to take action if they witnessed or suspected any abusive or neglectful practice. Not all staff had a good understanding of The Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS), but had an awareness of the principles behind it. The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We were given reassurance training was planned for and would be provided in the near future.

People who may be at risk of falling, developing pressure ulcers, or may not eat enough were identified and action taken to minimise the risk. Some people living in the home behaved in a way that could place themselves and others at risk of harm. We found an assessment tool was used to help staff identify reasons for changes in people's behaviours. This supported staff to take a pro-active approach to prevent any occurrence of this nature.

People had their medicines when they needed it. Medicines were managed safely. We found accurate records and appropriate processes were in place for the ordering, receipt, storage, administration and disposal of medicines.

The home was warm, clean and hygienic in all areas and people were satisfied with their bedrooms and living arrangements. Two bedrooms were identified as being problematic in odour control despite near daily carpet shampooing. Cleaning schedules were followed and staff were provided with essential protective clothing. There were contractual arrangements for the disposal of clinical and sanitary waste and the water supply was monitored for the control of Legionella. Water temperatures at source were maintained at a safe temperature.

Each person had an individual care plan although not all staff said they read these. Staff discussed people's needs on a daily basis and following any changes in people's needs. They took part in 'resident of the day' activities. This involved looking at people's care and welfare and their environment. Senior staff had taken lead roles, for example dignity in care, medication, fire safety, health and safety and infection control. People were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed.

A variety of activities were provided. The activity co-ordinator also engaged with people who preferred to or benefitted from having one to one activity sessions. Memory boxes and diaries were being introduced and visiting arrangements were good.

People told us they were confident to raise any issue of concern and that it would be taken seriously. Complaints were monitored and information used to bring about improvements if needed. There were opportunities for people to give feedback about the service in quality assurance surveys. Recent surveys showed overall satisfaction with the service.

People told us the management of the service was good although one person told us they thought there was still room for improvement. Staff, relatives and people using the service told us they had confidence in the registered

Summary of findings

manager and deputy manager. There were processes in place to support the registered manager to account for the actions, behaviours and the performance of staff and deal with this effectively.

During the inspection we found the service was meeting the required legal obligations and conditions of registrations. At the last inspection there was an outstanding breach in regulation because the planning and delivery of care did not fully protect people from receiving inappropriate or unsafe care. We found there had been significant improvements in meeting the required standards relating to this regulation.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe. Staff had a good understanding of what constituted abuse and were confident to report any abusive or neglectful practice they witnessed or suspected.

The home had sufficient skilled staff to look after people properly. However the deployment of staff at critical times such as when people got up and meal times did not always match with people's needs on the dementia unit. This was being dealt with. During our visit we observed staff in attendance in all areas of the home and people's calls for assistance were promptly responded to.

People had their medication when they needed it. Appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines.

The home was clean and hygienic.

Is the service effective?

Good

The service was effective. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate action was taken to make sure people's rights were protected. Decisions made took into account people's views and values.

People had access to healthcare services and received healthcare support.

Staff were supervised on a daily basis. All staff received a range of appropriate training and support to give them the necessary skills and knowledge to help them look after people properly and support people's changing needs.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Food served was nutritious and plentiful and people told us they enjoyed their meals.

Is the service caring?

Good

The service was caring. People we spoke with and relatives visiting told us they found the staff to be very caring. One relative told us staff kindness and compassion extended to them and they took comfort knowing this.

We found staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Where people required one to one support such as with eating and personal care this was given in a dignified manner.

The service recognised the importance of people's preferences and choices for end of life care. They had established good links with GP's and health care workers should their support be needed to prevent unnecessary admissions to hospitals.

Summary of findings

Is the service responsive?

Good

The service was responsive. People were given choices on how their care was given including the gender of their carer. People received care and support which was personalised and responsive to their needs.

People were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed.

There were opportunities for involvement in regular activities both inside and outside the home. People were involved in discussions and decisions about the activities they would prefer which helped make sure activities were tailored to each person.

People knew how to make a complaint and felt confident any issue they raised would be dealt with promptly. Records showed complaints had been investigated and responded to by the registered manager.

Is the service well-led?

Good

The service was well led. The registered manager monitored people's care and support and worked with other professionals to make sure people received appropriate care and support. The registered manager was committed to on-going improvement of the service and had a clear vision for providing good person centred care.

The quality of the service was monitored and had resulted in improvements being made with staff and the environment.

There were effective systems in place to seek people's views and opinions about the running of the home. This was supported by a variety of systems and methods to assess and monitor the quality of the service.

White Ash Brook

Detailed findings

Background to this inspection

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

We last inspected White Ash Brook on 5 February 2014 and found there was a breach of Regulation 9. This was because the planning and delivery of care did not fully protect people from receiving inappropriate or unsafe care

This inspection took place on 17, 18 and 19 November 2014 and was unannounced.

The inspection team consisted of a lead inspector and an expert by experience, who had experience of older people's services including dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The provider completed a Provider Information Return (PIR) that was given to us when we visited the service. 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 also spoke to the local authority social work and safeguarding teams, who provided us with feedback about the service. We reviewed information we currently held about the service that included notifications we had received prior to our visit.

We spoke with 12 people living at White Ash Brook, six relatives, eight care staff, a registered nurse, the registered manager, deputy manager and a representative of Harbour Healthcare. We observed care and support in communal areas and also looked around the premises and in some people's bedrooms. 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 looked at a sample of records including three people's care plans and other associated documentation, recruitment and staff records, medication records, policies and procedures and audits.

Is the service safe?

Our findings

We spoke with 12 people using the service and with six relatives who regularly visited the home. We asked people living in the home and visitors to the home if they had ever had cause for concern with regard to how staff treated them and other people using the service. One relative said, "No definitely not. I think they (staff) are very patient and considerate with people. They deal with all sorts of challenges on a daily basis. Well, some people don't know what they are doing." Another relative said, "They (staff) are marvellous with him and I'm very grateful." People living in the home told us they felt safe and were looked after well. Comments included, "The staff are very good. I can easily speak up if I'm not happy about anything; I'm not frightened to say my bit." And, "They are very good, no complaints in that direction."

Staff we spoke with told us people determined their own day. People using the service and relatives told us there were no institutional practices imposed such as what time people went to bed or got up in the morning. All routines were flexible enough to accommodate this. Staff spoke respectfully to us about the people they supported, and we observed they used safe ways of working, for example, when they assisted people to mobilise.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. We observed for example breakfast was served whenever people arrived in the dining room. People were able to walk about freely within the units and staff offered assistance when needed. People were comfortable around staff and did not show any signs of distress when staff approached them.

We looked at four staff recruitment files and spoke with three members of staff about their experiences of the recruitment and induction process. We found completed application forms, references received and evidence the Disclosure and Barring Service (DBS) were completed for applicants prior to them working. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helps employers make safer recruitment decisions. Staff told us they had completed an induction training programme and had shadowed more experienced staff when they started. They were given support and supervision, and were currently doing training. This included emergency procedures such as fire and first aid and the safe moving and handling of people.

We had received concerning information prior to this inspection telling us there were not enough staff to make sure people had the care and support they needed. We were given examples such as people not being changed regularly and people remaining in bed. We looked at the staffing rotas. We found the home had sufficient skilled nursing, care and ancillary staff to meet people's needs. We found the deployment of staff and routines at critical times such as when people got up and meal times did not always match with people's needs on the dementia unit. Equally some staff working on the unit had not been trained in dementia care. We discussed this with the manager and deputy manager. They told us there had been a big recruitment drive with emphasis on selecting people with the right qualities for the job. There had been a high turnover of staff due to the high standards set and this had resulted in several staff leaving. Significant progress was being made with recruitment and existing skilled and experienced staff were good role models for the newer staff to follow.

Staff spoken with told us any shortfalls, due to sickness or leave, were covered by existing staff or by regular agency staff. A relative said, "There does seem to be enough staff but the people here are quite challenging. That's when you need more staff." Another relative told us, "They do seem to be short of staff at times." During our visit we observed staff in attendance in all areas of the home and people's calls for assistance were promptly responded to.

We discussed safeguarding procedures with staff. They were clear about what to do if they had any concerns and indicated they would have no hesitation in informing the registered manager if needed. Staff were confidently able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. One staff member told us, "It doesn't matter who they are, if they aren't right with people they shouldn't be in this job. We have to protect people." There were policies and procedures in place for their reference including whistle blowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. There was guidance displayed informing people about abuse and

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who to inform if they suspected abuse was taking place. New staff told us they had not been formally trained in safeguarding vulnerable adults. We discussed this with the deputy manager and were told all staff were trained as routine and they were currently arranging a safeguarding training event.

We were able to establish risk assessments linked to peoples' welfare and safety had been completed and the management of known risk planned for. People who may be at risk of falling, developing pressure ulcers, or may not eat enough were identified. We found an assessment tool was used to help staff identify reasons for changes in people's behaviours that may challenge others and place themselves and others at risk of harm. This helped staff take a pro-active approach in recognising and taking preventative measures before a person's behaviour escalated and made people's support difficult to manage. Not all staff were familiar with existing risk assessments for people. New staff told us they took guidance from more experienced staff. We discussed this with the deputy manager as without formal guidance, people may be at risk of receiving inappropriate or unsafe care. The deputy manager told us they would address this as all staff were required to read and familiarise themselves with care plans.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. Arrangements were in place for confirming people's current medicines on admission to the home. Medication was delivered pre packed with corresponding Medication Administration Records (MAR) sheets for staff to use. We looked at MAR sheets and noted safe procedures were followed where hand written records of medication were used. We found that where new medicines were prescribed, these were promptly started and that sufficient stocks were maintained to allow continuity of treatment. People requiring urgent medication such as antibiotics received them promptly. Arrangements with the supplying pharmacy to deal with medication requirements were good and medicines were disposed of appropriately. All records seen were well maintained, complete and up to date and we saw evidence to demonstrate the medication systems were checked and audited on a regular basis.

Appropriate arrangements were in place for the management of controlled drugs. These are medicines which may be at risk of misuse and require extra monitoring. Controlled drugs were stored appropriately and recorded in a separate register. We checked five people's controlled drugs and found they corresponded accurately with the register. Care records showed people had consented to their medication being managed by the service on admission. Where medicines were prescribed 'when required' or medicines with a 'variable' dose, guidance was recorded to make sure these medicines were offered consistently by staff as good practice. Medicines required at different times during the day were managed well. The deputy manager told us all staff designated to administer medication had completed training. Staff confirmed this. We checked the policies and procedures relating to medication and found these reflected good practice.

We checked the arrangements for keeping the home clean and hygienic. We had received a concern during the year relating to the standard of hygiene in one persons' bedroom and en-suite. We found the home to be clean and hygienic. All of the toilets and bathrooms we checked were clean and had hand washing soap dispensers and paper towels. En-suite facilities in bedrooms were also clean and hygienic. There were two domestic staff and a laundry staff on duty at the time of our visit. We discussed cleaning arrangements with a domestic staff. They showed us the cleaning schedule they completed on a daily, weekly and monthly basis and the cleaning products they used. Two bedrooms were identified as being problematic in odour control despite near daily shampooing. We were told there were plans to replace these floor coverings in the near future.

There were policies and procedures in place for the control of infection and infection control audits were undertaken regularly. Staff were provided with personal protective equipment such as disposable gloves and aprons. There were contractual arrangements for the disposal of clinical and sanitary waste. The water supply was monitored for the control of Legionella and water temperatures checked to monitor water at source was at a safe temperature for people using the service.

Security to the premises was good and visitors were required to sign in and out. We discussed some areas we saw needing attention such as the exposed pipes in the bathrooms and paving around the home that was uneven

Is the service safe?

and unsafe. We were told the bathrooms were to be refurbished and the outside of the premises improved. This was currently in hand with evidence contractors were currently working on the improvements being made.

Is the service effective?

Our findings

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. Not all staff we spoke with demonstrated a basic awareness of these. The deputy manager reassured us new and existing staff would receive training on the topic.

There was clear evidence to support appropriate action had been taken to apply for DoLS authorisations in accordance with the MCA code of practice. The deputy manager told us they had not yet been approached by social services. They were currently waiting for a response to their applications for assessment to support any decision made to deprive a person of their liberty in order to safeguard them.

The deputy manager told us several people had Do Not Attempt Resuscitation (DNAR) consent forms in place. We discussed the protocol that had been followed to deal with this. We established best practice approach was taken and the MCA code of conduct and practice followed when the decision was considered and the person's views and values taken into account. These had been reviewed periodically.

People had a contract outlining the terms and conditions of residence that protected their legal rights. We had received some concerning information prior to our visit regarding contractual arrangements that were breached as a period of notice to leave was not given. We discussed the breakdown of the placement with the registered manager and deputy manager. We were told that in the interest of the person involved, this was the best decision to ensure they got the right level of expert help. We looked at pre admission assessments for two people. We found information recorded was basic. We discussed the need to make better records to support a judgement as to whether the service could effectively meet people's needs. The deputy manager assured us all relevant questions were asked but they would in future make sure all information disclosed was recorded.

During our visit we observed people being offered choices and consenting to care and treatment. Staff we spoke with were aware of people's capacity to make safe decisions and choices for themselves. Assessment of people's needs included mental capacity and also included information about their preferences and choices to help staff to support them as they wished. Pictorial signage was used where necessary such as for toilets and bathrooms.

New staff we spoke with told us they had or were working through induction training. They told us they had one to one supervision during their trial period. We found a high proportion of new staff working on the dementia unit in ratio to skilled staff. We discussed this with the registered manager as we had received a concern prior to this visit; people were being cared for by staff without relevant training, qualifications and skills. The deputy manager told us recruitment of staff had taken into account selecting people with the right attitudes and behaviours for dementia care. They emphasised the importance of these qualities and assured us there was a training plan in place to provide new staff with the relevant training and staff were currently working through this programme of training. The manager also told us their existing senior staff on the dementia unit were excellent carers and good role models for new staff. The registered manager also acknowledged this could be strenuous for the seniors as new staff were dependent on their continuing guidance. As new staff became more competent this should relieve the pressure of mentoring.

Records we looked at showed us people were registered with a GP and received care and support from other professionals. We saw that people were referred to other health and social care services as necessary such as mental health and social services, district nurse, falls prevention team and dietician. Routine checks including eye care, dentistry and chiropody were also planned for. People we spoke with told us if they needed their doctor to visit this was arranged. Relatives we spoke with told us their family member received the right health care support to ensure their wellbeing. A record had also been maintained of all health professionals' visits and of the outcome of these visits. Staff members we spoke with told us they had regular meetings to discuss changes in people's needs. This meant staff was kept updated of any changes in people's conditions and of any advice given or instructions to follow.

Staff spoken with had a good understanding of their role and responsibilities and of standards expected from the registered manager and provider. We discussed training opportunities with them. They told us they were given

Is the service effective?

opportunities and time to attend training. Training records showed most staff had been trained in moving and handling, fire safety, first aid, health and safety and safeguarding. One staff recently employed had not received moving and handling training since they started work. We discussed this with the registered manager. We were told us there was a training plan and their priority was to train new staff and train all staff in dementia care and end of life care.

We asked staff if they received supervision and had support from their managers. They told us they did have supervision but this was not often. They were however kept up to date with changes in people's needs and circumstances at the start of every shift with daily handover meetings everyone attended. The registered manager told us all staff had appraisals and were supervised on a daily basis which allowed work performance and development needs to be monitored. Formal supervision was planned for in the coming months.

We looked at measures the service had taken to make sure people were supported to have adequate nutrition and hydration. Nutritional needs had been assessed on admission and had continued to be assessed as part of routine review of care needs. Risk assessments were in place to support people with particular nutritional needs. We saw for example staff were instructed to weigh people and report any loss in weight or problems people had. All care plans we looked at contained a nutritional risk assessment.

We observed lunchtime on two days of our visit. We noted people were given support and assistance as necessary to eat their food. All of the residents we spoke with said that the food served in the home was excellent. There were good choices on offer and the cook actually visited everyone to inform them as to the days' menu. We noted people who could not use words effectively were offered a visual choice.

Meal times were unhurried; however two people became unsettled as they were waiting for their meal to be served. We had noted staff had sat people at the table some twenty minutes before the meal had arrived. We discussed the organisation of meal times as people with dementia do not always understand time and orientation to their surroundings. Staff told us it was not always like this and the meals had been a little late arriving. On the second day of our visit we noted a marked improvement.

We observed people who did not settle to eat their meal when it was served, were able to eat their meal later. We discussed this with the chef as we had been told prior to this inspection sometimes meals had been returned to the kitchen not eaten. The chef told us sometimes plated meals were returned, but these were kept to be heated and served when people were ready to eat later in the afternoon. This usually happened when people had a late breakfast. They said, "If people want to eat later they can. Sometimes people get up late and they have a good breakfast. It makes sense to eat lunch later and so we accommodate this." They also told us they catered for different dietary needs such as diabetic and soft/pureed requirements. These foods were served as separate components on people's plates to allow people to experience different tastes.

Care records included information about the risks associated with people's nutritional needs. People at risk were monitored and food and fluid intake charts were maintained. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

Is the service caring?

Our findings

People we spoke with said they were cared for very well. One person commented, “I love it here and everything about this place is great. The staff are very good with me, my room is lovely and the meals are too.” People we spoke with also considered staff helped them maintain their dignity and were respectful to them. From our observations over the three days we were at the home, we found staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care. Calls for assistance were responded to promptly and staff communicated very well with people. Where people required one to one support such as with eating and personal care this was given in a dignified manner.

The service had policies in place in relation to privacy and dignity. Staff induction covered principles of care such as privacy, dignity, independence, choice and rights. The manager told us one staff member was appointed their ‘dignity in care’ champion.

We spoke with four relatives visiting the home. They told us they were always kept informed about what was going on. One relative said, “It is a while since we had a meeting about his care. I’m in every day so I am involved. He can’t always tell them what he wants but they seem to understand him very well. He has clean clothes and bedding every day and he is well looked after. I have no problems at all; perhaps more staff on duty would be welcome. They all work so hard.” Another relative told us, “I visit when I can. They (staff) are marvellous with him. It’s very emotional to see him like this when you know what he was like before. It speaks volumes when not only do they care about him, but show they care about you and how you are feeling. I couldn’t fault anything they do and take comfort when I leave he is well looked after.” Relatives told us visiting arrangements were very good and they were made to feel welcome by all the staff.

We looked at three people’s care plans and a selection of records relating to other people’s care. Areas covered and planned for included known medical problems, mobility needs, dietary requirements, medication, daily care needs, and also social areas of need. There was evidence in daily records we viewed, staff responded to people's needs as required.

We spoke to care staff on duty and discussed people’s care needs and the support they provided. Staff gave a good account of and showed understanding of the varying needs of different people we had discussed with them. We saw that staff were observant and noticed changes in people’s needs, particularly changes in people with dementia care needs. Staff reported concerns promptly to senior staff and took guidance on action they needed to take.

Staff knew what was important to people and what they should be mindful of when providing their care and support, such as visual and hearing impairment. Staff told us they enjoyed their work. One staff member said “I enjoy working here and have nothing to complain about.” Another staff member said, “I really enjoy it here. Seniors delegate duties and everyone knows their job. They seem to match skills to people so everyone is supported.”

As part of our observations we checked on people who stayed in their room in order to gain an insight into how their care was being delivered. We saw people were attended to regularly throughout the day. Staff were observed to knock on people’s doors before entering although on two occasions after knocking on the doors staff walked in before being invited. Doors were closed when personal care was being delivered.

People had created a home from home environment in their room with personal effects such as family photographs, pictures and ornaments. Bedrooms had locks on that were the type not operated by a key.

We discussed end of life care with the manager and deputy manager. They told us they planned for staff to be trained in end of life care to build upon their existing skills. The registered manager told us it was important people’s preferences and choices for end of life care was acknowledged and they had established good links with GP’s and health care workers should their support be needed to prevent unnecessary admissions to hospitals.

Is the service responsive?

Our findings

We looked at assessment records for four people. These had been carried out by a suitably qualified member of staff. Although basic they included information about the person's care and welfare needs and mental capacity. This provided staff with some insight into their needs, expectations and life experience. People identified as having some difficulty making choices were supported during this process. We saw people who would act in their best interests were named, for example a relative. Emergency contact details for next of kin or representative were recorded in care records as routine. Relatives told us they were always contacted if there were any significant changes to their relation's needs. People were given choices on how their care was given including the gender of their carer.

The home had systems in place to ensure they could respond to people's changing needs. For example staff told us there was a handover at the start and end of each shift. They discussed how people were and any concerns they had. They also had meetings to discuss any incidents that had occurred so preventative measures could be put in place to prevent a re-occurrence such as increased supervision of people who presented behaviours that challenged others.

People were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed. There was evidence of involvement with district nurses, dietician, community mental health team and other health and social care professionals involved in people's care. We saw two people had one to one 24 hour care provided.

We asked the registered manager how essential information was relayed when people use or move between services such as admission to hospital or attended outpatient clinics. We were told staff escorted people if needed and all relevant details were taken with them and any information or guidance from the hospital, GP or outpatients was recorded and discussed to support people's continuing care.

We observed people making Christmas cards, others enjoying a game of bingo and some people were given one to one activity sessions with the activity co-ordinator . We observed people using the sensory sitting area at different times during our visit. We spoke with the activity co-ordinator about the activities people were involved in. We were told activities were varied and she tried to accommodate people's choices. Some people liked personal time and others enjoyed group activities. She had started to support people keep memory diaries and memory boxes and intended to make sure everyone had personalised social and recreational time. Staff we spoke with said activities were good. One staff said, "We now have more activities that are really good and people get one to one time given. She has made a big difference." People using the service told us activities were good. One person told us they had recently had a 1940's concert. Plans were being made for the Christmas celebrations.

Visitors we spoke with told us they were invited to any social event planned for and if requested could have a meal when they visited. They were currently planning a Christmas fayre. We were told a hairdresser visited regularly. Religious needs were taken into account and there was a notice announcing a service to be held very soon.

While some people did not say they were encouraged to make their views known some were quite happy to do so and felt that staff generally responded well. One person told us, "I've been here long enough and I can say what I want. They know me and when I say something I mean it." The service had a complaints procedure which was made available to people they supported and their family members. The manager told us they welcomed any comment or complaint about the service as it helped improve customer service. They had a suggestion box people could use and they sent out quality monitoring questionnaires to people suing the service and their relatives.

People we spoke with told us they knew how to make a complaint and felt confident any issue they raised would be dealt with promptly. We looked at details of two complaints received at the service that had been dealt with using the complaints procedure with details of the investigation carried out and conclusion recorded.

Is the service well-led?

Our findings

The manager at White Ash Brook was registered with the Care Quality Commission (CQC). The provider, Mimosa Healthcare was currently under receivership and Harbour Healthcare Limited were currently overseeing the management of the service. Some staff and residents did tell us they were concerned as to the future of the home and, in some cases, took heart from the renovations which were underway. One relative told us, "My husband is in here and I am very satisfied with the way they care for him. I am aware they have had some problems and that someone else may be taking over, but they have not let that interfere with his care. If I ever need a place I would not hesitate to book myself in here."

We were told by staff there had been a huge improvement since Harbour Healthcare had taken over the role of managing the home, with investment in the environment and a clear vision for providing good person centred care. One agency staff we spoke with told us, "Since Harbour took over, the place has improved not a 100 but 1,000%. I hardly recognised I was working at the same place." Another staff member told us, "We do have meetings and can make suggestions and I feel we are listened to. There have been improvements made that have been positive although at times staffing can be a problem especially if someone rings in sick. The workload is still the same."

People using the service said they were happy with the current management arrangements and felt that both the registered manager and the deputy manager were approachable. Visitors we spoke with were all happy with their relative's care and with the manager and the management of the home. One person using the service told us although the current management was good; they still thought there was room for improvement.

The provider had systems and procedures in place to monitor and assess the quality of their service delivery. These included for example, seeking the views of people they support through satisfaction surveys. It was clear people were pleased with the service. The results of the recent survey was analysed and a report written with action plans put in place to address areas identified as needing improvement. Other methods had been used to improve people's experience of using the service and had resulted in a complete appraisal of the staff employed. Recruitment was improved and as a result staff selected were considered to have the right qualities and characteristics to provide person centred care.

The provider had installed a computer based system for managing care records electronically. The system was designed to ensure a more personalised approach to people's care and to risk management. Staff had access to this information and could input and access information at any time. During our visit staff were working on transferring information relating to people's care from paper copies into computer records.

We found there were processes in place to support the registered manager to account for actions, behaviours and the performance of staff. Contractual arrangements with staff outlined policies and procedures in place that, if required, staff that were subject to disciplinary procedures for gross misconduct and found to be no longer fit to work in health or social care, would be referred to the appropriate bodies. Contractual arrangements also precluded staff from gaining financially from people they cared for. All staff we spoke with talked of their commitment to providing a good quality service for people who lived at the home. They said communication was good and they worked in teams that were managed by senior staff and had key worker responsibilities. They took part in 'resident of the day' activities. This involved looking at people's care and welfare and their environment. Senior staff had taken lead roles, for example dignity in care, medication, fire safety, health and safety and infection control.

We found quality assurance was carried out regularly with regard to the operation of the home. This covered the environment, care and welfare of people, and staffing issues. The maintenance personnel produced a comprehensive file of safety certification and maintenance carried out and conducted a fire test during our visit. We discussed how repairs and maintenance was managed. We were shown a communication book that was used for staff to report any work that needed doing. This was signed when the work was completed. Guidance was also followed such as health and safety in the work place, infection control, fire regulations and control of hazardous substances.

At the last inspection there was an outstanding breach in regulation 9 because the planning and delivery of care did

Is the service well-led?

not fully protect people from receiving inappropriate or unsafe care. During this inspection we found there had been significant improvements in meeting the required standards relating to this regulation. Information we hold about the service indicated the manager had notified the commission of any notifiable incidents in the home in line with the current regulations. During the inspection we found the service was meeting the required legal obligations and conditions of registrations.

The registered manager told us they received acknowledgements from family members complimenting them on the standard of care they provided during people's stay at the home. She said one of her key challenges for the year ahead was working with the new provider and having a stable staff force that were trained well.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.