Ashley Grange Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Ashley Grange Nursing Home provides accommodation which includes nursing and personal care for up to 55 older people. At the time of our visit 44 people were using the service. The bedrooms are arranged over two floors. There are communal lounges with dining areas on the ground floor with a central kitchen and laundry.

During the last inspection in September 2015, we found breaches of some of the legal requirements in the areas we looked at. Improvements were seen during this inspection which demonstrated the service had responded to our feedback and had implemented improvements in line with their action plan.

The inspection took place on 10 and 11 October 2016 and was unannounced.

A registered manager was employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager, managing director and operations director were present on both days of the inspection.

The ordering and disposal of medicines was managed effectively. However, the storage of medicines requiring refrigerated storage was not well managed. This was addressed during the inspection and processes immediately put in place to correct this.

People told us they felt safe when receiving care. Staff were able to tell us how to recognise signs of potential abuse and what action to take if they had any concerns. People's risk assessments had been completed and recorded in people's care files. Where accidents and incidents had occurred, these were documented and followed up as required.

There were sufficient numbers of suitable staff to support people however, people, their relatives and staff told us agency staff were often deployed, especially at evenings and weekends. People and their relatives told us agency staff did not have the same understanding and knowledge of how to care for people as regular staff and at times they waited longer for assistance. People who used the service and their relatives were positive about the care they received from regular staff and told us they had sufficient knowledge to provide support and keep them safe.

Staff received regular training in relation to their role and the people they supported and told us this training supported them to do their job effectively. Staff received regular supervisions and an appraisal where they could discuss personal development plans. This meant staff received the appropriate support to enable them to provide care to people who used the service.

People were encouraged to make decisions and staff gained people's consent prior to carrying out any

tasks. The service had a clear understanding on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

There was a choice of drinks, snacks and meals available and people told us they enjoyed the food.

Information on people who had been assessed as having poor fluid intake was communicated within the team and this information was also available in people's nutritional risk assessments. Although concerns relating to people's fluid intake were communicated to staff some of the documentation to monitor how much people were drinking was not consistently completed.

People had access to health services and a GP performed weekly visits to the home with additional visits according to any changing healthcare requirements. Health and social care professionals spoke positively about the service. They told us they were promptly informed when there were changes to a person's health and worked well as a team to ensure people received care according to their current health needs.

People and their relatives spoke positively about the care and support they or their family member received. Throughout our visit there was a relaxing and pleasant atmosphere and we saw people were treated in a kind and caring way. Staff had a good understanding of people's needs. They knew their preferences and offered people choices.

People received care which was personalised and responsive to their needs. Care plans were individualised and contained information on people's preferred routines, likes, dislikes and also included information on their current and past medical history. Records showed people and their relatives were involved in the planning of their care and care plans were regularly reviewed and updated as required.

People, their relatives and staff were encouraged to share their views on the quality of the service. The service responded to feedback and suggestions and communicated these through regular newsletters and meetings.

People, their relatives and staff spoke highly of how the service was managed and told us the management team were approachable and acted on any concerns promptly and effectively. There were systems in place to monitor and improve the quality and safety of the service provided. Where actions to improve the service had been identified, these had been acted upon.

We found a breach of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The storage of medicines was not safely managed. Where medicines required refrigerated storage, there was inadequate monitoring to ensure storage temperatures were within the required range.

People said they felt safe. Staff were knowledgeable in recognising signs of potential abuse and what to do if there were safeguarding concerns.

Risks assessments were in place and action plans detailed how to minimise these risks.

Is the service effective?

Good

The service was effective.

People said they liked the food and there was varied menu on offer. People also had access to specialist diets when required.

People were supported by staff who had the knowledge and skills to carry out their roles.

People had access to healthcare services and received on-going healthcare support.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about staff and the support they received.

Staff were caring in their approach and had a good understanding of people's needs, their preferences and how best to support them.

People were offered choices and staff sought permission prior to carrying out specific tasks.

Is the service responsive?

Good

The service was responsive.

Regular meetings were held for people and their relatives. The service valued feedback and responded to suggestions.

Care plans were individualised and contained information on people's preferred routines, likes and dislikes.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously.

Is the service well-led?

Good

The service was well led.

Systems were in place to monitor the quality and safety of the service provided. Where actions to improve the service had been identified, these were acted upon.

Staff said the management team were approachable, and felt they could raise concerns and seek guidance.

People and their relatives said they were regularly encouraged to provide their opinions and the service provided feedback and actions to these.

Ashley Grange Nursing Home

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.

This inspection took place 10 and 11 October 2016. The first day of the inspection was unannounced.

One inspector and one expert by experience carried out this inspection. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.
The areas of expertise for the expert by experience during this inspection was care homes and dementia care.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.
During the last inspection in September 2015, we found breaches to some of the legal requirements in the areas we looked at.

We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with nine people who use the service and nine visiting relatives about their views on the quality of care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included nine care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, managing director, operations director and 11 staff including care staff, registered nurses, activities coordinator, quality assurance and training officer and staff from the catering department.

Requires Improvement

Is the service safe?

Our findings

Although overall, medicines were managed well, the administration of some medicines was not consistently documented and monitoring of the temperature at which medicines were stored was not done in line with storage requirements and was poorly managed.

The provider informed us prior to the inspection that an electronic medication management system was being implemented on the 24th October 2016. This meant the provider was using an interim paper system during the inspection.

In one person's Medicines Administration Record (MAR) it showed they were prescribed topical patches. Although the MAR had been signed for most days to confirm this medicine had been administered, a supplementary sheet to record what time these patches were applied and removed had not been consistently completed. Over a period of 39 days there were 21 days where either no entry had been made on this form to indicate the time the patch was removed or had been applied and one day where neither MAR or supplementary sheet had been completed to indicate this medicine had been administered. In addition, where people had been prescribed topical creams the registered nurses had completed the MAR to indicate these had been applied by care staff however, these had not been consistently completed and newer charts did not always detail the name of the medication or directions for use. This was not in line with service's policies and procedures for administration of medicines which stated the position of patches should be documented and creams and lotions must be recorded on the MAR sheet and to include directions for use. When we spoke with the registered manager about this they confirmed that such discrepancies should be eradicated once the new electronic medicines management system was implemented at the end of October 2016.

Medicines which needed to be stored in a refrigerator did not have the storage temperature effectively monitored. When we asked one member of staff where daily fridge temperatures should be recorded they did not know where this information could be located. They told us the temperature was on the outside of the fridge and they would look at this before administering medicines from the fridge. When we asked the same staff member what the fridge temperature should be, they told us it should be between two and five degrees centigrade. At this point, the fridge thermometer showed the temperature as minus two degrees centigrade. We located the daily recorded fridge temperatures for the staff member which were hung on the wall in the same room. The temperatures which had been recorded daily for the refrigerator indicated they were out of range for the required storage temperature during the months of August, September and October up to the day of the inspection, on some days running as low as minus five degrees. The required storage temperature for storage of these medicines was between two and eight degrees centigrade. When we asked another staff member what the temperature for storage of refrigerated medicines should be they told us they thought it should be between four and five degrees centigrade. They also told us if the temperature reached freezing medicines could be affected. Despite, this, they told us they had seen the temperature had been out of range but thought this was due to the temperature probe being faulty. We raised this issue with the staff member and this was addressed immediately. A pharmacist and GP were consulted and a re-supply of medicines arranged. Further to staff investigating this and after placing a

replacement thermometer into this fridge it was found that the temperature was within normal ranges. Although an explanation of the low temperatures could have been due to a number of factors, including the fact that the thermometer may have been faulty, it was not possible to be certain that these medicines had not been stored at temperatures outside safe limits. Staff had not been aware of how to store these medicines safely despite this information being available in the same room as the fridge and also the company's policy on medicines management. A recent external medicines audit had also not identified this issue. This meant people were at risk of receiving medicines that were not effective which may have had a negative effect on their health and well-being.

These shortfalls were a breach of Regulation 12(2)(g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people were not protected against the risk associated with the unsafe management and use of medicines.

The ordering and disposal of medicines was managed effectively. We saw systems in place which included monthly audits for expiry of medicines and stock rotation. When medicines were disposed of there was a system in place to manage and document this.

During the inspection we observed a medicines administration round. Medicines trolleys were kept secure and locked when not attended and the nurse wore a tabard which indicated they should not be disturbed whilst they were administering medicines. This meant the nurse was not distracted during the medicines round and that medicines could be administered safely. The staff member explained to people what they were taking and signed for medicines only when they were sure they had been taken.

During the inspection, two people were being given their medicines covertly (without their knowledge, mixed with food and/or drink). Assessments had been undertaken in line with current legislation, to determine this was in their best interests. Records showed best interests meetings had taken place involving their relatives and GP. Confirmation on the safety in giving these medicines covertly was also sought from a pharmacist and documented accordingly.

People told us they felt safe living at the home. One person told us "I do feel safe here, we see the same faces regularly and they (the staff) check we are ok". Relatives also confirmed they had no concerns about the safety of their family member. One relative said "I wouldn't have (X) here if I didn't feel they were safe. The general attitude of the staff is very caring and there is a core of permanent staff who have been here a year or more who hold the place together".

Staff we spoke with could explain what keeping people safe meant. We saw from staff records that they had received training in safeguarding adults from abuse and whistleblowing. Staff knew the different types of abuse and said they were confident the registered manager and senior staff would act on their concerns. Staff were aware they could take concerns to agencies outside the service if they felt they were not being dealt with.

Sufficient staff were available to support people. We saw people had access to their call bells and when used, these were answered promptly. However, some people, their relatives and staff told us agency staff were frequently deployed and people and their relatives said they sometimes had to wait for staff to come and assist them. People told us having agency staff meant they did not always have the same staff to provide care for them. Comments from people's relatives included "Staff can usually be found but it will be a while before they can come and help", "The way the home runs seems pretty good but sometimes (X) can wait a long time when they need help" and "There are normally some agency staff on every shift but evening and weekends are the worst". When we discussed this with the registered manager and managing director,

they told us they were aware staffing was sometimes an issue and this was in the main due to staff calling in to cancel their shift at short notice. They told us staff were always found to cover shifts and this was often done by deploying agency staff. They had recently looked at addressing the issue of staff absence and told us how they had monitored this for trends. In doing so they had identified ways to reduce last minute absence by working with staff to ensure the rota was achievable and that they were able to cover the shifts they had been scheduled to work.

Safe recruitment and selection processes were in place. We looked at the files of four staff and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.
Risks to people's safety had been assessed and actions taken to mitigate these risks. Risk assessments were available in an electronic care document management system for each person using the service. These risk assessments included information on risks such as falls, mobility, skin integrity and nutrition. Where risks had been identified, care plans contained guidance for staff on how to manage and mitigate these risks. For example, a risk assessment had been carried out for someone who was at risk of choking. This risk assessment was linked to a care plan which included details of how this person should be supported when having a drink including what position they should be in and what sort of cup to use.

When people had accidents or incidents, these had been clearly documented in the electronic care document system. These included details of what actions had been taken as a result of the accident or incident. These were monitored on an ongoing basis to identify trends for example, in the number of falls; whether they occurred at a certain time or place within the home.

Good

Is the service effective?

Our findings

At our last inspection on 30 September and 01 October 2015, the provider was not meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. We found the service had not been meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards. Where people were deemed as lacking capacity, assessments were not always completed and sometimes gave conflicting information. 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 legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The provider wrote to us with a plan of actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken the necessary improvements and was in the process of implementing these as required to fully meet people's needs.

The registered manager and staff acted in accordance with the requirements of the Mental Capacity Act 2005. At the time of this inspection, the provider had introduced new paperwork to document mental capacity assessments and the best interests decision making process. The registered manager confirmed that following the last inspection, they were in the process of updating all records which related to consent and where people lacked the capacity to make specific decisions; mental capacity assessments and best interests processes. Although this documentation had not yet been updated for all people, there was a good understanding of the MCA and how consent to care should be sought in line with legislation and guidance. We were provided with a copy of the documents which explained a clear pathway of seeking and recording consent. We saw documentation for one person who lacked the capacity to make their own decisions and where a best interests decision process had been followed. In addition, the electronic care records system had been updated following the last inspection to enable the service to record information on mental capacity assessments.

The registered manager had identified people who they believed were being deprived of their liberty. They had made Deprivation of Liberty Safeguarding applications and submitted to these to the appropriate authority. Copies of these applications were filed in people's care records.

Staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity. During the inspection we saw staff seeking consent from people prior to carrying out tasks. For example, staff asked people before they assisted them with their care, when they would like to get up and where they would like to sit.

At our last inspection on 30 September and 01 October 2015, the provider was not meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. The provider had not ensured monitoring charts were used in a proactive way to ensure people's food and fluid

intake were being monitored correctly. Concerns about poor fluid intake had not been shared or communicated with the team. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken improvements regarding the monitoring of diet and fluids and this information was being shared with staff however, improvements in documenting people's fluid intake was not always being completed consistently.

An electronic care record system which was being trialled at the time of the last inspection was now fully implemented. Details of people's food and fluid intake were being entered by staff into electronic mobile devices in place of paper charts which had previously been used. We looked at the care records of two people who had been assessed as being at high risk of malnutrition and dehydration. Although records of food and fluid intake had been recorded on most days, there were occasions when fluid intake had not been noted for a number of hours. For example, in one person's fluid intake record, it stated from their first drink in the morning, they had two drinks amounting to 300mls over a period of 26 hours. For the second person, their daily records stated they had drunk 100mls one evening and then despite there being a note in their daily records stating they required encouragement to drink due to a low fluid intake over the last few hours no further drink had been documented until late afternoon the following day. The care plans of both people stated their fluid intake should be monitored. Despite this, the fluid intake and other important information such as whether people needed pressure care, wound care, pain relief and details following GP visits was well communicated to all staff during the staff handover.

We observed the lunch time meal for people on day one of the inspection. People said they enjoyed the food and drinks were available to them with their meals. Comments from people on the food included "The food is very good, and there are choices of food", "The food is good, I really enjoy it". People were offered a choice of drinks and where alternatives were requested these were given. There was a varied menu on display and people had the opportunity to choose what they would like. Overall, the lunchtime meal was well organised and people were supported well. However, it was noted that the trays being taken to people's rooms where they had chosen not to eat in the communal dining area, had both main course and desert on the tray which meant the hot desert may not have been as warm as it would have been if served when the person was ready to eat it.

When we spoke to the chef they told us they had information on people's likes and dislikes as well as any specific dietary requirements. This information was also on display in the kitchen. This information included whether people required a soft diet, thickened fluids and what equipment to use to help support them with eating their meals.

Staff received regular training to give them the skills to meet people's needs. New staff received a comprehensive induction which included shadowing more experienced members of staff before working independently. Mandatory training was completed during an induction period by new staff followed by refresher training. This included safeguarding, the mental capacity act, infection control, manual handling and health and safety. During the inspection, we spoke with the quality assurance and training officer. They explained in detail the staff training program. This incorporated the Care Certificate based on the standards set by Health Education England, Skills for Care and Skills for Health which staff were asked to complete within 12 weeks of starting their employment with the service. Records were in place which documented when training had been completed and when refresher training was next due for each staff member. At the time of the inspection, a new system was being produced which aimed at improving this process of tracking further, which would alert the quality assurance and training officer when this training was due for renewal. Staff told us they had received sufficient training to support them in their role and said if they requested further training or refresher training this would be arranged. The registered nurses had recently completed refresher training in venepuncture (obtaining blood samples) and catheter care to support them in their

role.

Records we looked at confirmed staff received regular supervision sessions and annual appraisals. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. One staff member told us how they had asked to have assistance to enhance their personal development as they were keen to progress to a more senior role. They were given the opportunity to complete further training to support them with this and have since, started their new role.

People were supported to maintain good health and had access to healthcare and other services to meet their needs. There were records of treatments relating to chiropody, eye care and GP and nurse visits and appointments with other health care professionals. For example, where people had been identified they may be at risk of choking a referral for a speech and language therapist had been made and steps were put in place to reduce their risk of choking and documentation was available in people's care records which confirmed this. We spoke with healthcare professionals during the inspection who visited the service. They told us the service liaised with them well and notified them when they sought advice or when referrals in response to people's changing health were required.

Good

Is the service caring?

Our findings

People and relatives said they were happy with the care and support they received from staff. Comments from people and their relatives included "The best things about this home is the staff patience – it makes such a difference", "The staff are so caring, we are always treated very well, it's just like being part of the family and they treat us just like their own family" and "Staff support me so much, I would feel it very hard to keep visiting without the staff supporting me like they do". A volunteer to the home told us "I have been coming here for many years now, and the carers always seem kind and considerate towards the residents, and the residents themselves always seem very happy". We also spoke with a healthcare professional who regularly visited the home. They told us they thought what was particularly good about the home was the "high level of caring" and that staff always ensured people were "happy and healthy".

Staff supported people in a caring, kind and friendly way and we observed some positive interactions on both days of the inspection. For example, we heard a person call out from their room. A staff member who was in the vicinity went straight away to assist them. The staff member asked them kindly what it was they needed. The person told them they would like help with their drink. The staff member spoke to them gently, seeking guidance from the person on when they had enough to drink and whether they would like to change their position. When the staff member had finished supporting this person with their drink, they enquired whether they were comfortable and supported them as required before leaving them. On another occasion we saw two members of staff supporting a person to transfer from their armchair to a wheelchair by using a standing hoist. Throughout the whole time they were supporting this person, they explained what they were going to do and continued to talk to this person in a reassuring way until they were safely in their chair.

Staff offered people choices and involved them in making decisions about their care, treatment and support. For example, on day two of the inspection, staff mentioned in the handover that one person had chosen to stay in bed for the day. This was communicated to staff who had just started their shift so they could be aware of this to ensure this person was able to continue with this choice. One person we spoke with told us "Staff always call me by my first name which I prefer, and will always cheer me up if I feel a bit grotty". People's bedrooms were personalised and people were surrounded by items within their rooms that were important and meaningful to them. This included items such as ornaments, photographs and their own furniture.

Staff knew what was important to people and were aware of their likes, dislikes and preferences. People's care plans detailed their life histories including important relationships, past employment and religious beliefs.

Throughout the majority of the inspection, we saw people were treated with dignity and respect.
We observed staff knocking on people's doors before entering their bedroom. Comments from one person's relative were "They (the staff) are very good with the residents and they are all treated with dignity and respect and really cared for". Staff were able to tell us about the importance of respecting people's rights to privacy and dignity. Although all staff we spoke with were able to tell us how they ensured people's dignity was maintained for example, covering them as necessary to prevent them being exposed during personal

care and whilst being hoisted; we did observe one occasion where this was not done. Whilst staff were supporting a person in a communal area to move between their armchair and wheelchair by using a hoist, while this person was in the hoist, their lower back was exposed and their underwear was visible. This did not demonstrate that staff always put their knowledge on how to protect people's dignity into practice. We spoke with the registered manager and managing director about this who told us this was unacceptable practice which would be addressed with staff.

Good

Is the service responsive?

Our findings

At our last inspection on 30 September and 01 October 2015, the provider was not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. Care plans had not always been completed to reflect people's preferences and how they wished to receive care and support. They had not always contained detailed information on how staff could ensure the person's needs were met. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken the necessary improvements regarding this.

People's needs were assessed prior to them moving into the service and care and support plans developed in line with this information detailing a person centred approach. People's care and support plans were personalised and were reviewed regularly. They detailed people's preferences, likes, dislikes and preferred routines. There was a section in the care plans called 'This is me' which included people's hobbies and interests, how they liked to spend their time and what their favourite things were. Care plans were detailed and provided staff clear information to guide them on how to respond to ensure people's care needs were met in their preferred way.

Care plans detailed guidance on how to support people in line with their risk assessments and specific healthcare needs. For example, one person who had diabetes needed their blood sugar levels monitoring. Staff confirmed this and we also saw where this was documented. However, some care plans which gave guidance to support people with behaviours that may challenge were not as detailed. For example, the care plan for one person stated a trigger to a behaviour may be certain noises but no specific noises had been detailed. In another care plan one suggestion given for when this person was agitated was to walk away leaving them in a safe position and return to do personal care later. Yet more specific details about likes and dislikes were also held elsewhere in the care plan which could be referred to by staff. These additional details stated what this person enjoyed and this information could have been included as part of the strategy to help this person when they became agitated. Although some care records did not provide specific information on how to support people with behaviours that may challenge, other care plans provided clear and detailed guidance and staff were able to support people appropriately when this was needed.

During the inspection, there had been some discussion amongst staff to find a way of encouraging a person to eat and drink. Staff had fed back that they noticed this person ate and drank more when supported by staff who were not in uniform. It was later confirmed that when a staff member supporting this person with their meal had worn a top over their uniform this person's diet and fluid intake increased. This showed staff were responsive to this person's needs.

People were supported to follow their interests and take part in social activities. Care plans detailed people's choices on what activities they would like to do. There were two activities coordinators in post who arranged various activities including trips out, singing, tea parties, quizzes, gardening and games. A noticeboard was on display in the communal areas of the home showing daily activities and people were

able to choose which activities they would like to participate in. Books, magazines and newspapers were available and where people were unable to read these, we saw staff sitting with people reading these to them. People were also offered a church service from the visiting clergy. People and their relatives told us they were always made very welcome and there was an 'open' visiting policy. During the inspection we observed a staff member do a crossword with a group of people. There was laughing and joking throughout and people looked to be enjoying themselves. People told us they enjoyed the activities. One person said "I enjoyed the singer recently, he was really good".

Staff told us people who were unable to join in group activities, for example, if they were being nursed in bed, would be offered other activities, such as being read to, having therapies such as a hand massage or simply having one to one chats. However, there was little documentation to show how much contact or activities people who were cared for in bed or who wished to stay in their bedrooms had been offered and if this had been refused.

Although staff would chat to people who stayed in their rooms during support with personal care, when drinks were taken to them and when they had their rooms cleaned there was not structure in place to ensure they had interactions other than those which were task focussed. We discussed this with the activities coordinator and managing director. They showed us where activities were recorded in people's care files. We looked at 'event reports' which had been completed for all people living at the home over a four week period. During that time, in the event report of some people, there was a lot of detail regarding what activities they had participated in, including a dialogue of their experiences and level of enjoyment. These activities had included gardening, cheese and wine tasting and live music and dancing. However, for people who were nursed in bed or chose to be in their rooms there were far fewer activities documented and for some, no activities had been recorded for these people. When we asked how the service ensured people were not overlooked, the activities coordinator said they sought to make sure every person had a one to one contact with them each week. However, they told us they had no plan in place to ensure people were not overlooked. As there was very little information documented to show when people had been offered activities or one to one contact this meant some people were at risk of not having any social interaction and becoming socially isolated.

People we spoke with and their relatives told us they felt able to raise any concerns and were confident that they would be acted upon and taken seriously. Comments from people's relatives included "I have raised concerns and made a complaint but they have been dealt with and resolved it to my satisfaction. I am comfortable with raising an issue and that staff will listen and deal with it appropriately making sure I'm happy in the end" and "I would be happy to raise a concern or make a complaint – I would speak my mind. I feel I can talk to them. X (staff member) is very good and will update me when I arrive about how X is" and Staff will always listen when issues are raised and will try to resolve them and often check back to make sure we are still happy".

The registered manager had a file of compliments and complaints they had received prior to our inspection. There was a procedure in place which outlined how the provider would respond to complaints. In the reception area and other areas throughout the home there was also information available for people and their relatives on how to make compliments, suggestions and complaints.

The provider valued feedback from people and their relatives and responded to their suggestions. Residents and relatives meetings were held throughout the year. Following feedback from people and their relatives a list of actions was drawn up and compiled in a poster which was on display in the home. This list included details of changes made to the design and decoration of the home to improve the facilities for the people living at the home.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was available throughout the inspection. The registered manager interacted positively with people who lived at the home. There were many positive comments about the registered manager and staff team. One person we spoke with said "X (registered manager) is always about and always talks to us, they always use our first names and we really like that". A person's relative told us "X (the registered manager) is very approachable and staff seem to relate to her very well. The atmosphere here is very good even when the manager is not around". Staff said they enjoyed working at the service. A visiting healthcare professional told us "X (registered manager) has a good handle on everything and all staff know people well". All the staff we spoke with said they had regular one to one time with the management team. Some staff told us this had also been helpful in their development as this had also given them the opportunity to progress in their role. Comments from staff on the management of the service included "I like working here because everyone is treated equally" and "There is always a lovely atmosphere. I get support from management from X (managing director) and X (registered manager)".

Staff told us the registered manager was approachable and encouraged them to report concerns. Regular staff meetings took place and newsletters were sent to staff providing updates and useful information. A most recent newsletter included reminders for staff such as how to protect people from the spread of infection, the current work and progress in updating people's care plans including the 'This is me' section, documentation on mental capacity assessments and best interests decision processes and details of the forthcoming training and roll out of the new electronic medicines management system. As well as these details, newsletters including praise to staff for what they were doing and updates on the latest 'staff member of the month' following feedback from staff, people and their relatives. The service also ran a 'good ideas scheme' which was aimed at encouraging members of staff to give feedback on their ideas for further improving the quality of the service. The registered manager told us that although there was an open door policy where staff could address their concerns at any time, in addition to this, there was also a suggestion box available to staff for posting concerns or suggestions anonymously too.

People and their relatives were encouraged to provide feedback on the quality of service. Feedback surveys were sent throughout the year and responses to these put on display around the home. Newsletters were also provided regularly to people and their relatives. These included information on meetings and informative evenings where certain topics could be discussed. Recently a meeting had taken place where people and their relatives were told about power of attorney and making a Will and plans for the next meeting to talk about dementia awareness.
The service regularly sought the opinion of people and their relatives to look at innovative ways to improve the service and the lives of people living there. For example, in a recent newsletter people and their relatives were asked about the suggestion of using a vehicle which would be disability friendly for relatives to take their family members out and whether they would be interested in this idea.

The service had effective systems in place to monitor the quality of the service being delivered. Audits were carried out periodically throughout the year by the registered manager, quality assurance and training officer and external auditors. These audits covered the management of medicines, equipment, accidents

and incidents and care planning. Where issues had been highlighted, actions had been put in place to address these. For example, in a recent medicines audit, it had been noted the running totals of medicines in stock for a certain group of medicines was not being regularly completed. From the records we saw during the inspection this was now been completed. In addition to this, staff had just begun training on a new electronic medicines management system which was due to be implemented at the end of October 2016. This new system was being implemented in response to the service carrying out quality assurance on their current system which they felt could be improved on in particular to help reduce errors in documenting the administration of medicines.

The maintenance of the home was managed well and included regular servicing and property safety checks to ensure people were safe. This included regular fire alarm testing and gas, electric and water inspections. Servicing of equipment was also completed and recorded to ensure it was fit for purpose. The service also had appropriate arrangements in place for managing emergencies including contingency plans in the event of a fire or loss of utilities.

The registered manager and managing director told us they networked with external services and organisations to keep up to date and share best practice. The managing director told us prior to beginning the implementation of their new electronic medicines management system they had visited another service to obtain useful information on the system and how it was working which they said helped them to gain a further understanding of the system and gave them the opportunity to highlight and prevent issues early in the planning phase. The registered manager also told us they kept up to date by reading professional journals, attending conferences and liaising with other healthcare professionals.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g)