Warmest Welcome Limited

Ashgrove House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection of Ashgrove House took place on 14 June 2016 and was unannounced. The home was previously inspected in May 2015 and found to be requiring improvement. It was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to issues with medication and Regulation 18 as there were not enough staff present. The registered provider had submitted a comprehensive action plan to remedy these breaches. During this inspection we checked to see whether improvements had been made.

Ashgrove House accommodates up to 30 older persons, the majority having either dementia or mental health care needs. The property is an adapted detached Georgian house. The service is owned by Warmest Welcome Ltd and is located in Sandal near Wakefield city centre, which is easily accessible by public transport. On the day of our inspection there were 28 people in the service, two of whom were in hospital.

There was a registered manager present during the inspection. 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.

People told us they felt safe and staff were able to explain to us what may constitute a safeguarding concern. They were aware of the necessary reporting procedures and confident in their knowledge.

The home had risk assessments in place but not all were pertinent to the specific person and some needed further detail around the risk reduction measures to be used to minimise the risk of harm. The Director of Care responded quickly to our concerns and sent a revised moving and handling assessment the day after our inspection which showed how eager they were to ensure best practice.

Staffing levels were appropriate for people's needs on the day of our inspection and we felt staff had time to talk to people in addition to carry out their key tasks.

There were serious issues in the competency of the staff member responsible for the administration of medication. We did not see appropriate infection control procedures in relation to people receiving medication, people were not supervised while taking their medication which resulted in a tablet being found on the floor and records were falsely completed in relation to people receiving their medication.

Staff had received a detailed induction and their knowledge was obvious in that they knew how to care appropriately for people. This was reflected in some of the compliments the home received. Staff also had regular supervision which reflected current good practice guidelines.

The registered manager was compliant with the requirements of the Mental Capacity Act 2005 as they had requested Deprivation of Liberty Safeguards authorisations where necessary. However, the registered

manager needed to further develop their assessment of decision specific capacity in line with legislation as the current assessments were not sufficient.

People were supported with access to health and social services as needed, and there was evidence of positive relationships with other services in the area. Nutritional and hydration needs were met throughout the day and specialist support obtained if required.

Staff displayed kindness, empathy and patience, ensuring their focus was on the people in the home. We heard numerous engaging conversations which reflected staff's interest and knowledge of people's specific circumstances. Staff were pro-active in seeking consent before undertaking any care provision.

The home had an activities co-ordinator, who along with the staff, supported people with a variety of engaging things to do such as communal games and gentle competitions. People appeared happy and settled and there was a positive atmosphere. The home had received a number of compliments and complaints were handled in a timely and thorough manner.

Care records reflected people's specific needs and were written in a clear format to enable staff to access information quickly. However, further links needed to be made between daily notes and evaluations which had been identified by the registered manager previously.

The registered manager and Director of Care jointly provided clear direction and leadership for all staff using their knowledge of best practice. Both were driven by the need to provide a safe and welcoming home for all people with a safe level of care. Although the home had a comprehensive auditing process these were not always utilised to their full potential which meant a risk of concerns being missed such as with medication.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe and staff had a clear understanding of how to respond to any concerns of a safeguarding nature.

Risk assessments were not always person specific and needed further clarity as to the method of how someone was to be transferred via the use of a hoist.

Staffing levels were appropriate to meet people's needs.

There were significant issues with the administration of medication which we discussed with the registered manager.

Is the service effective?

Good

The service was effective.

People were supported throughout the day with their nutritional and hydration needs and had access to prompt health and social care support if required.

The registered manager understood the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards and had appropriate authorisations in place.

Staff had access to a comprehensive supervision and training system which promoted their development and knowledge.

Is the service caring?

Good

The service was caring.

Staff were attentive, kind and patient, and evidently knew people well.

Consent was sought before any care task and reviews of care took place with relevant parties.

People's dignity was respected sensitively and discreetly.

Is the service responsive?

Good

The service was responsive.

The home had a variety of activities for people to partake in and people appeared engaged and happy.

Care records were person-centred and reflected people's needs and preferences. Further consideration was needed around incorporating daily records in the evaluations.

Complaints were handled well and the home had received many compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a positive atmosphere and people appeared happy and settled.

The registered manager was supported by a pro-active Director of Care who gave clear leadership and provided current practice guidelines.

Although there were many auditing tools they were not always completed by the most appropriate person and scrutiny did not always highlight areas which required improvement.

Ashgrove House

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 on 14 June 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with seven people using the service and two visitors. We spoke with five staff including one senior carer, one carer, the activity co-ordinator, the registered manager and the director of care.

We looked at seven are records including risk assessments, three staff records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

One person we spoke with said "I feel safe." This person had been part of a recent altercation between two people and was aware this had been handled appropriately by staff. We saw this recorded in the person's file with the circumstances surrounding the incident. Another said "I am safe as the ladies look after us."

We asked staff if they felt people were safe. One staff member told us "People are safe as we look after them and watch them to ensure they don't fall." They went on to tell us about various scenarios which might constitute a safeguarding concern such as a person not being supported to transfer properly or being spoken to in a harsh manner. They were able to explain how they would raise any concerns and what options were available if they felt things were not being followed up effectively such as reporting to the Care Quality Commission. Another staff member told us "Management deal with any concerns quickly and fairly."

The registered manager had reported safeguarding incidents appropriately and taken action to minimise a re-occurrence, especially where it involved altercations between people living in the home. Following a recent serious concern, the registered manager and registered provider had completed an unannounced night time inspection and found no evidence of any major concerns, completing a thorough investigation. The registered manager explained that where incidents had occurred, learning was shared with staff through supervision and meetings. We saw evidence of this in records.

In the reception area we saw the infection prevention and control audit certificate showing the home had achieved a rating of 99% in 2014-15 which had been followed by a 96% rating in February 2016. We found the premises to be very clean during the day.

The home had a detailed medication policy and clear procedures, based on the National Institute for Clinical Excellence (NICE) guidelines. However, we did not always see these being followed in practice. The staff member did not wash their hands before administering any medication and neither were they wearing any protective personal clothing such as gloves. The trolley was left unlocked on more than one occasion in the lounge as the staff member spoke with people in the dining room.

We did not see each tablet being checked prior to administration to ensure it was the right tablet for the right person in line with good practice as the staff member informed us "I know who everyone is". All the medication which came from original packets were touched by the staff member despite this not being policy and we observed the same medication pot being used for different people without being washed in between administration. The staff member signed for all medication being taken prior to the person actually receiving their medicine and did not observe people actually taking it. This meant that records were not an accurate reflection and it meant people may not have had their medication as prescribed.

During our observations of the medication round we saw the staff member tip a pot of tablets straight into a person's mouth. This was both a choking risk and unsafe practice as the staff member did not remain to observe the person swallowing the tablets, and therefore could not have ascertained whether they were all taken. We also saw someone drop a tablet which had been placed directly into their hand which we later

found on the floor. We spoke with the registered manager about this. This had been recorded on the medication records as having been taken. Asthma inhalers were administered to people quickly without due preparation as they were given to people at the breakfast table. We asked the staff member about PRN (as required) medication and they told us "I know who needs it and when." This was not in line with good practice or the home's policy as people need to be asked each time if they require any painkillers.

Although the home had a comprehensive medication audit in place this had been completed by the staff member we observed so we did not feel it was an accurate reflection of the home's practices. We checked this staff member's training record and found their competency had been assessed by the registered manager. When we raised our concerns with the registered manager and registered provider we were advised they were surprised at this practice. However, in our view, due to the number and variety of errors we feel this was a serious concern and that the staff member needed urgent re-training. The lack of competence displayed meant that people were at risk of significant harm as medication was not being given safely or as prescribed. The above examples all demonstrate a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the lunchtime one person was complaining of pain in their leg. A staff member came and spoke with them about where it hurt and adjusted the position of their foot rest to see if this eased the pain. As the person was not prescribed any painkillers the staff member contacted the GP to see what they suggested. Following their advice painkillers were obtained and duly given to the person. This showed that the home was responsive to people's needs and acted promptly to concerns.

We checked the controlled drugs storage and found this to be correct. However, the index was not being completed so this made finding the relevant records difficult. We spoke with the registered manager about this and they agreed to rectify immediately. Topical medication was stored appropriately and PRN (as required) medication protocols were evident showing how often medication was permitted, the time needed between each dose and what action to take if the dosage did not appear to be assisting. However, as referred to above these were not always followed. Room and fridge temperatures were all recorded daily and within the necessary limits.

We saw necessary evacuation equipment in the home in the event of a fire and staff told us they conducted regular fire drills. People had Personal Emergency Evacuation Plans (PEEPS) in place but the information was sometimes contradictory. In one it was noted 'able to leave with the assistance of one' but on the other side 'needs assistance of two staff'. We highlighted this to the registered manager who agreed to review the documentation. The home conducted weekly fire checks which showed they took safety seriously and they had also completed an evacuation exercise.

We looked at staffing records and found that all appropriate checks had been carried out. References were obtained and followed up if further information was required and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. The registered manager said that staff were not allowed to work with people until they had completed their induction and all references had been returned. We saw evidence that where staff conduct had fallen below expected standards disciplinary meetings were held and appropriate warnings issued.

One staff member told us "There are always five staff on duty during the day including the manager. We have low levels of sickness and we never use agency staff. If we're needed to cover, we always offer." Another member of staff told us "The staff team is pretty stable. There is not a high staff turnover." The registered manager advised us they were flexible in terms of staffing ratios and responded to need. The registered

manager explained no one was currently requiring one-to-one care but they would increase staffing if this altered. On the day of the inspection one person attended a hospital appointment and so an additional carer was working to accommodate the other member of staff being away from the service. We discussed staffing at night as a result of staff raising issues about lack of numbers but the registered manager informed us they had completed a night shift and felt that staffing levels were appropriate at the current time. People in the home did not indicate any level of concern around this.

The home had a number of risk assessments in relation to choking, falls and moving and handling. Each of these assessed a person's abilities based on a list of key significant factors such as a person's pain levels, behaviour and cognition, and were reviewed monthly. However, we could not always see the purpose of some assessments. In one file there was a choking risk assessment but no identified risk of choking due to swallowing difficulties. In another file the choking risk assessment was pertinent as the person was prone to eating too quickly thereby heightening their risk of harm. It specified clearly that they could choose their own meals and eat independently but needed observing due to the speed of their eating. We saw this person was suitably observed during our inspection.

Equally, although the assessments identified risk there was little evidence of reduction measures in place. If a person was recorded as at high risk of falls, we could not see evidence of how the service had attempted to minimise this risk apart from more general measures such as observation and well fitting footwear. Moving and handling assessments considered a person's ability to weight bear, the level of pain, physical and behavioural concerns and their weight. However, we could not see any method recorded as to how equipment was to be used in relation to that individual. This meant people's specific needs were not always assessed correctly and could have led to harm. The Director of Care responded the day after our inspection with a revised moving and handling assessment tool which they were intending to implement immediately. The registered manager advised us regular health and safety meetings were held where environmental risks were discussed along with the maintenance and housekeeping staff.

We observed a person being moved from a wheelchair into a more comfortable chair. Staff supported as best they could, ensuring the person remained safe but it appeared the sling was not the most appropriate. The home put in an urgent referral for an assessment as the registered manager advised us the person had only returned from hospital that morning and had been mobile prior to their hospital admission, so alternative provision had not yet been possible. An alternative sling was provided from another of the registered provider's homes and it was agreed the person should be on bed rest until a full moving and handling assessment had been completed by an occupational therapist.

We looked at accident and incident records and found that all were recorded properly and in detail, outlining what may have caused the incident and whether any injury resulted. Actions following any more serious incidents were logged such as a referral to a GP or to the falls service for a re-assessment of a person's needs. People's care plans were updated as were their risk assessments. Accidents and incidents were analysed on a monthly basis for any patterns showing the registered manager was aware of the importance of tackling any repeated concerns and ensuring everything possible had been done to minimise the risk of further harm.

Good

Is the service effective?

Our findings

One service user told us "It's very nice food. I enjoyed my toast I had for breakfast." Another said "Yes, we like it here. The food is quite nice. I can't grumble about the food."

We observed people's experience at lunchtime. Meals were served to people pre-plated with a heat retaining cover. We spoke with the cook as to how they knew people's choice and they showed us a previously completed list identifying people's preferences and portion size. However, some people had food on their plate they did not wish to have. One person said "I don't want stuffing. I have never cared for stuffing." This was promptly removed by a member of staff. People were supported with eating and drinking throughout the meal times and encouraged to have regular drinks throughout the day. Assistance was offered by the activities co-ordinator in cutting up the meat and people were regularly asked if they wished for more gravy.

One staff member was very encouraging to one person who did not appear to have much of an appetite and spent time talking to them. Another person who did not want their meal was offered an alternative and this was duly presented. We heard a conversation later in the day between the registered manager and the Director of Care about utilising a catering service that was in use in another of their homes to support someone with swallowing issues. The service was able to provide a bacon sandwich which was this person's choice in a texture that was safe for them to swallow. This showed the home was thinking about how to meet people's needs in a creative manner and to ensure that they had followed up alternative options.

Staff told us no one was currently nutritionally at risk nor that anyone had any pressure sores. The registered manager said two people had been referred to the dietician for more specialist advice. Both had actually gained weight since this extra support had been provided showing the home was effective in managing nutritional concerns.

The registered manager advised us the home was part of the local NHS vanguard project which aimed to improve the links between care homes and the local primary care services. They had been involved in the 'react to red' initiative which promoted swift reaction to any concerns regarding skin integrity by calling in the district nurse at the earliest possibility. If the home required other support from services then this was provided such as the Care Home Liaison Team who assisted with more complex behaviour concerns.

We found evidence that all staff had received an induction. This had included core safety information and an overview of key policies and procedures. One member of staff told us "I shadowed a team member after completing lots of training." Staff had received subsequent training in all key areas such as safeguarding, mental capacity, equality and diversity, dementia, moving and handling, fire safety, and medication dependant on their role. Each staff file contained certificates which detailed the content of the course. For example safeguarding showed that staff had considered the signs to look for if suspected abuse had taken place, how staff should proceed if they suspected abuse and what resources were available to support people. In one letter written to the home we saw a relative had said "Your professionalism and understanding of [name]'s condition was exemplary."

Staff received regular supervision which comprised a pre-printed sheet containing key information. Since the start of 2016 most staff had received supervisions looking at the role of Healthwatch, infection control, safeguarding, mental capacity and the use of restraint. For example the home had a no restraint policy and explained to staff how someone with dementia may require distraction and support to divert their attention from doing something unsafe. Staff had also received an annual appraisal assessing their performance and evaluating their learning. Objectives were set for each staff member focusing on their development and career progression. Each sheet was signed by the employee and the registered manager. Staff were encouraged by comments such as "a valued part of the care team. Always works to a high standard and always pleasant and polite to all service users" and offered access to further training if they wished. This showed staff received regular support and supervision which promoted high standards of practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked staff their understanding of DoLS. One staff member replied "It's a means of protecting someone if they are not able to judge risk. People can go out if they wish if they are safe." However, this staff member was not aware who had a DoLS in place and so this meant they were unable to ensure they adhered to any conditions that may have been in existence. The registered manager informed us there were three authorised DoLS in place, one of which had recently been renewed. They had applied for a further authorisation as one person had recently returned from hospital and was needing close supervision to maintain their safety. Each DoLS we saw had conditions attached which were integrated in to the person's care plan showing the home was adhering to the requirements of the MCA 2005. These conditions and the relevance of the DoLS were reviewed at regular intervals.

We spoke with staff about their understanding of mental capacity and one staff member said "We offer choices to people such as different clothing." The registered manager told us staff always presumed people had capacity and said most people in the home could make day to day decisions. They explained on the advice of the local authority they had compiled a cognitive impairment test which helped them formulate a care plan to evidence how to best meet a person's needs. If the person was deemed to be lacking in memory then decisions were made in that person's best interests and documented to that effect. We discussed with the registered manager and Director of Care that the cognitive test was not sufficient to assess capacity and had a dialogue with the local authority who have, since our inspection, clarified their position and shared pertinent assessment information. We also highlighted that the home needed to ensure that any relative who signed documents had the legal authority to do so and that each capacity test should be decision-specific. The home agreed to implement this with immediate effect.

The mental capacity training was comprehensive looking at the five principles, how to understand and assess for capacity, making decisions and acting in a person's best interests and then applying for DoLS if required. Other training materials showed evidence of detailed learning checks with staff required to complete questions showing what they had learnt.

The environment was well signposted. We noted both written and pictorial signage such as a mounted tray with plate and cutlery on the wall outside the dining room. There was also a picture of a dining table. Each toilet and bathroom had a picture and written sign to assist people in locating relevant rooms, and people had their photos and names on their room doors. However one service user told us "There are not enough toilets. We have to stand and wait all the time." The registered manager said the home had plans in place to consider an extension to improve provision. There were two toilets near the ground floor lounge but as most people were in this area during the day there was high demand on the facilities. The home had placed chairs near the toilets so people did not have to stand while waiting.

Good

Is the service caring?

Our findings

One person said to us "We couldn't have a better set of nurses. They are great." Another said "I can't grumble about this place. I'm waited on and the carers are very pleasant." A further person said "The carers do very well." One staff member said "Staff have a good understanding of people's needs as we get to know people well. We aim to understand people rather than think of their diagnosis." We observed this throughout our inspection.

One person needed assistance with their personal care and we observed a staff member discreetly offering support to the person, gently moving them away from the communal area to their room. Staff were patient, gentle and reassuring, offering clear guidance and information. One staff member said "All right, don't worry. We'll take them to be washed later" in relation to where the person had put their soiled clothing.

During the morning one person was talking to a member of staff about how their shoes needed cleaning. The staff member offered to get the person some shoe polish next time they went shopping. The conversation was two way and showed the staff member acknowledged the importance of the person looking smart.

Staff told us they had a keyworker system where they took the lead for ensuring people had all their necessary clothing and toiletries, and that their rooms were kept as they preferred. One staff member said "We keep a special look out for our people, ensuring they have everything they need."

People were asked where they would like to sit at mealtimes, thus promoting choice. Staff spent considerable time talking to people in between providing caring support. They showed consideration for people's emotional wellbeing as much as their physical care. We heard many conversations throughout the day which endorsed that staff focused on the individual and were happy to listen. It was evident staff knew people very well and all were able to engage in friendly banter yet retain appropriate professional boundaries.

We saw evidence family and other relevant people were invited to care plan review meetings to ensure people's needs were being met in the way they preferred.

We asked staff how they respected someone's privacy. One staff member told us "All individuals are treated with respect. If carrying out personal care we ensure doors are shut and people remain clothed as far as possible. We treat people as we would want to be treated." The registered manager said that although staff had not received training further to their induction they felt the culture of the home embodied respect and valuing people. Our observations of interactions between staff and people were positive and showed a good rapport between people.

The registered manager was aware one person had an advocate as they were supported through the Court of Protection and the advocate attended all relevant care planning meetings promoting the person's best interests.

Good

Is the service responsive?

Our findings

One person said "I enjoy the bingo" and another told us "I'm not really sure what I'm doing but it's fun!" The home had an activities co-ordinator who was present during the inspection. They had created a colourful display relating to the European football tournament on the display board in the foyer. There was also a large selection of books for people to access as they wished.

During the morning we saw people playing a large polystyrene dice. Initially we thought they were having a competition to throw the highest number but then realised they were playing a small board version of snakes and ladders which could not be seen by half of the people in the room. Although scores were shared and there was a positive rapport, we felt some people did not really appreciate the activity they were undertaking. We spoke with activities co-ordinator about resources and they advised us the budget was limited but had been looking for further equipment. However, when we later spoke with the registered provider, they agreed to look into more suitable provision.

The activities coordinator was assisted by a student from the local college who was providing support. The previous week they had arranged a tea for everyone in the local vicinity and some people from the home had attended. Later during the morning people were engaged in playing with a large beach ball to improve their co-ordination and response times. We also heard a game of 'I-Spy' and observed people taking part in a horse racing game. It was evident people enjoyed the activities and the range on offer was meeting people's needs well.

We looked at care records and saw each had a completed front sheet showing a person's preferred name, date of birth, named worker and a dated photograph. There were key contact details such as the GP and next of kin for easy access by staff. Files were ordered detailing care plans, risk assessments and notes from professionals' visits. Daily notes were completed for each person showing their activities over the day and night. We found notes were fairly generic in content referring to 'a good diet' or 'compliant with meds'. However, specific information regarding significant events for people was recorded such as their night-time activities. This showed the home had an understanding of the importance of records focusing on the individual but needed to develop this further in relation to regular tasks undertaken.

Care records contained life story books which detailed a person's childhood, previous career, hobbies, beliefs, their favourite things and photographs. People had care plans according to their needs and these included communication, nutrition, personal care, moving and handling, sexuality and sociability, activities and sleeping. Each plan had an assessment of the person's need which was broken down into a series of steps showing how these were to be met and evaluated monthly. People's preferences were recorded as to gender of carer and their choice of occupation whether in the communal lounge or their own room. In one file we saw that one person liked a non-alcoholic lager with their lunch and we saw this provided. In some care records we also saw evidence of discussions with people around their preferred end of life care.

The evaluation comments did not always reflect the recordings in the daily notes. In one file it was noted "sleeps well" but we saw from recent daily recordings the person was often up overnight walking around.

The care plan had initially been written in September 2014 but by October 2015 it had been recorded this person was often restless during the night. The home had installed some sensors to alert staff to the person being awake and the person had signed themselves to say they were in agreement with this. This showed the home understood the importance of obtaining someone's consent as the measures were potentially restrictive.

Records contained logs of all health and social care appointments and we saw these corresponded with particular events in people's experiences. We saw care files were audited at regular intervals and addressed areas that needed amending, being signed and dated by staff to show they had remedied the issues.

The home had a log of all compliments received. Comments included 'excellent care' and 'thank you for the kindness and care shown. [Name] seemed to be very happy.' There was also a complaints file with two complaints from 2015. These had been investigated thoroughly and in a timely manner with positive resolutions in both instances. One had resulted in an unannounced night time visit with a thorough report and action plan drawn up as a result, identifying further areas to improve practice. People had access to the complaints policy in their rooms.

Requires Improvement

Is the service well-led?

Our findings

One person said "This is a very nice place." We read in a compliment letter sent by a relative that "All the staff are fabulous and we couldn't have asked for better." One staff member said they liked working at the home as "It's a homely home."

Staff told us they felt well supported by the registered manager. One said "I very much enjoy working here. People are lovely and I want to help where I can. I find it hard if someone dies as we've got to know people so well. We do get offered support if that happens. I feel listened to." Another staff member said "Personally I think the registered manager is very supportive. They come and join in, and muck in when we are busy." The registered manager advised us "I don't expect staff to do anything I wouldn't be prepared to do. I occasionally work shifts so I can see what staff are dealing with." The registered manager, in turn, felt well supported by the Director of Care who was present on the day of our inspection and obviously knew the service well. They had regular meetings and were pro-active in seeking out the latest guidance.

The registered manager conducted regular meetings with staff and issued staff newsletters which summarised key changes effectively. We saw from minutes of a meeting in February that topics discussed included audits, policies, DoLS and fire safety including training. Other meetings included specific information around medication including administration, self administration, refusal and disposal, controlled drugs, drug errors and the correct completion of the MAR sheet. Clear guidelines were given to all staff about procedure and expectation. However, in view of our findings around medication this had not proved effective.

Health and safety was also discussed with staff receiving information about medical device alerts which identify problems with particular equipment or other concerns seen by the Department of Health. Accidents and incidents were discussed in these meetings and any trends or concerns noted. Care staff received clear direction about all aspects of their role including their conduct, the importance of hydration and respecting people's dignity. This information was shared from a current knowledge base including legislation and good practice.

The registered manager advised us they planned resident and relatives' meetings. However, attendance was poor and no one had attended the last one. We asked them why this was and they suggested that people did not have any issues so did not see the relevance of such a meeting. They also said people brought any concerns to their attention at the time as the registered manager had an 'open door' and so again, a meeting was not pertinent. However, they said they would consider scheduling a further meeting.

The home had the previous report on display in the reception area and information about local advocacy services. There was a suggestions and comments box for people to add their views.

Equipment had been serviced as required under Lifting Operations and Lifting Equipment Regulations (LOLER).

We asked staff how they knew they were providing a quality service. One told us "I know we're doing well as we get no complaints. I can't think of anything that could be improved." We asked the registered manager how they identified good practice. They said "Through positive feedback and meetings with people. We also respond to all information sent by the Director of Care such as equipment alerts and through attending and discussing any training undertaken." They also told us "I am keen to recognise when staff do well. I always acknowledge their good practice and praise them. I always thank them at the end of their shift."

The home had a selection of auditing tools but we felt the impartiality of these was sometimes in question as they were completed by the same member of staff with limited comments. The dining room audit was an example. Although the audit tool questions were detailed, the tick box system did not encourage recording of actual observations. However, we did note that people in the home were asked their opinion of the food which enabled people to shape the service they received.

The medication audits were carried out by the staff member we had observed not adhering to the medication process so we questioned the value of this. Although the score in January 2016 was downgraded to say that photographs in the medication files were not dated, it was recorded that the administration policy was followed. This was not reflected in the practice we observed. There was also a call buzzer check sheet but this had not been completed. Neither had the bed rail audit which had been completed in full in February and March but there was no evidence of any further checks. This lack of oversight meant there was a risk concerns could be missed and the opportunity to improve restricted.

We saw evidence of monthly audits of pressure sore care and mattresses alongside the measures that had been put in place to address any concerns. Kitchen audits were also completed which had resulted in the replacement of a freezer earlier in the year and other areas requiring action which had all been documented as completed. The Director of Care also visited the home regularly and conducted comprehensive audits which identified areas for action, and allocated tasks to specific people with completion dates. This showed the registered provider was keen to ensure optimum scrutiny over care provision and to remedy any issue as soon as possible.

We asked the registered manager what they felt their key achievements were. They said "Having a fantastic care team. All people who work here want to be here, keeping people safe. We rarely have any vacancies so that must mean something." They said the registered provider was very supportive with the provision of anything they needed. The home had had a new lift installed during December 2015 and was in the process of refurbishing some of the chairs. New blinds had been provided and new carpets showing the registered provider was keen to ensure all homely comforts. The registered manager said they also had good relationships with the local healthcare providers, especially the GP and district nursing team who visited at least weekly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We observed serious competency issues in relation to the administration of medicines which meant that people were at risk of choking and not receiving the correct medication.