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Ashley Manor Nursing Home - Southampton

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashley Manor Nursing Home provides accommodation and nursing care for up to 45 older people. The service is in a rural location near Shedfield, and provides accommodation over three floors in a converted residential dwelling. At the time of our inspection 12 people were living in the home.

We carried out an unannounced inspection of Ashley Manor Nursing Home on 2 and 3 April 2017. This was a comprehensive inspection that was carried out to check on the provider's progress in meeting the requirements required as a result of our inspection on 22, 23 and 25 November 2016. At the previous inspection continuing breaches of legal requirements were found in relation to staffing and clinical governance and a new breach was found in relation to recruitment. Following the inspection the provider sent us an action plan detailing how and by when they would meet the regulatory requirements.

At this inspection we found improvements had been made to the support provided to staff. Following our previous inspection staff had received training, supervision and appraisal to enable them to effectively undertake their roles and responsibilities. The provider had reviewed the induction for new staff and clinical supervisions were to commence for nurses in April 2017. Some time was needed for this to become part of the home's routine staffing practices.

Following our previous inspection improvements had been made to staff recruitment. The provider had implemented safe recruitment practices and we found all the required staff pre-employment checks had been completed to ensure staff would be suitable to work in the home.

Requirements relating to clinical governance had still not fully been met. This is the process whereby a provider assesses the standards, safety and effectiveness of care delivered to people. We found some clinical audits, for example in relation to falls and infections in the home, had taken place but these had not always been accurate or effective in identifying potential risks to people's health and welfare.

The home is required by a condition of its registration to have a registered manager. The home did not have a registered manager in place. However, the home manager had submitted their application to be registered with the CQC to ensure the provider would meet their registration requirements. 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.

Staff told us improvements had been made in the general running of the home. However, we found the provider did not have an effective system in place to ensure that clinical audits completed by nurses were always checked and the inaccuracies we found for example in relation to the falls audit had not been identified. Clinical governance systems were not operated effectively to ensure the home manager would routinely scrutinise all nursing and care decisions to ensure people received care in accordance with

national best practice.

People received their prescribed medicines safely and had access to healthcare services when they needed them. People liked the food and told us their preferences were catered for. People received the support they needed to eat and drink enough.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. Care plans were based around the individual risks and preferences of people as well as their medical needs. They informed staff what support people required and we saw people were supported in accordance with their care plans.

Staff sought people's consent before they provided their care and support. Where people were unable to make certain decisions about their care the legal requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

Staff knew people well and supported people living with dementia to manage their anxiety and agitation.

People were treated with kindness, compassion and respect and staff promoted people's independence and right to privacy. The staff were committed to enhancing people's lives and provided people with positive care experiences.

People knew how to make a complaint. People told us the manager and staff would do their best to put things right if they ever needed to complain.

We identified a continuing breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Good

The service was safe.

People felt safe when supported by staff and staff understood their responsibilities to report abuse.

People's risks to their health and safety had been identified and staff knew how to protect people from the risks associated with their care and treatment.

There were enough suitably skilled staff deployed to meet the needs of people. Recruitment processes for new staff ensured they were suitable to work with vulnerable people.

The provider had appropriate arrangements in place to safely administer people's medicines when required and staff understood the risks associated with people's medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People received effective care and support from staff who received the training they needed to perform their roles.

Clinical supervision had been introduced for nurses. Time was needed to ensure nurses would always receive the clinical support they needed to ensure their clinical skills and knowledge remained up to date and they would continue to be fit to practice.

People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked mental capacity relatives and other professionals were consulted when decisions needed to be made about people's care and treatment.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs and

preferences.

Staff worked effectively with health professionals to ensure people's health needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives gave positive comments about staff and how caring they were when supporting people. We observed staff offer support that was kind and compassionate.

People received care from staff who knew their history, likes, needs, communication skills and preferences.

Relatives ands people felt, and observations showed, people's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care plans detailed how people wished to receive the support they needed. The environment had been adapted to support people living with dementia to remain independent.

People had access to activities and events which they enjoyed. They were supported to maintain their personal relationships.

People and their relatives told us they felt involved and their concerns and complaints were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's audit systems and inspection action plan had led to improvements in some areas of the service but had not been effective in driving the required improvements consistently across the home.

Further improvement was needed to ensure the home's clinical

governance system would enable nursing decisions to be reviewed and monitored to ensure people always received care in accordance with best practice standards.

Although staff told us the culture in the service had improved, the leadership was at times reactive and staff were not always clear who held overall responsibility for care and nursing decisions.

Ashley Manor Nursing Home - Southampton

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 2 and 3 April 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information on the day.

Prior to the inspection we spoke with a nurse from the Clinical Commissioning Group and spoke with the GP during the inspection. a GP.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with eight people who used the service, one relatives and one person's friend. We spoke with the acting home manager, the provider, service administrator, five nurses, eight care assistants, the cook, two laundry assistants, two housekeeping staff, two activity co-ordinators, the maintenance person and two volunteers.

We reviewed records which included four people's care plans, 14 staff recruitment files and supervision and training records medicine records and records relating to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection in November 2016 we found the provider had not implemented safe recruitment practices as all the required staff pre-employment checks had not been completed before they were offered employment. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made in this area and this regulation had been met.

The provider had reviewed their recruitment and selection procedure. All of the required information was available in the staff files reviewed. Records showed appropriate checks had been undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Nursing and Midwifery Council (NMC) checks had also been completed to ensure nurses were fit to practice. A full employment history with written explanations of gaps in employment was available. References had been obtained from previous employers to alert the provider to any concerns in relation to staff's conduct in previous employment that might make them unsuitable to work with people using care services.

We asked the acting home manager what action they would take if the available pre-employment information raised concerns about an applicant's suitability, for example, if they had a previous criminal conviction. They explained how they would systematically evaluate the risks applicants could pose to people prior to making a making a decision about their suitability or deciding whether additional monitoring would be required during their probation period to confirm their suitability. People were supported by staff that had been appropriately recruited to ensure they were suitable to care for people.

People and their relatives told us they had no safety concerns when people received support from staff in the service. One person told us ''I feel safe here because the carers are so kind and gentle and take their time to make sure I'm okay."; ''A relative said, "The caring attitude of all the staff makes me totally confident that people living here are safe and well cared for." A visitor told us, "The thing I notice is how everyone living here and the nurses all look out for one another like a big family."

People said they would be confident speaking to any member of staff or the provider if they had any concerns. Staff had completed adult safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. Records showed the provider had investigated medicine errors and any unexplained bruising to people reported through their accident and incident procedures to identify if these raised any concerns in relation to potential abuse. The provider could explain how they would report any allegations of abuse in accordance with the agreed local multi-agency safeguarding procedures. Systems were in place to ensure people were protected from abuse.

Staff knew how to follow whistleblowing procedures and how to raise concerns anonymously if required. They told us they were confident that any issues they raised would be addressed to keep people safe and to improve the service people received. One nurse told us "If I had any concerns about any staff member I will speak immediately to provider''. Another nurse said, "I would feel comfortable speaking with one of the

owners (named provider) if I had concerns." All of the care staff told us they would initially speak with one of the regular nurses if they had concerns but would be happy to speak with the provider. Staff were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Risks to people's safety and staff supporting them had been identified using universally recognised screening tools, managed safely and reviewed. These areas of risk included any potential hazards in the environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure ulcers. For example, one person had been assessed as at high risk of falls and appropriate arrangements were put in place so staff would know how to support them to mobilise safely. This included supporting them to move to a room downstairs so that staff could promptly offer support when they got up. People had been provided with the necessary equipment such as mobility walkers to support them to walk safely and we observed staff encouraging people to use their mobility aids and support them in accordance with their mobility plans.

Records showed when people fell they were observed at regular intervals to assess them for any injury so that medical support could be requested in a timely manner if required. People's care plans had also been reviewed after a fall to ensure their mobility risk management strategies would remain effective. Staff had received training in safe moving and handling and could describe how they would use hoisting equipment safely. We observed staff appropriately supporting one person to reposition themselves in their personal armchair, in accordance with their moving and positioning plan.

People at risk of developing pressure ulcers who were cared for in bed had re-positioning charts in place which demonstrated that they were having their position changed as highlighted in their risk assessment to relieve the pressure on their skin. Records showed when changes in people's skin were identified nurses had made adjustments to people's risk plans, for example, increasing their re-positioning frequency from four to two hours and had notified the GP. We saw this had been effective in preventing people's skin from breaking down. Staff demonstrated that they knew what action to take to keep people safe in accordance with their care plans.

We observed there was sufficient staffing in the service. For example, we did not notice any people left waiting to be attended to, and on the occasions when we heard the call alarms or people calling for assistance they were responded to quickly. The provider's call bell audits confirmed people did not routinely wait longer that the provider's four minute response time target before being assisted when they pressed their call bell. When people were supported for example, to eat during lunch time, this was unrushed and provided at people's pace. The provider continued to recruit to staffing vacancies and absences and vacant posts were covered by existing staff, the provider's own bank staff or agency staff. Some care staff worked both days and nights and this ensured people received care from staff that knew them.

The provider used a staff calculation tool based on people's needs to assess the staffing level required for the service. We saw the records of this calculation which was current for the 12 people accommodated. There was some anxiety from staff about the future staffing levels if the number of people increased. The provider had assessed people's current staffing level requirements and explained how they had reviewed these in light of a new admission. They told us some improvements could be made to how staff were used on shifts to ensure people would get the time they needed to complete their care at their pace. Records showed the provider had monitored the effective use of night staff and had made some changes for example, where staff would be positioned in the home at night to increase their response time when people requested assistance. The provider told us they would be completing this work for the day shift as well. Although staff told us they were rushed in the mornings they generally described the staffing levels as sufficient to meet people's needs.

People told us they received their prescribed medicines at the right time and in the manner they preferred. One person told us "Sometimes I feel a bit sleepy and don't feel like taking my tablets so the girls (staff) come back a bit later but they always encourage me to take them." Another person said, "They (staff) always come when I am in pain and give me something to help or call the doctor." A relative told us the staff kept them fully informed when the GP had prescribed a change in their loved ones medicines.

Systems were in place to ensure people received their medicines safely as prescribed. People's medicines were stored safely and those requiring refrigeration were monitored appropriately. Controlled drugs (CDs - medicines with potential for misuse, requiring special storage and closer monitoring) were stored securely. Nurses carried out weekly CD records and stock balance checks to ensure people had received their CD's as required. Unwanted CDs were safely disposed of and CD records were kept according to legislation.

People's medicine administration records charts (MARs) were stored securely and included details of peoples' allergies and there were no missed doses. Information was available to staff to ensure "When required medicines" were given in a timely and consistent way by the staff. People's topical cream administration records indicated the name of the product, where and when the creams were to be applied. A body map was included to ensure staff would know where to administer people's creams. Staff signed when creams had been applied to people.

Medicines errors were reported, investigated and discussed by staff and they told us of the teaching sessions they had attended to reflect and learn from medicine errors.

We observed the morning medicines round and saw staff followed best practice when administering people's medicines. Nurses administered peoples' medicines. They completed annual medicines administration training to ensure they kept up to date with safe medicines administration practices.

Staff understood each person's vulnerability to infection and took action to protect them from the spread of infection. We saw staff washed their hands prior to undertaking any procedures and when delivering care. Staff and visitors had easy access to hand washing facilities in the home. There were sufficient supplies of protective equipment such as gloves and aprons and staff used these appropriately. Records showed that regular cleaning and infection control audits had been undertaken to ensure staff complied with the provider's infection control requirements. The service was well maintained and clean throughout the inspection.

The provider told us and records confirmed the service had been inspected by the county fire and rescue service on 28 October 2016 and a number of fire safety breaches were identified which the provider was required to rectify by 1 March 2017. The provider was able to demonstrate they had established contact with an independent fire safety provider who supported them to complete the work needed to meet the requirements of the fire safety order to ensure peoples' safety in relation to the risks from fire.

Records showed that other required checks in relation to gas, electrical and water safety had been completed. All equipment was safely maintained under service contracts by qualified engineers, for example; all mobile hoists, standing aids; specialised care baths and bath hoists had been inspected and serviced on 20 February 2017. All such equipment was cleaned after each use which was recorded in individual log books. During the last week of March 2017 the provider had completed a detailed audit of all slings in the home, which were used with different hoists and stand aids. This included a full check to ensure all personal slings were identified and of the appropriate size to ensure people were safe when they were used. Where people required equipment in relation to effective pressure area management, for example air beds, we observed these were serviced regularly and used in accordance with people's skin support plans.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in November 2016 we found not all of the staff had received the training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In the provider's action plan they informed us processes were in place to address these issues and they would meet the requirements of this regulation by 30 March 2017. At this inspection we found improvements had been made and the requirements of this regulation were now met. More time was required to ensure these improvements were sustained in the home. This included time for the new clinical lead to compile a nursing induction framework and complete the nurses' clinical supervision and competence assessments.

Staff were complimentary of the training opportunities they were provided. All staff told us that the training provided had significantly improved since the last inspection. One member of staff said, "The biggest improvement has been the training. It's much more organised and structured and there has been a lot of input regarding people's mental capacity, how to respond to safeguarding and extra training about how to move and position people safely." Another told us, "The training input makes you feel that they (the provider) realise that staff are important and need good support and training."

A training matrix was in place to record when staff had last completed training and when they required an update. This showed that, following our previous inspection, all staff had completed training to meet both health and safety and the provider's mandatory training requirements. This included training in for example, food hygiene, infection control, fire awareness and evacuation, moving and handling. All care staff had completed an assessment of their moving and handling skills and of their competency to witness and evidence that nurses had administered people's CD medicine correctly. All nurses had also refreshed their medicine training and plans were in place for the new Clinical Lead to assess nurse's medicine administration and moving and handling skills by 30 April 2017.

The provider worked with another local service to share a trainer and joint training sessions had taken place. The local Clinical Commissioning Group (CCG) had also delivered training to support people's specific care needs. Nurses were satisfied with the training they had received. They told us, "All of the important stuff has been refreshed like tissue viability, skin care, moving and positioning, mental capacity and safeguarding." Another nurse gave examples of additional training provided, including the use of specific equipment to meet people's needs, for example, in the administration of people's medicines. Plans were in place to ensure all staff would complete care specific training for example in dementia, which was booked to take place on 14 April 2017. Staff had received training to meet people's needs and systems were in place to assess care staff's competence to deliver care in accordance with the training they received.

Following our previous inspection the provider had reviewed their staff induction. They had met with a training provider and staff to review their expectation that all care staff should complete the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which new care staff need to meet before they can safely work unsupervised. Staff were already experienced care workers. It was

agreed that they would instead be supported to complete further care qualifications and that the Care Certificate was only to be completed by staff new to care. Records showed that three staff were completing qualifications in Health and Social Care.

Staff told us they felt supported in their role. One member of staff told us, "Things are much better now. There is more support from the owner and the nurses couldn't be better. They are always willing to help or give you advice." A bank nurse told us, "The management team are working hard to support the nurses through improving staff skills and management on the floor."

There was a variety of methods for keeping staff informed and updated of changes in people's needs and practice. These included daily handover meetings, staff meetings and nursing meetings had been introduced. Nurses also met twice a month with the Nurse Facilitator from the local CCG who reviewed people's needs with staff and demonstrated good practice. For example, they were supporting nurses to implement a system whereby people were routinely screened for any medical deterioration so that a timely clinical response could be triggered to investigate any health concerns. The Nurse Facilitator told us this had supported and trained staff to enhance their skills and improve their confidence by building on existing good practice.

People were supported by care staff who had received regular supervisions (one to one meetings) and an annual appraisal of their performance with their line manager following our previous inspection. Care staff told us this had given them the opportunity to reflect on their practice, to identify their learning needs and to be more aware of the needs of the people who lived in the home. The new Clinical Lead is a Practice Development Nurse and they will be completing clinical supervisions for the nurses by 30 April 2017. Time was needed to set up and embed nursing induction, competency checks and clinical supervision to ensure nurse's clinical skills and knowledge remained up to date so they would remain fit to practice.

Some people did not have the mental capacity to independently make decisions about their care arrangements. Staff had undertaken training on the Mental Capacity Act (MCA) 2005. 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff showed a good understanding of this legislation and were able to tell us about their responsibilities under the MCA. One staff member told us, "Some people here have capacity to make some decisions like what they would like for lunch but don't have capacity to make decisions about their treatment, so there are processes we follow to make sure decisions are made in their best interest." A relative told us ''My (family member) has quite advanced dementia so cannot make decisions about their treatment. The staff are very good at contacting me to ensure I am involved in any decisions about their care." Staff were observed seeking consent and explaining the tasks they were about to carry out, for example when asking people if they wanted any pain relief.

Nurses were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had received relevant training and records showed they had a good understanding of the legal process and the documentation they needed to complete. Staff had also encouraged people to make decisions about their care, treatment and preferred place of death whist they still had the mental capacity to make these decisions independently. Where people lacked capacity to make decisions about their care we saw these had been made in their best interests for example, when people could not consent to living at the home. One member of staff told us,

"We have some people here who have variable capacity. We know how to support them to understand the decisions they need to make and can support them to make their own decisions for as long as possible''.

For two people a best interest decision had been made to live at the service as they no longer had the capacity to understand the risks to their health and safety and the arrangements in place to keep them safe. The provider had made an appropriate Deprivation of Liberty Safeguard (DoLS) application for these people. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This meant people's rights were respected because staff understood their responsibilities in relation to the MCA.

People spoke positively about the quality and quantity of food available to them. One person told us, "We now have this food from an outside caterer which is very good and gives you lots of choice but we also like the old favourites like cottage pie. Things have improved lately because the cook cooks fresh food as well. They (the provider) have been very good at finding out what we like and what we don't like." Another person told us, "I don't like the new fangled meals but the cook is very good and will make me something I fancy." A relative told us, "The staff know (their loved one) so well and what she likes to eat and always serve small portions which she likes."

We observed the dining room experience of people at a lunch-time. There was a calm, pleasant atmosphere in the dining room. People chose where to sit and who to sit with. People in the dining room were served by one member of staff who was supported on the two days of the inspection by a volunteer. Both the staff member and the volunteer chatted with people as they served and supported them. People were supported to make their meal choice. The chef told us that if someone did not like the menu options offered then they would offer them an alternative of their choosing and the kitchen staff were aware of people's food and portion preferences. We saw people were regularly offered something to drink and jugs of water and juice were available in people's rooms and communal areas. Records were kept of how much people drank and these showed people remained hydrated. Staff promoted the importance of good nutrition and hydration.

People's nutritional needs had been assessed. Referrals were made to health professionals where people were at risk of malnutrition or had swallowing difficulties. Guidance received from the GP or the Speech and Language Therapist (SALT) was recorded in people's care plans. People's weight was monitored and staff were aware of those people who had lost weight and what action was needed to support them. Staff could describe how they supported people whose swallowing had diminished by encouraging small spoonfuls of food and ensuring food was of the correct thickness to prevent choking. The chef was able to tell us how they met the needs of a people who required pureed food. People required different levels of support and those who required help with their food were supported in a dignified way. We observed where people refused their food; staff were patient and skilled in encouraging people to eat. For example, offering them what they liked, sitting with them and making sure people had a positive meal time experience whilst being encouraged to eat.

Staff monitored people's health and wellbeing and records showed changes in people's health were identified promptly and care staff alerted the nurses when for example; concerns relating to people's skin, pain management, swallowing or mobility had been identified. People were supported to access a range of health professionals as required. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, community nurses, mental health nurses, diabetic nurses and podiatrists (foot specialists). Staff could describe the adjustments they had made to the support they provided to a person to manage their anxiety following a recent visit from their mental health nurse. People had also been seen by their social worker where required. People were supported to access

specialist health practitioners when needed.

A local GP visited the home at least weekly and also routinely reviewed people's medicines. People told us they were satisfied that their health needs were met. One person told us ''Whenever I am poorly the carers always call the doctor to make sure I'm alright. "One relative told us "The staff are first class and are really on the ball, they're very good at spotting any deterioration in (their loved one's) health and taking prompt action against things like infections." Another relative told us, "They (staff) seem to identify problems very quickly and nip it in the bud. They're very quick to call the doctor and get experts when required." People's health conditions for example, diabetes and Parkinson's were documented in their care plans and staff understood the support they needed to stay healthy.

Good

Is the service caring?

Our findings

People and relatives told us they liked the staff. One person said, "The staff are very caring, nothing is too much trouble and the girls (staff) make you feel special." A relative told us, "The staff are all very kind, friendly and gentle. They never rush and always let people know what is happening." Another person said, ""You can tell all of the staff want to be here and it's not just a job to them, which makes me feel that I really matter and am not a burden."

Interactions between people and staff were good humoured and caring. People appeared relaxed, comfortable and responded positively to staff when asked what they wanted to do or eat. Staff gave people time to respond to their questions, used short sentences and encouraged people to concentrate so that they could make their wishes known. We saw one person who appeared to be struggling to read their book was being supported by the provider. The provider knew the person and referred to them in a kind manner using their preferred name. They then supported the person to move into the conservatory were it was sunny so that they were able to read more easily.

Throughout the inspection, staff showed care and concern for people's wellbeing. We saw that one person sat in the lounge area shuffled in their wheelchair and appeared to be in discomfort. The nurse kneeled in front of them, made eye contact and ensured they were at the same level before speaking to them in a kind reassuring manner. The person said they could not hear the nurse. The nurse then readjusted the person's hearing aid in accordance with their communication support plan, providing a clear explanation before they did so. The person then said they wished to go to bed so the nurse began to support them back to their room. Whilst leaving the lounge area the person began gesturing and pointing towards the garden. The nurse then engaged them in another conversation and checked if the person wished to go into the garden which they were then supported to do. Once in the garden we saw the person smiling broadly whilst they were pushed around the grounds.

Staff supported people with consideration and kindness when they became distressed. Staff were observed speaking kindly to one person when they became anxious and worried that they were going to fall. Staff made sure the person was calm and settled before attempting to support them to get up again. They did so with clear, short instructions and showing the person where they needed to place their hands on their walker, whilst praising them throughout. We saw this provided the person with reassurance. We observed another person supported to walk by staff who demonstrated the type of steps they needed to take to reduce their risk of falling. Staff made the person laugh with humorous conversations about dancing which reduced their anxiety and provided reassurance to them.

People were encouraged to be as independent as possible and were involved in making decisions about things that affected them, for example; people were encouraged to manage their personal hygiene and appearance. Care plans included details of those areas people were independent in. Staff told us how they aimed to support people to maintain or develop their independence.

Staff told us they respected people's wishes about how they spent their time and the activities they liked to

be involved in. Staff understood when people preferred to spend time on their own in their bedroom and checked on them regularly to provide some company and check if they needed anything. One person who had chosen to watch television in their room was visited regularly by staff who sat down and chatted to them about their previous life and the programmes they were watching.

People had been involved in decisions about the décor of their rooms and were surrounded by objects they held dear. One person told us, "My room is full of happy memories because I am surrounded by my own personal treasures and photographs." We observed laughter and banter between people and staff. The language heard and recorded in care records was appropriate and respectful. Staff used touch to support people to understand instructions, we saw this was done appropriately and people seemed comfortable and reassured through physical contact with staff. Contact was unrushed, with smiles and kindly gestures, such as when asking where people would like to sit or when people appeared not to understand what was asked of them.

Family and friends were encouraged to visit whenever they wanted and staff supported people, who wanted to have regular and frequent contact with relatives. One person told us they looked forward to visits from their family and were looking forward to going out for something to eat and to see a film they had been longing to see. During the handover meeting we heard staff making arrangements to ensure this person was supported to be ready to leave with their family for their day out. When the person returned later that day staff enquired enthusiastically about the person's day and everyone joined in singing the soundtrack of the film.

Relatives were encouraged to support people during lunch time if they wanted to. One relative told us, "The manager and staff always encourage you to come and visit whenever you want and always offer you lunch or refreshments."

Staff explained to us that an important part of their job was to treat people with dignity and respect. Our observations confirmed that staff respected people's privacy and dignity. One person told us, "The carers are so kind and polite and treat us like their own family. We're always treated with dignity and respect''. A relative said, "The staff always show my (loved one) the utmost respect. Staff used people's preferred names and spoke with them in a kind and patient manner. If people required support with personal care tasks this was done discreetly, behind closed doors to ensure their dignity was maintained. When staff spoke with people using wheelchairs they showed respect by crouching or sitting down so that people could have a conversation at eye level.

Good

Is the service responsive?

Our findings

Each person's needs had been assessed and were used to develop a personalised care plan which reflected people's needs and preferences. This included an assessment of the person's needs before they were admitted to the service. One person told us, "When I first came the nurses spoke to me and my family to find out all they could about me and asked me all sorts so they knew all about my medical history and my life." One relative told us, "We were so glad when (their family member) was able to come here. Everybody was so friendly and welcoming and the manager and nurses sat us down to find out everything they could about (their loved one) and what they needed to do to care for them." Another relative told us they were reassured by the warm family atmosphere they experienced at the service on visits prior to their family member moving there.

Records showed relatives were kept informed if people became unwell or their needs changed. A relative told us, "Since my (family member) has been living here the impact of her dementia has increased so she needs more attention from staff. One thing they do really well is letting me know if she is poorly or if there are any problems or changes in her health." They had been given an opportunity to review people's care plans to ensure they provided information that people might not have been able to share. Another relative told us, "The manager and nurses regularly update me about the care they provide for (their loved one) and involve me in the planning about things which (their loved one) won't understand."

Personal information was available for each person, which included details of the person's background and preferences, such as bed time routines so staff would know how to plan and deliver individualised care.

People had care plans for personal care which recorded and included specific details of how staff should support people. These included tasks which people could do for themselves regarding their personal care and what staff needed to help people with. Staff could explain how they used the information in people's care plans about their life and employment history to initiate conversations with people and were familiar with the care instructions in people's care plans. Relatives confirmed that staff knew people well and what was important to them. One relative told us, "The staff are anxious to do all they can for the people living here and this is based on knowing them as people, including their life stories." All staff were able to demonstrate a detailed knowledge of each person's life story, which we observed during conversations whilst they delivered people's everyday care and support.

Decisions about people's care arrangements were made in consultation with them. For example, staff asked people living upstairs when rooms became available on the ground floor if they wanted to move. When people indicated that they preferred to stay upstairs this was respected.

Some people in the service lived with a diagnosis of dementia and staff understood how to support their needs. We saw good communication skills and dementia friendly practices were evident when staff supported people with dementia. For example, we observed care staff supporting people during lunch time. They spoke with people throughout, such as telling them what they were eating, or asking where they would like to eat. One person was becoming anxious and refused their food; staff gave them some time before

offering them a meal again which they then accepted. This meant people living with dementia benefitted from meaningful and effective support from skilled staff who understood their needs. The provider told us that following completion of the dementia training in April 2017, people's dementia care plans will again be reviewed. This would ensure people's dementia care plans were sufficiently individualised and gave new staff the information they needed to support people to meet their emotional needs.

Structured activities were available for people and they were able to choose whether they wished to join in or not. Events were held throughout the year and relatives were encouraged to take part in celebrations and events at the service. One person told us, "The staff shine out here, they are very caring and always come for a chat. They've even got me reading again. I used to love reading but stopped doing it a while ago. But now I'm back reading and I love it." A relative told us their family member, "Enjoys being in the company of people when there are group activities but does not always want to take part.", which was respected by staff. A relative told us their family member enjoyed and missed shopping at a specific store and that the manager was looking into arranging an outing there in the near future.

Activities included; pamper afternoons, card making, quizzes and lounge games. Records showed the activity worker also spent time individually with people to explore what they would like to do with their time. For example, a second person had been supported to take up reading again and records showed how they were supported to identify a quiet area in the home that would be their preferred reading space. We saw staff regularly chatting with people and walking with them in the garden. Some people occasionally displayed behaviours which may challenge others, for example, when they became anxious. We observed one such person who had been a keen gardener, walked the whole garden with the activities coordinator, providing their advice and guidance about what plants and shrubs to buy and where to plant them. During the tour of the garden the person was clearly enthused by the prospect of planting some new shrubs and flowers and was constantly smiling. The activities coordinator and provider confirmed they had purchased new plants and shrubs which they intended to plant as a group activity and to later arrange trips to the local garden centre as an on- going project.

The activity worker told us people were encouraged to share their memories and thoughts to support their communication skills and enable them to make sense of their world. One person was starting a project to reminisce about their time in the Royal Navy and another person was supported to talk about their feelings about selling their home. Staff also supported people to suggest activities they liked to undertake with their family for example, choosing a film they would like to see. The provider told us they would again review the structured activities available with the new activity worker once they had gotten to know people better. This meant people were given the opportunity to have an active and stimulating day with meaningful engagement.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. One person told us, "I trust the carers completely and feel I can tell them anything. I've never had any concerns but if I did I would tell (named staff) because she's my favourite and I speak to her all the time, but all the staff are lovely and I could speak to all of them." A relative told us, "All of the nurses and carers here are so friendly and helpful that no matter what the problem I would feel happy speaking to any of them and the manager goes out of their way to make sure everything is alright."

Care staff told us they would report people's complaints and concerns to the nurse. One care staff member said "We always try to sort things out straight away so they don't become a problem like this morning with (named person's) missing clothing". We had observed laundry staff support care staff with a person who was becoming upset because a particular item of clothing they wished to wear had gone missing. The missing item had been washed and had been placed in the airing cupboard to dry. The clothing was immediately

found and given to the person who became happier and more relaxed. One care staff told us, "We always tell the nurses first if there is a complaint or a problem because we are working with them all the time but if it was a concern about the nurse I would speak to (named provider) the owner.

The provider's complaints process was available to people and their representatives. This set out how people could make a complaint and how their complaint would be dealt with. Records showed the service had received no complaints following our previous inspection. There was a process for ensuring people's complaints and concerns were logged, investigated and responded to.

People and their relatives were provided with the opportunity through the resident/relatives meetings and individual review meetings to share their views about the service. We saw people's feedback had been taken into account when improvements were made to the service. For example, the provider had reviewed the food at the service following people's feedback that they would want to see some improvement. People told us the provider had taken their suggestions on board. They were satisfied with the food and the new menu reflected their preferences Staff were also consulted about the provision of the ready prepared meals. The cook told us, "I prefer to cook everything fresh but I now think we have the best of both worlds because the prepared pureed food actually looks like what they were before they were pureed, so people can recognise them." The cook told us that the management team had invested a lot of time to find out how people and staff felt about the new food and menus.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in November 2016 we found further improvements were needed to ensure all governance systems across the service became and remained effective in identifying shortfalls in the service and driving improvement. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found the provider had made some improvements in this area, however further improvement was needed before the service would meet the requirements of this regulation.

Following our previous inspection the provider had again reviewed their audit programme for monitoring quality and risk in the service. We found audits in relation to health and safety, infection control, kitchen and laundry, call bell response times, fluid, food and repositioning charts and staff recruitment files were completed routinely. These were effective in identifying concerns and action had been taken to make the required improvements. A training and supervision spread sheet had been introduced and was used by the provider to monitor that staff had received the required training and supervision. The provider could describe what improvements were needed and what action they were taking for example; to arrange dementia training. However, as we noted in our previous inspection the provider had still not kept a written record to demonstrate the actions needed to be taken, such as ensuring the outstanding training was arranged in a timely manner. There was a risk that planned improvements would therefore be delayed or not completed at all.

Clinical governance arrangements in the service still required improvement. Well-led nursing homes effectively implement governance systems that enable providers to scrutinise all aspects relating to people's nursing (clinical) care to ensure they provide people with a good service and meet appropriate quality standards and legal obligations. These systems for example, could include audits of a range of key clinical areas, such as infection control, falls, pressure ulcers, malnutrition and serious incidents. It ensures checks are in place to review nursing decisions in accordance with national good practice guidance and nurses are given opportunities to maintain and learn new skills to keep up with the latest developments.

We found some clinical audits had taken place but these had not always been accurate or effective in identifying potential risks to people's health and welfare. For example, a monthly falls audit had been completed. The 17 January 2017 falls audit showed one fall had occurred in the service over that month and the 26 February 2017 also showed one fall the next month. However, the accident and incident reports showed that two falls had occurred between 17 January 2017 to 26 February 2017. The provider relied on the falls audit to identify the number of falls in the home and the falls audit had not provided an accurate reflection of the number of falls that had occurred. As part of the falls audit a check was to be completed by the auditor to see if each person's falls management plan had been reviewed following their fall. However, these checks had not been completed for all the falls and assurance had not been gained that people's falls risk was being managed appropriately in each instance. We found the results of the audits had not always been reliable and there was a risk that the provider would not have accurate information to determine risk and quality concerns in the home. No system was in place for the manager to check completed audits to ensure they were completed accurately and if staff required further support to develop their skills in

completing these. They had therefore not identified the omissions and inaccuracies in the audits that we found.

The home manager did not operate the accident and incident system effectively and had not reviewed incidents for the past month to ensure staff had taken appropriate action to keep people safe. We found improvements had not been made following our previous inspection to analyse the cause of infections and falls or screen for any trends which might require action. These reviews were still not sufficiently developed to identify risks and drive service improvement for people.

Routine medicine and care plan audits did not always identify areas that required improvement. For example, we found some gaps in people's topical cream charts and some 'as required' medicine protocols required updating. One of the bank nurses had identified these concerns when they reviewed the last three months' MAR sheets on 1 April 2017. Action was being taken to address these concerns. However, the routine monthly medicine audits completed on 5 January 2017 and 15 February 2017 had not identified these shortfalls. When the provider had identified shortfalls that should have been identified by their routine audits, they had not evaluated their audit systems. This would have helped them understand why their routine audits had not identified the shortfalls and make improvements to their audit formats where required, to ensure they would remain effective.

Further improvement was needed in the monitoring of people's skin concerns and weight loss across the service. For example, screening tools were in place to identify when people were at risk of developing pressure ulcers or become malnourished and plans were in place to address these. However, a system was not in place to inform the provider and manager of who was at high risk, what management plans the nurses had in place and how these were to be reviewed and scrutinised to ensure they were effective and in accordance with national best practice guidance. There was a risk that trends could be overlooked and nurse's interventions could become fragmented in the absence of clear clinical oversight. At the time of the inspection nurses were scrutinising each other's decisions. However they told us this had led to some confusion, conflicting approaches to clinical issues and uncertainty about roles and responsibilities. It was not clear who was responsible and accountable for clinical decisions. A new clinical lead was starting in post on 4 April 2017 for two days a week. However at the time of our inspection arrangements were still not in place to ensure regular oversight of any clinical decisions that took place.

Care plan audits completed on 31 January 2017 and 14 February 2017 had not identified the required improvements the provider and nurses told us they were making to people's dementia care plans, bowel charts and weight records. These improvements were being made based on feedback from inspections, staff or visiting professionals. However the provider had not drawn up an improvement plan to track progress or prioritise improvements that needed to be made. This had led to new systems such as the bowel charts being introduced before the longer standing improvements required to people's dementia care plans been completed. The provider had not reviewed their care plan audits format so that the newly introduced systems would also be checked routinely to ensure they would be completed.

Although we found improvements had been made to the home these had not always been prioritised based on risk. The home manager had submitted the inspection action plan and told us they were responsible for ensuring its completion. The home manager and the provider told us they had not realised that the requirements for Regulation 17 had still not been met and that they had not completed the inspection action plan. They told us they had been busy with other improvement activities for example addressing staff absenteeism; as a result improvement actions had become fragmented. Not all the concerns identified at our previous inspection had been addressed and people were at risk of receiving a service that did not meet the requirements of HSCA regulations.

Improvements were needed to ensure all governance systems across the service became and remained effective if the number of people using this service increased. The provider did not operate effective quality assurance systems to assess, monitor and improve the quality and risks related to the service. Although some improvements had been made further improvement was needed to ensure the effectiveness of the service's governance system. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. A home manager had been appointed in September 2016 following the resignation of the previous acting home manager. The home manager had submitted their application to be registered with the CQC to ensure the provider would meet their registration requirements. Staff gave us mixed feedback about the home manager. They told us the general management in the home had improved for example staff absence had improved and there were increased management oversight of staff. However they told us that systems were not always effectively operated to support them to resolve clinical or practice concerns.

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

Staff reported that a culture of continuous improvement had developed. One nurse told us ''Everyone is now looking at how we can make things better and improve''. However, staff also told us that it was not always clear who was responsible for leading the improvements and why some improvements were being made. Staff felt at times improvements were made re-actively and they were unclear about what improvements were to be prioritised.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively to ensure the service; assessed monitored and improved the quality and safety of the service provided and assessed, monitored and mitigated risks relating to the health, safety and welfare of people who used the service and others. The provider did not maintain securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided.

The enforcement action we took:

We imposed a condition on the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care at Ashley Manor Nursing Home - Southampton. They are required to undertake regular audits to monitor quality and risks in relation to the management of the service, staff and support of people. They must send a monthly report to CQC noting the audit dates and outcomes, any actions taken and evaluate the effectiveness of their actions.