Ashlyn Healthcare Limited

Ashlyn

Inspection report

Vicarage Wood
Harlow
Essex
CM20 3HD

Tel: 01279868330

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We previously carried out an unannounced comprehensive inspection of this service on 8 and 20 July 2017. At that time Ashlyn was rated 'Inadequate' due to insufficient staffing levels, the provision of unsafe care and treatment, poor risk management and a lack of person-centred care which meant that people's preferences were not known or upheld. We also found a lack of leadership and oversight of the quality and safety of the service. During the inspection of July 2017 we found breaches of Regulation 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the high level of concerns regarding the breach of Regulation 9 (person-centred care) we served the Provider with a Warning Notice. This document set out where the service was failing and required the provider to address our concerns within a specific time frame. As a result of our inspection the service was placed in special measures. The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve within a set timeframe.

Following our inspection and subsequent enforcement action, the provider supplied us with an action plan, which set out what they would do to meet the legal requirements in relation to the breaches and to improve the service. We then undertook a further comprehensive inspection to check that the service had implemented their action plan and to confirm that they now met the legal requirements. At this inspection we found that the service had followed its plan to address the breaches and those aspects of the service that required improvement which meant that the service now met the legal requirements and was no longer in breach of the regulations.

The inspection took place during the day and into the evening of 19 March 2018 and was unannounced.

Ashlyn is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 60 people in one building, over two floors. At the time of our inspection there were 40 people living at the service some of whom were living with dementia.

Since the previous inspection the provider had recruited a new manager who was going through the process of applying to become the registered manager. 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.

Significant improvements had been made in terms of oversight of the service at both manager and provider level. Quality assurance mechanisms were now in place which were effective at identifying and addressing areas of the service that required improvement. A new style of leadership had been adopted by the new manager which reflected a more 'hands-on' approach. The visibility and approachability of the new manager had improved staff morale and the staff reported that they now felt listened to and supported. This

had a knock on effect on people who lived at the service who reported that there was a much nicer atmosphere in their home.

The new manager had made a positive impact on the culture of the service. Teamwork had improved and staff felt valued. The manager was a role model for staff and promoted the vision and values of the service which included putting the needs of people first and treating people as individuals.

Staffing numbers had been increased and systems and processes for care recording had been streamlined which meant staff had more time to spend with people and could safely meet their needs. Improvements in staffing levels and how staff were deployed also meant that people's routines and preferences were respected. People were supported to get up and go to bed when they wanted, they could choose when and where they ate their meals and how often they had a bath or shower.

Improvements had been made with regard to how risks to people were managed. Risk assessments were completed which met people's individual needs and management plans were in place which provided guidance for staff on how to minimise any risks. Improved systems and processes ensured that staff had the most up to date information about people to keep them safe.

At our last inspection we found people's health care needs were not well managed. During this inspection we found the necessary improvement had been made and new systems were in place to ensure that people's changing health and wellbeing needs were responded to appropriately.

Staff were kind and caring and greater consideration was demonstrated by staff to ensure people's dignity and privacy was consistently maintained. At the previous inspection we expressed concerns regarding the amount of time some people spent in wheelchairs. This issue had been addressed and staff were aware that unless people expressed a particular desire to stay seated in their wheelchairs then they were transferred into comfortable chairs as soon as practicable.

Staff supported people to express themselves and communicate in ways that helped them to be involved in decisions about how they wanted to be cared for. Independence was promoted and encouraged whilst maintaining people's safety.

People received their medicines safely and these were stored in accordance with the prescriber's directions. The service protected people from the risk of infection, and there was an understanding by staff of the importance of infection control and prevention.

Staff had received training in how to protect people from the risk of abuse. Where there were concerns about people being at risk of harm or abuse, action was taken to safeguard the individuals concerned.

Safe recruitment processes were adhered to and staff received ongoing support, training and supervision to ensure they were competent in their roles. Staff's training needs were kept under review and additional training was arranged in line with the specific needs of people who lived at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's consent was sought before care and support was provided.

People were encouraged to eat and drink and enjoyed a variety of food that was nicely cooked and presented. If people were identified at risk of not eating and drinking enough, medical advice and treatment

was sought to help people stay healthy.

The home environment met the needs of the people who lived there and the building was in a good state of repair. Ongoing refurbishment and decoration was in progress in response to feedback received from people who lived at the service. The atmosphere within the service was warm and welcoming. Visitors were made welcome which meant that people were supported to maintain relationships that were important to them.

People were provided with opportunities to engage in activities of their choosing. The service had formed links with the local community to encourage social inclusion. People enjoyed their individual hobbies and interests, as well as having the opportunity to experience social and leisure opportunities.

If people had particular wishes for end of life care these were discussed and recorded. Systems were in place to support people with symptom control and pain relief when they became unwell.

There was a system in place for responding to and acting on complaints and suggestions. Feedback was welcomed and was used to drive improvements.

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. There were sufficient staff who had been safely recruited to meet people's needs. Medicines were well managed. Staff were aware of the risks to people and knew how to safeguard people from abuse. The environment was safe and good infection control practices were adhered to.

Is the service effective?

Good

The service was effective. Staff felt well supported and received training and supervision to support their competence. Staff understood the importance of obtaining consent before providing care and support. People were encouraged to eat and drink and had access to a range of healthcare professionals, as required.

Is the service caring?

Good

The service was caring. Staff knew people well and included them in decisions about their care and support. People's dignity, privacy and independence was promoted. Visitors were made welcome at the service

Is the service responsive?

Good

The service was responsive. People's individual needs had been assessed and they received care and support that reflected their preferred routines and choices. People were supported to engage in activities at home and in the community. Complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well led. New leadership had improved staff morale and teamwork. Staff, people and relatives felt listened to and included in how the service was run. The systems and processes in place effectively measured the safety and quality of the service and identified areas requiring improvement.

Ashlyn

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 19 March 2018 and was unannounced. It was undertaken by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed all the information we held about the service including the inspection history, the provider's action plan and statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We looked at the information the provider sent us in their Provider Information Return. This is information we require providers to send us which gives key information about the service, what the service does well and improvements they plan to make. We also reviewed information shared with us by the local authority's quality improvement team.

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

Over the course of our inspection visits we spoke with the manager and 15 members of staff including day and night care staff, activities and domestic staff. We also spoke with 10 people who used the service and 4 relatives. We reviewed various documents including people's care records, staff files and other relevant documentation such as training and supervision records, quality audits, improvement plans and minutes of meetings.

Good

Is the service safe?

Our findings

At our previous inspection in July 2017 the service was rated as requires improvement in safe due to insufficient staffing levels which meant that people did not always receive safe and timely support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, risks to people were not always assessed and managed safely and the service was therefore found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection on 19 March 2018, to check if the improvements had been made, we found significant changes had been implemented in the service to keep people safe and the provider was no longer in breach of the above regulations. Lessons had been learned which meant that not only had staffing numbers been increased but the provider had also streamlined their systems and processes for recording the checks and monitoring of people. Less form filling meant that staff had more time to spend caring for people.

On the day of inspection we observed that there were sufficient staff deployed to safely meet people's needs. Staff had time to spend with people and were unhurried. We carried out several observations during the day in the communal lounge areas and at no point was the lounge left unattended. Staff were available to provide food, drinks and snacks throughout the day and were attentive, responding promptly when people used their call bells to ring for help. Call bells were placed within reach for people and those identified at particular risk of falls had wrist or neck pendants so that they could easily call for assistance. Feedback we received from people was generally positive. Comments included; "I've got a call button, it is very good and staff come fairly quickly." And, "When I buzz, they come quickly." And, "At about 7am I fell and pressed my buzzer, they [staff] came quickly." Some people said that whilst staff usually attended promptly they sometimes had to wait for support during busy times or if the service was short-staffed. One person told us, "Sometimes they [staff] are fairly quick but when it's busy there can be a bit of a wait."

Day staff we spoke with confirmed there had been a significant improvement in staffing numbers and how staff were organised. Comments from staff included; "When I first started there were only three staff, now it's much better." And, "We have six staff in the morning and five afternoon and evening, everything is now allocated on the handover sheet which makes it easier; we allocate staff to lounges and breaks."

During our last inspection we found that supervision by staff in communal and private areas at night-time to monitor people was cursory and inconsistent and placed people at risk of harm. Low staffing meant that people's emotional wellbeing was not always well managed. People had not always received support to go to bed when they were tired and were not safely supervised in the evening.

At this inspection we found substantial improvements in how people's night-time needs were being met. In the downstairs lounge there were four people who were alert and awake. They were able to tell us that it was their choice when they went to bed. One person told us, "They don't rush you to go to bed, you can go when you like; I like to go to bed at 10pm." There was a nice atmosphere in the lounge, the people were seated together and were enjoying social interaction. Staff were accessible and offered drinks and snacks and spent time chatting and singing with them.

Upstairs, we observed people's experience from 7pm onwards. Day staff were supporting people to go to bed if they chose. A staff member remained in the lounge at all times and supported people with tea, coffee and cake. The cake was taken around to people so people could choose what they wanted. One person said, "Lovely, I think I will have two pieces." Another person said, "That was gorgeous." Staff also sat with people for short periods of time and provided them with something to do. For example, one person was given a 'twiddlemuff' which occupied them for a time. Another person looked at a book from the 1950's with a staff member. When the night staff came on duty at 8pm there were only five people seated in the lounge area and the atmosphere was calm and settled, all had drinks within reach. Those people who were tired had been supported to go to bed.

The night staff we spoke with confirmed that staffing levels and information sharing had improved which meant safer care and support for people. One night staff member told us, "It has changed a lot for the better, we have two carers and one team leader and this can work fine, twilight was mentioned recently and that could help; we also get a better handover so we know who might be high risk and help them first." Another night staff member said, "Staffing is fine now and they [management] will sort out agency staff cover if it's needed."

We saw that in one person's care plan it was recorded that they were at risk of altercations with other people who use the service which could potentially lead to physical harm. We noted that this person sat in a particular area with at least two other people that joined them. All of the group were independently mobile and clearly preferred to sit in this area. We found that during the day this area was monitored quite carefully with staff responding to any potential triggers and diffusing any situations where potential for escalation to physical harm might have occurred. All staff including domestic staff, care staff and managers interacted with these individuals offering food, drink and things to do throughout the day. However, when we visited in the evening we found that this group of people remained in this area. Although the team leader was still monitoring them they had stayed later than their scheduled time so would normally not be available to observe whether the interactions between these people remained positive and without risk.

We spoke to the registered manager about our concerns. They told us they had been given authorisation to employ a 'twilight' member of staff who would be used to ensure this area was staffed throughout the evening until people went to bed. After our inspection the provider wrote to us to confirm that a 'twilight' shift had been implemented. There had also been a review of the environment and alterations had been made to the seating in this area to reduce the risk of further incidents. In addition referrals had been made to the relevant health professionals to support people's mental health and wellbeing.

During our last inspection we found that risks to people were not always well managed. Risk assessments were in place but these did not always accurately reflect the level of risks to people. At this inspection we found that risk assessments had been completed which were relevant to each person's individual needs. There were care plans associated with each risk assessment which provided comprehensive guidance for staff on how to minimise any risks. We observed that the care provided by staff matched the information found in people's care plans. When we spoke to staff they were aware of the risks associated with people and knew what to do to minimise the risk. A new hand-over form had been developed which was used to share information about people with new staff when they came on duty. The form provided an overview of each person and highlighted any risks or concerns. We saw that this was a live document which was updated by the manager on a daily basis to ensure staff always had the most up to date information to help them keep people safe.

People told us they felt safe living at the service. A person told us, "I feel safe, I've got staff around me." Another person said, "I feel safe and I see them (staff) quite often." We spoke with visiting relatives who also

told us they thought their family members were safe. Comments from relatives included; "We know [family member] is safe and well looked after." And, "[Family member] is safe, they care for them well and keep us informed."

Medicines were stored, administered and disposed of safely and in line with current professional guidelines. Only staff who had been trained and assessed as competent administered medicines. We observed a senior member of staff giving people their medicines. They were patient and kind and did not rush people, taking time to have a chat with people and ask how they were feeling. People were given their medicines from a cup or spoon and were given a drink of their choice. Medicine administration records (MAR) sheets were in place which had been completed correctly and there were no omissions of staff signatures which indicated that people had received their medicines as prescribed. Protocols for 'as needed' (PRN) medicines had been completed which provided instructions to staff on when and why to give PRN and in what dosage. People also had MAR sheets for creams and lotions (topical applications). We saw these had been filled in consistently evidencing that people had received good skin care.

The team leaders were responsible for completing a daily audit sheet which kept count of people's loose boxed medication to monitor that they had received their medicines as prescribed. We completed a stock count of people's loose medications and found that those which had been checked daily balanced. However, we found that some boxed medicines did not have an audit sheet and had not been checked daily and the stock count did not tally up. When we discussed this with the senior they assured us that daily audit forms for all boxed medicines would be completed immediately to ensure the stock control system was robust.

There were systems in place to protect people from the risks of abuse. Staff had received training in safeguarding vulnerable adults and understood the different signs of abuse and how to report any concerns. Staff were aware of the whistle-blowing policy which was on display in the reception area. Staff told us they would feel confident to whistle blow if necessary.

Safe recruitment processes were in place. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

There were arrangements in place to manage and maintain the premises and the equipment both internally and externally. We saw that the relevant health and safety checks, maintenance, fire drills and equipment and water testing had all been completed.

People were protected from the risk of infection. Staff had received training in infection control and demonstrated good knowledge and practice of infection control procedures. We saw that staff used protective clothing when required and regularly washed their hands. There were supplies of liquid soap, paper hand towels, hot water and protective gloves accessible throughout the building for staff use.

Good

Is the service effective?

Our findings

At our previous inspection we found the service was not effective and the rating given was Requires Improvement. Staff morale was low and supervision and support for staff was inconsistent. There was a lack of leadership and team cohesion all of which had contributed to the poor service people received. We also found that people's health needs were not always well met. At this inspection we observed significant improvements in all areas of concern and the rating is now good.

Throughout the inspection we saw evidence of strong leadership by senior staff and the management team. The manager and deputy worked out on the floor providing care and support which meant they got to know people who used the service and could monitor satisfaction levels. It also provided the managers with an opportunity to provide a positive role model for staff. We found that this 'hands-on' approach had improved staff morale and promoted good teamwork, all of which impacted positively on the experience of people living at the service. This was summed up by one care worker who told us, "Things have improved in all ways; the residents seem happier and the home is far more organised; it's been much better with the new manager, it's a different atmosphere, staff are getting on and this is having a knock on effect on people; we are a family now."

Staff told us and records confirmed that staff were receiving regular supervision and felt well supported. One staff member told us, "I have supervision with the deputy and we discuss any issues, there are also staff meetings and we get the minutes if we cannot attend." Another said, "There is a lot of support now and I find the new manager very approachable, they know the residents and come up regularly to see if we are okay."

At our last inspection in July 2017, we found that people's care plans did not always reflect their changing health needs. Although some people were referred for specialist advice and treatment not all care plans detailed the outcome of the referral. Therefore, staff did not always have up to date knowledge about the risks to people's health.

During this inspection we found the necessary improvement had been made and new systems were in place to ensure that people's health needs were being met safely and effectively. When people joined the service their physical, mental health and social needs were assessed in line with legislation and evidence based guidance. People's needs were reviewed on a monthly basis or sooner if something changed. When risks to people's health were identified appropriate referrals were made for specialist advice and intervention. The outcomes of the referrals and any guidance provided by health professionals was added to people's care plans and was also included on the handover paperwork which was then shared with staff. For example, in one person's care plan concerns had been identified related to weight loss. We saw that a referral had been made to the dietician who had telephoned the service and advised supplements and to fortify food. The person's nutrition care plan and the handover sheet had then been updated with the relevant information. Staff we spoke with were aware of the need to fortify the person's food and the person was now gradually gaining weight.

We found that staff knew the people they cared for well and liaised with other organisations such as district

nurses, community nurses, speech and language teams, social workers and GP's to ensure good health outcomes for people. We observed staff communicating with each other about any concerns they had and making pro-active decisions to support people's health and wellbeing. People had access to a wide range of healthcare services and received on-going healthcare support. Records confirmed that they were able to see a doctor, or other healthcare professional, such as optician, chiropodist or district nurse when needed. People with particular health conditions had specific care plans to provide staff with guidance on how to support them to stay healthy. For example, people with diabetes had care plans in place which instructed staff on the signs and symptoms to look for that the person might be unwell and the importance of good foot care.

We observed that staff had the skills, knowledge and experience to deliver effective care and support. Staff told us, and the records confirmed that they had received a thorough induction and training tailored to meet the specific needs of the people that used the service, for example, training in managing challenging behaviour. The induction new staff received was based on the care certificate which represents best practice for inducting new staff into the health and social care profession. Staff were positive about the training and their induction experience. One staff member told us; "I love training, I have been put forward to do the dementia training. I have completed the care certificate and had support with this; we had a person to support us and we could ring them at any time; they also contacted us to see how we were getting on." Another staff member told us, "We have recently been involved with prosper and that was interesting." Prosper is a local authority project which provides care staff with the knowledge and skills to help reduce the number of falls, pressure ulcers and urinary tract infections of people who live in care homes.
We saw that the service had arranged specialist dementia training and staff had been asked to reflect on what they had learned. We looked at staff written reflections and saw that staff had reported that the training had helped them to be understanding and empathetic towards people living with dementia. We saw evidence of these qualities displayed by staff throughout our inspection visit.

People were supported to have enough to eat and drink that met their health needs and preferences. A person told us, "The food is very good, the chef comes and asks you what you like and don't like." Another person said, "The food is very good; we get enough choice, roast pork yesterday was absolutely delicious and plenty of it." We observed the meal time experience and found that food was presented well with fresh vegetables. People living with dementia were shown the different plates of food to help them make a choice and were provided with an appropriate level of assistance to support them to have enough to eat and drink. Menu choices were displayed prominently in the corridor and an alternative menu was available for anyone who did not want the two choices available. People were able to choose where they wanted to eat with some people using the dining room, others remained in the lounge area and one person chose to eat in their room. One person did not eat much lunch we saw later that the person was given another bowl of chips and some bread and butter. People were asked throughout our visit if they wanted another cup of tea or a drink and snacks. We also noted when people asked for another cup of tea it was provided by whatever staff happened to overhear which included domestic staff and managers.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their health and wellbeing. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk or malnutrition. Where a risk was identified a risk assessment and management plan was implemented to support staff to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. People identified at risk also had food and fluid charts in place to monitor their intake. We saw that food and fluid was recorded consistently and centrally which meant that the information could be easily accessed by senior staff who monitored people at risk. Where a change in need was identified, we saw that people were supported to receive the appropriate treatment, for example, fortified foods or food

supplements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the Act, and whether conditions on authorisations to deprive a person of their liberty were being met. We found that the manager understood when an application for DoLS should be made and we found the home to be meeting the legal requirements.

Staff had received training in the MCA and understood the importance of gaining consent and supporting people to make their own choices. We observed staff throughout the day politely asking for people's permission before providing any care or support.

People's individual needs were met by the adaptions, design and decoration of the premises. The service was light, bright and airy and some areas had recently been decorated to a good standard. We did note that all bedrooms had a memory box outside but most were empty. When we spoke to the manager they stated that these were not always effective for people and said they would be looking at each person individually to see what might work to orientate them to their rooms. There were items available in communal areas for people to pick up, touch and feel which provided sensory stimulation and comfort to people living with dementia.

Good

Is the service caring?

Our findings

At our previous inspection we found the service was not consistently caring and the rating given in this domain was Requires Improvement. Staff were kind and caring however due to low staffing numbers there was a lack of sustained interactions with people. In addition, improvements were required to ensure the comfort and dignity of people was consistently adhered to. At this inspection we found the concerns we had raised had been addressed and the service is now rated Good.

We observed positive interactions between staff and people living in the service, such as a staff comforting people when distressed or speaking to people, positioned at eye level when communicating and when supporting them with eating their meals. We observed staff sitting and chatting with people, with lots of laughter and friendly interactions. Staff demonstrated consideration for people's happiness and comfort. A person told us, "Look, they have wrapped my cardigan around the back of my neck as I get a sore neck when I am sat in the chair, so thoughtful."

People reported that all of the staff including care and domestic staff were kind and friendly. One person told us, "The girls are all so lovely, it is their attitude and they make you laugh." Another said, "They (staff) talk to me when they can, all of them are nice, morning and night." Whilst we were talking to this person a member of the housekeeping team came along who smiled and stopped to chat to the person. They told the person, "I've got you some clean water." We saw that each time this staff member went past the person's door she waved to them.

We found information was recorded in relation to people's life histories, which is recognised as good practice to meet the needs of people living with dementia. An 'About me' section was included within the care plan which captured memories and information about a person's life. Staff used this information to get to know people and form positive relationships. We saw that staff knew people well, for example, staff were familiar with how many sugars people took in their drinks and their preferences at mealtimes. We heard one staff member say to a person, "What are you going to have for breakfast today, Weetabix is it, I know it is your favourite?" Another staff member told us, "[Named person] likes water painting and loves cats so we try to find them the cat pictures to paint as they have always had cats." People confirmed that staff knew them well. One person said, "I'm well looked after if I need any help I know they can help me; they know me off by heart; I have a cup of tea in the middle of the night around 2 to 3am; I press the buzzer and ask for tea and it helps me sleep."

People were encouraged by staff to make decisions about their care and support. This included what activities they wanted to do, what they wanted to eat and where they would like to spend time. Staff were aware of people with limited verbal communication and used non-verbal cues to involve people in decisions. For example, a staff member told us one person was not able to make verbal choices but when they held up two choices of outfits the person smiled at the choice they wanted. If English was not a person's first language staff made an effort to communicate with the person in their native tongue. We saw that one person had a book with pictures and phrases in their own language to help them communicate their needs and wishes to staff.

Where people required an advocate to support them express their views we saw that this had been arranged. Information on a range of topics including advocacy services was on display in public areas to provide information and advice to people and their families. Notice boards were maintained throughout the service and the information displayed was up to date, simple to read and informative. Consideration had been given to accessible communication. Easy read versions of the complaints policy and service user guide were on display.

During our last inspection we observed that whilst staff were competent moving and positioning people using a hoist, people's dignity was not always respected. For example, people's clothing had sometimes risen up whilst they were being hoisted which compromised their modesty. This had not always been noticed or addressed by staff. At this inspection we saw that staff demonstrated a good awareness of the need to promote people's dignity. When people were hoisted we saw that staff used a 'dignity blanket' to cover people to protect their modesty and privacy when being transferred. However, we did find that where people used incontinence pads these had not always been stored discreetly away. In some people's rooms there were several boxes of pads in plain sight. This did not represent dignified practice and was not respectful of people's privacy.

We discussed our concerns with the manager who advised that they were aware of the need for additional storage and were in the process of converting a room downstairs into a continence storage room which would solve the problem.

At the last inspection we raised concerns regarding the prolonged periods of time some people spent in their wheelchairs. It was not clear from people's care plans whether this was by choice as their wishes had not been documented. During this inspection we observed that people only spent short periods of time in wheelchairs whilst staff transferred people from one area to another. People were then supported to spend their time in comfortable chairs or in bed if they so chose. Lessons had been learned and the service had introduced a new policy which meant any person wishing to stay seated in their wheelchair would have a care plan in place documenting their wishes and any risks and that staff would check with people to ensure that their choices were respected. We saw evidence of this policy in practice as we heard a staff member asking a person, "Would you like to sit in an armchair or stay in your wheelchair, it is up to you?" The manager told us that at the time of our inspection there were no people living at the service who had expressed a preference to stay in their wheelchair for extended periods of time.

Staff understood the importance of promoting people's independence to support their health and wellbeing. We observed staff practice and saw staff providing people with opportunities to be independent. For example, we heard one staff member say to a person, "Do you want to come to Bingo? Want me to come and get you or you going to make your own way?"

Friends and relatives were made to feel welcome at the service. They came and went freely without restriction. This meant that people were supported to maintain relationships that were important to them. A person told us, "Staff are so good, so kind; when my husband comes in to visit me they give him a dinner too."

Good

Is the service responsive?

Our findings

At our previous inspection the service was rated as Inadequate in terms of responsiveness and was found in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulations) 2014. The care and support provided by staff was task-focussed and did not reflect people's individual needs. People's choices and preferences were not always known or respected, particularly around bathing to such an extent that we issued the service with a Warning Notice. The Warning Notice detailed the failings of the service and placed a requirement on the registered manager and provider to address our concerns within a set timeframe. At this inspection we found that significant improvements had been made and the service was no longer in breach of the regulations and the service is now Good.

Improvements in staff deployment and simplifying the systems and processes for recording care tasks meant that staff had more time to spend with people. This meant that staff were able to take a more person-centred approach when providing care and support. Person-centred care means providing care and support that is tailored to each person. People confirmed that they were receiving care and support the way they wanted it. One person told us, "They [staff] always leave me a drink where I can reach it; they tuck a cushion around me how I like it. I can't stand the dark so they always make sure to leave my door open a bit to let in light; they try to help me as much as possible; they take such good care of you and try to give you what you want all of the time."

Staff were enthusiastic about the positive changes in the service and were able to demonstrate empathy and understanding of each person's individual needs. For example, one staff member told us about a person who did not like to receive personal care. The staff member said, "We give her little kisses and then she will let us help her with her personal care." Another staff member told us that one person liked to lay in bed so they took them a coffee in first before supporting them with personal care.

An innovative feature of the service was the personalisation of place mats for mealtimes. People had been asked to choose something they liked and an image of their choice was printed on their place mat alongside their name. For example, one person had a picture of a dog whilst another had an image of 'bingo'. In addition, important information about the person was discreetly displayed, for example a small red triangle in the corner of some people's mats to indicate that they had diabetes. We saw that the mats served as a helpful reminder for people with memory problems regarding where they sat at mealtimes.

Throughout our inspection we observed a significant move away from staff practice that was task-focussed to a far more person-centred approach. People's care records included information about their needs and wishes, likes and dislikes, routines, hobbies and interests. This information supported staff to provide care and support the way people liked it. Daily notes showed that people were supported to get up and go to bed when they wanted to. They could choose when they wanted to get washed and dressed, eat their meals and engage in activities. We saw that one person was quite active and walked up and down the corridor continuously; a staff member took them out for a coffee and told us they went out most days with the person as it made them less anxious.

At the previous inspection we had particular concerns that people's preferences for bathing were not documented or upheld. People had a set day for baths or showers and if they missed their slot they had to wait another week. At this inspection, care records showed and people confirmed that they could have a bath or a shower at a time of their choosing. To ensure best practice was maintained, information about people's bathing needs was included on the daily hand-over sheets. The deputy manager then completed weekly checks to monitor that people's needs and preferences around bathing continued to be met.

The service involved people in planning their care and support. When new people joined the service their strengths and abilities were assessed and a care plan was designed to reflect their needs. Using a 'Resident of the Day' scheme, the service ensured people's care and support was reviewed on a monthly basis. Invites were sent to people's relatives to encourage participation in the reviews.

There were a range of activities taking place at the service throughout the week which people had a choice of attending or not depending on how they were feeling that day. On the day of our visit we observed a sensory session taking place in the upstairs lounge. Sensory stimulation represents good practice for supporting people with dementia to improve their mood, self-esteem and wellbeing. Sensory activities can trigger emotions and memories for people living with dementia helping them to connect with the world around them and evoke positive feelings. We observed a staff member going person to person with different smells to stimulate memories such as cut grass and different flowers. The staff member asked people, "Does this remind you of your garden." Other people were given items such as 'fiddlemuffs', magazines or books. A projector and sensory lights were featured in the room and one person said, "I like the colours the best." People were served drinks and snacks during the session.

The service also supported people to engage in activities out in the community with regular day trips arranged. People had been supported to obtain library cards and where they had expressed interests in attending community clubs such as arts and crafts and knitting, the service was supporting people to access these.

There were systems and processes were in place to respond to complaints. People were given a copy of the complaint policy and told us they knew how to make a complaint. The new manager adopted an open door policy and was pro-active in developing positive relationships with people and their relatives. We looked at past complaints and found they had been dealt with appropriately in line with the company's complaints policy. We saw that the manager had responded positively to people's concerns and took actions to try to resolve any issues. Where necessary, meetings were arranged which meant that people and their relatives felt listened to.

People were supported when making decisions about their preferences for end of life care. Staff had received training in end of life care and the service had formed links with the local hospice. The service kept important information, which included advanced care plans and preferred priorities for care documents. Where appropriate a DNACPR was in place. A DNACPR is a way of recording the decision that a person will not be resuscitated in the event of a cardiac arrest.

Good

Is the service well-led?

Our findings

At the previous inspection the service was not well led. The systems in place to monitor and check the safety and quality of the service were ineffective. Excessive paperwork had resulted in a lack of observation and oversight of the actual care being provided and the lived experience of people who used the service. Staff morale was low and staff did not feel listened to. These failings represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations) 2014 and the service was rated as inadequate. At this inspection we found that all of our previous concerns had been addressed and the necessary improvements had been made and the rating has improved to good.

There was a new manager in post who was currently going through the registration process. The manager was very well supported by their deputy manager, regional management team and the provider. Together they shared responsibility for the management and oversight of the service. Staff, management and the provider understood their roles and responsibilities with clear lines of accountability in place. Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found that the provider had met the requirements of this regulation. Since the previous inspection the service had worked with CQC and the local authority in an open and transparent way demonstrating a strong commitment to making the required improvements. Lessons had been learned from past failings and robust action plans were in place which evidenced that all necessary actions had been taken to address the areas of concern.

Regular checks and audits were undertaken by the management team and provider examining all aspects of the service. Where issues were identified, actions were taken to ensure continuous improvement. For example, night and weekend checks of the service were completed twice a month. We looked at the last night visit audit and saw that the deputy had noticed poor lighting in one corner of the building. In response, a new policy had been introduced to ensure the corridors were fully lit at night to support visibility and reduce the risk of falls.

Since our last inspection the service had worked hard to reduce all but essential paper care records. The computerised system of care recording was being used more effectively and contained up to date entries which accurately detailed the care and support people received. We found that this new way of working had improved practice and freed up staff so they had more time to spend with people and provide good quality care. This was confirmed by a member of staff who told us, "Things have greatly improved with care, staff have more empathy with residents, seem to make time for residents, tend to spend more time with them, they take time and are not making mistakes."

The manager had recognised that a new management style was required which was more 'hands-on' to help improve staff morale and provide leadership and direction. The manager told us "[named deputy] and I wash and dress someone every day; we lead by example to show that nothing is too much trouble; we are not office based, we are out on the floor." Throughout our inspection we saw evidence of the manager spending time with people to ensure they were happy and receiving good care. We observed a group activity and saw one person who became distressed. The manager stepped in and took the person for a walk

around the building. Their manner was kind and patient and we heard them say to the person, "Let's get some chocolate cake on the way back."
The new style of leadership demonstrated by the manager had a positive effect on staff morale. Staff feedback evidenced a significant improvement in communication between staff and management and improved staff morale. Staff comments included; "Things have improved and we work alongside team leaders, team working is a lot better and staff now work together." And, "The handover document has been a great help, anything new is in red so everybody is aware of any new concerns." And, "Morale is good now, the Manager is lovely, listens and any problems you can go to them and they do not rest until the problem is sorted."

Previously, we had received feedback from people, relatives and staff regarding a lack of visibility and approachability of the registered manager. At this inspection the feedback we received about the new manager was universally positive. Comments from people included; "The manager does listen, she is lovely and sometimes takes me out shopping, we went last Tuesday." And, "The Manager does a good job, she listens and comes and sees me, she got me a new mattress it is soft, got my own bed and chair and she is going to get me some blinds for the window as the light shines on my TV." A visiting relative told us, "The Manager is brilliant, always comes and says hello to all the residents, very visible, comes and speaks to me and I feel she does get things done." Staff were also very positive about the new manager and told us they felt very well supported. One staff member told us, "I definitely feel fully supported by the manager, she is a lovely lady, she will help out, if you are not sure or stuck you can go to her, she does not just sit there." And, "The manager has been very supportive to me; I've had a lot of personal problems, she listens to me. Ten out of ten I would give her."

There was recognition of the importance of demonstrating that staff were valued. The manager told us that the service now celebrated staff birthdays and special events, for example, organising baby showers for pregnant staff. This had a positive impact on the culture of the service. There was a renewed sense of teamwork, positivity and pulling together from staff. The manager told us they were committed to teambuilding and providing person-centred care. We saw this commitment was shared by everyone who worked at the service. This was summed up by one member of staff who told us, "We are a happy work force and residents needs come first."
At the previous inspection we found that whilst the service organised team meetings to include staff in the running of the service. Staff had told us that they did not always feel confident to express their opinions. At this inspection staff told us they felt included and listened to. One staff member told us, "The new manager listens to us and we know they will do something about it." Another said, "The manager will always listen if you want to talk to her."

People and relatives were also involved in how the service was run. Residents meetings were held monthly which were chaired by people who lived at the service. People's comments were invited and recorded and the service responded positively to feedback to improve the service. This meant that people felt listened to and included. A monthly newsletter was also sent out to people to improve communication and information sharing. To promote transparency and accountability 'You said, We did' posters were displayed publicly around the service, informing people of the changes the service made in response to feedback. For example, we saw that where people had asked for more trips out this had been arranged. People had also asked for named corridors to help them find their way about so new signs had been ordered.

We saw that the manager worked in partnership with external health professionals such as the community nurse and the local hospice. They had also forged links with the local community for the benefit of people who used the service. Students from the local school came to visit and read to people and a volunteer had been recruited to arrange the flowers. Where people had particular health conditions they were supported

to join specialist groups, for example, one person was supported to access the Parkinson's society.