Ashridge Court Ltd

Ashridge Court Care Centre

Inspection report

163 Barnhorn Road
Bexhill On Sea
East Sussex
TN39 4QL

Tel: 01424842357
Website: www.ashridgecourt.com

Date of inspection visit:
21 September 2017
22 September 2017

Date of publication:
22 November 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

We inspected Ashridge Court on the 21 and 22 September 2017.This was an unannounced inspection.

Ashridge Court Care Centre is a care home with nursing located in Bexhill On Sea. It is registered to support a maximum of 69 people. The service provides personal care and support to people with nursing needs, some of whom were living with dementia. The home has four separate wings offering residential care based on people's particular needs and requirements, including one which is a specifically designed dementia unit that can accommodate up to 16 people. On the day of our inspection, there were 63 people living at the service.

There was a registered manager in post. 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.

At our inspection on 16 December 2014 we found that the service was safe, effective, caring, responsive and well led. Our overall rating of the service was Good.

At this inspection improvements were needed to ensure that care delivery was supported by risk assessments that ensured that people's health needs were monitored and acted on when needed. This was because actions had not been taken to address high blood sugars, low blood pressures and some wound documentation was not accurate and did not follow good practice guidelines.

We recommend that the service seeks advice and support from a reputable source to ensure that staff are confident in the management of wound care, diabetes and hypotension.

Equipment such as pressure relieving mattresses were not set correctly as per the manufacturer's guidance. In addition, the quality monitoring systems had not identified these shortfalls. We found staff knowledge and understanding in areas such as the Mental Capacity Act 2015 (MCA) and behaviours that challenge required improvement. The provider had not ensured that staff completing MCA assessments had a clear understanding of how to capture and record people's capacity in line with legislation. MCA assessments did not evidence how staff had arrived at decisions related to people's capacity via best interest meetings and discussions. The documentation and guidance to manage behaviours that challenge for some people was about responses to behaviours shown, rather than proactive strategies to reduce the likelihood of negative behaviours that place staff and people at risk.

Medicines were given out in a safe way. Medicines were kept securely and there were full records of medicines administration. Some minor improvements were needed for 'as required' documentation in that they lacked monitoring of the effectiveness of the medicines.

People told us they felt safe in the home. Staff were knowledgeable about safeguarding policies and how to recognise different types of abuse. Routine health and safety checks were undertaken covering areas associated with fire safety, health and safety and servicing. The service had contingency plans in the event of an emergency evacuation. Staff and records indicated that fire training and testing was undertaking regularly. All staff were trained in first aid and resuscitation techniques.

People were satisfied with staffing levels. There were enough staff on duty to support people at busy times of the day such as meal times, and to support people with one to one time. The service had used regular agency nurses and care staff whilst recruiting to the vacancies at Ashridge Court. Staffing levels were regularly reviewed to ensure appropriate numbers of staff were available when people's dependency changed. The provider had safe systems for the recruitment of staff.

Medicines were given out in a safe way. Medicines were kept securely and there were full records of medicines administration. Some minor improvements were needed for 'as required' documentation in that they lacked monitoring of the effectiveness of the medicines.

People reported staff were trained and able to meet their needs. Staff supported people in an effective and safe way, for example when they needed to be supported in moving. New staff reported positively on induction to their roles. Staff were provided with the training they needed. Supervision systems ensured individual staff training needs were identified.

Involvement of a range of healthcare professionals, for example the tissue viability nurses had been procured as necessary. People who were assessed as being at nutritional risk were identified and supported in the way they needed to maintain or increase their weight. People were positive about the meals. There were systems to ensure people who were living with dementia could choose what they wanted to eat. Where people could not support themselves independently to eat their meals, they were fully supported by staff.

People said the staff were caring and supported them in the way they wanted. We saw staff supporting people who were frail and/or living with dementia in a way which encouraged them in making choices and being independent. Staff were consistently respectful to people and ensured their privacy and dignity.

Staff were responsive to people. Staff were aware of people's individual needs, developing care plans which identified these needs, for example in relation to changes in their mobility. A wide range of activities were provided to people. These included individual and large group activities. Activities were available seven days a week and there were regular trips out of the home.

People felt they could raise issues with the manager and if they did, the manager would take action. Records of complaints made by people showed the manager and provider took action where issues were reported to them.

People and staff were complimentary about the management of the home. Staff said the culture of the home was supportive to them. A member of staff reported, "I think it is amazing here I like the staff and the residents."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Ashridge Court was not consistently safe. Whilst risks related to people's support needs and the environment had been assessed, not all risks identified had been responded to. This included both health related needs and safe use of medical equipment.

Medicines were stored, administered and disposed of safely. However minor improvement needed to be made to the 'as required' medicines. Staff had received training on how to safeguard people and were clear on how to respond to any allegation or suspicion of abuse.

There were enough staff on duty to meet the needs of people. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service. There has been high agency usage that was now being reduced with new staff being employed by the organisation.

People told us they were happy living in the home and relatives felt people were safe.

Is the service effective?

Requires Improvement

Ashridge Court was not consistently effective. The provider had not ensured and evidenced staff had undertaken best interests assessments in line with the best practice framework associated with the MCA.

People had access to health care professionals for regular check-ups as needed.

Staff had undertaken essential and service specific training such as dementia care and had formal personal development plans, such as one to one supervision and appraisals. This meant staff were working with the necessary knowledge and skills to support people effectively.

People received a nutritious and varied diet. People were provided with menu choices and the cook catered for people's dietary needs.

Is the service caring?

Good

Ashridge Court was caring. Staff knew people well and had good relationships with them. People were treated with respect and their dignity promoted. People were involved in day to day decisions and given support when needed.

People and relatives were extremely positive about the care and support provided by staff.

Care records were maintained safely and people's information kept confidentially.

Is the service responsive?

Good

Ashridge Court was responsive. Care plans contained information to guide staff in responding to people's specific wishes and identified health needs.

There were activities for people to participate in as groups or individually.

People told us that they were able to make everyday choices, and we saw this happening during our visit.

A complaints policy was available and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated

Is the service well-led?

Requires Improvement

Ashridge Court was not consistently well-led. A range of systems for quality review were in place however had not always been effective and failed to identify the shortfalls we found.

The leadership created a culture of openness that made staff and people feel included and well supported.

There were systems for feedback from people, their relatives and staff. People commented favourably on the culture of the home.

Ashridge Court Care Centre

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 the 21 and 22 September 2017 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection 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.

During our inspection we spoke with seventeen people, three relatives, the registered manager, area manager, deputy manager, cook and six care staff. We reviewed nine care files, ten staff recruitment files and training records, medication records, audits and policies held at the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I have an alarm and there are always people around. I feel very safe." A second person said, "I have a call bell beside my bed. The carers put it on my lap in my chair once I'm up and dressed so that I have it to hand if I need to use it." A third person said, "I think living in the home is a much safer place than living in my own home. Living here in the home means there are other people around and I have better security."

A new computerised care plan system had been introduced five weeks before the inspection. Risk assessments had been implemented to provide guidance and support for staff to provide safe care. This included risk assessments for skin integrity, nutrition, falls and dependency levels. In the main, care plans demonstrated how people's health and well-being was being protected and promoted. There were areas however that needed to be improved to ensure people's individual needs were safely met.

Care plans contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers. There was specialised equipment such as pressure relieving mattresses for those people identified at risk from pressure damage. Systems had been put into place to ensure staff checked the settings on a daily basis. However, we found seven pressure relieving mattresses on incorrect settings. For example, one person's weight was 50.7kgs and the mattress was set on 3 which was equivalent to a weight of 74 kgs. For another person on bed rest the mattress was set on 60 when it should have been set on 40. We informed the registered manager who responded immediately by asking a senior care staff member to check all settings for those on pressure relieving mattresses. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage. Staff were not all aware of where the settings for pressure mattresses were now recorded since the change of the care plan system. This meant that staff were not always checking that the settings were correct as they didn't know where to find the up to date records. This was an area that requires improvement.

To monitor people's health and well-being, staff undertook regular heath checks on people such as blood pressure readings and blood glucose levels. However, there was a lack of guidance within the risk assessments as to the rationale of the need for these checks and what to do if they were not within a normal range. For example, we found six people whose records showed they had low blood pressure - less than 90/60, which medically indicates hypotension. Hypotension could lead to light headiness, collapses and therefore injury from falls. There was no recognition of these factors within the care documentation for these people. There was also no evidence of staff doing further checks on the person on the equipment or of contacting the GP for advice. The GP may wish to review medicines and do a full medical review to rule out underlying problems and of the need for further monitoring. This meant that risk to people's health was not fully mitigated.

One person who lived with diabetes had recorded blood glucose levels over a period of six weeks in excess of 21 millimoles (mmols) and reaching 23.4 mmols. The normal range for someone who lived with diabetes

is between 4 mmols and 7.2 mmols. This was extremely high and a potential risk to their health and well-being. No action had been recorded in the computerised care plan used by staff of any action taken to monitor more regularly or of the advice received from health professionals. We were informed following the inspection that these records had been archived when the new care plan system had been introduced. There was no reflection of these blood sugar readings reflected in risk assessments or daily notes of this health risk. There was no care plan for diabetes management, and no guidance as to what the blood sugar level should be or of what actions staff should take when responding to the results of blood tests. We also found that the chef did not know that the person required a low sugar/low fat diet. The handover sheet used to share key information between staff had not mentioned the need for low sugar diet or the high blood sugars. Care staff we spoke with were not aware of the high blood sugars and the need to monitor for symptoms of hyperglycaemia, such as increased thirst, headaches and blurred vision. The registered manager brought these issues to the clinical governance meeting with the registered nurses and immediate action was taken. The registered nurses used this as part of their reflective learning. During the inspection we were informed that the relevant GPs were informed. We also saw that the relevant care plans and risk assessments were updated immediately.

Wound care plans whilst in place needed to be improved to reflect the wound care guidance provided by The National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. Photographs of wounds were not always dated or accurately identifying the location of the wound. The status of wounds, including length and depth had not always been documented. One persons' wound was mislabelled and stated bruising instead of open wound and scratches. This meant the monitoring of wounds would be difficult to ascertain improvement or deterioration and could delay expert advice being sought.

We recommend that the service seeks advice and support from a reputable source to ensure that staff are confident in the management of wound care, diabetes and hypotension.

People received their medicines as prescribed. There were systems in place to manage medicines safely. This included the storage, ordering, disposal and administering of medicines. The provider had up to date medicine policies, procedures and protocols which included 'as required' medicines (PRN) and covert medicines. The protocols for PRN medicines gave provided clear guidelines as to when they be required and had visual cues for those people who were not able to verbally communicate. We looked at people's PRN documents. There were some minor improvements needed to the PRN document, in that the effectiveness of the PRN medicine was not always documented or monitored, this was taken forward immediately by the registered manager and discussed with the RN's at a clinical governance meeting on the first afternoon of the inspection.

Records relating to the administration of medicine were accurately completed. Medicine administration records (MAR) detailed the medicine administered from a monitored dosage system. Where medicines were not dispensed in a monitored dosage system MAR had details of the medicine which included; dose, strength, method of administration and frequency. Staff had completed medicines training which included competency checks, However, we found that medication competencies for registered nurses (RN) were not consistently completed. The registered manager informed us that they were aware of this and following the inspection we received confirmation that all training and competencies will be completed by October 2017.

People's medicines were securely stored in a clinical room. We observed two separate medicine administration times and saw that medicines were administrated safely and that staff signed the medicine administration records after administration. The clinical room was well organised and all medicines were stored correctly and at the correct temperature. There was a clear audit trail that defined what action was

taken following errors, such as medicine retraining and competency tests.

A system was in place to record accidents/incidents with actions taken to prevent them as far as possible. Accidents were recorded with information about what had happened, such as an unwitnessed fall in a person's bedroom or in the communal areas. The information recorded included action taken to prevent a further accident, such as increased checks and a sensor mat. Audits were carried out for the accident/incident forms to ensure sufficient information was recorded. Accidents were reported to the local authority in line with safeguarding policies.

The provider had followed safe recruitment practices to ensure new staff were suitable to work with the people. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. There was an up-to-date record of nurse's professional registration. Records confirmed that staff members were entitled to work in the UK.

People were protected against the risks of potential abuse. Staff understood safeguarding adults' procedures and what to do if they suspected any type of abuse. Staff members told us they would not hesitate to report any bad practice they witnessed or suspected, and they would report it to the manager straight away. One staff member said, "I would report abuse immediately. I would go to [Name of registered manager]." A second staff member said, "I would report it and I would have no worries in doing that. We have a whistleblowing number we can use too and I could approach [name of registered manager]." A safeguarding policy and whistleblowing policy were available to staff and the numbers for the local authority displayed in the home. The whistleblowing policy was also displayed on staff notice boards for everyone to see. Staff had received safeguarding training and referrals had been made appropriately.

People were supported by sufficient numbers of staff to meet their individual needs. This included a registered nurse allocated to each unit covering the 24 hours. In order to maintain the staffing numbers and skill mix the service relied on agency staff to complete the team. The registered manager confirmed that they used regular agency staff as much as possible to provide continuity for people. There had been a recent successful recruitment drive and three new registered nurses were currently on their induction. The registered manager told us recruitment was progressing well and they were aware of the challenges of using agency staff. A person said, "There are lots of staff to help us, sometimes they are not our normal staff but they are very nice." Another person said, "They work hard and we are well cared for." One staff member said, "Staff are busy, the morning is busier but during the afternoon we can interact with people more." They added, "I like the time during personal care as we can spend time one to one with people." A second staff member said, "I would like a bit more time (to interact with people) but we get everyone up on time. Those who are mobile we ensure we get them up for breakfast, I would hate to eat in bed."

We observed people's needs were met in good time and staff were not rushed. Call bells were answered within one minute throughout the days of the inspection, this told us there were sufficient numbers of staff at that time. Staff were able to sit with people and engage with them. The home used a dependency tool to calculate the staffing needed. On the day of the inspection the staffing available exceeded that calculated.

Routine health and safety checks were undertaken covering areas associated with fire safety, health and safety and servicing. Outcomes from these were recorded clearly. Maintenance and servicing of equipment such as the fire alarm and boiler were seen to be regularly completed. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "We are lucky the maintenance team is very good."

The service had contingency plans in the event of an emergency evacuation. The service had an 'emergency grab bag' available which contained information such as a copy of people's key contact numbers and copies of people's medicine requirements. Staff and records indicated that training and testing was undertaking regularly. The provider had an agreement in place with a nearby care service should the need arise to evacuate people from the building. All staff were trained in first aid and resuscitation techniques.

Requires Improvement

Is the service effective?

Our findings

People told us staff were trained to meet their needs. One person said "The staff are so good, they know what to do." Another person told us, "Carers are very well trained and polite. You couldn't ask for more." A person said when they visited, they always saw the same standard of care, so there was, "Nothing to be concerned about – lovely staff."

However, staff did not always demonstrate an understanding of involving people in decisions and asking their consent before providing care and support. 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's documentation considered capacity however, there was a lack of decision specific mental capacity assessments. We viewed one support plan that stated the person 'had some capacity' and another that there was 'fluctuating capacity'. In both examples there was no further information on which areas the person had or lacked capacity, nor any documentation regarding best interests decisions. Another person's support plan stated that they had capacity but that, 'a relative had written a letter to the GP to request that they did not receive life prolonging treatment'. Any best interest decisions made stated involvement from staff and relatives however lacked evidence of any involvement from the person, whether they had capacity or not. We also found in one care plan it stated that covert administration was in the person's best interest for their health but the care plan also stated the person had the capacity to make decisions and preferred a holistic approach. We were assured by the registered manager that a further MCA assessment would be undertaken for this person. Following the inspection we received confirmation with an action plan to address the MCA shortfalls.

Staff were aware of their responsibly under the Deprivation of Liberties Safeguards (DoLS). The manager had made applications to the Local Authority when relevant. Staff we spoke with were also aware of their individual responsibilities under DoLS. For example, one person had bed rails in place. Several members of staff told us the person had a tendency to roll out of bed if they were not there. Putting the person's bed close to the floor with crash mats had been considered as an alternative safety measure, but the person would have been deprived of being able to sit up independently and being able to see out of their bedroom door and window if they did this.

Staff met peoples' needs in an effective way. For example, staff supported people who needed help to move in a safe way, using equipment correctly for people when needed. The transfers we observed showed that staff were mindful of the person's safety and well-being. They also always made sure people knew and understood how they were going to support them in moving. Staff reported they had been trained in other areas relating to supporting people with a disability. For example, we saw a member of staff supporting a person to eat. The person was not able to open their mouth much. The carer worker supported them using a small teaspoon, putting small amounts of food on the spoon. They checked throughout the time they were

supporting them that the person was able to swallow safely, as well as checking they enjoyed their meal.

People received care from staff who had the skills and knowledge needed to carry out their roles. There was a full time trainer who worked at Ashridge Court. They monitored training and provided support for staff on a day to day basis. New staff were supported to complete a comprehensive induction programme before working on their own. The induction programme included training for their role and shadowing an experienced member of staff. The induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. One member of staff told us, "Induction was really helpful. I had training in health and safety, infection control, safeguarding, fire, medication, manual handling, challenging behaviour training and MCA. It prepared me for the role." Staff were supported to study for further qualifications. Staff told us training was available to them. One member of staff said, "We get training on illnesses such as dementia, moving and handling, infection control, food hygiene, diabetes and of anything we feel we need as people's health changes." Staff told us they felt supported by the range of training, both e-learning and face to face sessions. One staff member said, "It builds our confidence to have good training." Training records were audited by the manager so they could ensure all staff were up to date with necessary training.

Staff were supported to improve the quality of care they delivered to people through the supervision and appraisal process. Staff received their one to one supervision meetings with their line manager. This gave staff the opportunity to discuss their performance, raise concerns and identify any development needs they might have. Records showed that these checks were undertaken and identified any areas where the quality of care people received could be improved. Staff spoke positively about their experience of appraisals and supervisions and welcomed any feedback to improve their practice where they could. One member of staff told us, "I have supervisions every other month" and, "My supervisions give me an opportunity to meet my manager to discuss care, residents and any issues."

People's nutritional needs were met. We observed late breakfasts, a lunchtime meal and an evening meal on all units. There was a positive atmosphere in the dining rooms with lots of one to one interaction. Staff moved from table to table, sitting with people individually to engage in conversation and support with eating. We saw one staff member supporting a person to eat; there was lots of joking and laughter between them and eye contact was maintained throughout. Similar observations were made of people being supported to eat in their bedrooms. Staff sat beside them and talked throughout. Any food and drink charts in bedrooms were also completed.

People told us that they liked the food and the quality and presentation was of a high standard; pureed food was presented using food moulds which made the meal look appetising. There were drink and condiments available on each table and staff asked people what they would like to eat and drink. There were two choices for each course and alternatives were available if requested. One person's documentation stated that they were underweight, required support to eat and were 'very fond of sweet foods'. We observed staff giving encouragement, offering alternatives when food was declined and providing second portions of pudding.

We viewed kitchen documentation regarding diet requirements and allergens. A board on the wall detailed the room numbers of people that have specific diets, for those that required pureed or soft food there were codes to identify the consistency needed. The second chef informed us that they receive a menu check daily and that this is completed by the nurses for each unit. This documentation informs kitchen staff which people require alternative foods due to specific health conditions, personal or cultural preferences. A relative confirmed to us that food given was of the person's choice and that cultural preferences were respected and followed.

There were people living in the home assessed as being at risk of weight loss. The registered manager had an overview of people's weights. The chef was aware of how to effectively support people, including the use of fortified diets. Where people were at risk of weight loss, they had clear care plans. Many people who are living with dementia find it easier to eat 'little and often.' There were a range of 'grazing' foods available. These included chopped up fruit as well as biscuits and sweets. People helped themselves to these as and when they wanted.

All people who had food and fluid charts had them completed regularly. Fluid charts were totalled every 24 hours to review if a person was at risk of dehydration. The registered manager had a computerised weekly overview to monitor people's fluid intake. Staff told us people could vary in how much they were able to drink in 24 hours, they were planning to establish an average intake for people against the suggested input for their weight and health. They would then have an individual base-line for each person to discuss with healthcare professionals as relevant. Changes in these averages would also give staff an early indicator of possible changes in the person's health.

The service supported people to maintain good health through in-put from health professionals. One person had developed difficulties with swallowing and had a referral made to the Speech and Language Therapy Team. Staff were aware of this person's support needs and used powder to thicken drinks and food as prescribed. There was a FISH poster displayed in each unit which meant 'Find Information on Swallowing History'. This tool was used to identify if someone needed support with eating and drinking. If a picture of a fish was displayed in a person's bedroom, it alerted staff to read nutritional guidelines in their support plan. Staff told us that "This is useful, particularly with agency staff that may not be familiar with our resident's needs."

One visiting health professional informed us that the service "Listen well, take my advice and adhere to any guidance". They also stated, "I enjoy coming to Ashridge Court and think staff do a good job."

Good

Is the service caring?

Our findings

Staff at Ashridge Court were caring. One person said, "They have become like my family, they look after me well." A second person said, "All of the staff are caring both night and day, I think they do a good job personally."

We observed positive caring interactions. We heard people being asked how they were and were they comfortable. One person who was upset after lunch was reassured by staff in a caring way and the staff member sat with them until they were settled. We also saw that staff held people's hands whilst they talked with them and maintained eye contact. It was clear that the person appreciated the staff members company.

Staff knew people well. One person said, "Most of the staff know me well and they are very friendly." A second person said, "The staff know me very well and this makes me happy." Staff told us they got to know people by speaking with the person, their family and other carers.

People were encouraged to be independent. A person said, "I prefer my medicines being under their control. But at 6:30 in the morning, the nurse comes in to take my blood sugar and give my eye drops, then they leave my early tablets for me to take myself, along with my morning paper. I'm trusted to take the tablets without oversight and I appreciate that. I've been in control of my diabetes all my life and I still feel in control. They always tell me what my blood sugar reading is and they trust me to control my diet. I choose what I want and what is appropriate from the menu and always have a choice of fruit if the pudding is inappropriate." We saw staff encouraged people to make everyday choices, such as food and drink choices, and where they spent their time.

People and their relatives were actively involved in making decisions about their care. One person said, "I am always asked my opinion." A second person said, "The carers always gave me a choice of when to get up and get dressed. They ask me if I'm ready and then they say I'll come back in a minute if I'm not ready." A third person said, "I can make decisions for myself. I tell the carers when I would like to go to bed and let them know where I would like to eat my lunch and dinner." A relative said, "I attended a review meeting. I feel very much included in the decisions being made."

Staff promoted people's privacy and dignity. One person said, "All the staff knock on the door before entering." A second person said, "Even if the door is open they still knock and ask if they can come in." One relative said, "All staff members knock on the door before entering and they seem to care for dad in a dignified way." During the inspection we observed staff knocking on doors and waiting for a response before entering. We also observed nursing staff discreetly giving medicines to people. People's preferences for personal care were recorded and followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, bath and showers. People confirmed that they had regular baths and showers offered and received care in a way that they wanted. One person said, "They know how I want my care given." Care plans detailed how staff were to manage continence. This included providing assistance taking people to the toilet on waking or prompting to use the bathroom throughout the day. Throughout

our inspection we observed that people were prompted and offered the opportunity to visit the bathroom. People who were not independently mobile were taken regularly to bathrooms.

Ashridge Court provides an environment that is of a high standard but has retained a homely feel that people appreciated. Hazel unit demonstrated good dementia practice. The staff had introduced and designed fiddle boards, tactile wall art and had communal areas that were comfortable including a sensory room. There were plans to further develop the sensory room to encourage more people to use it. There was bright and clear signage on toilet and bathroom doors. All areas were clean and well-maintained. The registered manager shared plans to remove the numbers on bedroom doors and have pictures relevant to the person. The garden areas were safe and accessible for everyone. People told us that the views beautiful and that staff offered to take them outside regularly.

There were paintings displayed around the home which were vibrant and eye catching. A staff member told us that one person had fallen in love with one painting and it had been moved in to their room for their enjoyment. This demonstrated a caring culture.

The organisation looked after the well-being of their staff. There were yoga classes held, regular meetings and opportunities for staff to develop their career. This meant staff were happy in their work place and this impacted positively on the care they delivered to people. One staff member said, "I love coming to work, the support from the management is really good, calm and appreciative." Another said, "I wouldn't work anywhere else."

Staff understood the importance of confidentiality. They told us, "You need to protect confidentiality. I do not talk about a resident with another resident" and, "I only disclose personal information with prior consent of the person concerned except where there is clear safety risk or legal reason." People's support records were all computerised and password protected.

Relatives and friends were able to visit the home at any time. Visitors were made welcome. One relative said, 'I visit every day, I've never been made to feel a nuisance." We saw a number of relatives visit during the day. They were greeted and offered drinks. One relative who was visiting their family member who had not long moved in was asking a staff member several questions. The staff member spent time reassuring the relative and on several occasions said, "All you need to do is ask and we will help in any way we can, that's what we are here for."

People who were approaching their end of life were treated with compassion and respect. End of life wishes, such as funeral arrangements were recorded within the care plan and these were followed. The new care plan system had not yet individualised the personal side of the end of life plan such as personal preferences for mouth and lip care, music and emotional support. This had been identified by the registered manager and was being introduced. Staff were able to tell us that the end of life care goals were comfort, pain control and dignity. We visited one person who was approaching end of life and they were calm, comfortable and cared for with empathy by the staff. One staff member said, "I sit in the room to give company when it's quiet, it's important they know someone is with them."

Good

Is the service responsive?

Our findings

People told us they were listened to and felt involved in their care decisions. One person told us, "No complaints. Most staff have a good understanding of people and I'm happy with the attention I receive. Staff are there when I need them, without a shadow of a doubt. At night I like a cup of tea at 1am and 4am and it's always there." Relatives said they were involved in discussions about and the planning of people's care and felt able to talk to the staff about this at any time. One relative said, "I know there is a care plan and I get asked regularly for my input." Another relative said, "I am informed of any changes and if my relative is unwell the staff ring me."

People commented they were well looked after by care staff and that the service listened to them. One person said, "There are regular meetings, we are encouraged to be involved in what happens in the home."

Before people moved into Ashridge Court the registered manager carried out an assessment to make sure staff could provide them with the care and support they needed. Following this assessment the possible admission was discussed by the senior staff in the service to ensure a suitable placement and that the admission process is managed appropriately. For example, ensuring all appropriate equipment was available before admission. Where people were less able to express themselves verbally or they wanted less involvement people's next of kin or representative were involved in the assessment process. This meant people's views and choices were taken into account when care was planned. One person told us, "My family was involved and was able to contribute, it's such a big decision to come into a care home." The assessment took account of people's beliefs and cultural choices this included wishes surrounding people's death.

A new computer system had been introduced in July 2017 that included an individual iPod for care staff to input care information as they completed care. This included the recording of food and fluids. The registered manager and management team were aware that care plans needed further attention and were progressing this. The registered manager said, "We are still learning about the new system and tailoring it to what we want." We identified some wording that did not reflect the care delivered and this was found to be computer generated when staff completed a task, for example 'refused tea, content'. This was an area that the management team would discuss with the computer provider. Whilst training on the system had been provided to staff when implemented the system has not yet been fully imbedded into practice. We were told further training for all staff was to be progressed to ensure the system can be used effectively.

Care plans were written following admission and updated as people's needs changed and on a monthly basis. Reviews of care plans were completed in consultation with all staff. Relatives all told us they were kept fully informed of any changes in care and felt they were included and involved as their relatives would want.

Care plans had specific guidelines to care for people who were at risk from falling or were unable to use their call bells with records confirming hourly checks to be undertaken. Staff were regularly updated about changes in people's health and changed needs at handovers and throughout the day. During the inspection we saw staff communicating regularly with each other. Staff listened to each other and shared information provided by visiting professionals with care plans updated accordingly. Staff used a printed handover that

they updated regularly.

The service employed two specific staff to organise and facilitate activities and entertainment and they worked as part of the team. They knew people well and were attentive to people's individuality and differing needs and abilities. It was acknowledged that they needed to provide specific activities for those who lived with dementia on Hazel unit. A third activity person had just been recruited to join the team and work just on Hazel unit and they were to start work in October 2017. There was a full activity programme that reflected people's interests. This included quiz times, visits out, pet therapy and external entertainers. During the inspection there was a strictly come dancing event which was enjoyed by the people who attended. The activity team performed dances for people. Outings for people were arranged and people talked of trips out. One person said, "I couldn't imagine living anywhere else." There were celebrations and events held in the home which were enjoyed by the people living in Ashridge Court. Photographs of people enjoying events both inside the service and at external venues were also displayed around the home. One person said, "I like reading books. Staff bought some books in so that I could read them. I appreciated that." A second person said, "I enjoy meeting everyone and having a natter. I also do a variety of other activities such as handy crafts, singing and old musical stuff. If I choose to stay in my room the staff come and spend some time talking to me. I enjoy talking especially about my family."

People had their spiritual needs met. Staff told us that the home can arrange visits by ministers of all denominations. We were also told that if a person wishes to attend a church service then this would be facilitated.

Regular staff and resident/family meetings were held and we saw that times of meetings were displayed details of suggestions and discussion points were recorded and actioned. For example, laundry and meal choices. The registered manager was looking at ways to involve more people in contributing to the meetings and responding to the surveys. The action plan included surveys and regular meetings with the chef.

Service user/relatives satisfaction surveys were sent out yearly along with surveys to visiting professionals. Results of people's feedback had been used to make changes and improve the service. For example, activities and meals. A health professional who visited the service confirmed that they had received a survey and felt that communication was very positive with the staff at Ashridge Court.

A complaints procedure was displayed in the reception area of the home and in other communal areas. People told us they felt confident in raising any concerns or making a complaint. One person told us, "I would talk to the staff, nothing is too much trouble." Another said, "I have never had to complain, but I know I would be listened to." Complaints were recorded and responded to as per the organisational policy. A complaints log was kept and monitored by the registered manager and the senior management team of Ashridge Court. There was also a file of complimentary letters and cards received which were shared with all staff.

Requires Improvement

Is the service well-led?

Our findings

People were complimentary about Ashridge Court and felt that things were moving forward 'nicely after some staff changes'. People referred to the registered manager by name and told us, "No problem being listened to since (registered manager) has been here, you can take things up with her." Families told us, "It's a well-run place, staff will take time to chat and tell us what is going on, I think they are honest about certain challenges, but no place can be perfect." Another visitor said, "It's a very lovely setting, nice staff and our particular meal choices have been provided. Very happy with everything."

There was a clear management structure in place. The registered manager was supported by a deputy manager and area manager. Staff knew the management structure and said that the management team was supportive and approachable. People and visitors knew the manager and deputy manager by name and one visitor said, "Very approachable and always available."

The quality of care and support given to people was regularly reviewed. A wide range of audits were completed frequently. Despite having these management systems and quality audits, we identified some areas that required further development and improvement.

Management systems that included quality monitoring had not always ensured safe and best practice was followed in all areas. The provider's systems did not identify and respond to the areas of improvement we found. Such as, incomplete care records and lack of safe person centred care planning for people's health and well-being. People's health needs were being undertaken by staff but lacked a clear rationale for the monitoring and appropriate action had not been taken when required. For example, high blood sugar readings and low blood pressure. Care plans for these people were lacking in information, assessment and guidelines for staff to follow to ensure people received safe, person centred care. The use of specialist equipment whilst in place had not been accurately monitored to ensure it was safe and intended use. The settings of pressure relieving mattresses were not correct for some people. Wound care documentation was not following the wound guidelines set by NICE because they lacked accurate wound descriptions, dates, wound status and actions taken by staff. Further development of the MCA assessments was needed to ensure that people's rights were promoted and protected when fluctuating capacity had been observed. People's documentation considered capacity however there was a lack of decision specific mental capacity assessments. These were areas that required improvement.

The management team responded immediately to the areas identified during our inspection process and supplied an action plan of actions taken to reflect on practices and the way to mitigate the risk for the benefit of people who lived at Ashridge Court. This demonstrated that they were committed to continuous improvement.

The quality monitoring systems included medicines, accidents and incidents, safeguarding , and infections. The home was using a critical management tool which identified trends in a number of areas such as incidents and falls. Environmental audits of the kitchen, laundry and home, and infection control audits were also regularly completed. All actions from audits were recorded on a management system where the

registered manager recorded outcomes. Records demonstrated that actions were being completed.

In discussions with the registered manager, it was clear that she had a clear vision of what she wants to provide at Ashridge Court and has used the provider information report time as a quality document to refer to. She also told us that recruitment had been the main issue for the home on her arrival in October 2016. She told us there were plans to develop senior care staff as assistant practitioners in the near future which will relieve the pressure on the registered nurses and will allow registered nurses to be more involved on the floor. Another priority area has been updating Hazel unit. The service had had 12 weeks of in-reach support for dementia care and had recruited a new activity person for Hazel unit. There were plans also for two volunteers to integrate more with activities next year. The registered manager had worked very hard at driving improvement through a difficult time with staff changes.

People benefited from staff who understood and were confident about using the whistleblowing procedure. The provider had a whistle blowing policy that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff told us, "Yes. There is a whistleblowing policy to follow that gives me guidance on what to do."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems to report appropriately to CQC about reportable events.

Ashridge Court had clear values and principles established at provider level. All new staff had a thorough induction programme that covered the service's history and underlying principles, aims and objectives. These were reviewed and discussed within supervision sessions with staff.

The provider sought feedback from people and those who mattered to them in order to improve their service. Meetings were used to update people and families on events and works completed in the home and any changes including those of staff. People also used these meetings to talk about the quality of the food and activities in the home. Meetings were minuted and available for people to view.

Responses from the last survey sent to families were seen to be positive. The registered manager had ensured relatives who were unable to visit the service regularly were posted out a form. We spoke to health and social care professionals who were very positive in their feedback. Comments included, "Genuine caring approach, they know their people very well," "They approach us for advice and they really want to give the right care and make sure it's right," and "Always approachable, knowledgeable and caring."

Staff felt involved in the running of the home. Regular meetings took place where staff received important messages and shared good practice. A staff member said, "We have open discussions about things." The registered manager met with the registered nurses and the chef on a daily basis, and regularly with day care staff and night care staff. Since January 2017 the registered manager has undertaken three surprise night time checks and was pleased with the outcomes of her visits. It also gave her the opportunity to meet all the night staff whilst they were working rather than just at meetings. Minutes from these meetings evidenced staff discussed care delivery, team work, new ideas, new staff, outcomes of audits, the use of equipment, room checks, and the importance of call bells being within reach.

Staff told us they felt supported by the management. One staff member said, "The manager is very

approachable and supportive." A second staff member said, "It's very family orientated here. I feel comfortable asking for anything." The manager attended staff handovers on a regular basis to gauge staffing levels against people's needs and a staff member said, "It's good to have the manager at handovers because then she picks up on things and understands our challenges."