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Ashwood Residential Care Home

Inspection report

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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

This comprehensive inspection took place on 21 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 29 people living at the home. Ashwood Residential Care Home is registered to provide personal care and support for 36 people. It is situated in the centre of Ashton-in-Makerfield close to all local amenities including shops and bus routes.

At the last inspection on 19 September 2014 we found the service to be compliant with all regulations we assessed at that time.

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.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. The service took into account people's needs and their dependency level, using a dependency level tool. People we spoke with living at Ashwood and visitors told us they thought there were sufficient numbers of staff to meet their needs.

We looked at five staff personnel files and there was evidence of robust recruitment procedures.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. We spoke with three care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. The home had a whistleblowing policy in place.

We looked at how the service managed the administration of medicines and looked at medication administration records (MARs). We observed staff administering medicines and saw that people were given their medicines as required. Staff who administered medicines had all completed appropriate training in the safe handling of medicines. Records of medicines administration had been completed consistently and accurately. We saw some people were prescribed medicines 'when required' (PRN). We saw PRN protocols were in place for these medicines.

Accidents and incidents were recorded correctly including a record of the accident or incident, whether or not it was reportable under RIDDOR, a summary chart and action plan.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition.

We saw the home was clean and free from any malodours. We saw that bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility. People's changing care needs which required the support of other appropriate professionals were responded to promptly. People's care plans

contained records of visits by other health professionals.

We looked at how the service managed the control of infectious diseases. We saw that monthly infection control audits were in place and included areas such as beds and mattresses, furniture, bedrooms and the general environment and equipment. Staff were aware of precautions to take to help prevent the spread of infection.

There was an up to date a fire policy and procedure. Fire safety and fire risk assessments were in place. The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use.

There was a staff supervision schedule in place which identified meetings during the year. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Staff were subject to a formal induction process and probationary period. Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role.

The service was working within the principles of the MCA. Staff told us they had received training in the MCA and DoLS and most were able to explain the principles of this legislation to us. Staff were aware of how to seek consent from people before providing care or support.

The service had achieved a food hygiene rating score (FHRS) of five. There was a three week rolling menu cycle, which was nutritionally balanced. Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place.

We saw there were some adaptations to the environment, which included pictorial signs on some doors which would assist people living with a dementia.

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Staff spoken to had a good understanding of how to ensure dignity and respect when providing care and support and people we spoke with confirmed that they felt staff respected their privacy and dignity. We saw that the care staff knocked on people's bedroom doors and waited for a response before entering. Throughout the course of the inspection we heard lots of laughter between staff and people and there was a positive atmosphere within the home.

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and visitors to the service confirmed this was the case.

We looked at records of residents and relatives meetings which were held regularly. Records were kept of each meeting and notes were given to people and their relatives. We found the service aimed to embed equality and human rights through good person-centred care planning.

Care files were well organised and contained care plans that covered a range of health and social care support needs. We saw detailed personal profiles in the care records which included people's life story, a list of priorities about their care and quality of life, their memories, risk assessments and relationships. We saw people had a choice of activities to stimulate them.

People's care files identified that individuals and their relatives were involved in the planning of their care,

and personal preferences were discussed. The care records showed regular visits from relevant other professionals such as a GP, an optician, a chiropodist and advanced nurse practitioners.

We looked at how the service managed complaints and we found that the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use and this was up to date

People told us they could make choices such as when they went to bed or were supported with bathing. Staff we spoke with confirmed this was the case.

Each person using the service had an allocated key worker who consulted them about their preferences and listened to any concerns they had. Staff reviewed the weights of people who lived in the home on a weekly basis.

Staff said they liked working at the home. They told us they thought the home was well led and said that the registered manager was approachable and fair.

There were a variety of systems in place which helped the service to monitor the quality of care provided to the people who lived in the home. The service undertook a range of audits, which were completed according to different schedules and these included areas such as the environment and equipment.

We found that residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed.

The service had a business continuity plan that was recently reviewed in October 2015 A 'sister home' buddying system was in operation which identified another local care home who had a reciprocal arrangement with Ashwood in the event of the need to evacuate the premises for an extended period of time.

There was a full range of policies and procedures in place which were available in paper copy format and electronically.

There was evidence in minutes of staff team meetings that findings from audits were communicated to staff and actions taken. There was a monthly staff supervision schedule in operation.

Accident and incident forms were completed correctly and included the action taken to resolve the issue. The service appropriately submitted Statutory Notifications to the Care Quality Commission (CQC) as required and had notified the CQC of all significant events, which had occurred in line with their legal responsibilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with who lived at Ashwood told us they felt safe.

Records of medicines administration had been completed consistently and accurately. Accidents and incidents were recorded correctly including a record of the accident or incident.

Good ●

Is the service effective?

The service was effective. Staff were subject to a formal induction process and probationary period and there was a staff supervision schedule in place.

The service was complying with the conditions applied to DoLS authorisations.

Staff were aware of how to seek consent from people before providing care or support. People's care plans contained records of visits by other health professionals.

There were some adaptations to the environment to assist people living with a dementia.

Good ●

Is the service caring?

The service was caring. Staff spoken to had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of laughter between staff and people and there was a positive atmosphere within the home.

The service involved families when developing care plans or carrying out assessments.

Good ●

Is the service responsive?

Good ●

The service was responsive. Care files were well organised and contained care plans that covered a range of health and social care support needs.

People's care files identified that individuals and their relatives were involved in the planning of their care. Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

Is the service well-led?

The service was well-led. There was a registered manager in post.

There were a variety of systems in place which helped the service to monitor the quality of care provided and the service undertook a range of audits.

There was a monthly staff supervision schedule in operation.

Good ●

Ashwood Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection took place on 21 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, 29 people were living at Ashwood Residential Care Home.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Wigan Local Authority Quality Assurance Team, who regularly monitored the service and the local Healthwatch. Healthwatch England is the national consumer champion in health and care.

We spoke with six people who used the service, a visiting professional, three relatives, four members of care staff and the registered manager. We also looked at records held by the service, including five care files and five staff personnel files. As part of this inspection we 'case tracked' records of five people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and well-being were being appropriately managed by the service.

We observed care within the home throughout the day including the morning and lunchtime medicines round and the lunchtime meal.

Is the service safe?

Our findings

People we spoke with who lived at Ashwood told us they felt safe. One person said: "Oh yes I feel safe. It's secure and they look after you." Another person said: "I feel safe. They keep my spirits up." A visiting professional said: "People are safe and falls seem to be quite rare. If people do fall they aren't usually serious injuries. I think the care here is superb. I think there are a lot of staff here compared to the number of people using the service. The staff are very caring and attend to people's needs, and beyond."

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for January 2016 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. The service also operated a 'twilight shift' until 12.30am in the early morning to ensure the needs of people who required assistance to go to bed were met.

People we spoke with living at Ashwood and visitors told us they thought there were sufficient numbers of staff to meet their needs. A visiting professional told us: "There are always staff available when I visit and they attend to people's needs." A person who used the service said: "I've never noticed there hasn't been enough staff I must admit." A relative told us: "I've always found there to be enough staff. Nothing is ever too much trouble."

The service used the NHS Safety Thermometer. The NHS Safety Thermometer provides a quick and simple method for surveying harm to people in a variety of areas such as falls, pressure ulcers and infections. Results are analysed, which can be measured and which monitor local improvement and harm free care.

We looked at five staff personnel files and there was evidence of robust recruitment procedures in place. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. We spoke with three care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. Staff were aware of potential signs of abuse or neglect and of how to report any safeguarding concerns appropriately. Staff told us they had contact numbers for the local authority safeguarding team should they need it, which we observed during the inspection.

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns and this included contact details for the local authority and the Care Quality Commission. Staff we spoke with had a good understanding of the actions to take if they had any concerns.

We looked at how the service managed the administration of medicines and looked at medication administration records (MARs). We observed staff administering medicines and saw that people were given

their medicines as required. Staff who administered medicines had all completed appropriate training in the safe handling of medicines. Update training in medicines was provided by the supporting pharmacy.

Records of medicines administration had been completed consistently and accurately. We saw requirements relating to controlled drugs were being met. For example, we saw there were two signatures when controlled drugs were administered, which were stored in a separate, locked controlled drugs cabinet. Controlled drugs are certain medicines that are subject to additional legal controls in relation to their storage, administration and disposal. We carried out a stock check of controlled drugs and found that this was correct.

We saw some people were prescribed medicines 'when required' (PRN). We saw PRN protocols were in place for these medicines. PRN protocols provide details about when such medicines should be given. Creams were recorded on peoples' MAR charts and there was a separate creams chart and supporting body maps, which showed staff where to apply the cream.

Medicines were requested each week to ensure an adequate stock and a marker was placed on the MAR chart to remind staff of the need to re-order medicines and carry out a stock check. Any overstock of medicines was clearly identified with the persons' name and stored separately in preparation for collection by the supporting pharmacy. Disposal records were completed appropriately.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan. We checked historical accident records and found that they had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further injury in the future.

During the inspection we looked around the premises. The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. The premises were clean throughout and free from any malodours. We saw that bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility. We saw that liquid soap and paper towels were available in all bathrooms and toilets. The bathrooms were well kept and surfaces were clean and clutter free and the home was clean throughout. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use.

We looked at how the service managed the control of infectious diseases. We saw that monthly infection control audits were in place and included areas such as beds and mattresses, furniture, bedrooms and the general environment and equipment. Personal protective equipment (such as gloves and aprons) were available throughout the home. Weekly and daily cleaning schedules were in place and up to date.

Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was an infection control policy and procedure in place that identified to staff what actions to take to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak. A notice on each bathroom/toilet door read: 'Stop, are you wearing the correct PPE (personal protective equipment) before assisting your client?' We observed staff wore appropriate PPE clothing when assisting people.

There was an up to date fire policy and procedure. Fire safety and fire risk assessments were in place.

People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building. Tests of the fire system were made regularly and the servicing of related equipment, such as fire extinguishers was up to date.

Is the service effective?

Our findings

A person who used the service told us: "I'm very pleased with the care here. I have no objections and the staff look after you. I can watch what I want on TV and they look after me very well. If I'm taken to the toilet they ask before assisting me always." Another person said: "They come round and see what you want. I have never experienced them doing something without asking me first." A visiting professional told us: "There are always staff available when I visit and they attend to people's needs."

When we arrived at the service, a staff member was holding a telephone conversation with the advanced nurse practitioner service for residential and nursing homes. The staff member told us that calls to this service had to be made very early each day to ensure the availability of the relevant professional, such as the district nurse. Issues discussed related to the changing care needs of individual people that had been identified the previous day or evening. During the course of the inspection we saw that relevant professionals attended the service to follow up on the information supplied to them earlier in the day. This meant that peoples' changing care needs, which required the support of other appropriate professionals were identified and responded to promptly.

We looked at staff training, staff supervision and appraisal information. There was a staff supervision schedule in place, which identified meetings during the year. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Supervision sessions for care staff were conducted by the manager or deputy manager. We verified this by looking at the notes of staff supervision meetings. Staff told us they received supervision on a regular basis, which they found useful.

Staff were subject to a formal induction process and probationary period. One staff member said: "The induction covered moving and handling, policies and procedures, safeguarding and infection control to name a few. It was interesting. I was happy with it". Another staff member told us: "I was able to shadow a few medication rounds and the induction covered safeguarding, moving and handling and infection control. It was quite detailed actually."

We looked at five staff personnel files and saw that there were records, which referenced the successful completion of the probationary period and records of training undertaken during induction such as safeguarding, infection prevention and control and moving and handling.

Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role, such as food hygiene, fire safety, first aid and medicines safe handling and awareness. Staff told us they had received training in dementia care. Staff training records identified that all care staff, the management team and staff who provided ancillary support but not care, had completed training in dementia care.

The staff we spoke with were able to tell us about different forms of dementia and said they would meet the support needs of people living with dementia by providing prompting and reassurance. A member of staff told us: "Training is fine. I've just done dementia, safeguarding and medication. I have never looked back

since I started working here. The support is great that we all get".

There was a staff training checklist document that was used to determine staff training in relation to the health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was discussed between the manager and staff members on an individual basis. For example we saw that one staff member had required updated training in Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Safeguarding. The staff member had then completed this training and later provided written feedback, which was recorded on the checklist form.

There was a notice board displaying a list of staff members who were 'champions' in certain areas such as advanced care planning, falls prevention, medication, activities and infection control. Their role was to provide support to other staff members, raise awareness and to consult with the managers to ensure the appropriate delivery of care in each identified area.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw there had been eight applications for DoLS made to the supervisory body prior to the date of the inspection. The registered manager showed us records that demonstrated they had followed-up the status of the outstanding DoLS applications and this was recorded on a 'standard authorisation checklist' form.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was complying with the conditions applied to the authorisations. Where applications had not yet been authorised, peoples' care plans contained restrictive practice screening tools, which ensured that the least restrictive practice was being followed.

Staff told us they had received training in the MCA and DoLS and most were able to explain the principles of this legislation to us. Appropriate supporting policies and procedures were in place, for example, the service had policies on MCA/DoLS and safeguarding adults. We checked the training records and saw that 100% of care staff had completed training in MCA/DoLS. Other ancillary staff who were not employed in a care giving role had also completed this training.

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care. Staff told they would ask people again later if they had initially refused care. We saw people had mental capacity assessments in their care plans, which were up to date.

People's care plans contained records of visits by other health professionals. We saw that a range of professionals including GPs, speech and language therapists (SALTs) and district nurses had been involved in people's care. We saw people's weights were being monitored on a regular basis where a need for this had been identified.

When we arrived at the home we observed the breakfast meal. Breakfast was cereal, toast, jam or marmalade and a warm or cold drink. There was also a choice of a hot breakfast on request. The service had achieved a food hygiene rating score (FHRS) of five. Fridges and freezers were well-stocked in addition to a plentiful supply of dry food goods. There was a three week rolling menu cycle, which was displayed both inside and outside of the dining room. People who used the service could choose an alternative meal option on any day if they wished. Vegetarian options and specialist diets were also available. Fresh fruit and snacks were also provided in between meals.

Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place. Information on different diet types, such as a soft diet, had been sought from the speech and language therapy team (SALT) and this informed the kitchen staff how to prepare and serve these types of foods.

Food temperatures were recorded at each meal before serving. We observed staff taking breakfast to people who wished to stay in their room on nicely presented trays that helped to make the food look inviting to eat. Details of peoples' specialist diets were available in the kitchen and advice from the speech and language therapy team had been provided regarding thickened fluids.

A person using the service told us: "The food is champion and we get plenty of it. There is a good variety." Another person said: "The food is excellent. A good variety and it's cooked well. A visiting professional told us: "I always see nice homely food and I've never had any nutritional or hydration concerns." Staff reviewed and recorded peoples' weights on a weekly basis.

We saw there were some adaptations to the environment, which included pictorial signs on some doors which would assist people living with a dementia. There were assisted bathrooms with equipment to aid people with mobility problems.

Is the service caring?

Our findings

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. For example at the lunch time meal we saw staff gently encouraging people to eat their food. A person who used the service said: "I've been treated exceptionally since being here." Another person told us: "Their (the staff) general approach is very good. The staff don't talk down to me and I feel an equal person." Another person said: The staff never lose their temper. I have problems with my bowels but they just take it all in their stride."

Staff spoken to had a good understanding of how to ensure dignity and respect when providing care and support and people we spoke with confirmed that they felt staff respected their privacy and dignity. One staff member said: "One person has a catheter on their leg and I always make sure it is covered up so that people can't see it. I do things quietly and discreetly." Another staff member told us: "Closing doors and covering people during personal care are all extremely important." Another staff member said: If doors are closed then I knock. If there is no reply then I ask quietly if it is ok to come in. I close doors during personal care and leave people to it if they can manage in the shower."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. A visiting professional told us: "The manager is really attentive to people's needs."

As people came into the communal areas, the manager informed each person about the purpose of the CQC visit. The manager explained to us that one person had general anxieties about the security of their continued residence at Ashwood and may have misinterpreted the reasons for our visit. We saw the manager explained the reasons for our visit to this person and that this person was visibly relieved as a result of hearing this information.

We saw that the care staff knocked on people's bedroom doors and waited for a response before entering. We saw that people living at the home were well groomed and nicely presented. One person with sight loss had a sign on their bedroom door reminding staff to verbally identify themselves before entering the room.

Throughout the course of the inspection we heard lots of chatter between staff and people and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people.

People's care files contained end of life care plans, which documented people's wishes at this stage of life

where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and visitors to the service confirmed this was the case. At the time of the inspection no person was in receipt of end of life care and each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

Most peoples' bedrooms had their picture on the door, which would assist people living with dementia to find their own room. Peoples' spiritual needs were accommodated through the regular attendance at the home of different faith groups.

We looked at records of residents and relatives meetings, which were held regularly. Records were kept of each meeting and notes were given to people and their relatives.

Is the service responsive?

Our findings

We observed staff were patient, respectful and friendly towards the people who lived in the home. A family member told us: "It's been superb. It was a relief for us to find this home. We have had no problems whatsoever. The staff work hard and are dedicated. We can't fault any of them. We are perfectly happy with the place and it was recommended to us by someone else".

Care files were well organised and contained care plans that covered a range of health and social care support needs. This included information on mobility support, activity preferences, people's social histories, sleep, dressing and personal preferences and getting out and about. We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s). People's needs for support were carefully described on their care plans so care staff knew exactly what tasks to undertake.

We saw detailed personal profiles in the care records, which included people's life story, a list of priorities about their care and quality of life, their memories, risk assessments and relationships. This meant staff had information to ensure people's care was as personalised as possible. The staff we spoke with understood the contents of the care plans, knew people's needs and preferences and we saw diary sheets were updated several times during the course of the inspection. The staff we spoke with could describe what actions to take if a person fell or had an accident and injured themselves.

We saw people had a choice of activities to stimulate them. These included reminiscence, trips to the local shops and the local café, events in the home, watching films or sitting quietly in their room. Exotic animals, such as birds were also brought to the home by an appropriate organisation, on request. Our observations and discussions indicated people who used the service expressed their views and were involved in making decisions about their activities. The service celebrated peoples' birthdays where it was their wish to do so.

A number of 'fun' events took place throughout the year such as a 'beer and pie fest dinner' where people chose the best pie, and a cheese and wine evening. Events were also held at certain times of year such as Easter, Christmas and other public holidays when a special celebratory menu was provided. The service had recently informed people in advance of the National Nutrition and Hydration week in March 2016 in which the service was joining up with other venues in order to attempt to beat the world record for the largest afternoon tea party. People and their relatives were encouraged to contribute their ideas in order to inform the content of the event.

A person who used the service told us: "They (the staff) take me out when it's nice. Singers visit as well". Another person said: "There is bingo, quizzes and drawing. They (the staff) always keep us occupied." Another person told us: "There are always different singers at the home. There is enough to do and we like watching TV."

The service used an 'escort time sheet' which recorded the details of when people had left the premises for an external appointment or activity. We saw that this record was completed correctly, including the staff name, the date and time of the external activity and the name of the person being supported. This meant

that a number of different people had been regularly supported each month to leave the premises as requested/required.

Residents and relatives meetings were held regularly and information from these meetings was used to inform the delivery of the service. People we spoke with and their relatives told us they had attended meetings about the menu, activities and special events. We saw records from a range of meetings that verified this.

People's care files identified that individuals and their relatives were involved in the planning of their care, and personal preferences were discussed. The care records showed regular visits from relevant other professionals such as a GP, an optician, a chiropodist and advanced nurse practitioners. This meant appropriate healthcare professionals were accessed when people required them. Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment. The care plans were reviewed monthly by the senior carer or manager and relatives confirmed they were kept informed of any changes in their relative's needs.

We looked at how the service managed complaints and we found that the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use and this was up to date. We observed the compliments and complaints file and saw that issues were responded to in a timely manner. People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required. One person told us: "I have never needed to make a complaint because they don't need to do anything differently." Another person said: "I've never complained but I'd speak to staff and feel it would be sorted out." Another person said: "I would approach the staff team if I had a complaint and speak to them about it." Another person told us: "I've never made a complaint but I would speak with the person in charge."

Staff told us they would document any complaints and pass them to the registered manager. There was information displayed on the notice board on the process to follow if people wished to make a complaint.

People told us they could make choices such as when they went to bed or were supported with bathing. Staff we spoke with confirmed this was the case.

We asked staff how they ensured people had choice regarding their care and support needs. A member of staff said: "I offer people choice by asking what activities they want to do. I also ask people if they would like an alternative meal. The information is all in the care plan." Another staff member said: "In the afternoon I might approach people and see if they would like to choose tomorrow's clothes. I ask people if they want to eat in their room or lounge or have a bath or a shower."

Each person who used the service had an allocated key worker who consulted them about their preferences and listened to any concerns they had.

Is the service well-led?

Our findings

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.

Staff said they liked working at the home. They told us they thought the home was well led and said that the registered manager was approachable and fair. One staff member told us: "I find the leadership is good. They (the managers) make sure training is up to date. If they can help you in any way then they will." Another staff member said: "The manager is very approachable. We can speak about anything including work and home life and personal support is very good." A person who lived at the home said: "The manager is lovely."

A visiting professional told us: "The home has good relationships with my team. GP's also work well here. The leadership is fantastic. I would go as far as to say outstanding." A person using the service told us: "I feel it is a well-run home". Another person said: "It certainly is very well managed."

We reviewed documents, which the service used to monitor the quality of its service by seeking feedback from people who used the service, their families, staff and visitors. We found that residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed. The service held a meeting for people who lived in the home approximately once every three months, which included their relatives. This was an opportunity to discuss any concerns and encouraged suggestions to improve the home and the care provided.

The service worked in partnership with a wide variety of organisations and professionals including local faith groups and local schools, Admiral Nurses, the Care Liaison Team, various national associations, a local dementia café and the Home Care Forum. The home also held an annual charity event in support of several well-known charities. Records showed that the service had consulted people about which charity they wished to support via a residents meeting and a breakfast forum, and activities for the charity day event had been chosen by people using the service.

There were a variety of systems in place, which helped the service to monitor the quality of care provided. The service had sent out questionnaires for feedback from people who lived in the home and their visitors in February 2015. The relatives we spoke with confirmed they had received these surveys. We looked at a sample of the feedback received and saw that areas discussed included social contact, comfort, staff, food/drink, cleanliness/décor, accessibility/mobility, facilities and activities.

The service undertook a range of audits, which were completed according to different schedules and these included areas such as the environment and equipment. The manager received a 'handover' at the start of each day from the senior carers and deputy manager which included information on any incidents, visitors to the home and issues raised by staff. We saw there were reviews by health professionals who visited the home, reviews of safeguarding referrals, complaints, a care plan audit and health and safety audit. An

environmental risk assessment was reviewed monthly. The manager also carried out a daily walk-around of the entire premises. We saw evidence of action plans that the manager used to improve care or practice. Observations of medicines administration practice had also been carried out, which staff verified. The local supporting pharmacy also carried out regular audits of medicines and provided training to the home.

The service had a business continuity plan that was recently reviewed in October 2015. This included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT, an infectious outbreak or flood. The plan also included an emergency response checklist and contact details for all key suppliers, staff and other relevant professionals.

A 'sister home' buddying system was in operation, which identified another local care home who had a reciprocal arrangement with Ashwood in the event of the need to evacuate the premises for an extended period of time.

There was a full range of policies and procedures in place which were available in paper copy format and electronically. These covered all areas of care provision as well as providing specific guidance and safe systems of working in relation to use of equipment.

There was evidence in minutes of staff team meetings that findings from audits were communicated to staff and actions taken. For example an environmental health audit had identified the need for all food allergens to be identified on the menu. We saw that the menu had subsequently been updated to include this information.

Accident and incident forms were completed correctly and included the action taken to resolve the issue. The service appropriately submitted Statutory Notifications to the Care Quality Commission (CQC) as required and had notified the CQC of all significant events, which had occurred in line with their legal responsibilities.

Records of staff competency assessments via observation were also available and these included individual feedback to staff on their performance. There was a monthly staff supervision schedule in operation. A member of staff said: "I can approach management anytime with anything. The manager is friendly but is firm as well. We all work well as a staff team and have good consistency between us".