# Barchester Healthcare Homes Limited

# Ashcombe

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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? | **Good** |

# Summary of findings

## Overall summary

This inspection was unannounced and took place on the 8 and 9 August 2016. At the last inspection on 19 and 28 May 2015 we found that the provider had breached two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). The provider had not ensured that sufficient numbers of suitably trained and skilled staff were delivered. They had also not ensured that people's care records were accurately and contemporaneously completed.

We told the provider they needed to take action and we received a report setting out the action they would take to meet the regulations. At this inspection we found that improvements had been made with regard to each of the breaches identified and the provider was now meeting the legal requirements of the Regulations.

Ashcombe is a home which provides nursing and residential care for up to 33 older people who have a range of needs, including those living with dementia, epilepsy and diabetes. At the time of our inspection 27 people were living in the home.

Ashcombe is a two storey building set in grounds on the outskirts of Basingstoke town centre. The home comprises of both single and double sized bedrooms, some with washing facilities such as wash basins. There is a small secure garden to the rear of the home and sheltered seating area to the front of the home allowing people to enjoy sitting in the garden patio area in all weather conditions.

There was no registered manager at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the HSCA and associated Regulations about how the service is run. A new manager had been appointed by the provider two weeks before the inspection and they were in the process of becoming registered at the time of the inspection.

The provider ensured there were sufficient numbers of staff deployed to meet people's individual needs. Processes had been put in place to regularly review the required level of staff deployed to meet people's need. However these processes required additional time to ensure they remained embedded in working practices.

The home provided both long term and short term care for people and to those living with dementia however the environment did not always support people to move around the home safely enabling them to remain independent. Corridors were often used to store moving and handling equipment, handrails were not in place to aide people who were able to walk and appropriate signage was not always available to help people to orientate themselves around the home.

We have made a recommendation that the provider seeks further guidance on the environmental factors

which can be adapted to meet the needs of those living with dementia.

Relatives of people using the service told us they felt their family members were cared for safely. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place and regularly reviewed to keep people safe.

Thorough recruitment procedures were completed to ensure people were protected from the employment of unsuitable staff. Induction training for new staff was followed by a period of time working with experienced colleagues. This ensured staff had the skills and confidence to support people safely.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such as a loss of accommodation as a result of fire or flooding. Fire drills were documented, known by staff and practiced to ensure people were kept safe.

People were protected from the unsafe administration of medicines. Nurses responsible for administering medicines had received additional training and were subject to competency assessments to ensure people's medicines were administered, stored and disposed of correctly.

People received sufficient food and drink to maintain their health and wellbeing. Snacks and drinks were encouraged between meals to ensure people remained hydrated. People assessed as requiring a specialised diet, for example a pureed and diabetic diet, received these and the food was pleasantly presented.

People were supported by staff who had received an effective induction and period of support from more experienced members of staff. This enabled them to acquire the skills and confidence to deliver safe effective care. Regular supervisions had been delayed due to a change in management but documented processes were in place to ensure these were competed. Staff were happy to raise any concerns with their colleagues and senior staff and they felt supported as a result.

People were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

The staff and manager promptly engaged with other healthcare agencies and professionals to ensure people's safety and wellbeing

Staff demonstrated they knew and understood the needs of the people they were supporting and people told us they were happy with the care provided. The manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which were personalised to their needs and wishes. They contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People told us they did not always know how to complain however all said they would speak with senior staff if required. Procedures were in place for the manager to monitor, investigate and respond to complaints in an effective way. People, relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings and participation in the completion of annual survey questionnaires.

The provider's values were displayed within the home but were not immediately known by staff. However staff were able to describe how the manager wanted people to treat people. We could see these standards were evidenced in the way care was delivered.

The manager and staff promoted a culture which focused on providing care in the way that staff would wish to provide to their family members. The manager was newly in position but in the process of providing strong leadership and had fulfilled the requirements of their role as a manager. The manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe. They had also included taking positive action to address areas which had previously been identified as requiring action including conducting regular staffing rotas reviews and seeking feedback to improve the quality of service delivery.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

The provider ensured that sufficient numbers of suitably qualified staff were deployed in order to meet people's needs in a timely fashion. However processes in place to ensure these levels remained sufficient when people's needs changed required additional time to ensure they would remain effective.

There was a detailed recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

Medicines were administered safely by nurses whose competence was assessed by appropriately trained senior staff.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The home design did not support those living with dementia. The decoration did not support those living with poor eye sight associated with old age and dementia to move around the home independently.

People were able to eat and drink enough to maintain their nutritional and hydration needs. People who required a specialised diet received the food in an appropriate way to meet their health needs.

People were supported by staff who had the most up to date knowledge available from detailed care plans to best support their needs and wishes.

People were supported to make their own decisions and where

they lacked the capacity to do so staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met.

People were supported by staff who sought healthcare advice and support for them as required.

## Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff had developed positive and caring relationships with people.

People were encouraged to participate in creating their personal care plans. Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People received care which was respectful of their right to privacy whilst maintaining their safety

## Is the service responsive?

Good

The service was responsive.

There were sufficient opportunities to ensure all people received personalised one to one interaction when unable to participate in group activities.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis and when people's needs changed.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner.

## Is the service well-led?

Good

The service was well led.

The manager was new to the service and had implemented positive changes in the quality of service delivery. These included conducting regular staffing rotas reviews and seeking feedback to improve the quality of service delivery.

The manager and senior staff promoted a culture which placed

the emphasis on care delivery that was respectful and delivered by staff who felt they were caring for their own relative.

Staff were aware of the responsibilities of their role and felt supported by their colleagues. Staff told us they were able to raise concerns with the new manager and were confident they would be addressed.

The manager and provider regularly monitored the service provided. This was to identify where any potential improvements could be made to improve the quality of the service people received.

# Ashcombe

**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 function. This inspection checked whether the provider was 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 9 and 10 August 2016 and was unannounced. The inspection was conducted by an adult social care inspector and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service, on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, their relatives, observed mealtime sittings and interactions between staff and people living at the home

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. The provider also completed a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked this information as part of our inspection.

During the inspection we spoke with nine people, five relatives, the manager who was also a registered nurse, the deputy manager also a registered nurse, a further nurse, the chef, the activities coordinator, the regional director, the housekeeping assistant and three health care assistants (who will be referred to as staff throughout this report). We pathway tracked five people which meant we reviewed their care plans, daily notes and medication administration records to review the care they received. We also looked at staff related documentation which included five staff recruitment files, staff training records and staffing rotas for the dates 27 June to 10 August.

Documentation relating to the running of the home was reviewed which included quality assurance audits and the resulting action plans, the provider's policies and procedures, complaints and staff and relative meeting minutes. We also reviewed the results of the 2015 completed residents and relatives' quality

assurance questionnaires. During the inspection we spent time observing staff interactions with people including during two lunch time sittings and participation in activities.

The service was previously inspected on 19 and 28 May 2015 where two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been identified.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection on 19 and 28 May 2015 we found the service was not fully meeting the legal requirements relating to Regulation 18 (staffing) of the Health and Social Care act 2008 (Regulated Activities) 2014 (HSCA). The provider had not ensured that sufficient numbers of suitably qualified and experienced staff were deployed to be able to meet people's needs safely. At this inspection we found that the provider had taken positive steps to improve staffing levels as described in their action plan. This action plan had been implemented to address the shortfalls relating to the breach described and the service met the requirement of the regulations. However, changes in staffing level practices needed to be embedded and sustained, as it was not always clear if assessments made about levels of staffing led to quick enough changes when people's needs changed.

At the time of the inspection new processes had been put in place to accurately monitor and assess the correct levels of staffing numbers required when people's needs changed. The provider used their own Dependency Indicator Care Evaluation (DICE) tool to ensure that staffing was of a safe level to meet the dependency needs of those living in the home. Each person and their level of needs was assessed as low, medium and high in a number of key areas such as their ability to maintain their own hygiene, people's mobility needs and if they needed support, their behavioural, psychological dependence and whether people could manage their own continence.

The provider used the DICE tool to ensure that suitable and sufficient numbers of staff were deployed to meet people's needs. However it was not always clear that when people's needs had increased or decreased that the DICE had been updated in a timely fashion to reflect this change. This meant that it was not always clear that the provider had taken timely action to ensure staffing levels remained appropriate in response to changes in people's needs.

Suitable and robust monitoring processes had been put in place by the new manager to ensure that people's level of dependency and staffing levels were reviewed weekly. This would ensure sufficient staff were deployed to be able to meet people's needs. However, more time was needed to ensure that this practice was embedded and sustained. This would ensure that sufficient and suitable numbers of skilled staff would always be available when people's needs were to change.

Staffing rotas also showed that the home had, on a number of occasions worked with their below minimum levels of staffing however this had been due to last minute reported sickness. This was acknowledged by the regional director and the manager and was an area they were keen to examine and explore to see if improvements could be made.

Where there were shortfalls identified staff told us that other members of staff would offer to complete the shifts themselves or use bank staff. The use of regularly known staff promoted familiarity and continuity of care for those living at the home.

People and relatives we spoke with told us that people living at Ashcombe were safe. One person told us,

"Yes (feel safe) there's always plenty of people around". Another person said, "Everything here makes me feel safe" whilst another told us, "Yes (feel safe) there's always someone to keep an eye on me". Relatives agreed, one told us, "Yes, (he's) very safe, 100%...because of the staff, they look after him well, couldn't fault anyone". Another relative said, "Oh yes (family member is safe) they (staff) are just so amazing, always have her best interests at heart".

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe the physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns about the home. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert which included contacting the local social services safeguarding teams. Staff received training in safeguarding vulnerable adults and were required to refresh this training annually.

Where staff felt unable to raise concerns in person the provider had a whistleblowing policy to support staff to raise concerns anonymously. Records showed that when concerns had been raised anonymously they had been investigated thoroughly. Action had then been taken where appropriate to address areas where required, for example, when issues had been raised regarding the quality of the bed linen. Whilst not substantiated as a safeguarding concern the provider had responded proactively by purchasing new duvets and quilt covers for people living at the home. People were protected from the risks of abuse because staff understood the signs of abuse, the actions they should take if they identified these and the provider responded appropriately to issues raised.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility and safety, nutritional risks and where required risks around peoples inability to be able to use the call bell to request assistance. Risk assessments included information about action staff needed to take to minimise the possibility of harm occurring to people. For example, some people had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. Additional risk assessments were completed when required to manage new risks identified to people's safety. These risk assessments were reviewed monthly. This ensured that all current risks were identified and appropriate action documented for staff to take to mitigate this risk as soon as this change in need had become known. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Risks to people's care were identified, documented and staff knew how to support people's needs safely.

When accidents and incidents occurred these were documented fully and immediate and longer term actions identified to try to minimise the risk of a reoccurrence. For example, one person living at the home had suffered a fall which had resulted in injury which had not been immediately recognised as the person had not complained of any pain. It was discovered the following day that they had sustained a fracture as a result of their fall. The registered manager at that time completed a full investigation into the incident. Lessons identified post incident were documented and shared with the staff to minimise the opportunity for a similar incident occurring again. Accidents and incidents were documented, reviewed and actions taken as a result to mitigate the risk of future harm occurring.

There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood. The business continuity plan was situated in an emergency 'grab bag' situated by the front door to allow for easy access by staff and emergency personnel. This provided guidance of the steps to take in the event of an emergency to ensure people were kept safe. If an evacuation

were required this guidance detailed that the manager would move people to the providers other homes in the county. These plans allowed for people to continue receiving the care they required at the time it was needed.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been completed including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care service. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

People living at the home received their medicines safely. Nurses were responsible for administering medicines. Records showed that medicine administration records (MARS) were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to annual competency assessments to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance.

Some people were receiving medicines which are known as PRN or 'when required' which includes analgesics, sedatives and other medicines to manage people's pain. These are medicines that are not routinely required and may only be needed occasionally. Peoples MARS included a PRN protocol for nurses so they were able to see when PRN medicines were most appropriate, required and the dosage that it could be given. For example for people in receipt of painkillers, clear guidance was provided as to when it could be administered and the levels of which could be given and for how long. For people who were unable to verbally communicate if they required additional PRN a descriptive facial chart was in place for staff to refer to. This PRN protocol also described the physical symptoms people could display such as shaking when in extreme pain were also described. We could see the use of this PRN was being used appropriately and not routinely provided which would therefore change it from being a PRN to a regularly administered medication. This would then need to be reviewed and documented by a GP.

A medicines round was observed during which the nurse appropriately supported people to take their medicines as prescribed. Medicines were stored, administered and disposed of correctly which included those which required refrigeration to remain safe. The temperatures of drugs storage was routinely completed and documented to ensure it remained suitable for use.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented daily by the nurses to check that records and stock levels were correct.

Requires Improvement

# Is the service effective?

## Our findings

People and their relatives we spoke with were positive about the ability of staff to meet their and their family members care needs. People said that they felt staff had sufficient knowledge and skills to deliver care. One person we spoke with told us, "The staff are very good", another person told us they found the staff, "Very good". One relative told us they were, "100% happy with the home" and another relative said, "I'm very happy with my husband's care".

Despite providing care to some people living with dementia we could not see that the environment had been adapted to support people to live as independently as possible. The home not been specifically designed or decorated to meet the needs of those living with dementia. The corridors in places were not very wide due to the storage of hoists and other moving and handling equipment. There were also no handrails to support those who were able to mobilise independently which would be required to aide their movement as people's eye sight failed due to their dementia. Toilets, bathroom doors and doors leading to communal areas such as the lounge and dining room did not always have pictorial signage to make identification easier for people.

The manager was aware of the need for providing alternative means of storage and had identified looking at the environment was an area she wished to focus time to improve once she was established in her role.

We recommend that the provider seeks advice and guidance from a reputable source about developing a more dementia friendly living environment.

People were assisted by staff who received a thorough and effective induction into their role. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. New staff were required to complete an induction which followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. All staff had undergone training in areas such as, safeguarding, Mental Capacity Act, food safety, health and safety, infection control and moving and handling. A majority of this training was repeated annually to ensure staff skills remained current. Nurses were also afforded opportunities to further their training by being supported to undertaken mentoring courses and training in Cardio Pulmonary Resuscitation. All staff and nurses were supported by the provider to seek additional training allowing them to continue to further their knowledge and for nurses to retain their professional accreditation to remain registered nurses.

People were assisted by care staff who received support in their role. There had been a short period of time prior to the inspection where not all staff had received their latest quarterly supervision and annual appraisal. This has been identified during a recently completed quality control audit by the provider. The new manager had already ensured that there were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. Staff told us they were able to speak to their colleagues, the manager and the regional director at any time if they required

additional support of guidance.

Supervisions were also provided on a group basis or individual basis as soon as it had been identified there was an operational need to discuss matters. We saw that group supervisions had been conducted when it had been noted housekeeping staff had been changing their working hours without seeking prior approval. This had meant that there were limited housekeeping staff available to meet people's environmental needs. Other individual supervisions had occurred as a result of a medicines error so that lessons were learned and the incident would not be repeated. Processes were in place so that staff received the most relevant and current knowledge and support to enable them to conduct their role effectively

People's freedom was not unlawfully restricted without the appropriate authorisation being sought. 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 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. The manager and nurses showed an understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications and authorisations.

Records showed that decision specific mental capacity assessments and accompanying best interest decisions were made in relation to a number of aspects relating to people's person care and wellbeing. Staff were able to describe when a best interest decision would be most appropriate. Best interest decisions are made when someone no longer has the capacity to make a specific decision about their life or care. We saw that best interest meetings had been held for people when they no longer had the capacity to agree to a certain course of action involving their care. This included documenting and recording decisions that people had verbally agreed or a best interest decision had been made. This included the use of bed rails for people being supported in their bed to ensure their on-going safety.

Consent to care and care plans were agreed with people, their relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves. This process included involving those with a POA in assessing people's care needs before moving into Ashcombe, in regular care plan reviews and assisting in making best interest decisions. These meetings were held when people's physical and mental wellbeing were at risk of deteriorating due to the person not being able to provide their consent to a certain aspect of care. People were supported to have their views known and the provider ensured those with appropriate POA were involved in all aspects of people's care.

People and relatives were mainly complimentary about the food provided. One person told us about the food, "It's good", another person said about the food, "(It's) very good, I only like a small portion, (there are) a couple of things provided". A relative told us that their family member had eaten a limited diet before moving to Ashcombe which had not been sufficient to maintain their health or wellbeing. However since moving to the home, this relative told us, "He's eating, they do a special puree food for him and he's eating more and he's able to eat a few other things now".

People were supported to enjoy their meals at the time and pace appropriate to their needs. Observations showed that lunch was unhurried and relaxed, staff were supporting people to eat safely. The home's dining room was unable to accommodate all the people living in the home which meant a number of people were supported in the lounge area adjacent to the dining room or their rooms where preferred. When people stated that they did not wish to continue or had not eaten much of their meal staff sought alternatives from the main menu of two choices or other items the chef could make such as scrambled eggs to try to encourage these people to eat.

Staff came down to eye level to help the interaction with people to offer support whilst assisting them to eat. People were also provided with specially adapted weighted cutlery where appropriate to enable them to retain their independence and minimise the assistance they required from staff to eat. Squash and water were available in people's rooms with snacks available with biscuits and tea on frequent offer.

The chef was aware of people who had specific dietary needs such as diabetic diet, those who required a pureed or soft diet and people's personal preferences. We could see that care had been taken when presenting pureed food so that it retained an appetising visual appeal and was separated on the plates to allow people to identify what they were eating. The chef had worked at the home for over nine years in various kitchen roles before becoming the chef and knew the residents well. They had found out people's likes and dislikes to ensure that meals could be prepared to meet their specific needs and preferences.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of potential illness could be identified by regular review of people's risk assessments and care plans. Where people had difficulty eating or swallowing, speech and language therapist's assessments had been requested and completed. We could see that this advice was reviewed on a monthly basis to ensure it continued to meet people's needs or whether further assistance or guidance would be required.
One assessment completed confirmed the home was providing food in the appropriate format to meet that person's specific need. Where it was identified that people were at risk of losing weight the home sought appropriate guidance, meals were fortified, people's food and fluid intake was monitored and documented and people were weighed monthly so their progress could be assessed. At the time of the inspection no one living at the home was on a food or fluid chart as people had been supported to eat and drink sufficiently to ensure they regained and maintained their nutritional and hydration needs.

Specific and clear guidance was provided to support staff on how to manage people living with certain illness or injury for example those living with epilepsy and diabetes. Care plans provided detailed guidance for staff and showed regular healthcare professional input had been provided to ensure that people's specific health needs were managed effectively. For people living with diabetes clear and detailed guidance was provided for staff enabling them to quickly and effectively recognise when someone was at risk of suffering either a hyperglycaemic or hypoglycaemic episode. These are caused by the blood sugar levels in someone's blood being too high or too low which could result in serious health implications including a diabetic coma.

Care plans detailed how to recognise the signs of an impending health related issue and what action to take as soon as one of these incidents were recognised. For those living with catheters we could also see that guidance was provided for all staff on how to make sure these remained operational and how to treat any problems identified during their use in order to minimise the risk of infection for people using. Where an issue had been identified with a catheter potentially not working effectively immediate and appropriate additional healthcare professional advice had been sought to maintain this person's health and wellbeing. There was evidence of referral to and collaborative working with healthcare professionals, families, people

and staff.

Good

# Is the service caring?

## Our findings

People and relatives we spoke with told us that support was delivered by caring staff. One person told us they found the staff, "Lovely". A relative told us "Yes, (staff are caring) 100%...they're professional in the way they do their job, they're funny and interact". Another relative told us, "The staff they have here are super, they're all very good".

Professional, compassionate and caring relationships with people had been developed by staff. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans also included information and guidance for staff when interacting with people who were not always able to clearly verbally communicate. This included using non-verbal gestures and care plans documenting that staff should 'support people by taking a slow, loving and reassuring approach' to assisting people. We could see that staff followed this guidance and took time greeting people using their preferred name, talking about their families and their participation in recent activities as well as giving people the additional time and support to express their needs.

Staff knew the people they were supporting because most plans included information about what was important to them such as their family relationships and what help they required to support them and when. People's care plans included a 'Personal outcomes' which were attached to each area of a persons identified risk including personal hygiene, elimination and continence and pain plans for example. These documented the level of support and the outcome that the person wanted to achieve from the support they received. For example one person's personal outcome stated that they wished to be supported with their personal care helping them to achieve their expected standards and to be happy and comfortable. These assisted staff by enabling them to have an understanding of people's needs, preferences and what they wanted to achieve as a result of receiving care. We could see that these desired outcomes were known and people were supported in the way they wanted. We could see for example that people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked. Care plans provided staff with a detailed insight into people's wants and needs which we could see were followed during the inspection.

Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and previous work lives. Conversations between all staff including maintenance, housekeeping and activities staff, with residents showed a personalised knowledge of people and their lives and were lively, comforting and engaging.  All staff in the home took time to engage and listen to people. Staff spoke fondly of the people they supported and were able to discuss how they had developed relationships which had also been intellectually stimulating. These conversations and relationships involved staff and people sharing their own knowledge and experiences to enhance people's interests in subjects such as religion for example. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and to respond appropriately.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Staff were able to evidence they knew how to support people when they were experiencing a period of a low mood. Staff told us they had the time to be able to spend with people if they were feeling sad or upset. All the staff we spoke with were able to describe how they would support people in a caring way giving people the time and reassurance they required until they were no longer feeling unhappy.
We saw that on people's birthdays effort was made to ensure that a family party atmosphere was present in the home. Immediately following the inspection a Scottish Morning was being held at the home to celebrate one person's birthday. A bagpipe player was due to attend to provide people with some organised music to help this person celebrate with music they knew and recognised. We saw that staff were encouraging people to attend the following morning to ensure that an enjoyable experience was held to celebrate this persons special event.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people to engage with them. When communicating with people staff would lower themselves to eye level to ensure that people were engaged in conversation. Staff would also often gently place a hand on people's arms to communicate that they were to be engaged in conversation. We saw that people were comfortable and actively support this physical contact with staff.

During a lunch time sitting we observed one person starting to become upset as they did not want to eat their meal. A member of staff responded appropriately by reassuring them and holding their hand telling them that they were alright. This calmed the person who was then happy to try another menu choice which was offered. People were supported by staff who knew how to respond appropriately to people's emotional needs.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear, eat and drink and where they would like to spend their time.

People told us they were treated with respect and had their privacy maintained at all times. Staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. People's care plans provided specific guidance on how to support people in a way that was mindful and respectful of people's dignity which was followed. We saw that when people were being hoisted in a public area a towel would be placed over the knees of ladies being moved so as to preserve their dignity. Staff were seen to ask people before delivering or supporting with the delivery of care. The last completed resident and relative customer survey from 2015 asked the question, 'Are residents treated with kindness, dignity and respect', 100% of the respondents agreed that this was as true and accurate reflection of the action taken by staff at Ashcombe.

Good

# Is the service responsive?

## Our findings

Where possible people were engaged in creating their care plans. Where people were not able to engage in creating their care plans staff ensured that other people with a close relationship, interest and knowledge of the persons wellbeing were actively involved. This included people identifying friends and or relatives who they wished to participate in contributing to the initial assessment and the planning of the care provided. These individuals were also then involved in reviewing the care and as when necessary, one relative told us, "We're very pleased so far (with the care provided) we're kept up to date (when things changed)". Another relative told us, "Completely (involved in planning care), we were all involved, it was a group effort".

People's care needs had been assessed and documented by the nursing or managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met. People's individual risk assessments were reviewed monthly to ensure that any changes in people's needs were identifying in a timely manner and updated where appropriate. This regular updating ensured that care plans provided the most current information for staff to follow.

Peoples overall care plans were then reviewed approximately twice a year. People, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. One relative told us, "(As a family) we're involved in the reviews, they're ongoing here and when needed". When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. Records showed that during one review it was identified that they required additional support to meet their physical needs. This had resulted in healthcare professional advice being arranged and appropriate actions and equipment being sought to aid this person to remain comfortable.

Where reviews identified a change in situations which presented a new risk to someone's wellbeing this was appropriately documented. For example, during a monthly review it was established that a person was starting to exhibit signs they were experiencing a low mood. The persons care plan was updated to reflect the new medication and guidance provided by the GP. This was subject to continual and more regular reviews which showed a further change in this medication as staff had identified it had not been meeting their needs. This was accompanied by updating this person's care plan so that appropriate guidance was provided to keep this person safe and maintain their wellbeing. People were receiving care which was reviewed regularly to ensure it remained relevant to their needs.

Handover between staff were held at the change of shift. These were held between the nurses who then shared this information with care staff. The handover contained specific and detailed information in relation to people's needs such as their moving and handling needs and any changes in health such as new medication. Staff told us this was a useful process enabling them to have all the information they needed in order to provide the most current care and support required. People were supported by staff who knew their health needs and ensured that all members of staff responsible for their care were aware of any changes in the physical or mental wellbeing.

We could see that the provider actively sought to engage people in meaningful activities to keep people occupied. The home had a dedicated full time activities coordinator who ensured that a range of activities were available for people to participate in. The activities coordinator had worked previously as a member of care staff at the home which meant they knew people and their particular social interaction needs well. Staff spoke highly of the activity coordinator and their ability to provide opportunities of interest for people, one member of staff told us, "Yes, yes, they have (enough meaningful activities ) because we have (activities lady) we bow down to her she does a great job and involves everybody."

Activities offered in the home included internally provided events and outside volunteers and acts to interest people, the home also sought to involve family members in activities provided. Recently completed and planned activities for the month of the inspection included, quizzes, Zumba exercise glasses, hairdresser and manicure sessions, bingo, movie times, visiting musical acts and cooking sessions.

Most of the people and relatives we spoke with talked positively of the activities that were available to participate in however not all wished to participate. A 2015 resident and relatives questionnaire was completed and when people were asked '(does the home) Offer a range of activities to suit residents needs' 94% of people responded positively that there were. A positive comment was made stating, 'Activities are great for my brother'.

Care plans detailed people's particular social interactions and guidance was provided on how to support them to participate. Care plans also detailed people's hobbies and previous enjoyments to help staff to encourage people to participate in as broad a range of social activities as possible. One person's care plan stated that they enjoyed being sociable, having their nails painted and hair set each week as well as taking part in as many activities as possible. During the inspection we noted that this person was being encouraged to participate in the activities they had expressed they enjoyed.

The home also invited volunteers to assist in providing additional activities for people. During the inspection local young adults from a local college participating in a National Citizen Service Volunteer scheme were visiting the home. They were actively involved in preparing the garden for people to enjoy using money they had raised to plant roses, helping people to receive manicures, encouraging people to play puzzles and reading books with them. Where people did not wish to participate in activities staff sought ways to keep people entertained. We heard a singing session with a member of staff and a person upstairs who did not wish to participate in the group activity. When activities had occurred the activities coordinator sought to update and inform people's family of the activities they had joined in with to show they remained active. Photographs taken during group interactive sessions and those involving external performers were placed in people's rooms. These acted as a reminder to people of the activities they had participated in and enjoyed and to inform relatives the activities which had been provided should they wish to join in future.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were not always aware of the provider's complaints policy but were confident they could speak to staff or the manager to address any concerns.

Complaints made in writing and verbally received were documented and recorded in an Issues and Concerns folder in the manager's office. There had been three formal complaints and one informal complaint received since the last inspection. The informally received complaint had been documented and investigated by the registered manager at the time to show transparency in their investigations. Records showed that on each occasion the complaint was investigated fully, long term actions documented and take. The complainants then received full responses within a matter of a few days or making their original complaint. When responding with the investigative updates of complaints complainants were reminded

that if they were unhappy with the findings to the investigation they could escalate their complaint to the regional director, nominated individuals or to external agencies such as local authorities.

Good

# Is the service well-led?

## Our findings

At our last inspection on 19 and 28 May 2015 we found the service was not fully meeting the legal requirements relating to Regulation 17 (Good Governance) of the Health and Social Care act 2008 (Regulated Activities) 2014 (HSCA). The provider had not ensured that documentation relating to people's care plans were always accurately and contemporaneously completed.

At this inspection we found that the provider had followed the action plan they had implemented to address the shortfalls in relation to the breach described and the service met the requirement of the regulations. Documentation relating to people's care was accurately and contemporaneously completed and reviewed to ensure the guidance provided to staff was the most current available.

The service did not have a registered manager in post. The previous registered manager left the location four months before the inspection. As a result the provider had temporarily placed additional management support in place to provide direction and leadership to the service whilst recruiting for a new manager commenced. The new manager had been in post two weeks prior to the inspection and was in the process of becoming registered with the Care Quality Commission (CQC).
Whilst newly in position the manager was in the process of providing strong leadership and was fulfilling their role as a manager. They had already implemented robust procedures to ensure that staffing levels were subject to continual and weekly review by a variety of methods. These included checking people's dependency needs with the deputy manager each week to ensure that these were accurately documented. They had also sought feedback from staff about their time as manager at the home to enable them to provide honest and constructive feedback about what they wanted from their new manager.

The new manager wanted to promote a relaxed, caring and happy culture at Ashcombe where staff treated people living at the home as their own close family members. This aim was going to be underpinned by providing a homely environment. The manager was aware that the building required updating in areas including appropriate storage to be found for equipment which was stored in communal corridor areas to promote the homely feel for people.

People we spoke with had been confident in the previous registered manager's ability to manage the service and address concerns. Where relatives had spoken to the new manager they felt their concerns had been listened to and acted on appropriately. People and relatives told us they were happy with the quality of the service provided. One person told us, "It's good here", another person said, "It's very nice here". A relative told us, "We're very pleased so far, we're kept up to date (with changes)" and another relative said, "To be honest I don't think (there's anything the service could do better), it's really good".

Staff were not always aware of the provider's visions and values for the service. However all were able to describe how they felt care should be delivered with dignity and respect and a person centred way placing the person and their preferences at the centre of all action taken to support them. This was evidenced in the positive comments received from friends and family members of those who had lived at Ashcombe.

The manager wanted to be a visible presence to people, relatives, visitors and staff. Their office was situated at the front of the home by the entrance which meant they were easily seen by visitors and people living at the home. This allowed visitors and people living at the home to easily approach them when needed. The manager also wished to make themselves available to people and staff by completing a daily walk of the home. These walks were going to be completed to see if there were sufficient levels of staffing to meet people's needs and to interact with people, staff and those visiting the home.

Staff and people told us that whilst they had not all met the new manager that they were all happy and willing to raise any concerns they had with her. Staff told us that they were all open and honest with each other and were able to provide and receive feedback about their roles in a positive way. This meant when incidents had occurred feedback was provided in an immediate way which allowed for any reoccurrence of the original issue would be minimised.

The manager was able to evidence that they knew what was required of their role. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We use this information to monitor the service to ensure they respond appropriately to keep people safe. The manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance. The manager was also open and receptive to feedback provided during the inspection process and took immediate action to address and provide full and immediate feedback of actions taken. This included updating and reviewing training systems to ensure the information was accurate and providing detailed responses to questions raised during the inspection. The manager was keen to demonstrate strong leadership and had already asked some staff for feedback on how they had performed during their first week. She was keen to instil confidence in staff by leading by example, assisting with personal care if required and making sure through supervision and appraisal processes staff felt valued. Time was required to ensure that the manager's ability to provide strong leadership was effective and sustained in practice.

The quality of the service people experienced was monitored through regular care plan reviews and by the use of anonymous surveys completed by an external agency asking people to rate their happiness with the quality of the service provided. These surveys were conducted annually and the results reviewed by the provider to see where improvements could be made. The results from the 2015 survey were viewed. People were asked to rate the home in areas including, whether they and their relatives were happy living at the home, if they were satisfied with the overall standards of care and if people treated people with kindness, dignity and respect. The survey identified that all the majority of people who responded had done so. The provider actively sought feedback from people living at the home, their friends and family. This was in the form of. The provider actively sought feedback from people and saw this as a way to improve the quality of the service provided.

The provider also completed a number of quality assurance audits at the home to monitor the service provision. Audits were required to be completed on a regular bi-monthly basis by the regional director with additional themed reviews and audits conducted in medicines for example when it felt a need had been identified. These gathered evidence of compliance with the regulations from a range of sources which included auditing of documentation and speaking with staff and people receiving the service.

When these audits identified areas for improvement the actions were recorded and monitored for completion to ensure that the home was meeting the providers identified standards. The actions identified were placed onto a Central Action Database with a date for completion as well as an owner who was responsible for ensuring this compliance. This was visible from manager level through to directors and the provider and regularly reviewed to ensure that actions, when identified, where completed in accordance

with the time scales provided.

The last audit had been conducted by the operations manager in July 2016 identified that not all staff had received their appropriate supervision. This audit also identified that there was a need to increase the number of housekeeping hours to ensure that infection control standards were maintained. Steps had already been taken at the time of the inspection to rectify these areas with a documented system put in place to ensure all staff received supervisions at the appropriate frequency. The manager had in the two weeks they had been at the home themselves identified that more housekeeping hours were required. As a result they had already scheduled a budgeting meeting with the provider to discuss. The provider and manager had audits in place which were used effectively to identify areas where improvements could be made of the quality of the service provided.

Staff identified what they felt was high quality care and knew the importance of their role to deliver this. Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the manager, all staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.