

Coate Water Care Company Limited

Ashbury Lodge Residential 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 unannounced inspection took place on 15 and 16 August 2018.

Ashbury Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 44 people in one adapted building. At the time of our inspection 42 people were residing at the home. Accommodation is arranged over two floors which are accessed via a lift or stairs. There is a small garden to the front of the building and parking available.

At our last comprehensive inspection in May 2017 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not always obtained the appropriate consent from people and the care plans required improvement. We issued one requirement notice and a warning notice. We returned in November 2017 to do a focused inspection to check if the required improvement had been made. At that inspection we found enough improvement had been made to address the immediate concerns but further improvement was needed.

At this inspection we found the required improvements had been completed and therefore we have rated the service as 'Good' overall.

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.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. Staff had received Mental Capacity Act (2005) training and told us how it applied to their work.

People had their support and care needs assessed before moving to Ashbury Lodge. This information was then used to start an individual care plan. Care plans contained a good level of information that was clearly detailed, personalised and reviewed regularly. The service used an electronic care planning system which required an individual log in and password. This made sure information was held securely.

Risks had been identified, assessed and the most appropriate measures put in place to keep people free from avoidable harm. Risk assessments were reviewed monthly or sooner if needed.

Staff were trained in different topics and could ask for further training if they felt it was needed. Staff told us they felt supported and could approach the senior management at any time.

The service followed safe recruitment practice and all required pre-employment checks had been completed. There were sufficient staff deployed to meet people's needs.

People were protected from potential abuse from staff who were aware of the different types of abuse and when to report any concerns. Staff were confident appropriate action would be taken. People told us they felt safe at the service and knew where to go to report or raise any concern.

Medicines were managed safely as safe systems were in place to order, store, administer and dispose of medicines. Staff were trained to administer medicines and followed safe practice. Where appropriate people were referred to healthcare professionals. The service worked in partnership with a range of professionals such as GP's, district nurses and dieticians.

People had a choice of meals and where needed staff provided people with support to eat and drink. Mealtimes were relaxed and unhurried. Snacks and drinks were provided throughout the day.

There were activity workers in place who took the lead on providing activities at the service. People were able to participate in events based around their interests and abilities.

People and their relatives told us the staff team at Ashbury Lodge were kind and caring. We observed many positive social interactions between people and staff. Staff knew the people they were supporting and there was evidence of a mutual respect.

Complaints were well managed and documented. Where any lessons needed to be learned this was shared with staff and discussed. Team meetings were held regularly and there was a daily heads of department meeting.

End of life care was provided and people could record their wishes in their care plans. Where needed the service worked with other healthcare professionals to make sure people were comfortable and pain free.

The team worked closely with dementia specialists to improve the care and support provided. A dementia consultant was retained who provided guidance, advice and training on dementia care.

Quality monitoring systems were in place. Audits were completed across a range of areas to monitor the quality and safety. Action plans were produced and reviewed by senior management to make sure the required improvement was completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

There was sufficient staff deployed to keep people safe.
Recruitment practice was safe to make sure only suitable staff were employed.

Medicines were managed safely. Staff had been trained to administer medicines and assessed to ensure competence.

Risks had been identified and assessed. Appropriate safety measures were in place to keep people safe.

The premises were clean and staff were observed to use good practice in relation to infection prevention and control.

Is the service effective?

Good ●

The service was effective.

Staff received training in a range of areas to make sure they had the skills to meet people's needs.

The service worked within the principles of the Mental Capacity Act (2005) to make sure people were supported to make decisions.

Referrals were made to various healthcare professionals where needed. People were supported to maintain good health.

People's nutritional needs were catered for and monitored by staff at the service.

Is the service caring?

Good ●

The service was caring.

People and their relatives told us the staff were kind and caring. We observed many positive social interactions between people and staff.

Independence, choice and dignity was promoted by staff who

recognised people's rights.

Where people had difficulties communicating, staff used different approaches to engage with people.

Is the service responsive?

Good ●

The service was responsive.

People had their needs assessed prior to moving into the service. This information was then used to develop a care plan.

Care plans were detailed and reviewed on a regular basis. Where additional monitoring of needs was required this was completed and recorded.

Activities were available and organised by activity workers.

Complaints were well managed and recorded in full. There was an easy read complaints procedure and people told us they knew how to complain if needed.

Is the service well-led?

Good ●

The service was well-led.

Meetings were held for people, relatives and staff. Minutes were available and records kept of action taken.

People were encouraged to give feedback. This was used to make changes and improve the service provision.

Staff told us there was a visible and approachable manager in post. People and their relatives told us they thought the service was well-led.

Quality monitoring systems were established and completed across the service. Any actions identified were kept under review by the senior management.

Ashbury Lodge Residential 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.

This inspection took place on 15 and 16 August 2018 and was unannounced. The inspection was completed by two inspectors, an evidence review officer and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider is required to send us by law about events that happen at the service. We also reviewed the information included in the provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people, seven relatives, the registered manager, operations manager and 11 members of staff. We were able to speak to three healthcare professionals during our visit and contacted a further three following our inspection.

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

We looked at six care and support plans, four recruitment files and a range of other records related to the management of the service which included quality audits, accident and incident reports and complaints records.

Is the service safe?

Our findings

At our last comprehensive inspection in May 2017 we found the service required improvement in the key question of safe. This was because people's risk plans did not always contain enough detail to guide staff to provide the required support. At this inspection we found the required improvement had been made.

People told us they felt safe at Ashbury Lodge. Comments included, "Everything about the place makes me feel safe", "You don't get anything bad happening" and "There's always someone to help and they listen to you."

Risks to people's safety had been identified and assessed. People had risk assessments in a range of areas such as moving and handling, skin integrity and choking. Where people had been identified as being at risk, appropriate safety measures had been put in place. For example, one person had been assessed as being at risk of choking. They had been referred to the speech and language therapist who had identified a specific diet. The safety measures were recorded and the information was included in the person's care plan. We checked with staff who supported this person what their diet was and they were all able to tell us the correct specific diet. Some people had been prescribed a thickening agent to reduce the risks of choking. Thickeners can be added to food and fluids. We observed that staff used thickeners safely and in accordance with people's guidelines. Risk assessments had been reviewed monthly or sooner if needed.

Behaviour support plans were in place to give staff clear strategies to use where behaviour could be a concern. These were personalised and written sensitively. One person could become anxious at times when being supported with personal care. The strategy for staff was to use singing and encourage the person to sing with them. Staff told us they used this approach and found it helpful. Another person would only accept support with personal care when they chose. This meant that at times they were in their nightwear all day. The behaviour support plan recorded this and gave staff simple steps to use when this person was ready to accept support with personal care. These strategies aimed to reduce the incidents of distress caused to the person.

The service had risk assessments for other areas of the service. Each person had a personal emergency evacuation plan in place to support staff to help people out of the building safely in the case of emergency. There were regular safety checks carried out by the maintenance person and external contractors. Records were kept with safety certificates where appropriate. Fire alarm systems were checked weekly. We noted there were occasional gaps in the records when the maintenance person was on leave. We raised this with the registered manager during our inspection. They confirmed they would put a system in place to carry out checks in the absence of the maintenance person. The service carried out regular fire drills so that staff could practice the action they would take in the event of an emergency.

There were safe systems in place to order, store, administer and dispose of medicines. Unit leaders and senior care assistants who had undertaken medicine management training were responsible for the administration of medicines at the service. Records seen indicated that after initial medicines management training, staff undertook annual refresher training that included a competency assessment. The quantity of

medicines received from the pharmacy was recorded and signed for on the person's medication administration record (MAR).

Medicines were stored in appropriate secure medicine trolleys which were kept in locked storage rooms. The temperature of the storage room was recorded daily and those reviewed were within acceptable limits. Any medicines returned to the pharmacy were recorded in log books. We observed staff administering medicines and their practice was seen to be safe. There were no gaps in the MAR's seen which meant people had received their prescribed medicines. Some MAR sheets contained handwritten amendments. We saw that two members of staff had signed these amendments which reduced the risk of transcribing errors. Individual protocols for the use of 'when required' (PRN) medicines were available. These gave staff clear guidance on when to administer PRN medicines.

There was a system in place for the recording of prescribed topical medicines, such as creams and lotions. Topical medicine application recording sheets (TMAR) had been signed by staff following application. There were also body maps available which guided the staff to know where on the body to apply specific creams.

During our inspection we observed there were sufficient staff deployed to meet people's needs. The registered manager told us they used a 'whole home approach'. This meant that all staff regardless of their role were involved in supporting people at key times such as mealtimes. We observed the 'whole home approach' and saw that staff such as maintenance worker, administrator and the registered manager were on hand to support people. Staff told us people could at times need one or two more members of staff. We discussed this with the registered manager who said they used a dependency tool which guided them to deploy safe numbers of staff. People and their relatives told us they felt there were sufficient staff on duty. Comments included, "There are plenty of carers about", "Always someone around" and "If you want help you only have to ask and they [staff] are there for you."

Staff were recruited safely as all the required pre-employment checks had been completed. All staff had a disclosure and barring service (DBS) check prior to employment. A DBS check helps employers to make safer recruiting decisions and prevents unsuitable staff from being employed. The service had obtained references from previous employers, a full employment history and an identity check.

Staff were provided with training on safeguarding and knew the different types of abuse. They told us the signs they look for and how to report any concern. All the staff we spoke with would not hesitate to involve external agencies such as the police if needed. Staff were aware of the whistleblowing procedure. Whistleblowing is a process where staff report any suspected wrongdoing at work.

Prior to our inspection we had received a number of concerns about unpleasant odours present at the service. We had shared these concerns with the registered manager. During our visit to the service we did not find any unpleasant odours were present. The service was clean throughout and there were cleaning schedules in place for staff to follow. We observed staff use personal protective equipment appropriately such as gloves and aprons. Good practice such as handwashing was observed. Staff encouraged people to wash their hands where appropriate such as before their lunch.

We observed the fire evacuation information displayed next to fire alarm points differed from that displayed for relatives on the noticeboard in the foyer of the home. The information by the fire alarms stated that people should evacuate the building and assemble in the car park. The information on the notice board stated that relatives and residents should close the doors of their rooms and stay there until instructed by staff. The fire procedure for staff was to assemble by the fire panel in the home and await instruction. The manager and maintenance person were informed of this finding and said that they would consolidate the

information on display without delay.

The service had been inspected in April 2018 by an environmental health officer from Swindon Council who had awarded the kitchen a 'five' rating. This meant that the kitchen had very good hygiene standards. Records demonstrated that staff completed food hygiene training.

Records seen indicated that staff were aware of how to report accidents and incidents. Those seen were fully completed and had been reviewed by the registered manager. Accident reports were generated monthly and reviewed by the registered manager to look for trends or repeat occurrences. Where incidents had occurred, the team aimed to learn from these situations and put measures in place to prevent re-occurrence. For example, the service had experienced some medicines errors. Whilst this had not caused harm to people the staff reflected on actions to try to improve the processes. The registered manager told us, "We learn as a team, there is no blame culture, we need to discuss and put into place measure to prevent things happening again."

Is the service effective?

Our findings

At the previous inspection in May 2017 we found the service required improvement and a requirement notice was issued for concerns relating to consent. At this inspection we found the required improvement had been made.

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 be as least restrictive as possible. We found the service was working within the principles of the MCA. Assessments of capacity had been completed where appropriate, where people lacked capacity best interests' decisions had been made involving relevant people and professionals. Staff we spoke with had received training on the MCA and could tell us how it applied to their work.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The service had applied for appropriate DoLS authorisations and kept a DoLS register. This enabled the registered manager to keep track of applications. A number of applications had been made to the local authority and were awaiting approval. Where they had been granted the registered manager had notified us and met any identified conditions.

People told us they enjoyed the food at the service. Comments included, "The food is brilliant", "After I had an operation they gave me special food, I never had to ask", "I won't starve in here", "They always make something you like, I've never gone hungry" and "I love the puddings."

People had a choice of food and there were specialised diets provided for people where needed. People ate their meals where they wanted to, some chose the dining areas, the lounges or in their rooms. Food looked appetising and there seemed to be plenty available. Dessert was presented on a trolley so people could see the options. Snacks and drinks were available in communal areas so people could help themselves. Outside of the mealtime people were also offered hot and cold drinks, cakes, fruit and biscuits.

Staff supported people to eat where needed. We observed staff sat down next to people and offer encouragement. This support was given at a relaxed pace, the mealtime experience was not rushed at all. Staff knew people's needs and provided them with the appropriate crockery and cutlery. This was done discreetly to maintain people's dignity. For example, one person wanted to eat with their fingers. The staff gave them food in a bowl which enabled them to do this in a dignified way.

People's needs were assessed in line with best practice guidance to make sure the service was effective in meeting their needs. For example, the service used a Malnutrition Universal Screening Tool (MUST) to assess people's needs in relation to nutrition. People who were nutritionally at risk were referred to their GP and the dietician. The kitchen had an up to date list of people who had been assessed as being at risk. The chef

told us they provided these people with a fortified diet. This is a specialist diet that aims to increase the calorie intake for people who need to gain weight.

People were referred to healthcare professionals appropriately. Records demonstrated that there had been visits from professionals such as GP's, physiotherapists and district nurses. Where this was needed referrals had been timely. One healthcare professional told us they felt there was good communication between them and the staff. They said the staff were very proactive about reporting concerns about people's health. They described the staff as "helpful and receptive" saying that staff took on board their advice. They gave an example of how they had noticed an improvement in relation to people's skin integrity following introduction of skin care routines using topical creams.

Where people's well-being and behaviour had caused concern, the service referred them to the care home liaison team. This is a service that aims to support care homes to improve care, maintain people to stay in their current home and prevent unnecessary hospital admissions. They supported people at the service to improve outcomes. They assessed people's needs and advised on medicines. The care home liaison team comprised of professionals that specialised in dementia care. They were supporting one individual at the service whose behaviour had caused concern. The care home liaison team were working with the person's GP to make sure their medicines were appropriate.

The provider also employed a specialist dementia nurse in a consulting role. They were working with the staff to assess people living with dementia and advise on appropriate support needed. They had encouraged and supported the staff to use nationally recognised assessment tools such as the Cohen-Mansfield Agitation Inventory and the Abbey Pain Scale. Both are observation assessment tools to record people's well-being and behaviour.

A senior carer showed us the work they had completed using these assessment tools. They told us they found them useful and had improved outcomes for people. For example, one person who was not able to communicate their needs easily was at times agitated. The senior carer told us they used the Abbey Pain Scale which indicated the person may be in pain. They involved the person's GP who prescribed pain relief. The senior carer re-assessed the person using the Abbey Pain Scale which showed the person was still experiencing pain. They asked the GP to visit again, they increased the dose of the pain relief. Another assessment demonstrated this person's well-being had improved indicating the correct level of pain relief.

Training was available to staff which covered a range of topics such as moving and handling, first aid and fire training. Dementia training was provided by healthcare professionals who were specialists in dementia care and support. One healthcare professional told us, "The staff are skilled to be able to work with people with dementia." Staff told us they enjoyed this training. One member of staff said, "I have been here 18 years and still learn all the time. I enjoy the training we have particularly the dementia training, there is so much to learn."

There was regular opportunity for staff to have supervision. This is a process where staff could meet with their supervisor and discuss any concerns, training needs or good practice. Staff told us they felt well supported and found supervision beneficial. One member of staff said, "I have regular supervision which I use to look back at what I have achieved." Another member of staff said, "I find supervision supportive, I can ask for guidance and then get the support I need."

The environment was bright and homely. There was good signage to help people find their way around. At the time of our inspection people had their own rooms, however there were larger rooms which people could share if required. There was a small garden area where people could sit and enjoy the outdoors. There

was a large conservatory which was a quieter space for people to enjoy.

Is the service caring?

Our findings

People told us they were happy living at Ashbury Lodge. Comments included, "I am very happy here", "I enjoy the banter and jokes with the staff, that is what makes it feel like home here" and "It's absolutely lovely here". Relatives told us they thought their family members were happy living at the service. One relative said, "It would be difficult to find any complaint."

People and their relatives thought the staff were caring. We heard comments such as, "The staff are lovely people", "I think the staff are very well chosen, they don't seem to do it for their salary, they do it because they love it", "The staff are 100% kind and caring", and "I don't think there's a person here I don't like from the top to the bottom." One relative told us, "The care [relative] gets is wonderful. The staff provide loving care which I find very comforting. They always listen to me and they report daily how he is." One healthcare professional told us, 'I have always found the staff passionate, compassionate, available and person centred'.

We observed staff were respectful, kind and treated people with dignity. Staff called people by their preferred names, communicated what they were doing, they sat and listened to people and knocked on people's doors before going in rooms. Staff gave us examples of how they maintained dignity when supporting people with personal care. They told us they made sure doors and curtains were closed, covered people with towels so people did not feel vulnerable and they approached people discreetly when offering support. People told us they were treated with kindness, dignity and respect. One person told us, "I've never found anyone angry, they [staff] have a lot of patience, never rude or cross." One relative told us, "They are very respectful to [relative] and us."

Every morning the service operated a 'stop at 10' system. This was a process recently introduced to encourage staff to spend time with people. With a morning cup of tea or coffee all the staff stopped what they were doing and sat down with people to talk to them. We observed this system on both days of our inspection and saw positive social interactions. The registered manager told us they had introduced this system to encourage staff to think about people's social needs. They hoped that it would send the message to staff that it was ok to stop and talk to people, it was encouraged and part of their roles.

There was a 'resident of the day' system. This was a system which identified a different person to be 'resident of the day'. The registered manager told us that this system worked well at the service and had been embraced by people and staff. When a person was 'resident of the day' all the heads of department checked with the person the information they had was correct. This enabled people to be involved in reviewing their care plan and checking with the kitchen what their dietary likes and dislikes were. The maintenance person checked with people that their room was as they wanted it, if not changes could be made. As part of this system staff were encouraged to find out five new things about people. This information was then built into people's life history or care plan to be shared with all the staff.

People from different backgrounds and cultures were supported by a diverse team of staff. One relative told us, "My [relative] was polish, staff learned a bit of polish, they were very patient and tried to communicate

with them."

People could choose what gender of care worker they wanted to support them with their personal care. The registered manager told us if people specified a particular gender then this was recorded in their care plan. For example, if a person had requested female staff only this was recorded and staff made aware.

Nobody at the service needed an advocate but there was information available about advocacy services if needed. Advocates could act as a representative for a person if they needed help voicing their views, making decisions or protecting their rights. People were supported to be independent as much as possible which they valued. One person told us, "They [staff] never rush me and I like to feel independent." The registered manager said they had identified that some people wanted to be able to do their own washing. In order to maintain people's independence in this area the service was looking to install a small domestic washing machine.

The service had received compliments about the care provided from relatives. One relative had written, 'Thank you for all your caring and kindness looking after my wife'. Another relative had written, 'We would like to express our sincere thanks for the care and support given to [relative]. Special thanks to [staff] who showed care and compassion as well as respect'.

Is the service responsive?

Our findings

At our comprehensive inspection in May 2017 we found that care plans required improvement. As this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we issued the provider with a warning notice. We returned to the service in November 2017 to check the required improvement had been completed. We found the service had improved care plans to meet Regulation 17 but further improvement was required.

At this inspection we found the improvement had continued so care plans were personalised and contained all the information staff needed to support people. The registered manager or a senior carer would complete a pre-admission assessment prior to people moving into the service. This assessment was the start of the person's individual care plan. There was a photo of the person in their care plan. Photos we viewed were of people smiling and they were recent. Information was available about people's medical history and a range of needs such as mobility, nutrition, skin care and sleeping and resting.

Information was detailed and written in a personalised way. It gave staff clear direction about what the person's needs were and how to meet those needs. Mobility care plans included what equipment was needed and how many staff were required. Nutritional care plans recorded whether the person was at risk, and the importance of showing the person options so they could choose what to eat. Skin care recorded what risk people were at developing pressure ulcers and how staff were to support the person to minimise risks. For example, one person scored high risk on the pressure ulcer development risk assessment. In the person's care plan, it recorded the specialist mattress the person had and the topical creams staff were to apply.

A summary of people's needs was available to staff in people's rooms on a 'pen profile'. This was a one-page summary of people's needs, their likes and dislikes. We observed the 'pen profiles' were stored on the back of people's wardrobe doors so they were not immediately visible. The registered manager told us this one-page summary gave staff an overview of people's needs. They said this was particularly important for new or agency staff who might not have had an opportunity to read the full care plan.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. This was checked and the service was found to be meeting this standard.

People's communication needs were recorded in care plans and where needed aids that helped. For example, if people had a hearing impairment and required hearing aids this was recorded. Where people required specific strategies to help them communicate and understand information this was recorded. For example, one person who had dementia required a hoist to mobilise at times. The care plan recorded the strategy for staff to use to communicate with them about using this equipment. It stated that one member of staff was to take the lead and communicate clearly. We observed this person being supported using the hoist and saw staff adopted this strategy which worked for the person.

Information could be provided to people in a variety of formats. If people required a larger font this could be arranged and pictorial information could be provided where appropriate. The service had an easy read complaints procedure to help people to understand this process. People were aware of how to complain if needed. One person told us, "I haven't a bad word to say about anything and I would speak up if I needed to." When we asked them if they knew how to complain they confirmed that they did.

There was a complaints log in place which recorded all complaints received and actions taken. Complaints had been recorded with copies of any investigation and correspondence. The registered manager also noted if the complaint was upheld, not upheld or upheld in part and the reasons why.

At our last focused inspection in November 2017 we found activities provided at the service required improvement. The registered manager told us they were going to recruit a second activity worker. This recruitment had taken place so the service now had two activity workers. This had helped to improve the activity provided.

The service used the Pool Activity Level (PAL) instrument which is a widely used framework to provide activity for people with dementia. This framework identified what type of activity would be beneficial for people. For example, some people would benefit from a sensory based activity, or an exploratory or planned activity. We observed that people had their PAL on the wall in their room which outlined their needs and what activity would best suit.

Activities were planned and there was a timetable in place. Feedback about activities was mixed but overall people were happy with what was provided. Comments included, "We do exercises, not often enough, but they do help", "We don't have many entertainers coming in but I like the activities" and "We have lots of things going on." People told us they had been out on trips to the theatre, garden centre and shopping.

To improve the activity provision at the service the registered manager had encouraged all the staff to become involved. During our inspection we observed the activity worker, care staff, maintenance worker and chef involved in activity with people. For example, the chef encouraged one person to help them ice some cakes. The person engaged in this activity with support from the chef and clearly enjoyed themselves. We observed group activities provided by the care staff. People were encouraged to keep active during a game. Encouragement was provided and there was a lot of laughter heard.

The registered manager told us they encouraged staff to think about how they could turn all tasks into activity for people. They told us staff were encouraged to involve people in activities such as laying tables for meals, folding laundry and gardening. One person told us, "They give you things to do like laying the table. You are made to feel useful." There were two small birds in a cage in one lounge. People were involved in caring for them, providing them with food and drink. We observed people were clearly fond of the birds and spent time watching them and talking to them.

People had the opportunity to record their wishes for their end of life care in their care plans. This ranged from who they wanted present, to simple requests such as making sure they had their treasured belongings. Where appropriate the service involved healthcare professionals to make sure people were comfortable and pain free. One relative told us, "I was really happy with the end of life care provided to [relative]. Whenever I visited staff were sat with them, holding their hand, that is what they wanted." They went on to tell us that the district nurse had been involved and supported the service with pain management.

Relatives had written to the service to thank them for the end of life care provided. One relative wrote, 'Would like to thank each and every one of you who cared so well for [relative]. We want to tell you how very

much we appreciated all you did for them especially at the end'. Another had written, 'I can never thank you enough for all the care and attention you showed [relative]. Your patience and extreme kindness, he was so well looked after'.

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well-led and there was a lovely atmosphere. Comments included, "The [registered] manager is very good. She has some wonderful ideas for the residents and the home" and "It is well managed and you can feel a good atmosphere here" and "I think it's a very good care home."

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. The registered manager was employed as a general manager and worked at two of the provider's care homes. Prior to the inspection there were two registered managers at Ashbury Lodge. One had left the service leaving one in post. The provider informed us they were in the process of recruiting another registered manager. This would make sure the service had continuous management cover.

Staff were clear about their responsibilities and role and told us they thought the service was well-led. Comments included, "The [registered] manager is lovely, there to listen to us, they are supportive and understands", "The [registered] manager is approachable and I feel able to talk to her", "If the [registered] manager is not here we have got good seniors" and "I find the management very supportive, I can ask them any questions at any time." Prior to our inspection we had received information that there was not always management cover at the service. We did not find any evidence to substantiate those concerns. The registered manager told us there was two unit leaders that were knowledgeable and demonstrated good leadership skills. They were available if the registered manager was not. One relative told us, "They have done wonders over the past seven months; the senior carers are just like trained nurses. They're wonderful."

Staff told us they enjoyed working at Ashbury Lodge and morale amongst staff was good. Comments from staff included, "I love it here it is a nice place to work", "Ashbury Lodge is a homely place" and "I love the work I do, the residents are lovely and we [staff] all get on." The registered manager told us that morale had been low but the provider had made some changes which had improved communication. For example, there were now regular staff meetings and regular supervisions. The registered manager told us they encouraged an ethos of inclusion rather than a 'them and us' culture. They always reminded staff they were working in a person's home therefore it should be treated as such.

Staff from different countries told us they felt welcome at the service and felt part of the team. One member of staff said, "There is good teamwork here, we help each other, I feel welcome and have never been excluded." There were regular opportunities for staff to share their views and discuss concerns. Team meetings were held regularly for all the team. One member of staff told us, "You can give ideas and then see the changes, that is good."

The registered manager told us they received support from the provider. In addition to their own supervisions they were able to attend regular managers meetings with other registered managers. This gave

them the opportunity to gain support from their peers and share good practice.

The management recognised the need to continuously improve at the service. The registered manager told us they were always open to trying new ideas and making improvement. For example, a recent initiative was for night workers to wear pyjamas to work at night. The registered manager told us this was to support people living with dementia. If a person woke in the night it would be reassuring for them to see others in pyjamas rather than a uniform. The service had plans to improve the garden space to introduce some plants to support sensory experiences.

The service gained feedback from people and their relatives in a variety of ways. The chef told us they asked people their views every day about the food and used that to produce menus. They recorded this feedback in their kitchen log book with action taken. One person told us, "The chef always chats to us to find out whether we are happy."

In the front reception there was a suggestions box which anyone could use to write comments and leave for the service. The provider used surveys to formally gather feedback from people and relatives. There were also regular resident and relative's meetings which were open to all. One person told us, "I like to hope the service listen to me, so far I think they totally listen to me." People were able to voice their opinions and make changes. At a residents meeting people requested that pink wafer biscuits be made available daily. This request was respected.

The registered manager told us there was a group of volunteers from a local college who visited the service to help with decoration. For example, recently they had visited and helped to paint the summer house and garden fence. The service liaised with local schools and encouraged visits from children. The registered manager hoped to develop this relationship and encourage people to visit the children in school. The service worked in partnership with various healthcare professionals and other services to make sure people had access. Services that regularly visited were a chiropodist and a local hairdresser. There was partnership working with the local authority quality monitoring team. They had recently visited and produced a report with no actions required.

Quality monitoring was completed at provider and service level. The operations manager visited at least monthly to complete monthly management audits. They also completed themed audits which focused on a specific area of practice for example, medicines audits. All the actions raised were recorded in the service continuing improvement plan. This enabled the provider and the registered manager to maintain an overview of improvement required and monitor when actions were closed. In a recent medicine audit it was raised that 'as required' medicines protocols for staff required review. This action was shared with the senior care staff who had completed the reviews. Observations of practice during mealtimes were regularly completed by a variety of people to gain objective views. For example, a volunteer had completed one recently which gave the service a different point of view about the dining experience.

There was a daily 'flash' meeting in the morning. This was a brief meeting with all heads of department to communicate information such as events, complaints, incidents and accidents, admissions or healthcare professional visits. This process made sure all departments communicated with each other to meet daily needs. We observed a meeting and saw all staff present could raise and discuss any concern.