

Silverdale Care Homes Limited

Ashbourne House Nursing Home

Inspection report

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17 February 2016

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an unannounced inspection, which took place on the evening of 15 and 17 February 2016. We last inspected Ashbourne House in July 2015. At that inspection the service was rated as 'requires improvement'. We made four breaches in regulation identifying where improvements were required in relation to the effective monitoring of the service, staff training and development, accurate records to show sufficient staff available and information to be notified to CQC where people had been deprivations of liberty. The provider sent us an action plan following the inspection telling us how they intended to address the action required. During this inspection we looked to see what improvements had been made.

Ashbourne House Nursing Home is based in Middleton and is registered to provide accommodation and nursing and personal care for up to 29 older people. Accommodation is provided on two floors, accessible by a passenger lift. The home is on a main road, close to public transport and the motorway network. There is a small parking area to the front of the property or on road parking. At the time of the inspection there were 17 people living at the home.

The service is managed on a day to day basis by the registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We identified five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

We found systems were not in place to demonstrate all areas of the service were monitored and reviewed. Records about people's care were not maintained in full providing an accurate record of when people received the care they needed.

Although the overall system in place for managing oral medicines was safe, the inadequate administration of prescribed skin creams placed people at risk of harm.

The provider could not demonstrate that appropriate action had been taken to address the work required on the 5 year electrics check to ensure the system was safe and people were protected from harm or injury.

People's care monitoring charts were not always clearly dated to show that people were receiving the care and support they require.

Opportunities for people to participate in a range of activities needed enhancing to meet the individual needs of people. We have made a recommendation about the type of opportunities made available to people to promote their well-being and encourage their independence.

Recruitment procedures did not address all areas of the homes policies and procedure ensuring detailed information about the suitability of candidates was gathered. We have made a recommendation about the provider referring to good practice guidance so that they system in place is robust and helps keep people safe.

We were aware that there were two on-going safeguarding investigations in relation to Ashbourne House. Policies and procedures were in place to guide staff in safeguarding people from abuse and whistle blowing. Staff spoken were aware of what to do if they were concerned about people. Whilst those staff we spoke with said that training had been received, training records showed that some staff required up to date training in this area. This training is important to help staff recognise signs of abuse and know what action to take where necessary.

Some opportunities for staff training and development were provided. Staff spoken with confirmed they had completed some training and felt supported by the manager. However systems to monitor the completion of training was not effective as we found some staff required updates in training.

We found the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People's care plans contained enough information to guide staff on the care and support required. Records showed that risks to people's health and well-being had been identified and plans to reduce or eliminate the risk were put into place. We saw people were supported to access health care professionals, such as GP's, community nurses and dieticians so their current and changing health needs were met.

Suitable arrangements had been put in place to support people where additional needs had been identified. People told us and we saw that sufficient staff were available to respond to people's needs. People's visitors were complimentary about the staff and the care and support offered to their family member. Staff were seen to be polite and respectful towards people, offering assistance when needed.

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We saw that food stocks were good and people were able to choose what they wanted for their meals.

A programme of redecoration and refurbishment was in place to enhance the standard of accommodation and facilities provided for people. Hygiene standards had been improved; minimising the risks of cross infection.

The registered manager had a system in place for reporting and responding to any complaints brought to their attention. People's visitors told us the manager and staff were approachable and felt confident they would listen and respond if any concerns were raised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service did not always ensure people were kept safe.

Medicines were not managed safely as there was no clear evidence available to show how often and where, prescribed topical creams were to be applied. There was also no accurate recording of when prescribed 'thickeners' were given.

Action had not been taken with regards to the unsatisfactory electric circuits report ensuring people were kept safe. Other checks to the premises and equipment had been completed and suitable arrangements were in place with regards to infection control and fire safety to help minimise the risks to people.

People were cared for by sufficient numbers of staff. Recruitment checks were completed prior to new staff commencing work. Staff training and procedures were available to guide staff on safeguarding people from abuse.

Care records showed that risks to people's health and well-being had been identified and plans had been put in place to reduce or eliminate the risk to people.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Some opportunities for staff training and development were provided. Staff confirmed they had completed some areas of training and felt supported by the manager. However systems to monitor the completion of training by staff were not as effective as they should have been as we found some staff required updates in training.

Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure relevant authorisation was in place.

People were provided with a choice of suitable food ensuring their nutritional needs were met. Relevant advice and support had been sought where people had been assessed as being at nutritional risk.

Requires Improvement ●

A programme of on-going redecoration and refurbishment was being completed to improve the standard of accommodation offered to people.

Is the service caring?

Good ●

The service was caring.

People's visitors spoke positively about the care and support offered by staff. People at the end of their life and their families were said to be cared for in a sensitive manner.

We saw staff were kind and respectful when interacting with people and were seen to offer reassurance and assistance when people needed help.

People's records were stored securely so that people's privacy and confidentiality was maintained.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care monitoring records were not always clearly dated to show that people were receiving the care and support they required.

We found people were offered occasional activities. Further opportunities for people could be explored so that more meaningful opportunities are provided helping to promote people's health and mental wellbeing.

Effective systems were in place for reporting and responding to people's complaints and concerns.

Is the service well-led?

Requires Improvement ●

The service was not well-led.

Systems to effectively monitor, review and improve the quality of service provided were not robust so that people were protected from the risks of unsafe or inappropriate care and support.

The manager had notified the CQC as required by legislation, of all incidents, which occurred at the home to demonstrate how people were kept safe.

The manager was registered with the Care Quality Commission (CQC). People spoke positively about the new manager and the improvements being made within the service.

Ashbourne House Nursing 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.

Before the inspection, we had been made aware of two current safeguarding investigations, which were of concern to ourselves, partner agencies, and relatives. This incident had resulted in significant media attention. We also reviewed information sent to us by the local authority infection control team and considered information we held about the service, such as notifications received from the registered manager, eight safeguarding concerns and whistle-blower information from four people.

This inspection took place on the 15 and 17 February 2016 and was unannounced. Two adult social care inspectors visited during the evening of the 15 February 2016 so that night staff could be spoken with and night routines explored. Three adult social care inspectors visited the home on the 17 February 2016.

During the inspection we spent time speaking with one person who used the service, the relatives of seven people, a visiting practice nurse, two nursing staff and six care staff, chef and domestic worker. We also spoke with the provider, registered manager and a consultant involved with the service. Immediately following the inspection we received feedback from four other visitors through our 'share you experience' forms and the Greater Manchester Fire officer who had recently inspected the home.

As most people living at Ashbourne House Nursing Home were not able to clearly tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed the support provided during the lunchtime period.

We looked at the environment and the standard of accommodation offered to people as well as five care records, six medication administration records (MARs), eight topical/cream administration charts, ten personal hygiene/ positional turn charts, four staff recruitment files and training records as well as information about the management and conduct of the service.

A completed PIR was provided prior to our inspection in July 2015. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. These are requested on an annual basis. Therefore we did not ask the provider to complete a further PIR prior to this inspection.

Is the service safe?

Our findings

We spoke with one person about living at the home. They told us they felt safe, adding "Staff are always popping in to see if I'm alright." People's visitors also told us; "If it hadn't have been for Ashbourne my relative would have been in a sorry state"; another said they felt reassured their relative was being looked after.

We looked to see how the medicines were managed. We checked the systems for the receipt, storage, administration and disposal of medicines. We also checked the medicine administration records (MARs) of five people who used the service. In addition we checked the 'topical/skin cream administration charts' (known as cream charts) of six people who used the service.

We found the medicines were stored securely. The medicines were kept in a locked trolley in a locked medicine room and we were told that only the registered nurses had access to the medicines. We looked in the controlled drugs cupboard and saw that no controlled drugs (CDs) were in use. A discussion with the registered nurse (RN) and inspection of the MARs confirmed this. CD's are very strong medicines that may be misused. We saw that money was being stored in the CD cupboard. The Nursing and Midwifery Council (NMC) Standards for Medicine Management state that the CD cupboard must be dedicated to the storage of controlled drugs. No other medicines or items may be stored in the controlled drug cupboard. The RN removed the money whilst we were present.

The RN informed us that the medicine keys were, at all times, kept with the nurse on duty and were not given out to anybody else. We did see that the controlled drug key (marked CD) was kept separately from the medicine keys in a key box in the medicine room. There was no explanation given for this apart from the registered manager telling us that was what they had always done. The NMC Standards for Medicine Management state that the registered nurse should know at all times the whereabouts of the CD keys. This is not possible if they are not on their person. The RN attached the CD key to the other medicine keys that they held whilst we were present.

We saw there was a medicine management policy and procedure in place. The RN informed us that they had undertaken training in relation to medicine management in the last three months.

We saw that appropriate arrangements were in place for ordering and receiving new medicines. There was also a safe system in place to dispose of medicines that were no longer needed.

We checked six MARs and found they showed that people were given their oral medicines as prescribed, ensuring their health and well-being were protected.

We saw that people's prescribed creams were stored in individual boxes in the locked medical room. We were told by the RN that sometimes the RNs applied the creams and sometimes it was the care staff. We were told that the care staff would ask the RN for the cream, apply it and then record on a 'cream chart' that it had been applied. The six cream charts we looked at showed that the care staff applied the prescribed

creams. Of the five MAR's that we looked at only one of them had prescribed topical creams and it was recorded on the cream chart that it had been administered by the care staff.

We were told that the care staff who applied the creams had been trained to do so. Records showed that medication training was provided for all staff. Staff spoken with said they had been told what to do by the nursing staff.

We looked at two boxes of creams and saw that the instructions were 'apply topically as directed' and 'apply topically when required'. There were no further instructions and no body maps attached to either the MARs or cream charts to show where the creams were to be applied or how often. The RN told us that they would refer back to the GP and /or the pharmacist for precise instructions.

We looked at six of the cream charts that were filled in by the care staff. Four of the charts stated apply twice daily with no instructions as to where to apply the cream. The records showed the prescribed creams were not consistently applied twice daily; they were, in the main, applied daily. The RN was not able to tell us who had prescribed the frequency of the cream applications. Medicines must be administered accurately in accordance with a prescriber's instruction. As no clear evidence was available to show how often the creams were to be applied and staff failed to follow the directions that were in place, this placed the health and welfare of people at risk of harm.

We saw that some people who used the service were prescribed 'thickeners'. Thickeners are added to drinks, and sometimes to food, for people who have difficulty swallowing. They may help to prevent a person from choking. Although staff we spoke with were aware of how much thickener was to be added to the persons' drinks, there was no accurate recording of when the thickeners were being given. It is important that staff record when a thickener is given to ensure that people are given their medicines as prescribed.

We found that medicines were not managed safely. This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

The medication policy and procedure included a policy on the covert administration of medicines. Covert medication is the administration of medicines in a disguised form, usually by administering it in food or drink.

One of the MARs we looked at showed that the person was given their medicines covertly. We saw that the home had obtained consent from the person's GP for this to happen. The registered nurse told us this had been discussed with staff, family and the GP and was considered to be in the person's best interest to give their medicines covertly. This helps to protect people against the risks of not being given their medicines whilst at the same time safeguarding them against the risk of abuse.

We looked at what systems were in place in the event of an emergency. We were told that a recent inspection had been carried out by the fire officer from Greater Manchester Fire Service. We contacted the fire officer who confirmed a visit had taken place. They said, overall fire safety was well managed and the registered manager was aware of her responsibilities. We saw up to date servicing of the emergency lighting, fire alarm and fire equipment. There was further evidence of individual personal emergency evacuation plans (PEEPs). This information assists the emergency services in the event of an emergency arising, helping to keep people safe. Training records showed that fire training had been provided. Some staff required refresher training.

The service had a business continuity plan. On examination this was a generic document and not specific to

Ashbourne House. Immediately following the inspection the registered manager sent us an updated plan. This contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or mains failure so that steps were taken to keep people safe.

We asked the registered manager for certificates to show the equipment and services within the home were examined and maintained in accordance with the manufacturers' instructions. We saw up to date checks in portable appliance, hoisting equipment and passenger lift. We found there was no up to date check with regards to gas safety held on site. Immediately following the inspection a copy of the up to date report obtained from the provider.

We saw the 5 year electric circuit's check had been completed in July 2015. This report was 'unsatisfactory' and action was required. We asked the registered manager for evidence that this had been addressed. We were told this would be followed up to check relevant work had been completed. As there was no clear evidence to show appropriate action had been taken to address the electrical faults, this potentially placed the health and welfare of people at risk of harm. This meant there was a breach in Regulation 15(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's care records to see how identified risks to the health and well-being were managed. The care records we looked at contained risk assessments. These were in relation to assessing risks if the people had problems with certain aspects of their health, such as a history of falls, anxiety and agitation, a need for support with moving and handling, being at risk of developing pressure ulcers or poor nutrition. Staff had written down what action they would need to take to reduce or eliminate any identified risk. We saw that people's weights were monitored regularly. The records we looked at showed that people's weights had remained fairly stable. The relative of one person we spoke with said they had previously raised concerns about their relative losing weight. Adding, this was acted upon; an action plan was put in place and additional supplements were provided.

The two care records we looked at in relation to the people who had fallen on several occasions showed that risk assessments and preventative care plans were in place to help to eliminate or reduce the number of falls. We saw that a record was kept of any falls that had occurred. On a third file we saw a risk assessment for self-harm. Information had also been detailed in the person's care plan about how the behaviour may present, circumstances that may cause anxiety and known triggers. This information should help staff understand and reduce the risk to the person. We were told and saw that staff provided one to one support for this person so that any concerns or changes in behaviour could be dealt with quickly.

We looked at the system in place to safeguard adults from abuse. Policies and procedures were in place with regards to safeguarding, whistle-blowing and confidentiality. Information on how to contact CQC and the local authority were included in the safeguarding policy.

We were aware of an on-going investigation being completed by the local authority in relation care and treatment of one person. We are also aware of an incident involving two staff, which had received media attention which is still the subject of investigation by the local authority.

The registered manager was a trained trainer in safeguarding adults and provided training to the team in addition to an on-line safeguarding training course. A check of training records showed that of the 27 staff, 18 had completed up to date on-line training. There was no information for nine staff to show when they last completed this training. This training is important to help staff recognise signs of abuse and know what action to take where necessary. Seven of the staff we spoke with during the inspection confirmed they had completed the on-line safeguarding training and when asked were able to demonstrate their understanding

of the policy and procedure and knew what to do if they witnessed or suspected abuse taking place.

During this inspection we looked at four staff personnel files to check how the service had recruited members of the team. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The registered manager said the company administrator carried out checks of all the nurses' registration with the Nursing and Midwifery Council (NMC) twice a year to ensure they remained authorised to work as a registered nurse.

Recruitment files also contained an application form, copies of the person's identification, written references, contract of employment and job description. We noted on one file there were no dates of employment and there were no interview records on two of the files we looked at. This did not comply with the home's policy and procedure, which stated 'It is a requirement that for each interview a strategy is implemented to test applicants, and that these tests are carried out and recorded'. These records help to demonstrate that those people appointed to work at the home have been assessed as having the qualities and skills required for the role. We recommend the service considers current good practice guidance in relation to robust recruitment practice so that only suitable candidates are appointed to work at the service.

We asked the registered manager about checks carried out when using staff from outside agencies. The registered manager told us and records showed that relevant information had been received confirming recruitment checks and completed training of agency workers. This helps to protect people from being cared for by unsuitable staff.

At our last inspection we identified that rota's did not accurately reflect the numbers of staff available to meet people's needs at all times. During this inspection we checked the staffing arrangements. We spoke with staff and visitors to the home, looked at rotas and spent time observing the support provided. Rotas identified sufficient numbers of staff were available; this included where agency staff had been utilised. We saw that a nurse and five care staff were provided during the day, with a nurse and three care staff at night. In addition to the care team there were designated kitchen, domestic, laundry and activity staff.

We were informed that two people, as part of their agreed package of care received additional 1-2-1 support from staff due to their specific needs. We were told the nurse in charge would allocate two hourly sessions to care staff on duty that day to provide this support. This was confirmed by the care staff we spoke with.

All the visitors and staff we spoke with felt there were enough staff were available to support people. One night staff member said, "If anyone rings in sick, the manager would call other staff to cover, if not then agency would be called", adding "We never run short". The relative of one person told us, "There's always staff present in the lounge".

We looked at how hygiene standards were maintained within the home. We found the home to be clean, tidy and free from malodours. We were told designated laundry and domestic staff were responsible for completing the laundry and cleaning of the home.

We spoke with the domestic about their role. We were told and saw records to show daily cleaning schedules for bedrooms as well as checks to mattresses. Lounges, dining room, bathrooms and corridors were also cleaned daily. In addition there were monthly schedules for the deep cleaning of bedrooms, curtains washed, slings checks and carpet cleaning. The provider also told us that sanitising equipment had been purchased, which helped when carrying out a thorough clean of rooms.

Staff had access to and were seen wearing protective clothing, such as; disposable gloves and aprons when carrying out personal care duties. Hand-wash sinks with liquid soap and paper towels were in place in all areas where personal care and support was provided. We also saw red and yellow bags, used for the management of soiled or clinical waste were also available.

We looked at the laundry, which was small and comprised of one washing machine and one dryer. We were told to minimise the risk of cross infection between dirty and clean clothing, clean clothes were taken to people's rooms and put away. Laundry staff said they had completed infection control training in 2015. Training records showed that training in infection control and health and safety were provided as part of the training programme.

Prior to the inspection we were informed that the service had been inspected by the local authority health protection team in November 2015. The service achieved 92% compliance.

Is the service effective?

Our findings

At our last inspection we found staff had not completed training relevant to their role. During the inspection we looked at further training opportunities that had been provided for staff.

The registered manager told us they had completed train the trainer courses in nine areas. Courses included; moving and handling, safeguarding, food hygiene, infection control, dementia, nutrition, medication, equality and diversity and fire safety. The registered manager said she completed refresher training each year so that she was able to deliver the programme of training for staff. We were also told staff also had access to distance learning and vocational training in health and social care. It was identified on the training record that staff were expected to complete all areas of training on an annual basis. Staff spoken said they had regular training and felt this was sufficient to support the needs of people. However systems to monitor the completion of training by staff were not as effective as it should have been as we found some staff had not completed annual updates in training as set out by the provider.

We saw information to show a one day dementia training day was planned for all staff the week following the inspection. This was to be facilitated by staff from the Outreach Team. This service offers advice and support to care providers with regards to the specific needs of people living with dementia.

One nurse we spoke with, who was newly qualified, said they had recently attended training in relation to the use of syringe drivers and another nurse was due to attend training with the NHS on tissue viability. We were told that at the time of our inspection nurses were not treating anyone for pressure sores, catheter care or at end of life.

Staff spoken with confirmed they had completed training in moving and handling, dementia awareness, fire safety, infection control, safeguarding, breakaway techniques and diabetes. One staff member said they had also attended an external course in end of life. Two visitors we spoke with commented on the support from staff. One person said; "I feel staff have the knowledge and skills needed". Whilst another added; "Some staff have different levels of competence".

We spoke with one member of staff who had recently been employed to work at the home as a night carer. They told us as part of their induction they had spent time shadowing existing staff. This included both day and night shifts so they had an opportunity to meet with people and develop their understanding of people's support needs before going on the rota. They said they had also completed moving and handling training with the registered manager. A second staff member said they too had shadowed existing staff on commencing work. The agency care worker on duty during the inspection told us that the nurse had shown them around in the morning and introduced them to the people who used the service. They said they worked with other staff when moving people or supporting them with personal care.

We saw the provider had introduced the care certificate booklets. The Care Certificate, developed by Skills for care and Skills for Health is a set of minimum standards that social care and health workers should apply to their daily working life and should be covered as part of the induction training of new care workers. We

saw a matrix and information on staff personnel files which showed booklets had been distributed to staff.

We were told by the night nurse and care staff that handovers were completed at each shift change. This discussion involved nurses and care staff and a record was completed. We saw evidence of the handovers which recorded brief information about people's well-being, general observations or changes. This was to ensure people's current and changing needs were properly communicated.

Staff spoken with said team meetings were also held, providing them with further opportunities to discuss their work and any issues or events within home. One staff member said, "We have them every couple of months". A review of records showed a number of meetings had taken place, the last one being November 2015.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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 registered manager provided information to show that applications to deprive people of their liberty had been made to the relevant supervisory body (local authority). These had been made for all 17 people living at Ashbourne House.

We saw on one application that a condition had been made as part of the DoLS. We discussed this with the registered manager, who said that the matter had been addressed.

People, where able, and their relatives were involved in making decisions about the care and support they needed. We saw a 'review file' where phone calls and conversations with families had been recorded. These had last been completed in September 2015. People's relatives told us they were consulted when any decisions needed to be made. One person's visitor said, "The manager is good and always helps me to understand my relative's issues".

We saw that training in MCA and DoLS was provided as part of the training programme for staff. One staff member we spoke with said they had not yet completed the training but gave us examples of how they would offer people choices where possible. This training is important and should help staff understand that where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure their rights are safeguarded. We were told the pocket books in MCA and DoLS had been ordered for all staff to help them understand the procedures.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. Two visitors felt the food provided was good and said that they too were offered refreshments when visiting. The relative of one person was seen having lunch at the home and said that they had joined their relative for Christmas dinner at the home. Another person commented, "The food is home cooked freshly each day".

We looked at the kitchen and food storage areas and saw good stocks of fresh, frozen, dried and tinned food were available. The chef told us that food was always available out of hours; staff we spoke with confirmed that this information was correct. We saw records were maintained with regards to temperature checks to food, fridges and freezers as well as daily and weekly cleaning schedules.

We looked at the four weekly rotating menus. They showed that the meals provided were varied and nutritionally balanced and that people had a choice. We saw that the main meal was served in the evening with a lighter meal at lunchtime. One person told us the food was not too bad, adding, "You get 3 meals a day."

We saw good interactions between people and staff at lunch time. Staff asked people what they wanted and were offered an alternative if they did not want the choice on offer. People were encouraged to eat their meals themselves however those people requiring support were assisted by staff. Staff were seen chatting with people they supported and we found the atmosphere at lunchtime was calm.

Where people had specific dietary needs, such as a soft diet, this was provided. A discussion with the chef showed they were knowledgeable about allergens in food and any special diets that people needed. The chef was also aware of how to fortify foods to improve a person's nutrition.

Staff we spoke with said that arrangements would be made to support people to attend appointments or in the event of an emergency. We were told contact would initially be made to the person's relative. If they were unable to attend then staff would always provide an escort. This helped to ensure the needs of people were communicated to other agencies so that continuity of care could be provided. The relatives of four people confirmed what we had been told.

The care records we looked at showed that people had an eating and drinking care plan and they were assessed in relation to the risk of inadequate nutrition and hydration.

Ashbourne House comprises of 29 en-suite bedrooms on two floors. On the ground floor people had access to a large lounge, conservatory and two separate dining rooms. Some bedrooms had been personalised with pictures of families and people had their own televisions and toiletries. The relative of one person told us, "Their bedroom is gorgeous; always clean and tidy".

We were shown a plan of redecoration and refurbishment exploring all areas of the home. We saw hallways had been repainted and carpets replaced. Maintenance staff were seen at the home decorating some of the bedrooms which were unoccupied.

Is the service caring?

Our findings

At our last inspection we found care practice did not ensure people living at Ashbourne House Nursing Home were treated with dignity and respect. During this inspection we spent time observing how staff offered support and interacted with people.

For those people not able to tell us about their experiences, we spent some time observing how they were spoken to and supported by care staff. We saw people were clean and appropriately dressed. When one person had clearly been incontinent, staff addressed this straightaway and assisted the person to change to help ensure their dignity was maintained. The visitor for one person commented; "I've seen staff respond to people when they call for assistance". Another person's visitor told us, "My relative is always clean and tidy". We found staff interactions were kind and respectful. We observed one staff member spoke with people in a quiet unhurried way; they explained what they were doing when offering drinks and when assisting people to move. Another staff member was seen to be patient and supportive of one person who needed lots of reassurance.

We spent time asking people and their visitors for their views about the care and support provided by staff at Ashbourne House. One person we spoke with told us, "I get on with staff". People's visitors spoke positively about their experiences and observations when visiting their family members. One visitor said this was the "best place" for their relative, adding "[relative] is really well looked after" and "I go home knowing they are well looked after". Other comments included; "Can't fault them", "Brilliant, we have no problems" and "The attitude and care from staff is good, I'm very happy".

Care staff we spoke with felt they had good relationships with people who lived at Ashbourne House and their families. We saw visitors come and go throughout the day. Visitors we spoke with told us they were always made welcome and able to visit at any time. One person felt the service was "Family orientated". Another person said, "It's very relaxed" and "Residents have a lot of freedom" and a third person said, "I visit the home and have always found the staff to be friendly and attentive to the needs of the residents". "It's always a pleasure to go there".

Due to current occupancy levels being low, all but one person was accommodated in a ground floor bedroom close to communal areas and bathrooms. Aids and adaptations were fitted throughout including handrails, assisted bathing, raised toilet seats and grab rails. This helped to promote people's independence and keep them safe.

The relatives of three people told us about their experiences when their relative was being cared for at the end of their life. Two people had other relatives living at Ashbourne House. They said staff had been caring and compassionate towards them and their relative. We were told family members were able to spend as much time as they wanted with their relative. One person told us, "Staff looked after us as well as our relative". Another person said, "Staff couldn't do enough for my relative towards the end of their life".

We saw information about people who used the service was treated confidentially. Care records were kept

in lockable filing cabinets at the nurse's desk and were easily accessible to all staff. Staff spoken with said they had access to care files and were able to read them.

Is the service responsive?

Our findings

People's visitors told us their relative's health care needs were met. People commented, "My relative is well looked after and always gets the treatment that is required" "Nursing staff are excellent and so are the care staff, nothing is too much trouble", and "Staff are good and very caring".

The relative of one person told us about the assessment completed prior to their family member moving into Ashbourne House. They said staff from the home carried out a thorough assessment of their relatives needs and had made sure equipment, such as pressure aids were in place prior to their arrival. They said there was "always a quick response" where changing needs had been identified.

We looked at five care plans; two in detail and three in relation to a specific aspect of the care provided to two people who had fallen on several occasions and one person at risk of self-harm.

The care plans we looked at in detail contained enough information to show how the people were to be supported and cared for. There was also information about the person's preferred routines and their likes and dislikes. Care records showed that their families had been involved in reviews of their care.

Information in the care records showed that the staff at the home involved other healthcare professionals in the care and support of the people who used the service. We saw evidence of visits from GPs, the district nurses, a dietician and an optician. One staff member told us they would go to the nurse if someone was not well. Adding "I look at facial expressions or they become agitated as some people can't tell you if they aren't well or in pain."

The care records also contained a 'Hospital Passport'. This contained a summary of the persons' care needs and contact details of their next of kin and their GP. This was to be used in the event of them being transferred to hospital or to another service. This helps to ensure continuity of care.

We found that several of the care monitoring charts such as personal hygiene, night time checks and pressure care records were not dated or did not include the full names of the staff who had delivered the care. To ensure that information contained in the records is relevant the records must be completed in full. Without accurate relevant records it is not possible to know if people are receiving, when needed, the care and support they require. We found this was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see what activities were provided for people. We were told there had been a change in activity staff. The designated activity worker had been in the post a couple of months. A review of the rota showed they worked each week day.

We were told various activities and events were arranged for people. Staff said the activity worker, who was on leave during the inspection, provided art and crafts, painted people's nails and did 'singalongs'. One person's visitor told us; "The families can visit all day and also get invited to events held at the home". They

told us there had been a recent Valentines party with an outside entertainer, which they and other family members had joined.

We did not see any formal activities on the day of our inspection. However one of the care staff was seen playing cards with someone and those staff in the lounge area were seen engaging with people and chatting with them; there was music on in the lounge. We found one staff member struggled to communicate with us as English was not their first language. We raised this with the registered manager and provider during feedback for them to follow up. We saw them sat with people but there was little interaction between them. It is recognised that most people living at Ashbourne House Nursing home live with dementia and were not always able or did not wish to join in any of the activities. We recommend the service considers current good practice guidance in relation to the choice of activities offered to help promote the well-being of people with living with dementia, helping to promote their involvement and enable them to retain their independence.

We looked at how the registered manager handled people's complaints and concerns. We saw information about how to make a complaint was displayed in the home. We looked at the complaints/compliments file. We saw two items had been raised since our last inspection; one complaint and one compliment. A log was made and action taken. Staff spoken with told us that any issues raised directly with them would be report to the registered manager or the nurse in charge, who would deal with the matter.

We asked people's visitors if they knew what to do if they had any issues or concerns. All the people we spoke with felt they could speak directly with staff and the registered manager. One person told us; "We've had no complaints at all". If they [the home] have brought things to our attention it has been done professionally". Another person said; "The manager is very approachable and if concerns are raised regarding my family member she always deals with them".

Is the service well-led?

Our findings

The service was managed by a registered manager who took responsibility for the overall management of the service. The registered manager was supported by the Provider and the lead nurse. During our last inspection in July 2015 we were advised that the registered manager had also taken on the role of area manager, supporting all the provider's other homes. To allow the registered manager to operate as an Area Manager, a new manager had been appointed to this home. It was intended that the new manager would become the registered manager. However prior to this inspection we had been made aware that the new manager had left the employment of the provider.

During this inspection we discussed the management arrangements with the provider and registered manager. Due to recent concerns we wanted to clarify that effective management arrangements were in place to oversee the day to day running of the service. We were told the area manager role had now been 'put on hold' and the registered manager was again working full time at Ashbourne House Nursing Home and would do so for the foreseeable future. It is an expectation of the Commission that any person registered as the manager is in day to day control of the home and works at the home on a full time basis. Any change to this should be discussed with the Commission prior to changes taking place.

We spent some time speaking with the provider and registered manager about the recent media attention following an incident at the home, which involved day staff. We were aware the provider had taken immediate action following the disclosure and had notified the CQC and local authority. The provider had also met with family members to advise them of the action taken and discuss any concerns they may have. People we spoke said they had no issues or concerns about the attitude and conduct of the remaining staff. Each of them, whilst upset about events, felt the provider had dealt with the matter promptly and offered reassurance. Comments received included; "Nothing but praise for how it was dealt with" and "Two bad apples, spoilt it for others".

We spoke with eight staff about recent events and whether they had witnessed poor practice. None of the staff we spoke with were aware of any issues or had witnessed anything. One staff member said they were "really upset and disappointed". Another said that it "came out of the blue" and they "couldn't believe it". All the staff we spoke with said they could speak with the registered manager if they had any concerns and were confident that she would take action. One staff member said they could also go to the clinical lead or provider if the manager was not available.

We asked the registered manager and provider about the action they had taken. They told us that relevant policies, such as safeguarding, whistleblowing (the reporting of unsafe and/or poor practice), social media, confidentiality and code of conduct had been in place prior to the incident and staff were aware what was expected of them. Following the incident the registered manager and a consultant working for the provider were meeting with staff to reinforce the policies in place and what was expected of them. Staff spoken with confirmed these meetings had taken place. We saw records to show seven staff had signed to say they had read the code of conduct for nursing and healthcare workers and adult social care workers in England.

At our last inspection we identified that improvements were needed to demonstrate that effective monitoring of all areas of the service was carried out. We saw some information to show that checks had been completed, such as care reviews, the environment, mattress checks and medication. Audits needed developing in other areas however, such as care records and staff training and development.

During this inspection we looked at how the management team monitored and reviewed the quality of service provided. We were told the provider had brought in a consultant to help the registered manager identify shortfalls in the service and implement any improvements needed. They told us they had identified where some improvements could be made. We were told these focused on current and future work priorities, work relationships, care records, policies and procedures and staff training needs.

We asked the registered manager to show us what audits were completed. We saw 'area manager audits' had been completed in March and June 2015. These explored the environment, medication records, a review of accidents and incidents, pressure sore prevention, infection control and supervision of staff. Prior to this the registered manager had completed a 'manager quality assurance assessments', which explored areas of care and support, the home and staffing. We saw this had been completed up to January 2015, however had stopped when the registered manager took over the responsibility of area manager. We saw evidence of other checks being completed including a monthly falls analysis, audit of catering arrangements, infection control procedures and medication. There was also a redecoration and refurbishment plan outlining the improvements being made to the home.

We found systems to monitor the completion of staff training were not effective as some staff required updates in training in line with the home's annual plan. Recruitment records did not include all information as detailed in the home's policy and procedure and care records were not kept accurate or complete. We saw there was a 'daily manager walk around sheet'. This included checks to communal areas, laundry and where people were being cared for in bed a check to see if they had call bells in place and if fluids were in reach. We saw records to show these had been completed up to December 2015. However they had not been completed during 2016. We were also told the registered manager and provider had carried out spot checks, however the purpose of the visits and their findings were not formally recorded. This information helps to demonstrate staff practice is monitored and where necessary poor performance is quickly addressed.

Opportunities had been provided for people's visitors and staff to feedback on the service provided. We saw feedback surveys had been last been distributed to people's relatives in June 2015, however the response was poor. We also found that telephone reviews carried out with family members had last been carried out in September 2015. Staff spoken with said team meetings were held as needed, but were not on a regular basis.

Without clear and effective monitoring of the service people's health and well-being may be placed at risk. This meant there was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014.

The home had detailed policies and procedures in place to guide staff. These were reviewed and updated externally and the service was alerted to any changes in legislation and guidance.

At our last inspection we identified that notifications, as required by legislation, had not been submitted with regards to people being deprived of their liberty. Prior to this inspection we reviewed our records and saw that reportable events, which CQC should be made aware of, had been notified to us.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely. This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment there was no clear evidence to show appropriate action had been taken to address the electrical faults, this potentially placed the health and welfare of people at risk of harm. This meant there was a breach in Regulation 15(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Without clear and effective monitoring of the service people's health and well-being may be placed at risk. This was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. Without accurate relevant records it is not possible to know if people are receiving, when needed, the care and support they require. This was a breach of Regulation 17 (2) (c) of the

Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.