

Bamford Care Limited

# Ashbourne Nursing 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?

Requires Improvement ●

# Summary of findings

## Overall summary

This was an unannounced inspection which took place on 18 and 19 October 2016. The service was last inspected on 27 October 2015 when we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This resulted in us making four requirement actions and two recommendations.

We received action plans from the provider that stated they would be compliant with the requirement actions by 31 March 2016. We undertook this inspection of 18 and 19 October 2016 to re-rate the service and to check they were compliant with the requirement actions.

Ashbourne Nursing Home provides accommodation for up to 41 people who have personal care needs, including those with dementia. There were 38 people living in the service on the day of our inspection. The service did not have a registered manager in place at the time of our inspection. 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. A new manager had been appointed, however they had only been in post seven weeks. They were in the process of registering with us.

During this inspection we found improvements had been made and the provider had met all the requirement actions from the previous inspection.

At our inspection of 27 October 2015 we found the service had not considered any risks the environment may pose to people who used the service, staff members and visitors. We also found that where risks associated with people's care and treatment had been assessed control measures to reduce the risks had not been identified or put in place. During this inspection we examined four care files and found improvements had been made. We saw that risk assessments had been completed for health related issues and for the environment.

Concerns raised by us at our inspection of 27 October 2015 in relation to the recording of accidents and incidents had been addressed. During this inspection we found new documentation was in place which evidenced what actions had been taken and learning from these.

We looked at all the records in relation to fire safety. We saw a risk assessment was in place, regular checks of fire systems were in place and fire drills were undertaken on a regular basis. At our inspection of 27 October 2015 we found personal emergency evacuation plans (PEEPs) were not in place for people who used the service. During this inspection we found each person within the service had a PEEP which should ensure they were evacuated effectively in an emergency situation.

All the staff members we spoke with told us they felt staffing levels were adequate to meet the needs of people who used the service. Records we looked at confirmed the staffing levels the manager told us were required daily.

We reviewed the systems and processes in place to ensure the safe management of medicines. We have made a recommendation that the service considers current best practice guidance in relation to the administration of creams.

Wheelchairs, hoists and moving and handling equipment had been serviced to ensure it was safe to use. Records showed that staff members had received training in moving and handling procedures.

Although the manager had not commenced supervisions and appraisals with staff members (as they had only been in post for seven weeks) they were able to show us a supervision and appraisal pack they had developed and were due to put in place.

People who used the service had access to healthcare professionals. We saw that people had been referred to dieticians, speech and language therapists and had access to their GP.

At our inspection of 27 October 2015 we found the environment did not suitably meet the needs of those people living with dementia due to a lack of pictorial signage. During this inspection we found improvements had been made. We saw that pictorial signs were in place to identify toilets, bathrooms, dining room and the lounge.

Bedrooms we looked at provided ample space for people to be able to personalise them. In some rooms we noted people had brought their own items of furniture, ornaments and pictures.

At our inspection of 27 October 2015 we made a recommendation that the service considered its own policies and procedures in relation to the privacy and dignity of people who used the service. This was due to people's bedroom doors being left open without documented evidence of this being agreed. During this inspection we found one person was being nursed in bed with their door open. However, this had been fully documented in their care plan as being their wishes.

Concerns were raised by us at our Inspection of 27 October 2015 in relation to pre-admission assessment and care plans. Pre-admissions assessments did not contain enough detail and care plans did not reflect personal preferences. During this inspection we found improvements had been made. Pre-admission assessments were more detailed and care plans had been re-written to reflect preferences and guidance for staff.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager.

There were policies and procedures for staff to follow good practice.

We saw there was a service user guide in place. This was given to each person who used the service and should ensure that people new to the service were equipped with a good understanding of the service and what it offered.

At our inspection of 27 October 2015 we found effective and robust systems were not in place; namely quality assurance audits. During this inspection we found some improvements had been made. We found audits had been developed and were being completed until the previous manager left. The new manager showed us a new planner they had developed to ensure audits were completed monthly going forward, commencing in October 2016.

## 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 ●

People who used the service told us they felt safe. Staff had been trained in safeguarding and knew their responsibilities in relation to this.

Moving and handling equipment throughout the service had been maintained and serviced on a regular basis. Staff knew their responsibilities to check the safety of all equipment prior to use.

Robust systems and processes were in place when recruiting new staff members.

### Is the service effective?

Good ●

The service was effective.

Staff members told us they had completed an induction when they commenced employment in the service. Records we looked at confirmed what we had been told.

Records we looked at showed a number of people within the service were either subjected to a DoLS authorisation or an application had been made to the local authority; no one was being unlawfully deprived of their liberty.

People who used the service told us the food was good and they were given choices.

### Is the service caring?

Good ●

The service was caring.

People who used the service told us staff members were kind and caring. Relatives also told us their loved ones were supported by kind staff members.

All confidential and personal information was stored safely and securely and in line with the service policy and procedure. Staff were able to explain their responsibilities in relation to confidential information.

Staff members told us they supported people to remain

independent. We observed staff members asking people if they required assistance prior to giving support.

### Is the service responsive?

**Good** ●

The service was responsive.

The service had an activities co-ordinator in place. We saw a range of activities being undertaken throughout our inspection as well as activities people had undertaken in the past.

One person who used the service told us they had needed to make a complaint once. They told us this had been dealt with to their satisfaction.

Throughout our inspection we saw staff members giving people choices such as what they wanted to eat, what they wanted to drink and where they wanted to spend their day.

### Is the service well-led?

**Requires Improvement** ●

There was no registered manager in place. Limiters in place prevent this domain being rated above requires improvement at this time.

There was a new manager in place who was in the process of applying to the Commission to register. They had been in post for seven weeks. People who used the service, relatives and staff members told us the manager was approachable and fair.

We observed the atmosphere in the service to be relaxed, friendly and happy. Singing and laughter was heard throughout both days of our inspections and there was positive banter between staff members and people who used the service.

The manager was able to tell us of their visions for the future of the service and improvements they were intending on making.

# Ashbourne 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 18 and 19 October 2016 and was unannounced.

The inspection team consisted of one adult social care inspector.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); 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. We received this prior to our inspection and used the information to help with planning.

We contacted the local authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. No concerns were raised with us.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who used the service and three visitors. We also spoke with the provider, manager, deputy manager, a senior care staff member and a care staff member.

We looked at the care records for four people who used the service and the personnel files for four staff members. We also looked at a range of records relating to how the service was managed. These included training records, quality assurance systems and policies and procedures.

# Is the service safe?

## Our findings

People who used the service told us they felt safe. Comments we received included, "Yes I feel very safe here. I am well looked after" and "Yes of course I feel safe." One relative told us, "Yes my relative is definitely safe here."

Staff we spoke with told us they had completed training in safeguarding and knew their responsibilities in relation to this. Comments we received included, "I have had training in safeguarding. If I had any concerns I would complete a form, write what had happened and take it to the manager. Then she would contact safeguarding" and "I have done lots of training on safeguarding. It is about looking after residents and best interests – reporting things as well like inappropriate behaviour such as abuse. Anything under those lines I would report straight away." Another staff member told us, "My role is to monitor the actions of others even in the sense of how they speak to other and how they act. Are they offering the service they should be? I look for signs of physical abuse, such as bruises and that is the kind of thing we would body map, paying particular attention to areas you wouldn't expect to see bruises. If I notice anything I would not only tell the manager I would act on it."

We saw from the training matrix and staff files that staff had received safeguarding training. Staff had policies and procedures to report safeguarding issues. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told staff about the types of abuse, how to report abuse and what to do to keep people safe.

The service also provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith. There had not been any safeguarding incidents at the service. Staff members we spoke with told us, "If I was in a room and I saw a colleague do something wrong I would report it straight away" and "I would report it and if I felt they had not done anything about it I would go over them and report it to someone else."

At our inspection of 27 October 2015 we found the service had not considered any risks the environment may pose to people who used the service, staff members and visitors such as health and safety or hazardous substances. We also found that where risks associated with people's care and treatment had been assessed control measures to reduce the risks had not been identified or put in place. This meant that sometimes people were not safe.

During this inspection we examined four care files and found improvements had been made. We saw that risk assessments had been completed for health related issues such as pressure ulcers, bed rails, nutrition, catheter care, moving and handling and falls. The risk assessments were completed to keep people safe and not restrict what they wanted to do. Information contained in risk assessments had been transferred to individual care plans so that staff members knew how to manage the risks. One relative told us, "My [relative] has been nursed in bed since December 2015 and they have not had one pressure sore." Staff members we spoke with told us they were aware of risk assessments. Comments we received included, "I have not written a risk assessment as yet but I go through them and make sure there are no changes" and

"Some I am aware of and some I have not read yet. We can have risk assessments for everything at the minute." Another staff member told us, "We also write them as and when required. One person wanted to go out for a walk today on his own, so I wrote a risk assessment as he is at risk of falling whilst he is out. He could then go out on his own."

We also saw risk assessments had been completed for the environment such as the building and its structure (windows, roof tiles, lighting), electricity supply, grounds and gardens, exterior features, lifts and hoists, bedrooms and portable electrical appliances. This showed the service had considered the health and safety of people using the service.

At our last inspection of 27 October 2015 we raised concerns about the amount of falls one person had sustained within the service. These falls had been recorded but actions taken as a result had not been documented. During this inspection we found this process had improved and the new manager had developed a form to accompany the accident and incident sheet to provide more details such as, treatment given, how the accident happened and action taken to prevent reoccurrence such as being checked more frequently during the night or obtaining a motion sensor. One staff member we spoke with told us, "We have an accident book and we have an additional form to fill in – they are to record more details on what has happened and if there is an injury. If there is an injury we will use the body maps." The service also had a policy and procedure in relation to accidents and a new policy on the care of someone who had suffered a fall. These were detailed to ensure that staff members knew what action to take if someone had fallen or had an accident.

At our inspection of 27 October 2015 we found people who used the service did not have personal emergency evacuation plans (PEEPs) in place. This meant that people who used the service may not be evacuated safely in the event of an emergency situation. During this inspection we looked at all the records relating to fire safety and found improvements had been made.

We found that PEEP's had been developed and were detailed. They showed the assistance and equipment needed to ensure that people were evacuated as safely as possible. For example wheelchair and two staff members were required for one person and if the person would be able to hear the fire alarm in the event of a fire situation. These were also signed by the person (where possible) to show they agreed to the evacuation plan.

Records we looked at showed a fire risk assessment was in place. Weekly inspections were undertaken of fire doors, fire alarms, fire exits, dorguards (specially designed equipment to keep doors open that automatically close when the fire alarm sounds), window restrictors and security lights. Fire drills were also conducted on a weekly basis; staff who had attended were documented to ensure all staff had been involved regularly. Emergency lighting was tested on a monthly basis. Fire control panels and fire doors were also checked on a weekly basis. The training matrix showed that fire safety training was mandatory and staff had completed this. One staff member we spoke with told us "I have completed fire safety training and we have fire drills every week where all the staff have to exit." We saw the fire procedure was on display in the entrance to the service and a fire safety policy was in place.

We saw moving and handling equipment throughout the service, such as mobile hoists. Records we looked at showed these had been serviced regularly and wheelchairs were checked monthly by the maintenance person. We observed staff using moving and handling equipment; we heard staff members directing the person on where to hold and what they were doing to encourage and support the person. We asked staff members how they ensured equipment within the service was safe to use. Comments we received included, "They get checked by an external company. They have a sticker on them when they have been checked. The



handyman checks the wheelchairs and if I see anything wrong I report it", "We have a moving and handling person that does risk assessments and gets the hoists serviced. The hoists and slings have dates on and if they don't we don't use them" and "Hoists are service every six months – stickers are on them. We always check before using any equipment and any faulty equipment is put out of service; this could be anything even in the kitchen."

Records we looked at showed that all the gas and electrical equipment had been serviced and checked. This included the fire alarm system, electrical installation, gas appliances, portable electric appliances, fire extinguishers and emergency lighting. Hot water outlet temperatures were checked to ensure they did not scald people. Windows had a suitable device fitted to prevent people who used the service from falling out accidentally and radiators were covered so they did not pose a threat to people's welfare. The service had a contingency plan in place in case of emergency, including electrical failure and gas failure. Control measures were in place for staff to follow.

We looked at the systems in place to ensure staff were safely recruited. We reviewed four staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. 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 service also had a recruitment policy in place to guide the manager on safe recruitment processes. Staff members we spoke with told us, "I had to fill an application form in and I gave two references. I had to wait for my DBS to come through before I started working. I brought my passport in as identification and had to supply a photograph for my file", "Yes I filled in an application form and provided references from school. I had to wait nearly eight weeks for my DBS to come through before I could start work" and "Part of my interview was scenario based questions and my past work history as well as competency based questions. I had to wait for my DBS which didn't take long. I then got my uniform and did two induction shifts with a bank nurse (who was a regular bank nurse in the service). I was introduced to all the systems, fire exits, alarms and had to get my documents signed off."

One person we spoke with told us, "They seem to be a bit short staffed at the moment." A relative told us, "There always seems to be enough staff."

All the staff members we spoke with told us there were enough staff on duty to meet the needs of people who used the service. Comments we received included, "Yeah there is enough staff. Things have took a really good turn with staffing", "To be honest a few staff have gone but staffing levels are alright at the minute. I get time to sit and talk to them or paint their nails. I like getting time to sit down and have a one to one with them, it is so interesting" and "Yes the staffing levels are alright at the moment. It is also about efficiency and staff dynamics can sometimes make it less efficient."

The manager told us staffing levels during the day consisted of one registered nurse and one senior care staff for the whole of the day, along with six care staff in the morning and four care staff in the afternoon. They told us that currently the night staff consisted of one registered nurse and three care staff members; however they were looking to increase this by employing a senior care staff member for nights and bringing in a 'twilight shift' (a shift which covers late evening into the early hours). We were shown a number of applications to evidence that recruitment was on-going and the manager told us they had employed a lot of new staff since they commenced in post. Also on duty were a cook, a catering assistant, a laundry person, a domestic assistant, a maintenance person and an activities co-ordinator. Rotas we looked at confirmed what we had been told and demonstrated these staffing levels were consistent.

We asked people who used the service if they received their medicines on time. Comments we received

included, "Staff always give me my medicines. I have eleven in a morning, two at lunchtime, six at tea time and two before I go to bed" and "Yes I always get them on time. I have bandages on my legs and the staff nurse is brilliant at doing them for me." One relative told us, "Yes the staff give the medicines to her and there has never been a problem. She seems better in her mind and I think this is because of the regular medicines."

We spoke with two staff members who were responsible for administering medicines within the service. They told us, "I went on biodose (type of medicines) training. I trained with another senior as well for a few weeks – just watching her and then I started with them shadowing me. We have competency checks done. I have had to do a questionnaire which had to be signed off as well" and "My role is quite different to others as I do all the ordering, the prescriptions, clerking and carrying forward. I only administer medicines for the nursing residents – I do not interfere with the senior care staff medicines as I am not responsible for them. I check all the controlled drugs and make sure everything is there."

We reviewed the systems in place to ensure the safe administration of medicines. Only registered nurses and senior care staff that had completed medicines training were permitted to administer medicines within the service. Competency checks were undertaken by the manager to ensure that staff remained competent to administer medicines. We saw the service had a medicines policy and procedure in place which provided staff members with information on the storage, recording, disposal and ordering of medicines. We saw this was available in the treatment room. Patient information leaflets were available for medicines and the service had a British National Formulary (BNF) to reference for possible side effects or contra-indications. Protocols were in place for those medicines which people were prescribed on an 'as required basis'.

We saw that there was a record of the temperatures where medicines were stored, including the fridge to ensure medicines were stored to manufacturers guidelines. There was a safe system for the disposal of unused medicines. Creams that were in use had been dated when opened. This ensured that medicines that required discarding after a period of time, such as 28 days, would be discarded appropriately and within time frames. However we found that creams were being administered by care staff but registered nurses and senior staff were signing to state they had administered them. We spoke with the manager regarding this. They assured us they would ensure that a system was put in place where only the person administering the creams would sign for them. There were also no body maps in place to show where any creams were to be placed, to ensure they were administered correctly. Again we were told by the manager that this would be addressed. We recommend the service considers current best practice guidance in relation to the administration of creams.

Appropriate arrangements were in place in relation to obtaining medicines. We saw that sufficient stocks of medicines were maintained to allow continuity of treatment. When a medicine was received into the home staff recorded the quantity received onto the MAR. Staff also recorded how much medicine had been brought forward from the previous month. This helped ensure that the medicines could be accounted for as the stock of medicines could be checked against the amount recorded as being given; thereby checking that people received their medicines as prescribed. We saw stock medicines and medicines to be returned to pharmacy were not stored in a suitable, tamper-proof container. We spoke with the manager and deputy manager regarding this and a solution was sought immediately. The manager was arranging for a cupboard already in stock to be placed in the medicines stock room so they could be stored safely. This was not completed before the end of our inspection but we have confidence in the manager and that this will be dealt with as a matter of importance.

We checked to see that controlled drugs were safely managed. We found records relating to the administration of controlled drugs (medicines which are controlled under the Misuse of Drugs legislation)

were signed by two staff members to confirm these drugs had been administered as prescribed; the practice of dual signatures is intended to protect people who used the service and staff from the risks associated with the misuse of certain medicines.

We asked people who used the service if they felt Ashbourne Nursing Home was clean. One person told us, "You can't fault the cleanliness of the place. Everywhere is lovely and clean."

Staff we spoke with knew their responsibilities in relation to infection control. Comments we received included, "I make sure I wear gloves and aprons and dispose of them correctly so I am not cross contaminating" and "I change gloves every time and change my apron. If I am going in the kitchen I wear a blue one. I also make sure I disinfect commodes and make sure they are clean."

Infection control training was highlighted on the training matrix as mandatory for all staff members and showed that the majority of staff had completed this. We observed staff throughout the day wearing Personal Protective Equipment (PPE) such as aprons when undertaking personal care or serving meals. We checked a number of bathrooms throughout the service and found that liquid hand wash and paper towels were available. We also saw hand sanitizer was available at points throughout the service. We observed the service was clean and tidy and free from offensive odours.

The service had an infection control policy in place. This gave detailed information around topics such as effective hand-washing, cleaning spillages, handling soiled waste and the use of protective clothing. We saw shower heads were cleaned monthly to prevent the spread of legionella and shower curtains were cleaned weekly. Water temperature checks were undertaken by the maintenance person to ensure they remained within normal ranges; not too hot where they may scald someone.

The laundry was sited well away from food preparation areas. There was a system for dirty laundry to come in and clean laundry to go out without cross contamination. There was dedicated laundry staff. There was one industrial washer, one normal 'household' type washer and one industrial dryer. The service used colour coded bags to safely wash or dispose of contaminated waste. There was a supply of hand wash gel and paper towels for staff to use to prevent the spread of infection in the laundry. There was also hand washing advice for staff to follow good practice. The laundry also contained other equipment such as irons to keep people's clothes presentable.

## Is the service effective?

### Our findings

We asked people who used the service if they felt staff members had the appropriate skills and knowledge to care for them. Comments we received included, "The staff know what they are doing. One in particular is very good" and "Yes they all know me well. There has been a big change of staff and management recently but you soon get to know them."

Throughout the inspection we observed interactions between staff members and people who used the service. We saw that staff knew people well, including what their likes and dislikes were.

We asked staff members if they had an induction when they commenced employment at Ashbourne Nursing Home. Comments we received included, "I had to fill in an induction pack. My first day I came in and shadowed one of the other staff members. Then I shadowed for a morning and commenced two induction days. I was not left on my own to work – I worked with someone for a good couple of weeks. I also couldn't do anything until I had completed my moving and handling training" and "I remember I had an induction booklet and shadowed a senior member of staff for a week or two. It is a long time ago so I can't remember much of it. I was shown properly and made to feel comfortable and not thrown in the deep end."

The service had a new induction in place that they adapted from the care certificate to meet the service needs. The care certificate is considered best practice for people new to the care industry. This replaced the previous induction that most staff members had completed. The new induction consisted of eight standards including the role of the health and social care worker, personal development, communicating effectively and equality and inclusion. Each standard had reading material and then a series of questions the new staff member had to complete which was then marked. Once the new staff member had successfully completed all of the induction they received a certificate. All new staff members, regardless of their experience, were expected to complete the induction.

We asked staff members what training they had completed within the last 12 months. They told us, "I have done fire, first aid, safeguarding, end of life and coming up I have dementia training and infection control", "I have done dementia training, end of life, safeguarding, food hygiene, first aid and MCA and DoLS" and "I have done safeguarding and biodose (medicines). I have not been here long but have got some planned in – first aid, MCA, DoLS. I was going on dementia training but I was on shift. They are running it again so I will go then. Before I came here I had done lots of training – 16 mandatory courses."

All staff were expected to complete mandatory training which included moving and handling, safeguarding, medicines (for senior care staff), fire safety, infection control, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), end of life, nutrition and hydration and first aid. Records we looked at showed that staff had completed the necessary training. The deputy manager had also completed 'train the trainer' training in moving and handling and was therefore able to train staff members in this area. We saw there was a mental capacity champion and a safeguarding champion in place. These were people that had undergone further training in these areas and were able to support staff members in the workplace if they needed advice.

We looked at the training matrix. This showed some staff members had not completed some of the training; however they were either new staff members or had already been booked on a course in the near future. The manager had spent some time arranging courses to get all staff members up to date with all their training needs. On the day of our inspection we saw that some staff members were on MCA and DoLS training and end of life training.

Other training courses we saw available to staff included dementia, continence care, dignity in care, diabetes and falls. Some staff members had expressed their interest in attending a workshop entitled 'Finding the Words'. This was a workshop designed to develop communication skills. We also saw some staff members were undertaking a National Vocational Qualification in care or had already achieved this. The mandatory courses and other courses available should ensure that staff have the relevant knowledge and skills to meet the needs of people who used the service.

We asked staff members if they received supervisions and appraisals. Comments we received included, "Yes, but I have not had one with [name of manager] yet. I used to have them with [name of previous manager] when she was here" and "I haven't had one recently because everything has changed with management."

The manager told us that as they had only been in post for seven weeks they had not yet started with supervisions. Despite this the manager and deputy manager had developed a supervision pack for each staff member which was ready to be implemented. The pack consisted of a standard letter inviting the staff member to a supervision meeting, a supervision agreement, a supervision contract, a record of supervision and a staff appraisal questionnaire. The manager was in the process of putting a timetable in place to ensure each staff member had regular supervisions.

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. Then they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest 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.

At our inspection of 27 October 2015 we found the service was depriving people of their liberty for the purpose of receiving care or treatment without the correct authority in place. During this inspection we found 14 people within the service were either subjected to a DoLS authorisation or an application had been made to the local authority; no one was being unlawfully deprived of their liberty. DoLS authorisations contained detailed information about the restrictions in place on people. The service had a document in place which showed which people had an authorisation in place, when it expired, when an application had been sent, when an urgent request had been made and when a DoLS had been granted. This should ensure people are not restricted without the correct authority in place.

Records we looked at and staff members we spoke with confirmed that they had received training in MCA and DoLS. Staff told us, "It is about if people have got the capacity to make their own decisions. The DoLS team have put them in place for those without capacity. If someone was trying to leave the building I would not have a choice but to let them without a DoLS in place as this would be stopping them from making their

own decisions" and "DoLS are put in place for people that have not got the capacity to make decisions for themselves, so a DoLS gets put in place as you might be restricting someone."

At our inspection of 27 October 2015 we found care and treatment was being provided without the consent of the relevant person. During this inspection we found consent was always sought from the person or a relevant other prior to any care and treatment being provided.

We asked one person who used the service if staff always gained their consent before undertaking any personal care or treatment. They told us, "They always check with me before they do anything. I am fortunate in that I am able to speak for myself and tell them what I want." Staff members we spoke with told us, "I always ask. We have it in the care plans but I would always ask people as well if they are happy for me to do something" and "I ask them, such as what they want to do or what they want to wear."

Consent forms were in place for areas such as safe keeping of money, personal care, photographs, medicines and permitting visitors. We saw that those people who had capacity to do so had signed to show they agreed with them. Those people who lack capacity had been assessed and best interest meetings had been undertaken.

Records we looked at showed people had access to a range of healthcare professionals in order for their health care needs to be met. Records we looked at showed that visiting professionals included GP's, dietician and speech and language therapists. On one person's records it was noted that they had requested to see their GP. We saw the GP had visited and prescribed some treatment for the person. Another person's records showed they had been referred to an aftercare service for people who had suffered a stroke. This service offered support, information and advice to people.

We asked people who used the service what the food was like. Comments we received included, "The food is lovely", "You can't fault the food here. There is always plenty of choice and it is really good" and "The food is great. We get plenty of choices." Relatives we spoke with told us, "My [relative] can't eat much but she has just had sweet and sour pork. They give her fresh fruit every day. If she doesn't want a meal they will bring her some toast. She drinks lots of water – they boil it for her as that's how she likes it. The food always looks good. There have been times when they have offered me lunch, they will always make a tea a coffee" and "The meal we just had was very nice. Very, very nice."

We looked at how people were supported in meeting their nutritional needs. We saw that people who used the service could have what they wanted for breakfast, such as cereal, toast and cooked breakfast. We saw that lunchtime was a choice of two hot meals. On the first day of our inspection people were offered country cottage pie or sweet and sour pork, with a choice of two desserts. The evening meal consisted of soup, sandwiches and lighter options. On the second day of our inspection we observed the kitchen assistant went to each person and informed them what the choice was for the next day. For those people living with dementia there were pictorial menus in place so they could make an informed choice.

At the lunchtime meal service 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 found the lunch time meal service was a relaxed occasion. Tables were laid with linen napkins, condiments and music was playing on the radio. Staff brought pots of tea and coffee to each table for people to choose which they wanted. We observed there was a warm and friendly atmosphere with chatter and laughter between people who used the service and staff members.

We asked staff members how they supported people with their nutritional needs. Comments we received

included, "We have some people who are weighed weekly and they have diet and fluid charts. We also have people that are weighed monthly. It depends how at risk they are", "If people are at risk they go on weekly weights, some people are on 'Ensure' (a nutritional supplement) and cream will be added to their diet. We also encourage them to eat. We make sure food diaries, fluid charts and weight charts are filled in to keep a track on how much weight they are losing" and "Most recently I have created a weight tracker file. Those people on weekly weights are deemed as at risk. Anyone with a Malnutrition Universal Screening Tool (MUST) score of one we ring the GP for four weeks minimum of supplements. I do all the reviews and if people's weight starts to balance I take them off the supplements. We do not go straight to referring people to the dietician anymore." Records we looked at showed that people were weighed regularly, food and fluid charts were completed for those people at risk, some people were on supplements and regular reviews of people's nutrition were undertaken.

At our inspection of 27 October 2015 we found the environment did not suitably meet the needs of those people living with dementia. During this inspection we found improvements had been made. We saw that pictorial signs were in place to identify toilets, bathrooms, dining room and the lounge; this should support people to remain independent when mobilising around the service. The bathroom that was being used as a storeroom at our previous inspection had been cleared and items were no longer being stored in there. People had also chosen signs (if they wished) that they liked for their bedroom doors so that they could recognise which bedroom was theirs.

We asked people who used the service what they thought of the environment. One person told us, "I have personal things in my room. I have a 42 inch television and I have all photographs of my family." Another person told us, "I like it here because it is homely." One relative we spoke with told us, "We brought some pictures in for our relative and the handyman put them up in her room for her straight away. We have brought some more in and he will put those up later on."

Bedrooms we looked at provided ample space for people to be able to personalise them. In some rooms we noted people had brought their own items of furniture, ornaments and pictures. This showed the service encouraged people to make their rooms as homely and comfortable as possible. Communal areas within the service were bright and homely with plenty of seating for people. We saw plenty of reclining chairs and foot stools for people to sit comfortably. Pictures, ornaments, plants and flowers made the lounge inviting.



## Is the service caring?

### Our findings

We asked people who used the service if they felt staff were kind and caring. Comments we received included, "Yes, they are very kind", "I cannot fault the staff. They are all very good. Yes they are kind", "Yes they are kind", "The staff are lovely" and "My family can visit whenever they want. My grandchildren come as well."

One relative told us, "Staff are very kind and caring. There have been a few changes in staffing, including management but [person who used the service] has always been happy. As happy as she can be as she always wanted to go home. Under the circumstances she has the best life possible. She told us they changed her nightie every day whether she needed it or not (meaning she felt well looked after). If I want to speak to her I ring here and they will take the phone to her. They walk past her room and go in; she said staff members spoil her."

We asked one relative if they felt involved in the care and support of their loved one. They told us, "We have not got involved in a lot of things but if I ask them to do anything they do it and if there is anything I need to know they tell me."

Staff members told us they kept families updated in relation to their relatives. Comments we received included, "If there is anything families need to know we just give them a courtesy call to update them. We update them when they come in to visit as well. Sometimes it can be a small thing but it is a big thing to them" and "It is more seniors that get in contact with the families. The senior will sit and speak to them. If a GP is needed then we will get in contact with the family."

At our inspection of 27 October 2015 we made a recommendation that the service considered its own policies and procedures in relation to the privacy and dignity of people who used the service. This was due to people's bedroom doors being left open without documented evidence of this being agreed. During this inspection we found one person was being nursed in bed with their door open. However, this had been fully documented in their care plan as being their wishes.

We spoke with staff members to ask them how they maintained people's privacy and dignity. Comments we received included "I always close the curtains and their door. If their family is there I ask them if we can have five minutes" and "I always ensure the curtains are closed and the door is closed."

All confidential and personal information was stored safely and securely and available only to those people who needed access to it. There was a policy and procedure in place which detailed the employer's and employee's responsibilities to keep information confidential, acceptable disclosure and safety of care records. Staff members were able to tell us what confidentiality meant to them. Comments we received included, "All care records are locked away. We are not allowed to discuss people outside of the home. I wouldn't go home and start discussing one of my residents" and "I wouldn't discuss anything outside of work. If a resident spoke and asked in confidence not to repeat it I wouldn't, unless it was really serious."



We asked people who used the service what the atmosphere was like in the home. One person told us "It is a lovely place. Better than some of the others I have been in." Another person told us "You just cannot fault the place." We observed the atmosphere in the service was both relaxed and happy. We observed a number of occasions when staff members were singing and/or dancing with people in the lounge. There were visitors coming and going throughout both days of our inspection and a constant buzz of activity.

We looked at how people were supported to remain independent. One person we spoke with told us "Staff allow me to do things for myself and will help me if I need it." We observed staff asking people if they want help or if they wanted to do things for themselves. One staff member spoke to a person and asked "Do you want help or would you like to do it alone?" Staff members told us, "We encourage people. If they can walk and they can do things for themselves we encourage this" and "I encourage them to do things and not take away their independence. Simple things like allowing them to put a top on or walking if they can." This showed people were encouraged to remain as independent as possible, whilst supporting people when they required it.

Staff we spoke with were able to tell us how they would care for people who were at the end of their life. They told us, "It is about giving family support as well as meeting the wishes of the person. Seeing if they want the priest, what pain relief they need, ensuring adequate pain relief and keeping in touch with the GP" and "Making sure they are comfortable, reassuring the family and just being there for them."

We saw the end of life care plans for two people who used the service. These contained information such as where the person wanted to be cared for, what involvement the family wanted, if they wanted to listen to certain music and pain management. However we found none of the end of life care plans recorded the religious or spiritual wishes of people. We spoke with the provider and the manager regarding this. The provider showed us a new end of life plan they were putting in place for everyone who used the service. Once in place these will provide detailed information for staff members about people's wishes, including their spiritual and religious wishes/needs.

## Is the service responsive?

### Our findings

We spoke to people who used the service to ask them about activities within the service. One person told us, "I don't really get involved in the activities. A lot of them are for people with dementia like playing with a balloon or a ball and it is not my cup of tea. They always ask me if I want to join in though", "We do get to go out locally when the minibus is working. We should have been going to Blackpool illuminations last Monday but it was cancelled because the minibus had broken down so we are going next Monday" and "We have a singer who comes in every two weeks. He is very good. He will sing requests if we ask him."

We spoke with one relative about the activities on offer within the service. They told us their relative was being nursed in bed due to their illness. They commented, "The activity co-ordinator has been into her room and painted her nails and they have been doing exercises with her. When the singer was in they got them to go in her bedroom and sing her a song." This showed the service considered the needs of those people who were not able to join in with activities in the main lounge.

Staff members spoke about the activities within the service. They told us, "We have an activities co-ordinator. She has singers coming in a lot. She takes people out in the garden when it is nice and they have ice cream. We have a coffee shop up the road and she takes some people there. There is a trip to Blackpool illuminations soon."

The service had an activities co-ordinator who worked five days per week. They had an activities board outside the lounge area which contained lots of information relating to activities such as activities for the day, if there were any birthdays coming up and any external trips. We saw a trip was planned to a local memory café; this is where people living with dementia can get together with others who understand and talk to each other to learn from each other's experiences. During our inspection we saw the activities co-ordinator arranged chair exercises, dancing and a sing-along. Records showed other activities people had attended included pet therapy, hand massage, one to one outings to the local café or shopping in the local town, listening to music, concerts and nail treatments. We also observed the activities co-ordinator spent time with people on a one to one basis. On the first day of our inspection the hairdresser was in the service for those people who wished to have their hair washed, cut or blow dried.

One person who used the service told us they had needed to make one complaint in relation to an agency staff member. They told us, "They once had an agency worker in and he was horrible. I just didn't like the way he was with me. I told the staff members the next day and said don't send him in to help me again. I never saw him again so they must have dealt with it." One relative we spoke with told us they had never needed to make a complaint.

The service had a complaints policy in place. This provided guidance for staff members on verbal complaints, written complaints, investigating and following up actions. We looked at complaints that the service had received and found these had been dealt with in line with their policies and procedures and showed a clear process that had been followed.

At our inspection of 27 October 2015 we found that people were not fully assessed prior to moving into Ashbourne Nursing Home. During this inspection we found improvements had been made. Records we looked at showed that prior to moving into Ashbourne Nursing Home a pre-admission assessment was undertaken. This provided the manager and staff with the information required to assess if Ashbourne Nursing Home could meet the needs of people being referred to the service prior to them moving in.

At our inspection of 27 October 2017 we found care plans were not person centred and did not reflect people's preferences. During this inspection we found improvements had been made and all care plans had been re-written. We looked at the care records for four people who used the service. The care records contained detailed information to guide staff on the care and support to be provided, including what people were able to do for themselves. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had all been incorporated into their care plans; what time the person liked to go to bed, how often they liked a shower or a bath and what they liked to do during the day. We saw the care records were reviewed regularly to ensure the information reflected the person's current support needs.

Staff members we spoke with told us they had access to care plans. Comments we received included, "Yes all staff have access to them, they are used a lot. Staff need to read one or two care plans on a weekly basis and they have to sign to say they have read them. They are all key workers as well so they have to make sure their [people who use the service] weights are done, their bedrooms are alright or if they need anything. They do a thorough room check as well" and "We read the care plans. I have not read them all yet. We learn a lot from them because a lot have their life stories in there."

All the people we spoke with told us they were given choices. We observed staff members gave people choices about what they would like to eat, drink, what activities they would like to do and if they wanted to remain in the lounge or go to their room.

## Is the service well-led?

### Our findings

The service did not have a registered manager. The previous registered manager de-registered with us on 23 March 2016. The service had employed a new manager who was in the process of submitting an application to the Care Quality Commission (CQC) to become registered. Due to limiters in place a service cannot be judged as good in this domain if there is no manager registered with the CQC. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people who used the service if they felt the new manager was approachable. One person told us "The new manager is very good." Another person told us, "The new manager is very nice. She is very down to earth, no airs and graces about her. She will come and speak to me if she sees I am sat alone." One relative told us "The new manager is lovely. They have a lot of time for you – all the staff do."

Staff members spoke to us about the manager. They told us "She is very approachable and fair", "She is fair. I could go and knock on her door anytime", "I find [name of manager] very approachable and fair. She will listen to you. If there is anything she would listen to two sides of the story. She tells us if she is in the office not to knock and to go straight in" and "I find [name of manager] really approachable. She has done a lot really and whatever she has done she has done it for the best of the residents. She is never in the office. She will help with personal care regularly. I don't think staff members always see how much work she has to do."

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

At our inspection of 27 October 2016 we found effective and robust systems were not in place to ensure the health, safety and welfare of people who used the service. This was due to a lack of audits being undertaken. During this inspection we found some improvements had been made.

We saw audits were now in place for medicines, COSHH, consent, respecting and involving people, complaints, nutrition, equipment, health and safety, mattresses, kitchen and lounge. We saw the majority of these were last completed in April 2016 when the previous manager was in post. The new manager told us that in the seven weeks they had been in post they had developed a planner for auditing. We were shown the plan which commenced in October 2016 and showed what areas were to be audited each month. This showed that although the service was behind with their auditing they had a plan going forward.

There were policies and procedures for staff to follow good practice. We looked at several policies and procedures which included safeguarding, whistleblowing, fire safety, medicines, infection control, confidentiality, MCA, DoLS, accidents, nutrition, end of life and complaints. These were accessible for staff

and provided them with guidance to undertake their role and duties.

We asked one relative what they felt the culture of the service was like. They told us, "There is no smell of urine. [Name of service user] is incontinent and she is always fresh and clean. They check her regularly and sometimes when I am here. She is always clean and comfortable."

Staff members we spoke with were complimentary about the culture in the service. They told us, "It is a lovely home. It is warm, nice and welcoming and all the residents are absolutely lovely", "I would be happy for my mum or dad to live here" and "It is friendly. It was a bit 'clicky' but staffing has changed. There was a definite defiance against authority. Now everyone seems to get on with everyone."

We observed the atmosphere in the service to be relaxed, friendly and happy. Singing and laughter was heard throughout both days of our inspections and there was positive banter between staff members and people who used the service.

We saw a number of thank you cards that the service had received. Comments included, "Just to say a big thank you on [name of service user] birthday for everything you continue to do for her", "To all the management and staff, thanks for all you did for mum" and "Thank you so very much to all the carers and kitchen staff who worked so hard on Saturday to make mum's birthday a memorable occasion. The buffet was lovely as was the singer who entertained all the residents."

We saw there was a service user guide in place. This was given to each person who used the service and included information such as the management structure, the service mission and purpose, personal care and support, health care, dining, leisure activities, facilities, staffing and the complaints procedure. This should ensure that people new to the service were equipped with a good understanding of the service and what it offered.

We saw surveys had been distributed to people who used the service and relatives by the local authority. Of the ones sent we saw one service user and three relatives had responded. The service user had responded positively to the questions asked about the service, for example they always felt safe where they lived, they always felt in control of planning their life, they always had a say in who supported them and they always felt the people who supported them understood them. Of the surveys relatives had completed we noted some further comments had been made. Comments included, "I have seen positive changes at Ashbourne. The staff there work hard to ensure a calm and homely atmosphere. Definitely improved. I feel more confident regarding the care of our mum" and "My [relative] has been a resident in Ashbourne for over two years. During that time whilst there has been some staffing changes, the one constant feature has been the quality of care provided by individual members of staff at all levels. Nothing has ever been too much trouble and my [relative] has always been treated with respect and in ways that best meet her needs. She regards the environment as her home and feels comfortable and safe. As the primary relative this means an awful lot to me." The service also had their own surveys which they sent out to people who used the service, relatives and staff members although one had not been done in recent times.

The new manager had also introduced a suggestion box which was placed in the entrance of the service. This was so people who used the service, relatives and visiting professionals could make suggestions to improve the service.

The manager told us the service held a meeting for relatives on the day they had attended for their interview. No notes had been taken for this meeting as it was in the evening when the secretary was off duty. The manager is aware of the importance of these and going forward is planning to undertake these every two to

three months. Whilst no official meeting had been held we observed on numerous occasions that relatives were in the manager's office having discussions with them. This showed the manager had an open door policy and that relatives could have a discussion with her at any time.

A recent staff meeting had been held in the service. Topics for discussion within this meeting included the CQC report, documentation, accidents and incidents, staffing levels, routines, complaints, annual leave, training and NVQ's. Minutes of the meeting showed staff members were able to voice their opinions and ask questions during this meeting. Staff members also confirmed they had staff meetings. One staff member told us, "We have only had one full staff meeting and a senior meeting since the new manager has been here."

We spoke with the manager to ask them what visions and values they had for the future of the service. They told us that whilst they were still finding their feet in regards to their role, they were very passionate about their job and wanted nothing but the best for people who used the service. They told us they were in the process of developing 'Ashbourne Gazette', a newspaper which would be sent out six times per year and will include useful information for people who used the service. On the 10 November 2016 and every Thursday thereafter a 'tuck shop' would be available for people who used the service where they could purchase sweets, snacks and toiletries.

After speaking to staff members we asked them if there was anything else they wanted to tell us. Comments we received included, "I am very happy working here. I think everything is good", "I would be happy for my mum or dad to live here. The girls are lovely, the management are nice, the meals that are provided are nice. People can have a cup of tea whenever they want. It is a nice home" and "We had a lot of agency staff as we had a lot of people leaving. Since I came here the service has come on leaps and bounds. The standard of care and the safety of things are a lot better. It is a safer place to live. I would be happy for my mum or dad to be here and I am confident they would be looked after."