# Astley Grange Homes Limited

# Astley Grange

**Inspection report**

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

## Overall summary

We carried out this unannounced inspection on 20 October 2015. At our last inspection on 7 August 2013 the service was found to be meeting all regulatory requirements.

Astley Grange provides nursing care for up to 28 adults with a range of complexity of physical and mental health needs. The provider is Astley Grange Homes Ltd. The home is situated on a main road into Bolton town centre, close to shops and other local amenities. Car parking is available at the front of the home. At the time of the inspection 27 people were using the service.

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

People who used the service, their relatives and professionals we contacted told us they felt the service

# Summary of findings

was safe. There were appropriate risk assessments in place with guidance on how to minimise the risks. Safeguarding policies were in place and staff had an understanding of the issues and procedures.

People's nutrition and hydration needs were met appropriately and they were given choices with regard to food and drinks. Care plans included appropriate personal and health information and were up to date.

The environment was not consistently effective for people living with dementia and provided little stimulation. There was insufficient signage to aid people's orientation and help them to be as independent as possible.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who used the service and their relatives told us the staff were caring and kind. We observed staff interacting with people who used the service in a kind and considerate manner, ensuring people's dignity and privacy were respected.

There was an appropriate complaints procedure, complaints were followed up appropriately and people who used the service and their relatives knew how to make a complaint.

A number of audits were carried out by the service, issues identified and actions put into place.

Medication policies were appropriate and medicines were administered, stored, ordered and disposed of safely.

Staff had a good understanding of DoLS and the MCA, the importance of consent to care and treatment and how to act in peoples best interests.

People's care plans showed evidence of effective partnership working and we saw information in peoples care files that showed the involvement of relatives where appropriate.

We observed the lunchtime meal using 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. There was a relaxed unrushed atmosphere and we saw that staff interacted with people in a respectful and dignified manner, recognising people as individuals' and encouraging their engagement. We saw staff responded and supported people with dementia care needs appropriately.

There was a four week, seasonal menu cycle in use which was nutritionally balanced and offered a good range of choice.

We observed care in the home throughout the day. Relationships between people who used the service and staff members were very warm. Conversations were of a friendly nature and there was a caring atmosphere. Staff attitude to people was polite and respectful using their names and the right approach and people responded well to staff.

The home had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose which is a document that includes a standard required set of information about a service.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates.

There was evidence of multi-disciplinary team reviews in people's care files including the involvement of an Independent Mental Capacity Advocate (IMCA) where appropriate and evidence of best-interest decisions and discussions

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s) and a trial period of residence was offered.

Each person who lived at Astley Grange had a contract of residence and people's spiritual needs were met through the provision of regular visits from different faith groups.

There was a 'key worker' system in operation for both day and night shifts. There was a person centred care policy in place. We saw that information about personal preferences, social interests and hobbies was recorded in people's care files. The service produced a monthly newsletter for people and their relatives. We found that resident's surveys were also undertaken.

The home employed an activities coordinator. A wide variety of information and photographs of previous activities was displayed throughout the home.

# Summary of findings

The home had Investors in People status. The service was also accredited with the Gold Standards Framework in Care Homes

There were a range of monthly audits in place and all information was completed correctly and up to date.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues appropriately on a one to one basis. The manager carried out a registered nurse competency check under the home's competency framework.

There was a business continuity management plan in place that identified actions to be taken in the event of an unforeseen event.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**

Good

The service was safe.

People we spoke with and their relatives told us they felt safe.

There were robust systems in place for the management of medicines.

There was evidence of robust recruitment procedures.

The home was adequately maintained including the servicing and maintenance of equipment used within the home.

**Is the service effective?**

Good

The service was not always effective.

People's care plans showed evidence of effective partnership working and the involvement of relatives where appropriate.

Staff provided assistance to people who required it as identified in their care plan.

There was a four week, seasonal menu cycle in use which was nutritionally balanced and offered a good range of choice.

There were few adaptations to the environment to make it dementia friendly. However a variety of appropriate equipment was ordered immediately after the date of the inspection.

**Is the service caring?**

Good

The service was caring.

Relationships between people who used the service and staff members were very warm and staff demonstrated a good understanding of the people they supported.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates.

There was evidence of multi-disciplinary team reviews in people's care files including the involvement of an Independent Mental Capacity Advocate (IMCA) where appropriate.

Prior to any new admission a pre-assessment was carried out with the person and their relative(s) and a trial period of residence was offered.

**Is the service responsive?**

Good

The service was responsive.

Relationships between people who used the service and staff members were very warm.

The staff we spoke with demonstrated a good understanding of the people they supported.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates.

# Summary of findings

There was evidence of multi-disciplinary team reviews in people's care files including the involvement of an Independent Mental Capacity Advocate (IMCA) where appropriate.

**Is the service well-led?**

Good

The service was well-led.

There was a registered manager in post as is a condition of Astley Grange's

registration with CQC.

People we spoke with and their relatives told us they thought the service was well-led.

There were a range of monthly audits in place.

# Astley Grange

**Detailed findings**

## Background to this inspection

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

This comprehensive inspection took place on 20 October 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as notifications of accidents and incidents. We also contacted Bolton Local Authority quality assurance team, and Bolton Healthwatch. Healthwatch England is the national consumer champion in health and care.

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

During the inspection we looked at all areas of the home including people's bedrooms, the kitchen, bathrooms and communal areas such as the dining room and lounge. We observed the mid-day meal and spent time observing people in the lounge. We spoke with ten staff members, which included the registered manager, five carers, two qualified nurses, the chef and the domestic and a visiting NHS community health worker. We also looked at questionnaires completed by people who used the service and their relatives. We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation.

Good

# Is the service safe?

## Our findings

People we spoke with and their relatives told us they felt safe. A relative of a person using the service said: “Before (my relative) came here, the home was recommended to us. (My relative) is comfortable here and accepts it’s (their) home. (My relative) has been increasing in health since being here. I feel (my relative) is cared for and safe.” A person who used the service said: “The carers are brilliant, I have no complaints.” A visiting professional told us: “People are cared for very well.” Another visiting professional told us: “The home is clean, tidy and jolly. There is a warm atmosphere”.

We looked at the staff rotas for September and October 2015 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service and care staff told us they felt there were sufficient staffing numbers. Staffing rotas were determined two weeks in advance and the registered manager authorised any requested changes prior to implementation. One member of staff felt there had been a need to increase staffing levels prior to the date of the inspection. This had been immediately addressed by the registered manager by recruiting a new staff member.

When determining the level of staff required the service took into account people's individual needs and their dependency level, using a dependency level tool. This tool produced an indicative set of numbers of nurse and care staff required at different times of the day in addition to identifying the number of catering domestic and laundry staff required. Staffing levels were therefore sufficient to meet the needs of people who used the service.

We observed throughout the day that when people used their nurse-call bells to summon staff assistance whilst in their rooms, these were responded to immediately.

We looked at how the service managed accidents and incidents. There was an appropriate up to date accident/ incident policy in place. Records of accidents and incidents were recorded appropriately within people’s care files. Additionally an accident log was completed and this included a monthly audit and analysis of incidents that had occurred. Where appropriate, referrals had been made to the community falls prevention team. The service also submitted monthly information to Bolton Clinical Commissioning Group, which contained a number of quality indicators such as the number of complaints received, the number of incidents occurring, pressure sores and infection prevention and control status.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. We spoke with three care staff who demonstrated a very good understanding of safeguarding and were able to describe how they would make a safeguarding referral. The home also had an abuse policy, which was up to date and reviewed in November 2014. This included definitions of abuse, the actions to be taken when suspecting abuse and details of contact numbers. There was a safeguarding board in the downstairs hallway which had information and the contact details of the specialist practitioner for safeguarding from the Clinical Commissioning Group (CCG). This meant that safeguarding information was readily available to people who used the service and their relatives.

There was a safeguarding log in place which recorded any safeguarding incidents and this was completed appropriately, including actions and outcomes required. The home had a whistleblowing policy in place and staff knew how to raise any concerns they may have.

We looked at how the service managed medicines. There was an up to date medicines policy in place which included information on covert medicines, self-medication, consent, as required (PRN) medicines and swallowing difficulties. We observed staff administering medicines to people and saw that the staff member did this in a friendly and professional way, talking to people before administering any medicine so that they were aware of what was happening and were able to give their consent. The staff member made correct entries on the Medication Administration record (MAR) charts immediately after the medicine had been taken. All staff who administered medicines had undertaken appropriate training. The manager told us that an electronic system for recording medicines administration was shortly to be introduced in December 2015. They anticipated this would cut down on the amount of time it took to complete the medicines round and provide real-time data that would be available electronically to the manager for immediate daily analysis.

There were safe systems for ordering, receiving, storage, administration and disposal of medicines. There was a

Good

# Is the service safe?

fridge in which certain medicines were stored. Fridge temperatures were taken twice daily and were up to date. The fridge was locked and the fridge cleaning schedule was up to date.

There was an appropriate locked room for storing medicines. The medicines trolley was locked and securely stored. There was a controlled drugs (CD) cupboard and CD book, which contained two staff signatures as required and this was checked twice each day.

Robust systems for identifying and following up on errors and omissions to MAR charts were in place. Each person had a PRN sheet for 'when required' medicines. This was written in time ranges to help prevent overdosing. There was a homely remedies cupboard in use. If a person was prone to refusing medicines this was recorded in their care records. Any covert medicines were agreed through a best interests meeting with the person's GP. The front cover of all MAR charts contained a photograph of the person and each person's care file contained a record sheet with their GP name, the type of medicine and how it was taken. Personal safety information and risk assessments were in people's care files and up to date.

We looked at how the service managed the control of infectious diseases. There was an Infection Control policy in place which included information on the different sources and types of potential outbreaks and the management of these situations. We saw that monthly audits were in place and included areas such as furniture, bedrooms and the general environment, hand hygiene and equipment. Personal protective equipment (such as gloves and aprons) was available throughout the home.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. We undertook a tour of the building to ensure that it was safe for the people who lived there and found that it was secure. There was access to a garden area with assistance from staff. There was a building refurbishment plan in place which identified areas requiring improvement such as the entrance area, people's bedrooms and external windows. A 'handyman' was employed at the home who carried out daily, weekly and monthly tasks and check lists in relation to the premises security, water supplies, temperatures and boilers, fire safety and fire alarms, the nurse-call system, doors and lighting.

There was a domestic cleaning schedule in use which included daily, weekly and periodic cleaning records. There was a maintenance file that included all the required equipment servicing certificates. A fire risk assessment had been competed in April 2015 by an appropriate external agency. There was a secure fire evacuation box in the entrance hallway that contained individual Personal Emergency Evacuation Plans (PEEPS) which were up to date. There were also a variety of building and equipment related risk assessments in place. The home was clean throughout and free from any malodours.

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

Good

# Is the service effective?

## Our findings

A person who used the service said: "Any help you need you can ask and they (the staff) will help you". A visiting professional said: "There are no problems with documentation. The home makes referrals appropriately and carries out timely reviews of people's care." Another visiting professional told us: "Patients are cared for very well". A relative told us: "I am very satisfied with the care (my relative receives) and staff always keep us well informed."

The staff we spoke with explained their roles well and had a good understanding of what was required of them and how to deliver care safely. We looked at staff supervision and appraisal information and saw that a supervision cycle was in place. Staff appraisals were carried out annually and supervision with a line-manager occurred at least bi-monthly. Staff we spoke with confirmed they had regular supervisions and found them to be useful.

There was a staff training matrix in place. Care staff had completed training in various areas, for example all staff had completed manual handling and infection control training and the relevant care staff had completed training in food hygiene. All staff had attended training in dementia and some staff were booked onto refresher courses in 2016. All staff had received training in the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding. Some staff were also booked onto refresher training in 2016 which we verified by looking at training records. The home also used a 'training frequencies' document that identified the type of training course, when staff needed to attend, the frequency that this training was required, who the training was for and whether or not it was mandatory.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living

are looked after in a way that does not inappropriately restrict their freedom. Staff had a good understanding of DoLS and the MCA, the importance of consent to care and treatment and how to act in peoples best interests.

There were appropriate records relating to the people who were currently subject to DoLS. A list of people subject to DoLS was kept in the office and was up to date. Applications for DoLS had been made where required and these were up to date and reviewed regularly to capture any changes in the person's capacity. There was documentation of techniques used to ensure restrictions were as minimal as possible. There were appropriate MCA assessments in place, which were linked to screening tools and restrictive practice tools which outlined the issues and concerns.

We also saw that the conditions relating to DoLS authorisations were met and related to what was recorded within the care plans about people's support. Appropriate supporting policies and procedures were in place, for example, the service had policies on DNACPR, Physical Restraint, DoLS and MCA and Safeguarding Adults.

We looked at care plans for people living at Astley Grange. These showed evidence of effective partnership working, for example one person whose behaviour was complex had been referred to a consultant psychiatrist. Specialist advice had also been sought regarding a specialist area of care for another person.

People's care files contained appropriate risk assessments and monitoring information, for example regarding weight, pressure area care, fluid intake, nutritional intake and special diet, sensory requirements, mobility issues and dexterity, oral health, falls, continence. These were all reviewed monthly and were up to date. Any allergies were clearly recorded in addition to information regarding dysphagia (swallowing difficulty) where applicable.

Consent forms regarding the administration of medicines were in place and signed by the person using the service where possible, or by a family member or social worker as appropriate. Mental state and cognition were also assessed and a behavioural care plan was in place where appropriate. Visits by other professionals such as the GP or chiropodist were accurately recorded and referrals to these professionals were made in a timely manner.

We saw information in people's care files that showed the involvement of relatives where appropriate. We saw that where people had a 'do not actively resuscitate' (DNAR) form in their care file these had been completed correctly and were reviewed by the person's GP. Additionally we saw that the service had made every effort to clarify people's diagnosis with them and their relatives in order to inform end of life planning.

Good

# Is the service effective?

We observed the lunchtime meal using 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. There was a relaxed unrushed atmosphere and we saw that staff interacted with people in a respectful and dignified manner, recognising people as individuals' and encouraging their engagement. There was discussion and laughter between people who were dining. Staff provided assistance to people who required it as identified in their care plan, and spoke politely to people asking them about what they wanted to eat and drink before serving it. The dining room was clean and homely with nicely laid out crockery and cutlery. Prior to serving any food, staff washed their hands and used appropriate personal protective equipment (PPE) such as gloves and aprons.

A person who used the service told us: "The cooking is especially good – I have seconds. The carers are brilliant, I have no complaints and I'm enjoying my stay." Another person said: "The food is very good and I've had a beautiful meal today."

There was a four week, seasonal menu cycle in use which was nutritionally balanced and offered a good range of choice. The menu was displayed on the dining room tables and on a notice board in the entrance area hallway. There were two choices for the lunchtime and evening meal and two pudding choices in addition to a hot or cold drink. Breakfast was largely a selection of cereals, toast and jam or fruit plus a hot or cold drink. Early morning drinks. Afternoon tea and late evening snacks were also provided. People's food preferences were recorded on admission and discussions regarding food were held at 'residents meetings.' Additionally there was a 'comments book' in the dining room that was available for people to make comments and suggestions about the quality of food and this was passed onto the cook. Comments included: '(The person) said the lunch today as beautiful' and '(The person) said (they) thoroughly enjoyed their meal.'

A relative of a person using the service said: "(My relative) had a sore leg whilst in hospital which they (the hospital) couldn't heal but it has healed since being in the home." We checked the care records for this person and saw that there was a wound assessment, wound care record and body map which evidenced that the wound had healed.

We found there were people living at Astley Grange who were living with dementia. We saw staff responded and supported people with dementia care needs appropriately. However, although some adaptations had been made to the premises such as hand rails and grab-rails that would assist people when using the bathroom or toilet, and the provision of a variety of different seating to suit different people's need, there were few adaptations to the environment to make it dementia friendly or that would support people living with dementia to retain independence within their home. For example there were no adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people to mobilise round the building or understand where they were if assisted by staff.

The registered manager acknowledged that Astley Grange required some improvements to the physical environment to update it, for example the refurbishment of the entrance doorway area, which would improve access for patient transport services.

Shortly after the date of the inspection the service obtained a variety of coloured toilet seats, grab rails and directional signs and were also creating a remembrance collection for people living with Dementia.

Good

# Is the service caring?

## Our findings

The relative of a person who used the service said: ""I wouldn't have (my relative) anywhere else". "They (the staff) are angels without wings." A visiting professional told us: "It's very homely at Astley Grange, always tidy and clean. I'm always made to feel welcome by staff. They are always very pleasant. All relatives are involved in reviews (attended by the visiting professional) and have been positive about the home". Another visiting professional said: "The environment is very pleasant, clean and smells fresh. There is always a member of staff to help you when you come in. The nurses do what they can and contact others appropriately. They follow advice and instructions."

We observed care in the home throughout the day. Interactions between people who used the service and staff members were very warm. Conversations were of a friendly nature and there was a caring atmosphere. Staff attitude to people was polite and respectful using their names and the right approach and people responded well to staff. For example at the lunch time meal we saw a staff member gently assisting one person to put salt on their meal, encouraging the involvement of the person and providing reassuring assistance whilst maximising the person's independence and recognising what they could do for them self. We heard lots of positive chatter between staff and people thorough the course of the inspection.

The staff we spoke with demonstrated a good understanding of the people they supported, their care needs and their wishes. They were able to tell us about people's preferences and how they endeavoured to ensure care and support provided was tailored to each person's individual needs. Staff spoken with could give examples of how privacy and dignity was respected, for example by knocking on doors, covering up people whilst providing personal care, asking permission before carrying out any assistance and explaining reasons for interventions.

We saw there was a dignity policy, which was up to date. Staff were aware of this policy and how to follow it. There was a 'dignity board' in the entrance hallway containing a wide variety of useful information for people and their relatives. A wide variety of information about activities was also displayed in the entrance area.

The home had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose which is a document that includes a standard required set of information about a service. The guide contained information on how to raise any issues of concern and referenced the local authority and the Care Quality Commission (CQC). Attached to the guide were a copy of the contract of residence, a copy of the complaints procedure, a sample menu, a sample of people's views about the home and a copy of the latest CQC inspection report. Relatives we spoke with confirmed they had been given a copy of these documents. There was an open door visiting policy in place and relatives could visit at any time though the home endeavoured to avoid visits at meal times.

The home had an End of Life Care Policy in place and people's wishes regarding end of life were recorded in their care files, including any updates. The home was accredited with the Gold Standards Framework in Care Homes (GSFCH). The GSFCH Programme, supported by the Department of Health End of Life Care Strategy, is a comprehensive programme to enhance end of life care in care homes as people near the end of their lives. The accreditation process involves continuous assessment against 20 standards of best practice across a three year period and an official inspection visit at the end. We found that all the required GSF coding was kept up to date in people's care files.

Whilst reviewing the care plans of people who used the service we found that a number of people had 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place. These were all up to date and completed correctly, including any MCA assessments where appropriate. Additionally the service had provided useful information to people's relatives about the home's responsibilities when a person passed away and what the family would have to do independently.

There was evidence of multi-disciplinary team reviews in people's care files including the involvement of an Independent Mental Capacity Advocate (IMCA) where appropriate and evidence of best-interest decisions and discussions. For example one person who was refusing food had been referred to the psychiatrist and the dementia in-reach team. A visiting professional told us: "The home liaises with the correct bodies like the dementia in-reach team"

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s) and a

Good

# Is the service caring?

trial period of residence was offered. We verified this by looking at care records. A relative told us: “The manager came to see (my relative) in hospital to do an assessment. The process was very easy and completed within a week. Recently an out-of-hours doctor was called and we were informed. Staff kept in touch and told us about a new painkiller that had been prescribed. We get a carers newsletter so that’s good.”

A variety of thank you cards were on display such as: “You treated (my relative) with dignity, for that, thank you from the bottom of my heart;” “Astley Grange will always have a special place in my heart;” “I know (my relative) was only with you for a short while, but I was comforted knowing (my relative) was well looked after, especially in last few days”. Other written feedback from people who used the service and their relatives included: “Friendly staff, cleanliness, good food and excellent management contribute to a quality of experience for the residents and I would highly recommend the home to anyone wishing to secure a happy and fulfilling experience,” and: ”Astley Grange scores top marks from myself and my family. The staff are all caring and friendly people.”

Good

# Is the service responsive?

## Our findings

A person who used the service said: "I do what I want to do every day". The relative of a person using the service told us: "Staff explain things to you, take time to talk to you, nothing is too much trouble. I feel (my relative) has improved tremendously in time they have been at the home. Another relative said: "If there are any issues they (the home) keep us well informed. They (the home) put on a show for (my relative's) wedding anniversary, which was their idea and everyone came and had a good time. You get these little extra touches here like a rose in every room on valentines day."

On arrival at the home we saw that one person who was from a different cultural background was being assisted to access a local culturally specific community centre which was recorded in the person's care file. The person had chosen to attend the facility on one particular day each week which was their choice. This meant that the person had access to a local community that was culturally specific to them. A staff member was in post who was able to assist with any potential communication difficulties by translating what this person said in addition to the use of 'flash cards.' A flash card is a card bearing information, as words, pictures or numbers, on either or both sides. Another member of staff said: "Listening is the main key."

Each person who lived at Astley Grange had a contract of residence and people's spiritual needs were met through the provision of regular visits from different faith groups. There was an up to date complaints policy in place. Information on how to make a complaint was posted in each bedroom, in the Service User Guide and Statement of Purpose.

There was a 'key worker' system in operation for both day and night shifts, under which each care staff member had specific responsibility for two or three people during the day and for five or six people at nights. In addition each person using the service had an allocated named nurse which would assist with continuity of care. Within the staff group there were nominated 'champions' for example for weight and food chart checks, cream chart checks, commodes and mattresses. There were also named 'champions' for end of life care and dementia, sight loss, hearing loss, dignity and infection control. There was a safeguarding board in the home which identified these staff champions.

There was a person centred care policy in place. We saw that information about personal preferences, social interests and hobbies was recorded in people's care files. Refusals of personal care were also recorded in addition to evidence that staff tried again later where care had initially been refused. Information in care files evidenced that people and their families were involved in care planning and this included dates and signatures where applicable.

The home employed an activities coordinator. They described how some people liked to reminisce by looking at old newspaper articles and old money or sometimes just by chatting about their past life. One person, who spent a lot of time in their room due to becoming easily tired, enjoyed looking through old photograph albums which provided them with stimulation and interaction.

A staff member told us: "A lot of participation depends on the mood of the person at the time. Because a person says 'no' one minute, you can ask a short time later and they will have changed their mind. For example when making decorations for Halloween (one person) didn't want to take part until all the equipment was laid out. I had a feeling (the person) would change their mind when (they) saw what was going on."

A wide variety of information and photographs of previous activities was displayed throughout the home. There was a large activities planner in place and displayed in the entrance area that identified activities for each day and future events such as bingo with tea and scones, a Halloween party, a quiz with tea and cakes and 'active sounds'. Activities on offer included arts and crafts, baking, reminiscence, music therapy, bingo, quiz, word search and puzzles. A hairdresser visited every Thursday. Entertainment such as bingo with scones and tea, a Halloween party, a November quiz and cakes, fun exercise with active sounds and a Christmas party and pantomime had been planned and details of these events were posted on the notice board so that people and their families knew what was planned for the future.

The service produced a monthly newsletter for people and their relatives. This included information about activities past and present, general information such as upgrading facilities within the home and news from the manager. Residents and relatives' meetings were frequent and the next meeting was planned for 26 November 2015.

Good

# Is the service well-led?

## Our findings

The relative of a person using the service said: "The manager is knowledgeable and approachable. The admission process was very clear." A visiting professional told us: "The manager is always cooperative and approachable and involved in all reviews. Discussions take place about how to support staff to achieve their potential." Another visiting professional said: "(The manager) has (their) finger on the pulse and will remind you if things need doing." A staff member said: "The manager is approachable, firm but fair." Another staff member said: "The manager is very approachable."

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

The home had Investors in People status. This is an accreditation scheme that focuses on the provider's commitment to good business and people management excellence. The service was also accredited with the Gold Standards Framework in Care Homes. The service worked in partnership with and received referrals from other organisations such as Bolton Clinical Commissioning Group (CCG), Bolton Council, Chorley & South Ribble CCG and Blackpool Council.

We looked at the systems in place to monitor the quality of service provided at the home. There were a range of monthly audits in place, including: invasive devices; pressure sores; accident statistics; skin tear monitoring; infection control and complaints. All of these audits were complete and up to date. There was also a 'pressure ulcer root cause analysis tool in use that identified the cause, the analysis and actions taken in the event. All information was completed correctly and up to date in the audits we looked at. We saw that the home had a monthly 'NHS incident reporting' file in place. This included information on incidents, action taken and the learning outcomes achieved.

We saw evidence of recent staff meetings in January, May and July 2015, where discussions included record keeping, quality of care, complaints, communication, training, safeguarding, infection control, respecting people, accidents, food and drink, mattress checks, DoLS, and the role of the CQC.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues on a one to one basis. Staff appraisals were carried out annually and were used to look at progress made, training needs and goals for the future. There was a staff supervision planner in use and this identified planned and actual dates for meetings for the whole year through to December 2015. The frequency of meetings was in accordance with the home's supervision policy.

Regular 'Heads of Department' meetings were also undertaken and these discussed issues such as activities, the kitchen, health and safety, MCA and safeguarding and general building maintenance.

The manager carried out a registered nurse competency check under the home's competency framework. This assessed and discussed areas such as communication, record keeping, the prevention and management of pressure ulcers and wound care. Each competency assessment included an 'identified needs and learning plan' document which recorded all learning needs identified and included the description of the activity identified , the timescale for achieving the activity and the outcome of the subsequent review.

We found that residents' surveys were also undertaken. We looked at a 'residents' care survey' from March 2015 and a 'residents social and cultural survey' from January 2015. The intention of these surveys was to solicit information to help improve the quality of service. The results from these surveys were positive and comments included: "Happy with the way things are." Each survey contained an associated action plan. We saw in one of these surveys that people who used the service had identified they always receive their medicines on time. In response the registered manager had subsequently commented that this was not always possible due to the volume of medicines being administered and this had prompted an action to re-write the question in this area so that it was more appropriate for people living with dementia.

There was a business continuity management plan in place that identified actions to be taken in the event of an

Good

# Is the service well-led?

unforeseen event such as the loss of utilities supplies, loss of the telephone system, supplier failure, epidemics and pandemics (such as flu) and flood and fire. This was recently reviewed in May 2015.

The home also submitted monthly information using the NHS Safety Thermometer. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Additionally the service submitted quarterly Continuing Healthcare (CHC) performance information to the CCG. NHS (CHC) is care and support provided to adults aged 18 or over, that is arranged and funded solely by the NHS.

The service had completed an 'Over2You Quality Insight Report.' Over2You is a project funded by the Department of Health, focussing on improving the quality of health and social care services. The aim is to empower people to give feedback to their service provider so that improvements can be made to the service.

General observations from the quality researcher who conducted this report included: "From the beginning of this consultation, I have found the staff extremely friendly and open." Positive feedback from people using the service included: "Management and staff get to now residents and cater for their needs." They went on to say that communication and dedication played a big role in getting to know one person's needs. People also felt that the abilities and professionalism of staff and management had given them the freedom to get on with their own lives. All people spoken to said that staff would always respond well to any feedback and any concerns were always discussed thoroughly.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff. They also started work each day at a time that allowed them to attend the handover meeting between night and day staff. This meant that they were immediately aware of updates to people's circumstances. We saw that the registered manager was very visible within the home and actively involved in provision of care and support to people living at Astley Grange.