Barchester Healthcare Homes Limited

Ashminster House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 15 August 2018. The inspection was unannounced.

Ashminster House is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashminster House provides accommodation and support for up to 60 older people. There were 55 people living at the service at the time of our inspection, however one person was in hospital so 54 people were present during the inspection. People had varying care needs. Some people were living with dementia, some people had diabetes or had suffered a stroke, some people were receiving end of life care. Some people required support with their mobility around the home and others were able to walk independently.

The service was split into three units. Two units provided nursing care with registered nurses leading the staff team on each of those units. One of these units was called 'memory lane', to care for people who were living with dementia in the more advanced stages. The third unit provided registered care for those people who required 24 hours care, however, did not need nursing care. This unit was led by a team leader who was not a registered nurse, but skilled and experienced in providing social care. Lounges and dining areas were available in each unit.

A registered manager was employed at the service by the provider. 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.

At our last inspection on 22 June 2017, the service was rated as 'Requires improvement.' We found breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to the health and safety of people receiving care had not been mitigated to prevent harm; checks and audits had not always been effective and action had not been taken to address shortfalls; the provider had not acted on people's and stakeholder's views to improve the service.

At this inspection improvements had been made and the provider was now compliant with Regulations 12 and 17. People were safer as risk assessments were comprehensive and up to date. Staff had the guidance they needed to support people to maintain and improve their independence while at the same time preventing harm. A range of audits were now undertaken to check the quality and safety of the service provided and action had been taken where necessary when areas for improvement had been identified.

We also made two recommendations to the provider, that they assessed the dependency levels of people in their care in order to calculate the numbers of staff needed; that care plans provide a more consistent approach within different sections of the care plan.

The provider had introduced a tool to assess the dependency levels of people and this was reviewed each week. This provided the information the registered manager needed to ensure staffing levels were in line with people's needs. We found staffing levels were suitable to meet people's needs.

People's care plans now covered all the areas of care and support they had been assessed as requiring. A more holistic approach was taken when planning people's care.

Two further areas were noted as requiring improvement at the inspection on 22 June 2017, a better understanding was needed amongst staff of people's rights within the principles of the Mental Capacity Act 2005; staff one to one supervision meetings were focused on the negative areas of their work and did not address personal development.

Staff now showed a better understanding of the Mental Capacity Act 2005 and documents showed the basic principles were being adhered to. The registered manager made appropriate applications to the supervising authority to deprive people of their liberty when people were assessed as lacking capacity to consent to their care and treatment.

Staff supervision now showed a more proactive and inclusive approach to their personal development. Positive encouragement was given as well as constructive criticism to support development.

Staff were aware of their responsibilities in keeping people safe and reporting any suspicions of abuse. Staff knew what the reporting procedures were and were confident their concerns would be listened to by the registered manager.

Accidents and incidents were appropriately recorded by staff; action was taken and followed up by the registered manager. Infection control procedures were in place and followed by staff to protect people from cross infection.

The procedures for the administration of people's prescribed medicines were managed and recorded appropriately so people received their medicines in a safe way. Regular audits of medicines were undertaken to ensure safe procedures continued to be followed and action was taken when errors were made.

The registered manager and deputy manager carried out a comprehensive initial assessment with people before they moved in to the service. People were fully involved in the assessment, together with their relatives where appropriate.

Care plans were developed and regularly updated and reviewed to consider people's changing needs. People's specific needs were taken account of and addressed in care planning to ensure equality of access to services.

People had access to a range of activities to choose from. Some people preferred their own company and wished to spend time in their room reading or watching TV and this was respected by staff. People were asked their views of the service and action was taken to make improvements where necessary.

Registered nurses were employed to ensure people's nursing care needs were met by skilled and professional staff. People were supported to access external healthcare professionals when they needed additional advice or treatment.

There was clear evidence of the caring approach of staff. People and their relatives were happy about the staff who supported them, describing them as caring, saying they were confident in the care they received. Staff knew people well and were able to respond to their needs on an individual basis.

The provider used safe recruitment practices so only suitable staff were employed to work with people who required care and support.

Staff were supported well by the registered manager and the deputy manager. Staff told us they were approachable and listened to their views and suggestions. Nurses received the training they needed to maintain their professional development and all staff had access to the training they required to provide people's care and support. Regular staff meetings were held to aid communication within the team and to provide updates and feedback.

People and their relatives knew how to make a complaint should they need to. Where complaints had been made, these had been investigated appropriately and the outcome shared as described in the provider's complaints procedure.

People and their relatives thought the service was well run. People knew the registered manager and the deputy manager and were happy with the service provided.

All the appropriate maintenance of the premises and servicing of equipment was carried out at suitable intervals.

Further information is in the detailed findings below.

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.

Staff knew how to protect people from abuse. Risks were assessed, and steps taken to mitigate against them.

People's prescribed medicines were being managed in a safe way.

There were enough staff to meet people's needs.

People were protected from the spread of infection by prevention and control procedures.

Accidents and incidents were reported by staff following the provider's policy.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were being met. Registered nurses made sure nursing needs were met and referrals were made to other healthcare professionals when needed.

People's needs were assessed in line with current legislation to plan their care.

Nurses and staff had received the training and had the skills to meet people's needs. Clinical guidance was provided to nurses and all staff were supported in their role through a supervision process.

People's needs were met by the design and adaptation of the premises.

Staff were knowledgeable and received training about the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People were supported to express their views and told us they were involved in making decisions about their care.

People's privacy, dignity and independence were promoted and respected.

Is the service responsive?

Good

The service was responsive.

A holistic approach was taken to provide people's care and support in a personalised way.

A range of activities were planned for people to take part in if they wished.

People were encouraged to maintain relationships with those who mattered to them.

People told us they were confident to raise complaints about the care and support they received.

People were supported to voice their wishes to plan for the end of their life.

Is the service well-led?

Good

The service was well led.

Quality assurance systems were effective in identifying shortfalls in service delivery and plans were put in place to rectify where necessary.

People, their families and staff were encouraged to be engaged and involved with the service.

Staff were supported and provided with updates to keep them informed.

The registered manager had notified CQC of all significant events.

There were close links with the local community and across the provider's network.

Ashminster House

Detailed findings

Background to this inspection

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

This inspection took place on 15 August 2018. The inspection was unannounced. The inspection was carried out by one inspector, one assistant inspector, a specialist nurse adviser and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We also looked at the previous inspection reports and action plans the provider had sent us. We used this information to help us plan our inspection.

We spoke with 12 people who lived at the service and seven relatives, to gain their views and experience of the service provided. In addition, 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 speak with us. We also spoke to the registered manager, the deputy manager, a senior general manager and seven staff including registered nurses, team leaders and care staff. We contacted health and social care professionals and local authority commissioners to invite them to give us their views of the service.

We spent time observing the care provided and the interaction between staff and people in the communal areas. We looked at seven people's care files, medicine administration records, six staff records including recruitment, supervision and staff training, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

We asked the registered manager to email further information to us and we received this within the timescale given.

Good

Is the service safe?

Our findings

At our last inspection on 22 June 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to, risks to people had been identified and assessed but guidelines were not always clear or detailed enough for staff to know how to manage or reduce those risks; information regarding individualised risks were inconsistent through the care plans; the provider had not developed personal emergency evacuation plans for people to make sure they could be successfully evacuated from the building in an emergency situation.

At this inspection we found improvements had been made in all areas and the assessment of individualised risk was more robust, including the management guidance staff needed.

Many people were not able to articulate their views of the service to be able to tell us if they felt they received a safe service. We did not see or hear anything that gave us cause to be concerned for people's safety and the people who did speak to us said they felt safe. They said, "I feel safe, I've got my alarm, I've got my phone and there's always people walking up and down. I don't even worry about the window being open at night, I'd never have left it open at home"; "I feel safe now because I have the sides up on my bed"; "I feel very safe, I have been living here for five years." A relative told us, "Very happy with the care, very confident with the staff."

Individual risks had been assessed and safety measures put in place to prevent harm. Risks in relation to personal care had been assessed for each person, identifying their individual needs. Where people were at risk of falls, their assessment showed the measures staff needed to take to keep them safe. For example, the equipment to assist them such as a zimmer frame, or to encourage people to wear suitable footwear. A falls diary was kept to assist staff in identifying common reasons for the falls. People who were at risk of acquiring pressure sores had prevention measures in place for staff to follow to ensure their skin remained intact. Where people had a sore area, photographs were taken to track the progress of healing. For example, one person was admitted to the service with a sore area. A written description was made, a body map showed the part of the body the sore area affected and a photograph was taken so nurses could monitor the situation. Individual risks were assessed and monitored to prevent harm and deterioration to people's health.

Some people had behaviour that others may find challenging. Safe processes were in place to protect people and those around them. One person sometimes refused help with their personal care and could become verbally and physically aggressive at these times. A risk assessment gave specific guidance to staff to respect their wishes but to ensure they received the care they required. Measures included, leaving the person for 10 minutes before attending and trying again; if they continued to refuse, staff were guided to request another member of staff approach the person and ask again. Behavioural charts were completed for incidents of challenging behaviour. These recorded, what the person was doing before the incident; what the behaviour consisted of and what happened after the incident. The registered nurses and registered manager monitored the behaviour charts to check if there were any recurring themes to incidents, such as the time of day or the same staff supporting the person at the time. This meant nurses had the information

to review and amend the risk assessment when necessary.

One person had started to display behaviour that was considered challenging to others and staff. Their records showed nurses had acted promptly, updating care plans and risk assessments with significant guidance for staff; updating the registered manager; contacting the mental health team for advice and support; contacting relatives to update them. The person was prescribed a medicine used to reduce anxiety, to be used as and when necessary. This was referred to within the person's care plan. However, it was clear this must only be used as a last resort and nurses had quoted NICE guidance within the care plan to ensure this was understood. The National Institute for Health and Care Excellence (NICE) is an independent public body that provides national guidance and advice to improve health and social care in England. This showed nurses and staff had the skills and experience to make sure people were kept safe from harm.

People now had an individual personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical, communication and equipment requirements that each person has to ensure they could be safely evacuated from the service in the event of an emergency. Regular fire drills were carried out to keep people safe. Fire safety equipment such as fire alarms and fire extinguishers were serviced regularly to make sure they remained in good working order.

At the last inspection, on 22 June 2017, we made a recommendation to the provider that the staffing levels and staff time management were reviewed to make sure there were sufficient staff across the service. At this inspection, although some people thought there were not always enough staff at night, we found that the provider used a reputable dependency assessment tool to calculate staffing levels. The tool was used to calculate the needs of each person, based on their current assessment, giving a range of low, medium or high. The scores were fed in to the provider's electronic system which calculated the numbers of staff required to provide the care and support needed across the service. We checked the staffing rotas and staffing levels were observed to be sufficient. We told the registered manager what some people had fed back to us about night time staffing levels and they told us they would look into this further and report people's views to the provider. We asked some people if staff responded in a reasonable time when they used their call bell. One person said, "The staff know I don't push the bell very often so if I push it they are very quick as they know it's an emergency", and another person told us, "If I ring the bell it depends how busy they are as to how long it takes to answer."

One member of staff had not turned up for their shift on the day of inspection and the registered manager told us because of staff annual leave they were working to their minimum staffing level. The registered manager had therefore contacted managers from the provider's other services in the area to ask for help. Two members of staff arrived to assist. We spoke to the two staff who told us they had the training necessary to provide care to people living with dementia as they worked within a similar service. They said it was not unusual to be asked to support another service in the area if needed.

The administration of people's medicines were managed well, keeping people safe from the risks associated with prescribed medicines. The ordering, storage and disposal of medicines were well organised. Medicines administration records were neatly recorded with legible signatures and no gaps in recording. Medicines were administered by registered nurses who had their competency checked regularly. Nurses were seen to take their time when administering medicines, people were not rushed and were given the time to take their medicines properly. Guidance was available for nurses administering medicines including what they were used for and any side effects to look out for. PRN (as and when necessary) protocols were in place which clearly showed the reasons medicines such as inhalers or Paracetamol were prescribed and when they should be administered. Nurses used a pain assessment tool to support their decisions when considering pain relief for people who were not able to verbally articulate if they were in pain or not. Records showed

that GP's regularly reviewed people's prescribed medicines to ensure their treatment continued to be appropriate.

Staff recorded accidents and incidents, describing the incident, the action taken such as observation and who they reported the incident to – the nurse in charge or the registered manager, and the outcome. The registered manager recorded the action they had taken and completed an analysis of accidents and incidents each month. This helped the registered manager to identify themes such as times of the day falls happened or if falls were witnessed or unwitnessed. Safeguards were put in place if common themes were found. One person had refused to go to bed one night and remained sitting in the lounge. Although night staff tried to encourage them to go to bed, they continued to refuse. Following the incident, the registered manager and deputy manager had identified areas for further staff training and improvement. These had been addressed with individual staff and a coaching session for all staff was held to ensure lessons were learnt and to improve staff skills.

The registered manager promoted an environment where people were kept safe. Staff had a good understanding of their responsibilities in protecting the people in their care from abuse. Staff were confident the registered manager and deputy manager would deal quickly and appropriately with any concerns raised, however they were aware they could report outside of the service if their concerns were not dealt with.

The service was clean and smelled fresh. Domestic staff were employed to take care of the cleaning and dedicated staff had the responsibility of laundry duties. Schedules were in place for both the domestic staff and the laundry staff to record, to make sure all the tasks were completed as required. All staff completed infection control training to ensure they had the skills and knowledge to prevent cross infection. Personal protective equipment (PPE) such as disposable gloves and aprons were available for staff to use when providing personal care. This helped to prevent the spread of infection.

Safe recruitment practices were followed to ensure that staff were suitable to support people living in the service. The appropriate checks such as Disclosure and Barring Service (DBS), following up of references and proof of identity were completed. A DBS check highlights any issues there may be about staff having criminal convictions or if they are barred from working with people who need safeguarding.

A maintenance person was employed in the service which meant that any repairs identified could be dealt with without delay. All essential maintenance works and servicing were carried out at suitable intervals by the appropriate professional services including servicing of fire equipment. These included gas safety checks, electrical wiring, asbestos surveys, legionella testing and portable appliance testing. The registered manager held health and safety meetings on a regular basis with all heads of department within the service to ensure safe working practices continued and concerns were addressed quickly. Health and safety audits were completed by a senior member of staff each month and the providers representative visited every three months to ensure compliance with the provider's safety procedures.

Good

Is the service effective?

Our findings

Many people were not able to tell us whether the staff had the skills and experience to provide their care and support. We observed staff supporting people within the communal areas and saw good practice such as assisting people with their meals and administering medicines. The service was clean and well maintained and people told us they were happy with their food. A relative told us, "The staff have had PEG training especially for my [relative] and [relative] has only been here two weeks, I am confident they know what they are doing". Another relative said, "Excellent hoisting, seem very well trained (staff)."

At the last inspection, on 22 June 2017, we found two areas that required further improvement, staff one to one supervision focused on the negative aspects of staff's work and did not focus on staff development or what staff were doing well; sometimes relatives had signed people's care plans when the person was assumed to have capacity without an explanation as to why. It was not clear whether the person had actually seen their care plan and agreed to their care.

At this inspection we found that the recommendations had been taken into account and work had been done on both areas to make improvements.

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where necessary, mental capacity assessments had been undertaken to determine if people could retain the information to make particular decisions. Where people were found to lack capacity, discussions had been made with relevant people such as relatives to make decisions in the person's best interests.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The 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 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were found to lack the capacity to consent to their care and treatment in the service the registered manager had made the appropriate DoLS applications to the local supervising authority. Care plans were in place for those people with a DoLS authorisation, giving guidance to staff on people's rights and what their responsibilities were in ensuring any attached conditions were followed.

Staff had received one to one and some group supervisions where they had the opportunity to contribute to their personal development and now received positive comments and constructive criticism. The registered manager told us they were aware staff supervision was not yet as regular as expected by the provider as they had been concentrating on other areas of priority since taking up their role. This had also been identified during the provider's auditing processes. The registered manager shared an action plan they had developed

to ensure one to one supervisions were planned through the year. Annual appraisals were also planned to take place by the end September 2018. Staff said they felt supported by the registered manager and deputy manager. One staff member said, "We are made to feel appreciated and are given encouragement with positive feedback."

Staff told us they received the training and updates they required to successfully carry out their role. Training records confirmed this was the case. One staff member described the training, a mixture of training sessions with a trainer who visited the service and online training. Staff told us they could ask for additional training if they felt they needed it or if they were interested in a specific area of their work. Staff were complimentary about the induction they received when they first took up their new post. They told us they felt equipped to carry out their role following induction and a period of shadowing more experienced staff. One staff member said, "I feel I have been invested in and been given the tools to do the job."

People's needs were assessed and their care was planned to ensure their care and nursing needs were met. The registered manager or deputy manager carried out an initial assessment before people moved in to the service. People, and their family members where appropriate, were fully involved in the process. The assessment covered the person's needs including, mobility; personal care; eating and drinking; history of falls; mental capacity; medical diagnoses. The assessment identified what support was needed and this was used to develop the care plan. This enabled the registered manager to make an informed decision that the nursing and staff team had the skills and experience necessary to support people with their assessed needs.

The registered manager told us they asked people if they had specific equality and diversity needs during the assessment process. They said they were not aware that they were supporting anyone with lesbian, gay, bisexual or transgender (LGBT) needs. Although they were aware some people may wish to keep some elements of their personal life private. The registered manager said they would support any person's needs on an equal basis, however was aware this was an area that would continuously improve.

People were supported to maintain their health. Registered nurses were employed to take responsibility for the health and nursing care needs of people living in the service. Where nurses identified a referral was required to a healthcare professional this had been instigated. One person told us, "The nurses are quite good at deciding if you need the doctor" and a relative said, "We use the optician, chiropodist and the hairdresser." Records were kept of all appointments and contact with healthcare professionals such as GP's, dieticians, dentists and chiropodists.

People told us they were happy with the food and meals provided. We received comments such as, "I like to see the dining room laid out nicely"; "Food has been changing a bit but very nice"; "Food is good, I don't like broccoli but they still put it on my plate." Relatives also gave us their views of the food provided, "I have eaten here a couple of times, the food is very good" and "The food is good although [relative] has not got a very good appetite."

The dining areas were pleasant with set places, creating a pleasing ambience for eating meals. A menu was shown to people individually each morning to choose their meals for the day. People could choose whether they ate in their bedroom or in one of the dining rooms. Many people chose to eat in a dining room and we saw people who needed help being assisted by staff.

People who were at risk of malnutrition or dehydration had food and fluid charts so the nurses and registered manager could monitor their intake. Staff were responsible for recording what people had eaten or drank and how much they had taken. We saw that records were well kept by staff which reduced the risk of people not receiving timely support from a healthcare professional such as a GP or a dietician if required.

Some people were being seen by a dietician. A dietician had been involved in one person's plan of care as they had low weight. Their records showed nurses had monitored their weight and followed the advice of the dietician. The person's weight had improved and was stable so they were no longer under the care of the dietician.

The deputy manager told us although most people did not have any religious or cultural requirements regarding the meals they ate, one person was a vegetarian. They told us the chef was more than able and was willing to accommodate any specific needs people may have when they came to live in the service. People's likes and dislikes around food were recorded in their care plan and communicated to the kitchen staff.

The design and adaptation of the premises were suitable for the people living at Ashminster House. The premises had been partly refurbished on the ground floor, providing pleasant and well decorated areas for people to sit and to spend time with their visitors. The service had three distinct units so people with similar needs could be cared for in each area. People living with dementia were supported throughout the service, however, people in the more advanced stages were cared for in the dementia nursing unit, memory lane. Clearly themed and coloured areas within memory lane helped people to find their way around easier, to identify where their bedroom or the bathroom was for example.

Good

Is the service caring?

Our findings

People were very happy with the care they received from staff. They told us they found the staff had a good attitude and were caring. The comments we received included, "Very nice place, I like the carers they are helpful and very good"; "I'm happy and the staff are nice, they listen to what you have to say"; "I have fun with the staff, it's very nice"; "Generally the attitude of staff and carers is excellent."

People's relatives were confident their loved one was receiving care from staff who cared, "A number of the staff have been here since mum first came and they know mum very well which I think speaks volumes"; "General care is good which is what I want for him"; "Carers encourage him to get up, he is getting his confidence back after having had a few falls"; "He gets upset when people (visitors) leave but carers are aware of this and always go in straight away as we are leaving to make the transition easier."

Staff were chatting and laughing with people and clearly knew people well. We saw and heard many exchanges throughout the day. For example, a member of staff supporting a person to attend the weekly coffee morning was having a joke saying, "We don't like sharing the cakes do we." One person, who tended to get frustrated, came out of the coffee morning talking and swearing to themselves. A member of staff saw the person and asked what was wrong. The staff member took them to quiet area and then a few minutes later, they returned less anxious and ready to join in again.

People were supported to express their views and be actively involved in making decisions about their care and support. One person said, "I can have a bath or shower when I like" and another person told us, "I like to look nice, I choose my own clothes and jewellery."

An emphasis on privacy and dignity was included through the care planning process. We saw that staff spoke to people with respect, bending down to speak closely when having a conversation or asking a question. People told us staff were respectful and were mindful of their privacy, "I have a full body wash in bed they (staff) are very discreet"; "I am treated with respect and called by the name I prefer"; "Staff always knock on the door, in fact if they go out and come back in they knock on the door again." One relative told us, "They (staff) really look after and care for dad and treat him with respect and as an individual."

People were supported to maintain and increase their independence where possible. Care plans supported this. We saw people walking around independently and others who staff supported to varying degrees, giving words of encouragement. Staff were walking along with some people and they took their time, taking the opportunity to have a chat on the way. One person's relative said, "Gets better and better every week, she's getting the care that she needs, total change in the last six months, when she came in six months ago she was put on end of life meds."

People's visitors were welcomed at any time and they could see their visitors wherever they wished. The reception area had recently been refurbished and provided a pleasant seating area with hot and cold drink making facilities available for people and visitors to help themselves to. We saw people sitting there through the day enjoying a chat with their relatives and joining in with staff. One person's relative told us, "Everyone

(staff) is always welcoming, you can come anytime, we always get offered a drink when we arrive." A quiet lounge was also tastefully decorated and furnished close to the reception area and we saw this being used for visiting purposes. One person said, "I like the quiet lounge we can make a coffee and sit together and have a chat."

The staff were happy and up-beat, they appeared to enjoy their work and this was reflected in the care we saw being provided in the communal areas. A member of staff said, "It is really enjoyable – hard work but rewarding."

Records were kept confidentially, locked in appropriate cupboards within the nurse's station. Handover records for communication between nurse and staff shifts were locked within the room so that staff had access to the information they needed but were not accessible to visitors.

People were given a service guide to provide the information they needed about the service before moving in and to use while living there. This included information about staff and services as well as how to make a complaint.

Good

Is the service responsive?

Our findings

People were involved in contributing to their care plan and reviewing it when they could be. People's relatives confirmed their involvement in their loved one's care, "I completed his care plan with the manager"; "We have meetings to update the care plan"; "We update the care plan regularly."

At the last inspection, on 22 June 2017, we made a recommendation to the provider that the systems in place to make sure people received the right support and their care was person centred were reviewed. At this inspection we found improvements had been made. Care plans recorded the person centred detail to make sure staff had the information they needed to deliver the care and support identified through assessment.

A range of care plans were in place to describe people's assessed care and support needs. Care plans took a holistic approach to people's nursing and personal care, providing staff with information individual to each person. Person centred care plans recorded the assistance people needed with all elements of their care throughout the day including, personal care; communication; mental health and cognition; nutrition and hydration; pain. People's specific needs were identified through assessment and a care plan developed to make sure the care needed was provided. One person had a percutaneous endoscopic gastrostomy (PEG) tube inserted. A PEG is a feeding tube through the skin and into the stomach to give the nutrients and fluids needed if swallowing food is difficult. A clearly documented care plan was in place to ensure the correct advice was followed when carrying out feeding through the PEG. As part of the care plan, risks were assessed to make sure the person received their nutrition in a safe way.

Where people were unable to use the call bell to ask for assistance, this was recorded in the care plan and a risk assessment in place which stated hourly checks must be made. One person's daily documents showed hourly checks had been recorded by staff to ensure the person remained safe.

People's care plans included a summary of their life history to give staff personal information to enable a person centred approach. Relatives were involved in helping to gather the information necessary. One person's life history told of their early life and siblings, the job they did, the places they had lived and the relationships that were important to them, including their sons and daughters.

People's religious and cultural needs were considered through care planning. The people living in the service at the time of inspection were known to be either Christian or did not practice a faith. The registered manager and nurses told us they checked people's cultural needs during assessment and whatever people's needs were they would gather the information they needed to accommodate their support needs.

Daily records were kept for staff to document the care and support they had given throughout the day. Staff clearly recorded the care given for each individually assessed need. Daily records were respectfully written including the detail required to provide communication and consistency to the next shift of staff.

Care plans were reviewed each month confirming the continued effectiveness of the plan or if changes were

required. Changes in circumstances and need in between reviews were recorded by nurses. One person had a care plan review with their close relative present. Their relative was able to help their loved one to make staff aware they no longer wished to have porridge for breakfast. Their care plan had been updated accordingly.

People and their relatives were encouraged and supported to discuss their wishes for the end of their life. One relative told us, "End of life has been discussed, dad was involved" and another said, "We have talked about end of life care it was very sensitive." Clear information was recorded to show what the person's wishes were when they came to the end of their life, including where they wanted to spend their last days and who they wanted to be with them.

The registered manager was aware of the Accessible Information Standards and the need to make sure people's documentation was in a format they were able to understand. They told us they checked people's needs during the assessment and took advice if necessary to ensure people could understand the documents in relation to their care.

People and their relatives told us they thought there were enough activities to join in with if they chose to. They were also supported to maintain their own interests if this was what they preferred. People had easy access to a well maintained garden. People said, "Have seen [activities coordinator] she showed me her [electronic tablet] the other day and we were looking at something which she is going to transfer to my [electronic tablet] for me"; "I love the garden"; "I use the garden when the weather is nice"; "I have the paper delivered daily so I spend time reading that." Relatives commented, "There are enough activities, she joins in depending on her mood" and "Enjoyed the coffee morning this morning."

Two activities coordinators were employed to organise and plan activities to suit people's interests and needs. They covered the seven days of the week to make sure people had access to stimulation or conversation throughout the week. People had an activities assessment completed that was comprehensive, including people's interests and preferences and what they were able to take part in. An activities plan was developed that was reviewed monthly. One member of staff told us about a musical entertainer who visited. They brought in bongos for people to try. People were encouraged to tap out a beat on the bongos and the staff member said, "It brought the place alive, everyone loved it as they could do it."

A regular weekly coffee morning was underway on the memory lane unit during the inspection. People across the service were invited to attend every week and were supported to attend. Many people joined in and cakes and biscuits were displayed on cake stands for people to choose what they wanted.

An extra television was erected on the wall in the hallway of the memory lane unit. A cowboy musical film was showing. One person who was walking around, unsure of where they were, stopped when a particular song was being sung by a cowboy. They started singing along and a member of staff got a chair for the person to sit down. The staff member sang along with them but the person knew all the words and was really happy, reminiscing, saying it was one of their favourite songs.

The people we spoke with told us they had not had any reason to make a complaint but knew who they would speak to if they did. One person said, "I have no complaints" and another person told us, "I haven't got any problems because they take notice of what I say." The relatives who were visiting said the same thing, one relative said, "If I had a complaint I would be happy to make one, I would talk to the person in charge on her unit" and another commented, "If I had a complaint I would have no problem in complaining I would probably go to the deputy manager first."

Complaints made had been fully recorded according to the provider's complaints procedure. All complaints were briefly summarised on a complaints logging form to keep track of when they came in and when they had been dealt with. We looked at eight complaints. An initial acknowledgement was sent to the person making the complaint as soon as possible. Records showed that all complaints had been fully investigated by the registered manager and a detailed response sent to the complainant within the timescale specified in the complaints procedure. Guidance on how to appeal the outcome was included in the outcome letter. All complaints were logged on the provider's electronic recording system and monitored by senior managers to ensure the correct and timely process was followed.

Good

Is the service well-led?

Our findings

At our last inspection on 22 June 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to, records were not always accurate or fully completed; checks and audits had not always been effective and action had not been taken to address shortfalls; a clear development plan and had not acted on people's and stakeholders views to improve the service.

At this inspection we found improvements had been made. The provider and registered manager had implemented a clear process for monitoring the quality and safety of the service where areas for improvement had been identified and action taken.

The provider and registered manager now had a comprehensive range of audits in place to monitor the quality and safety of the service provided. The areas checked regularly by the registered manager or management team included, care plan documentation; medicines; infection control; accidents and incidents; complaints; nutrition and the dining experience; maintenance including fire records; and cleaning. In addition, the provider's staff external to the service carried out a series of visits to monitor the compliance of the registered manager and their processes. These included, a monthly quality assurance visit by a senior manager; a three monthly full quality improvement review looking at all areas across the service. Each area was rated red as immediate attention required, amber where improvement was required or green as no concerns found. Audits were up to date and findings were recorded in detail. Action plans were developed where areas for improvement were found, identifying who was responsible for taking action and the date the action was to be completed by. Once the improvements had been made and action taken, the registered manager recorded this electronically to enable provider monitoring. A senior manager checked the improvements had been made at their next audit and verified the provider's electronic recording system. This meant shortfalls in the quality of care were identified promptly so remedial action could be taken.

Meetings were held with people and their relatives to gain their views and provide updates about the service. People and their relatives raised areas that were important to them which often included the food and the activities on offer. In one meeting relatives of people living on the dementia unit, memory lane, said they thought there were less group activities on offer. The activities coordinator explained that they were concentrating on one to one activities given the nature of peoples' care needs. Some people told us about the meetings, "Residents meetings are held about once every six months. Meal times have been changed due to suggestions at the resident's meetings"; "My daughter attends the resident's meetings."

People and their relatives were asked their views of the service they received through an annual survey. The questionnaires were sent out by the provider's head office and were returned there. The head office staff completed a full analysis of the scores given and the comments made and sent this to the service for action where necessary and to display within the service. The service was compared to other services within the provider's group and Ashminster House proved to score higher than the average overall. The results were evident within the reception area and on notice boards for people and their relatives to see. The most recent

had been completed in 2017 and the next survey was due to be undertaken. Ashminster House had positive results about the service they provided from people and their relatives.

Some people were not able to tell us if they knew who the manager was. One person did say, "Manager is very approachable and easy to talk to." Relatives felt confident in the management team, "The manager is very approachable, in fact all the staff are that I have met"; "Great communication, the manager is very approachable, very happy with the management."

Staff told us they felt supported by their team leaders on the unit they worked on as well as by the registered manager and deputy manager. Nurses said the management team gave positive feedback and addressed issues when they arose. The staff we spoke with felt there was an open culture where they were able to raise concerns and were confident they would be addressed. One staff member said, "The registered manager is very good and supportive. There are still improvements to be made but it is all very positive."

The registered manager held regular staff meetings to provide information, support, sharing of good practice and where things have not gone well and lessons needed to be learnt. The notes of the meetings showed staff were given the opportunity to raise queries or concerns and they received answers. For example, when a discussion was held regarding a new approach to where staff ate their meals, staff asked why the decision had been made. The registered manager explained the rationale, informing staff it was to maintain and improve the quality of care to people. In addition, the registered manager held monthly health and safety meetings and clinical governance meetings with all the heads of department present.

The staff structure within the service supported the quality of care people received. The registered manager was supported by a deputy manager. Registered nurses were responsible for the running of the two nursing units and a senior care worker led the non-nursing unit. Heads of department had responsibility for their own specific areas, kitchen; housekeeping including laundry; maintenance. The registered manager was supported by their line manager and a management structure to provide policy and guidance.

The registered manager maintained relationships within the local area, attending forums. They kept up to date with local and national guidance through the provider's network of registered managers and senior managers. The provider had an intranet site where guidance and policy was easily available to the registered manager and staff. A senior clinical lead within the provider's organisation provided the advice and guidance registered nurses needed to remain up to date with new professional practice and guidelines.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area and their ratings were displayed on their website.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths without delay. Notifications had been received by CQC about important events that had occurred since the last inspection.