Ideal Carehomes (Number One) Limited

Ashworth 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

Summary of findings

Overall summary

The inspection took place on 26 September and 1 October 2018 and was unannounced. At the last inspection on 13 and 17 June 2018 the registered provider was not meeting the regulations related to safe care and treatment and good governance.

Following the last inspection the registered provider sent us an action plan to show what they would do and by when to improve the key questions safe and well led to at least good. At this inspection we checked to see whether improvements had been made and found the registered provider was meeting all the regulatory requirements.

Ashworth Grange is a 'care home'. People in care homes receive accommodation and nursing or 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.

Ashworth Grange is registered to accommodate up to 64 people. The service provides care for people with residential needs as well as those living with dementia. The home is divided into four units over two floors connected by a lift. At the time of our inspection 54 people were using the service. One unit for people living with dementia had been re-opened following our last inspection.

A registered manager was 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.

Emergency procedures were robust to protect people in the event of the need to evacuate the building. We found the systems for managing people's medicines were safe and competency checks on the administration of medicines were comprehensive and up to date.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. Safe recruitment and selection processes were in place.

The required number of staff was provided to meet people's assessed needs and provide a good level of interaction.

Risks were assessed and well managed. Incidents and accidents were analysed to prevent future risks to people and learning from incidents was evident.

Staff told us they felt very well supported and they received regular supervision, training and appraisal to meet their development needs. Staff had received an induction and role specific training, which ensured they had the knowledge and skills to support the people who lived at the home.

People told us they enjoyed their meals and meals were planned around their tastes and preferences. People were supported to eat a balanced diet and action was taken where people's nutritional intake had declined.

People were supported to maintain good health and had access to healthcare professionals and services. The service was adapted to meet people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Positive relationships between staff and people who lived at Ashworth Grange were evident. Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs.

People were involved in arranging their support and staff facilitated this on a daily basis. People were supported to be as independent as possible throughout their daily lives.

The management team promoted an open and inclusive culture whereby people were encouraged to express their diverse needs and preferences.

Care records contained detailed information about how to support people and people engaged in social and leisure activities which were person-centred.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were approachable.

Everyone told us the service was well-led. The registered manager was visible in the home and knew people's needs. Staff at the home knew their roles and welcomed feedback on how to improve the service.

Improvements had been made to the system of governance and audits within the service and the management team had an effective overview of the quality and safety of the service.

The registered provider had increased resources and senior management input to the home. This had proved effective in driving improvements.

People who used the service and their representatives were asked for their views about the service and they were acted on.

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 were aware of the correct procedure to follow in the event of the need to evacuate the building.

Risk assessments were in place and medicines were managed in a safe way for people.

Staff had a good understanding of safeguarding people from abuse.

Sufficient staff were deployed to meet peoples assessed needs.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to enable them to provide support to people who lived at Ashworth Grange.

People were supported to eat a balanced diet and had access to external health care professionals.

People's mental capacity was considered when decisions needed to be made.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

Care plans contained sufficient and relevant information to provide person centred care and support.

People had access to activities in line with their tastes and interests.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Good

The service was well-led.

People and staff were positive about the registered manager, who was visible within the service.

Effective systems were in place to assess, monitor and improve the quality and safety of the service.

The registered provider had invested in improving the service and made improvements in quality and safety.

The culture was positive, person centred, open and inclusive.

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

This inspection took place on 26 September and 01 October 2018 and was unannounced. The inspection was conducted by three adult social care inspectors on the first day and two adult social care inspectors on the second day.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. On this occasion we did not ask 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.

Some people who used the service used nonverbal, as well as verbal communication methods. As we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time observing the support people received. We spoke with five people who used the service and five of their relatives. We spoke with four care assistants, one senior care assistant, one night care manager, two night care assistants, one kitchen manager, the head housekeeper, the lifestyle manager, two deputy managers, one care manager, the registered manager and the regional director. We looked around the building including some people's bedrooms with permission.

During our inspection we spent time looking at four people's care and support records in depth as well as six others for specific areas of information. We also looked at five records relating to staff supervision, training and recruitment, medicines administration records, incident records, maintenance records and a selection of audits.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Ashworth Grange. One person said, "Oh yes I am safe." A second person said, "Yes I feel safe, but people sometimes wander in here meddling with my things." We spoke with the registered manager about this and they said they would arrange for the person to have a key to lock their bedroom door from the outside when they were out of their bedroom.

At our last inspection we found the service was not meeting the regulations because emergency procedures were not robust to protect people in the event of the need to evacuate the building. At this inspection we found improvements had been made and staff were aware of the correct procedure to follow and had received fire drills in line with the registered providers policy. People had an individual personal emergency evacuation plan (PEEP) in their care records and also located in a red folder in the office by the exit door to the home. PEEPs are a record of how each person should be supported if the building needs to be evacuated.

At our last inspection the registered provider was not meeting the regulations related to managing risk because the level of detail in some risk assessments was not consistent. Behavioural support plans did not always contain sufficient detail to investigate the causes of behaviour that may challenge others and to support staff to prevent and manage behaviour effectively. At this inspection we found improvements had been made and there was evidence behavioural incidents were analysed for the cause and action taken to try to prevent recurrence. We saw a detailed person-specific care plan was in place for a person who could become agitated. This included diversion and distraction techniques shown to be effective for the person.

Senior staff had completed risk assessments for the risk of malnutrition, choking, developing pressure ulcers, falls, continence, finance and leaving the home unsupported. In addition, person specific risks had been assessed when appropriate, such as the risk of having a kettle in a bedroom, or attending a specific outing. Staff said they read people's care records and senior staff shared information at handover meetings, so they had enough information to enable them to care for people safely. This showed the registered provider had systems in place to reduce risks to people.

Air flow mattresses are used to minimise the risk of pressure damage to people's skin, where they may have limited independent mobility or be assessed as having a high risk of skin damage. We found two of the three air flow pressure settings we checked were in line with the care plan and staff were aware of where this information was located. One pressure relieving mattress for a person who had been recently admitted was not set correctly. The deputy manager rectified this immediately and the registered manager added a pressure mattress check reminder to the electronic system to ensure it remained correct. The regional operations manager said they would consider providing a self-setting pressure mattress for the person to ensure they were not able to accidentally alter the setting themselves.

We discussed one risk assessment related to choking with the registered manager.The level of risk was not recorded prior to measures being put in place, to show the person was at high risk of choking without the measures being put in place to reduce the risk. The registered manager and operations manager said they

would look at how this was recorded. We had no concerns the risk was not well managed.

We asked people if they thought there were enough staff on duty to meet people's needs. Four people told us there were enough staff. One person said, "I don't like it in a morning. You are waiting on someone coming. Otherwise it's alright."

One relative said, "There is generally someone about. Ninety nine percent of the time there is someone in the lounge. They could do with an extra one at night." A second relative said, "Yes there are enough staff. They can be stretched if two of them have to do something with another resident in the bedrooms." A third relative said, "When I have been here they call someone in if they have to leave the floor [lounge]." A fourth relative said, "Most of the time there is plenty during the day."

We observed there were appropriate staffing levels on the days of our inspection which meant people received sufficient support. Staff we spoke with told us there were enough staff on duty. The registered manager told us staff numbers were allocated according to a dependency tool and they aimed to provide staff numbers above the level required by the dependency tool. We reviewed historic rotas and found staffing levels were usually appropriate and only occasionally fell short of the registered providers aim of 11 staff on duty during the day. At other times additional staff were on duty to support people on trips out of the home into the community. Where possible any short notice staff absence was replaced with bank staff or familiar agency staff.

The regional manager told us when the home was at full occupancy they would deploy 12 care and senior care staff during the day, including the deputy manager and the care manager. They also told us six night staff would regularly be on duty if the home was at full occupancy. Two senior staff were usually deployed on each night shift and three care staff and occasionally six staff members had been on duty at night. Agency staff were in use on night shifts only alongside permanent staff members to ensure consistency.

We reviewed the call bell monitoring system for the service and found response times were being monitored and the deputy manager told us any concerns had been followed up.

Medicines were managed only by senior staff who had been trained and assessed as competent to administer medicines. Medicines competence assessments and training materials were thorough and evidenced use of best practice guidelines.

The service had a system in place to ensure medicines were ordered and supplied in time to be available when the person needed them. We saw the amounts supplied had been recorded on the medication administration records (MAR) and the count of any remaining tablets was brought forward when appropriate and tallied with the numbers remaining.

We observed the administration of medicines and found they were administered in line with good practice guidelines. We saw time specific medicines were administered as prescribed and the senior staff said they would write the times of administration on the MARs to evidence this going forward.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. This meant people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

Covert administration is the term used when medicines are administered in a disguised format, without the

knowledge or consent of the person receiving them. Administering medicines in food or drink can significantly alter their therapeutic properties and effects so that they become unsuitable or ineffective. Pharmacist advice is always necessary. We found advice had been sought from a pharmacist and an appropriate mental capacity assessment and best interest decision was in place.

The administration of topical creams was recorded by care staff on the electronic system. Medicated creams were administered by senior staff and recorded on MARs.

Medicines were audited monthly by a senior staff member and any issues found had been addressed. Medicines audits had not been completed in August 2018 due to miscommunication. The registered managers audit had identified this and they had taken action to prevent it from happening again. When completing the audit, if a standard was not met, such as when photographic identification had not been in the medication administration records, action had been documented and was signed and dated when complete. This demonstrated the home had good medicines governance systems in place.

People who lived at the home, staff and visitors were protected against the risks of unsafe or unsuitable premises. Checks had been completed on fire safety equipment, emergency lights and the fire alarm and action taken to rectify any issues. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. Staff were aware of any escalating concerns and took appropriate action. The incident records showed the event was subject to senior staff review with any lessons learned translated into care plans. The registered provider had an overview of incidents and accidents which meant they were keeping an overview of the safety of the service.

Staff we spoke with understood their role in protecting people from abuse and knew how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. We saw information around the home about reporting abuse and whistleblowing. One staff member said, "I look after the people here as you would your own grandparents. I have reported a staff member where I used to work for bad practice. I am here for the residents at the end of the day."

Records showed safeguarding incidents had been dealt with appropriately when they arose and measures were put in place to ensure people were kept safe. Safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

We reviewed recruitment records for five staff members. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice and we found recruitment systems were robust.

People were protected from the spread of infection by good staff practice. On the first day of our inspection an infection was in progress and inspectors stayed in the office to minimise any risk of the infection spreading. The management team dealt with the infection well, immediately putting measures in place to prevent the spread of infection and keep people safe. On the second day of our inspection the infection had ceased. The home and equipment we saw was visually clean and smelt pleasant and fresh, with the exception of one en-suite shower room, which had not yet been cleaned that day. Staff had access to personal protective equipment (PPE) and discussed when they used gloves and aprons and when they washed their hands to prevent infection.

Good

Is the service effective?

Our findings

Staff had completed training to enable them to meet people's needs effectively. Staff told us they completed initial induction training and shadowed a more experienced staff member for around three shifts, before they were counted in the staffing numbers.

Staff new to care completed an induction based on the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills and knowledge to ensure they provide high quality care and support. This demonstrated new employees were supported in their role.

Staff completed training including fire safety, moving and handling, first aid, infection prevention and control, nutrition and hydration, mental capacity, equality and diversity and safeguarding adults. We looked at the training records for five staff members and saw they had completed further training in areas such as dementia awareness, mental health and epilepsy. All staff were given training to support people who might have behaviours that challenged. Out of 64 staff only three new staff had not yet had this training. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff were receiving regular management supervision to monitor their performance and development needs. Staff we spoke with told us they felt appropriately supported by managers and had regular supervision, an annual appraisal and regular staff meetings. Supervision and appraisal are used to develop and motivate staff, review their practice or behaviours, and focus on professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

It was clear from observations, people's autonomy and choices were promoted and the service was working within the principles of the MCA. One staff member said, "[Name] has capacity. They can weigh risks and decide if they want to go out alone." We asked the registered manager about the MCA and DoLS and they were able to describe to us the procedure they would follow. DoLS authorisations had been applied for appropriately to ensure people's rights were protected.

We found there was evidence of good practice in the assessment of mental capacity for important decisions, such as coming to live at the service, finance, administration of medicines, medical interventions and use of

bedrails and room sensors.

We checked to see if people's consent was being sought in line with legislation and guidance. We found the electronic system used by the provider to create and store care plans and mental capacity assessments did not currently enable people to sign the documents to demonstrate consent. The registered manager showed us an example of how they had asked families and representatives to come into the home to review consent and best interest discussions, which would then be scanned on to the system.

People told us they enjoyed their meals. One person said, "It's top quality stuff. Very tasty." A second person said, "The meals are very good. You get a choice." At breakfast one person was brought hot chocolate and said, "This is what I get. My favourite."

A relative said, "Yes the food is definitely OK. The pop up restaurant is nice. The next one is a British brunch." A second relative said, "[My relative] loves the meals."
We saw staff offered people a choice of meals, including showing people meals that had been plated up, to support them to make a meaningful choice. Staff were attentive throughout the meal, provided timely support and no one was rushed. Housekeeping staff worked additional hours at meal times to help with meal service. The kitchen manager told us they had made scampi and chips served in paper the previous day on one unit and people had enjoyed the change.

The service ensured people's nutritional needs were monitored and action taken if required. Professional guidance was included in people's care plans and we saw people received their meals and drinks in line with this. Staff monitored people's dietary intake to ensure their dietary needs were met, for example; we saw one person, who had been asleep during lunch, was supported to eat their meal later in the afternoon. Staff recorded people's weight and if there were any concerns, action was taken. Small cups of fresh fruit were available on the tea trolley as well as biscuits, yogurt and cakes, and snacks such as packets of crisps were available throughout the day.

We spoke with the kitchen manager who told us about the different options offered to people according to their preferences and needs. Some people needed their food to be of a different consistency and this was clearly indicated on a board in the kitchen and was updated if people's needs changed.

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice guidance. Care plans included up to date information on health conditions people were living with and how to minimise their impact and provide support to people. Technology was used effectively to meet people's needs, for example, room sensors were is use where people were unable to summon help physically, or were at risk of falls.

People had access to external health professionals as the need arose and systems were in place to make sure people's healthcare needs were met. We saw from people's care records a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy, physiotherapists and the falls team. This showed people who used the service received additional support when required for meeting their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. Ashworth Grange was homely and spacious and comfortably furnished. There were pictures and photographs in the communal areas and the lounges were arranged in a way that encouraged social interaction. Bedroom doors were painted on one unit like a front door and people had chosen the colours they preferred. People

had access to the well-kept secure gardens with seating.

Good

Is the service caring?

Our findings

People told us they liked the staff and we saw there were warm and positive relationships between them. One person said, "Yes staff certainly are nice." A second person said, "Some of the staff are lovely." A third person said, "They are nice. [Name of care assistant] is lovely. The longer you are here, the better they get to know you."

One relative said, "They are all good lasses." A second relative said, "I love the feel of the place. The warmth. The staff have been great. The girls on the door are amazing. Always smiling." A third relative said, "Very good care. The staff are all very caring. The care has to be number one. To give dignity and respect. No shouting. I have never heard anything like that, and I come at all sorts of times."

Staff we spoke with enjoyed working at Ashworth Grange and supporting people. One staff member said, "I love to care for people, so people are well looked after, look nice and are well fed." A second staff member said, "I love it. I know I'm helping residents and giving them 100 percent attention."

We asked staff to talk about individuals living in the home and they talked with genuine care and concern and knew people well. They used this knowledge to engage people in meaningful ways, for example, with conversations about activities or music they knew the person liked. We saw people laughing and smiling with staff.
People looked comfortable and relaxed when interacting with staff and staff maintained compassionate relationships with people. For example, we saw one person became distressed and was supported by the deputy manager to get cup of tea and have a chat.

People's diverse needs were respected and care plans recorded the gender of carer they preferred to support them, as well as their religious and cultural needs. The registered manager told us they were not currently supporting any individuals from different ethnic backgrounds, but gave examples of how they supported people with their religious needs. This demonstrated the service respected people's individual preferences.

People were supported to make choices and decisions about their daily lives. People told us they had a choice of meals, what time to get up or go to bed, clothing, activities or when to have a bath or shower. Staff used speech, gestures, objects of reference and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or meals to support them to make every day decisions if they communicated none verbally. Care plans contained details of how to recognise when a person may be in pain, unhappy or happy using non-verbal cues.

People appeared well groomed and looked cared for, individual rooms were personalised to their taste with furniture, personal items, photographs and bedding they had chosen. One staff member said, "We knock on doors before we enter. If they are in the lounge in their nightie we cover them with a blanket to protect dignity." People's private information was respected and records were kept securely.

People were encouraged to do things for themselves in their daily life. We saw one person helped with washing up after lunch. Care plans detailed what people could do for themselves and areas where they might need support. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Relatives told us they were welcome to visit any time. One said, "I can speak to staff anytime, they are always there." This meant people were supported to maintain contact with people who were important to them.

Some people had independent mental capacity advocates and staff were aware of how to access advocacy services for people when the need arose. An advocate is a person who can speak on a person's behalf, when they may not be able to, or may need assistance in doing so, for themselves.

Good

Is the service responsive?

Our findings

Through speaking with people and their relatives we felt confident people's views were taken into account in planning their care. One relative said, "They ring if there is a problem. They know [my relative] well. We generally leave it to them."

We found care plans were person centred and explained how people liked to be supported, for example, 'Likes to be smartly dressed but informal.' And for another person, 'likes to wear makeup. Will apply themselves.' This is important as some of the people who lived at the home had memory impairments and were not always able to communicate their preferences. A 'Likes to talk about' section of the care plan detailed topics of conversation to engage people, according to their interests.
We found staff knew people's needs and preferences well and we observed care was delivered in line with these. A short personal history was included in care plans. The lifestyle manager had been working with people and families to create personal history folders to give a more rounded picture of the person and store memories and family photographs.

We looked at the care plan for a person who had recently moved to the home and found all information was in place for staff to be able to provide effective care. Care plans covered areas such as skin integrity, communication, continence, personal care and mobility. n one person's moving and positioning care plan, where a hoist was used to transfer the person, the care plan did not specify which loops on the sling should be used and the registered manager rectified this immediately. People's care plans were reviewed monthly or as soon as their situation changed and were up to date.

The electronic care planning system used hand held devices for staff to record the daily care and support provided. Staff accessed a summary screen for each person which informed them of the main elements of care and highlighted any risks, such as allergies, risk of falls or special diets.

Recording of daily support such as re-positioning, personal care and the application of topical creams had improved since our last inspection and an up to date and accurate picture of care and support was available. A 'hospital pack' detailed key information, including daily records for the previous week was also available on the electronic system should the person need to be transferred to hospital at short notice. This helped to ensure important information could be shared quickly in the event of an emergency.

The registered manager was aware of the Accessible Information Standard. This requires the service to ask, record, flag and share information about people's communication needs. Services should take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We saw staff used appropriate communication methods with people. Information regarding people's communication needs, was recorded in care plans, for example information about people's hearing, vision, communication and memory.

People told us they could access activities in line with their tastes and interests. One person said, "A lady does a lot of craft. I like craft. They have a piano now, but I can't play." A second person said, "There is plenty

going on."

One relative said, "[My relative] loves singing. We go into the café. We play the radio and records." A second relative said, "There is loads on. Last week [my relative] went to a sensory farm. There is a café, singers, local walks. The best thing about the home is the various activities."

Staff spoke with good insight into people's personal interests and we saw from activity records people had taken part in activities both inside and outside the home. One staff member said, "This is quite a good home. You can sit with people and spend time with them. They loved the Scarborough trip. To see their faces." The registered provider employed a lifestyle manager and another staff member was allocated 25 further hours to arrange and complete activities with people. Additionally, extra care staff were deployed to take people out on trips.

On the days of our inspection people took part in craft activities, music and movement, visiting the homes sweet shop, table top games, puzzles and gardening. People had taken part in a range of activities including a recent trip to a sensory farm designed for people living with dementia, themed events such as a French pop up restaurant that relatives were also invited to, film nights, and trips to Scarborough and Blackpool. The lifestyle manager recorded who had attended trips out to ensure everyone had the same access to outings and had the opportunity to take part if they wished. A sensory quiet room was also available, for people who may respond better to a more sensory environment.

One relative said, "Staff seem to know what they are doing. I can't complain about anything I have seen here." A second relative said, "I have never had to complain. I'm sure they would act if I did."

We saw complaints had been dealt with appropriately when they arose and action taken when required. Staff we spoke with said if a person wished to make a complaint they would facilitate this. The registered manager was clear about their responsibilities to respond to and investigate any concerns received and demonstrated learning from complaints was implemented to improve the service.

Care staff had received training to support people at the end of their life to have a comfortable, dignified and pain free death. People and their relatives had discussed preferences and choices for their end of life care including in relation to their spiritual and cultural needs. This was recorded and kept under review. This meant people's end of life wishes were clearly recorded to provide direction for staff and ensure people's wishes were respected.

Good

Is the service well-led?

Our findings

People told us the home was well led. One person said, "I talk to the chief." One relative said, "[Name of manager] has been fantastic. I cannot praise that woman enough. I have got one hundred and fifty percent trust in this home. If I've got a problem I can speak to [name of manager] and it will be dealt with. I have recommended it to other people." A second relative said, "It is better since [name of manager came]. It can't improve. I would recommend it." A third relative said, "I'm happy with the home. I would definitely recommend."

At the last inspection on 13 and 17 June 2018 the registered provider was not meeting the regulations related to good governance because systems and processes to assess, monitor and improve the quality and safety of services were not always operated effectively. The registered provider sent us an action plan to show what they would do and when they would meet the regulations. At this inspection we found improvements had been made and the registered provider was meeting all the regulations.

Effective quality monitoring systems were in place. There was evidence of internal daily, weekly and monthly quality audits and actions identified showed who was responsible and by which date. Audits of medicines, health and safety, catering and infection prevention and control were conducted. Care plans and documents were reviewed and audited regularly.

A daily walk round was completed by a member of the management team and action was evidenced if required. A 'resident of the day' quality assurance check was also in place. Each person had a number of person centred checks to ensure they were happy with the service, their room was in good order and they were achieving the outcomes in their care plan.

Information was passed to the registered provider in areas including incidents and accidents, safeguarding, training compliance and recruitment. The electronic records system enabled the registered provider to monitor and analyse live information; for example, whether people's fluid intake targets were being met every day.

The registered manager told us they felt supported by the registered provider, and could contact a senior manager at any time for support. The regional director completed regular quality and support visits. The registered manager worked to an action plan completed in conjunction with the regional director and we saw action had been completed within the timescales set.

Staff told us they felt supported by the registered manager and management team, who acted on any concerns. One staff member said, "We all work as a team. We care for each other. It runs smoothly. If I had any concerns I would speak to the deputy manager or manager and it is dealt with." A second staff member said, "I've seen a massive improvement in the last twelve months. [Name of manager] has turned it around. It's all focused on the residents." A third staff member said, "[Name of manager] is approachable and responsive to feedback. They go above and beyond for the residents."

The registered manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this and we saw the registered manager engaging with people throughout the day.

The registered manager told us their aim was to provide an outstanding service. They told us they attended managers' meetings, training and events to keep up to date with good practice, and had nationally recognised qualifications in social care management. This meant they were open to new ideas to achieve good outcomes for people living at Ashworth Grange.

We found the management team worked in partnership with community professionals and there was no delay in involving partners to ensure people's wellbeing.

People who lived at the home, their representatives and staff were asked for their views about the service and they were acted on. Residents' social committee meetings were held every month and topics discussed included feedback on activities and future ideas and arrangements for outings.

Three 'first impression' surveys had been completed by relatives and a manager from another home which provided feedback on areas such as cleanliness of the environment and friendliness of staff. Anonymous questionnaires about different aspects of the quality of the service were also completed with people every month. We saw feedback was largely positive and where suggestions were made, action was taken by the management team. Information was posted in the entrance to the home demonstrating action had been taken in response to feedback from people.

Anonymous questionnaires were sent out to family members and professionals every six months by the registered provider and feedback had been acted on. The registered manager had created a newsletter which they sent to relatives to keep them up to date and involve them in the home.

People were invited to complete forms voting for staff who had been exceptional each month and prizes were given to 'staff of the month' winner and runner's up. We saw a memo from the registered manager praising all staff, "It's a big Well Done to all staff… amazing job…" Positive comments from management can raise both standards and staff morale.

Staff meetings were held every month. Topics discussed included mattress checks, sensor checks, staff development and training, activities, encouraging fluids, bath temperature checks, daily records and staff of the month. Actions from the last meeting were discussed and goals were set from the meeting. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

The registered manager understood her responsibilities with respect to the submission of statutory notifications to the CQC. Notifications for all incidents which required submission to CQC had been made.