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

Overall summary

The inspection visit was carried out on 19 and 20 May 2015 and was unannounced. The previous inspection was carried out in March 2014, and there were no concerns.

Ashminster House provides accommodation, personal care and nursing care for up to sixty older people, some of whom are people living with dementia. The premises provides care on two floors in three units. There is a passenger lift between floors. The ground floor (Windmill Lodge) is for up to 24 older people with nursing needs; and the first floor has two units for people living with dementia. 'Memory Lane' is for up to 21 older people with nursing needs and living with dementia; and 'Rose Court' is a 12 bed unit for people with residential needs and living with dementia.

The service is run by a registered manager, who was present on the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Applications had been made to the DoLS department for all of the people living with dementia for depriving people of their liberty for their own safety. This was because the doors to the units and the passenger lift were safeguarded by key pad locks.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so.

The service had systems in place for on-going monitoring of the environment and facilities. This included maintenance checks, and health and safety checks. There were comprehensive risk assessments in place for each area of the premises. These showed how to minimise the assessed risks. The registered manager or deputy reviewed these with the regional director as part of monthly monitoring programmes. There were individual risk assessments for each person living at the service. These included risks such as the risk of falls, or the risk of choking; the use of bed rails and the risk of developing pressure sores. All of the risk assessments were written in relation to each person's needs. Actions were identified and put in place to lessen the risks. Emergency procedures were suitably detailed and included a personal emergency evacuation plan for each person.

Staff were visible in all areas of the service during the inspection visit. There were sufficient numbers of staff to meet people's individual needs without rushing them. People spoke highly of the staff and said they "Always have time for us". The service had robust recruitment procedures in place to check that staff were suitable for their job roles.

Staff were given a detailed induction, and were supported through their probationary period. This included essential training such as fire safety, safeguarding adults, and food hygiene. Staff training records showed that staff kept up to date with training requirements, and were given additional training relevant to their job roles. This included dementia care, and customer care. Most care staff had completed formal qualifications in health and social care or were in the process of studying for these. Records of supervision and appraisals confirmed that staff were working to appropriate standards and were supported by the registered manager and the deputy manager. Staff were encouraged to attend meetings, and to take their part in the development of the service.

Nurses were able to keep up to date with their skills and competencies and complete training or refresher courses in subjects such as catheterisation or venepuncture (taking blood samples). Nursing and senior staff administered medicines and followed safe practices for this.

The premises were visibly well maintained and well presented. There were no offensive odours, and people told us "They always keep it very clean". There was an on-going business plan to keep the service in a good state of repair, and to make changes to further enhance the environment. This included regular redecorating and refurbishment of bedrooms and communal areas.

People's own views were listened to and taken into account, and their care plans showed that their independence was promoted and their dignity was respected. People were given choice in how they lived their lives, and made their own decisions about when they wished to get up and go to bed, their meal choices, their clothes, and social activities. They were given clear information about the service, and discussions were carried out with the person and/or their representative for any changes in their care planning. People who lacked mental capacity or had fluctuating capacity were supported with decision-making. This followed agreed protocols to involve their next of kin or representative, and health and social care professionals, to make decisions on their behalf and in their best interests. Staff were fully informed about the importance of applying the Mental Capacity Act 2005, and to enable people to make decisions within their capacity.

Summary of findings

The nurses and care staff maintained good links with the local GP practices, and contacted people's doctors as needed. Referrals were made to other health professionals such as dieticians and dentists when necessary.

People were able to choose their food at each meal time, and snacks were always available. Each unit had it's own kitchenette area where staff could make drinks and snacks for people. People spoke highly of the food, using words such as "Excellent" and "First-class". The food was home-cooked, including home-made biscuits and cakes each day. Dining areas were attractively presented with tables laid with tablecloths, napkins and fresh flowers, and several people said how much they appreciated this.

People said that staff had a very caring approach. This was evident from the welcome received in the reception area, through to care staff, nurses, and other staff on each unit. Relatives and visitors were made welcome and were encouraged to recognise it as people's home. The different units maintained a homely feel with pictures, games and ornaments in evidence. Units for people living with dementia had many items available to support people throughout the day with familiar objects to trigger memories and enjoyment.

An activities co-ordinator oversaw the management of activities programmes and entertainment, but the staff had a holistic approach, and all of the staff saw it as their responsibility to spend time with people, talk with people, and carry out small acts of kindness (such as getting drinks or showing people where to go). Each person was provided with a key worker who spent a minimum of three occasions per week talking with people they supported, to see that they were happy and settled in the service, and to identify any areas where they could be further supported. There was a wide range of individual and group activities every day, and we observed people laughing together, playing cards, playing dominoes and skittles and enjoying music and singing.

People's care plans were person-centred, were discussed with people and their relatives (as preferred), and contained comprehensive information. Separate care plans were written for each aspect of care, and monthly reviews were carried out. People's family members were invited to take part in reviews if they wished for this. People were informed about the service's complaints procedure and this was clearly displayed. There were systems in place to monitor and follow through minor concerns as well as complaints. These showed that people's views were taken into account, were listened to, and changes were made in response where needed.

The service was led by a registered manager who worked closely with the deputy manager and the staff team. Staff were fully informed about the ethos of the service and its vision and values. They recognised their own roles as important in the whole staff team, and there was good team work throughout the inspection. Staff showed respect and value for one another as well as for people living at the service and their family members. Staff spoke highly of the registered manager and deputy manager, and said they were always available and very supportive. They led by example, and spent time wherever possible working alongside the rest of the staff team. Staff said they made them "Feel valued". People and their relatives said they could "Not speak highly enough" of the registered manager and deputy. Relatives often nominated staff for care awards given by the company. This was due to how they "Spent time with people, had a cheerful attitude and gave consistently good care".

The registered manager carried out monthly audits to monitor the progress of the service. Quality assurance surveys were carried out for people living in the home and relatives, and the results were displayed in the reception area. The results for 2014 had been very positive, with an overall score for all aspects of the service as 927 points out of a possible 1000.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe and secure in the home, and said that staff looked after them well.

Staff were trained in safeguarding and emergency procedures. Environmental checks and individual risk assessments were carried out to maintain people's safety.

There were robust staff recruitment procedures to ensure staff were suitable for their job roles. Staffing numbers were maintained to a level which ensured that people's needs and preferences were met.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff kept up to date with all essential training requirements, and carried out additional training relevant to their job roles. Staff received regular individual supervision and appraisals.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

The service provided a variety of food and drinks to provide people with a nutritious diet. Staff were knowledgeable about people's health needs and ensured these were met.

Is the service caring?

Good

The service was caring. Staff were kind to people, and spent individual time with them. Staff respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, and gave them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Is the service responsive?

Good

The service was responsive. People and their relatives were involved with their care planning, and the care plans reflected people's individual needs.

The service provided people with meaningful activities in different formats, and included individual time as well as group activities.

Concerns and complaints were taken seriously, and were appropriately investigated and responded to.

Is the service well-led?

Good

The service was well-led. The registered manager led the staff team in providing a reliable service where people's health and wellbeing were of the highest importance.

Summary of findings

The service had an ethos of continual development and improvement, to enhance people's experience of living in the service.

There were effective systems in place to monitor the service's progress and quality using audits and questionnaires. Records were kept up to date and were accurately maintained.

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 checked whether the provider was 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.

The inspection took place on 19 and 20 May 2015 and was unannounced. It was carried out by two inspectors, a specialist nurse advisor, and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service, and the expert was experienced in older people's care.

Before the inspection, we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) A notification is information about important events which the service is required to tell us about the law. We contacted five health and social care professionals for their views of the service before our inspection, and received replies from three of these.

We viewed all areas of the service, and talked with 17 people who were receiving care and treatment. Conversations took place with individual people in their own rooms, and with groups of people in communal areas. We also had conversations with five relatives and visitors, and 13 members of staff as well as the registered manager.

During the inspection we carried out an observation in one of the units (Rose Court) called a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff interactions with people and care provision throughout the day.

During the inspection visit, we reviewed a variety of documents. These included 12 people's care plans, three staff recruitment files, staff induction and training records, staffing rotas for two weeks, medicine administration records, health and safety records, environmental risk assessments, activities records, quality assurance questionnaires and relatives' surveys for 2014, minutes for staff meetings, audits, the service users' guide, complaints log, and some of the home's policies and procedures.

Good

Is the service safe?

Our findings

People said that they felt safe in the home. Some of their comments included, "I sleep very well here. It feels very safe as there are so many people around"; "It's fine living here"; and, "Everything seems fine and it is a safe place to be". Visitors said, "The staff are prompt to react to things", and, "My relative is safe here. He was quite unsettled when he came in which was a worry, but they sorted it out and now he is much more settled".

One of the people living with dementia in the residential unit happily showed us her bedroom and the rest of the unit where she lived. She showed us where the doors of the unit were secured with key pad locks, and told us "You can't go through there. It keeps us safe and stops us falling down the stairs." And for another door, "That one is a fire exit".

Staff training records showed that all of the staff had received training in safeguarding adults. Staff confirmed their understanding of the different types of abuse and what action to take if they suspected abuse might have taken place. They were also informed about the home's whistleblowing policy, whereby staff should be able to report concerns about other staff members in a way that did not cause them discrimination. The manager was familiar with the processes to follow if any abuse was suspected in the home; and how to contact the local authority safeguarding team. There was a copy of the Kent and Medway safeguarding protocols which was easily accessible for the staff. In the reception area, there were two notices displayed which informed people about the whistleblowing procedure and safeguarding adults. These included a confidential helpline for anyone who wished to 'blow the whistle'; and explained the different types of abuse that people could experience. This provided people and visitors with clear information about unacceptable treatment and abuse, and who to contact if they had any concerns of this nature.

The service provided a comprehensive range of environmental risk assessments. These included risks associated with every area of the service, including the kitchens, communal rooms, bathrooms, bedrooms and garden. They highlighted possible risks such as burns and scalds in the kitchen and kitchenettes (on the units); slips, trips and falls in different areas; fire risks for all areas (for example, associated with washing machines and tumble dryers in the laundry); risk of legionella bacteria in the water, and risks of unsafe rubbish disposal. Specific risks were identified for different tasks. These included risks which might occur during activities. For example, it was noted that there was a higher risk of slips, trips and falls if a communal room was darkened for a film show; and there would be an increased risk of falls or fire risks at entertainment events if seating was not correctly arranged to provide a clear walk way to emergency exits. Each risk assessment showed how to lessen the identified risks.

Health and safety committee meetings were held on a regular basis and showed that safety measures were reviewed at each meeting for infection control, food hygiene, use of chemicals, environmental risks, accidents and incidents, staff training in health and safety, and hazard warning notices. Action was put in place to prevent or minimise risks at each meeting, and were reviewed at the next meeting to ensure the actions had been carried out. For example, safety measures included the use of hot trolleys for delivering food to units for people living with dementia. Staff were particularly made aware of any people who might be at risk of touching these and to ensure a staff member always stayed near the hot trolley to prevent contact.

Emergency plans were provided, and there was an agreement with premises opposite the service for people to go to in the event of emergency evacuation of the premises. Fire equipment and emergency lighting were checked at required intervals, and there were emergency 'ski-pads' available for assisting people downstairs. The service had a 'grab bag', which included a 'personal emergency evacuation plan' (PEEP) for each person, and showed if they were at high, medium or low risk if they needed to be moved out of the home in the event of an emergency.

Each person had individual risk assessments in their care plans. The service's policy ensured that these always included the risk of falls, risks associated with mobility and moving and handling, risk of developing pressure sores, risk of poor nutrition, and the risk of choking. Additional risk assessments were included as needed, such as the risk of using bed rails, risk of being unable to use a nurse call bell, and risk of equipment use such as hoists and pressure mat alarms. Each risk assessment showed how the risks were minimised, and risk assessments were all reviewed

monthly. For example, people living with dementia and at risk of falls, were provided with pressure alarm mats by their beds. These alerted staff if they got out of bed unattended during the night.

Accidents and incidents were recorded and monitored for each person and each unit. Staff were informed about any identified trends. For example, if there was an increased number of falls, this would be discussed with staff, and checks would be made to ensure that staff knew the people who were at the highest risk, and if they were following the measures to lessen the risks. This included people who had been assessed as needing hip protectors to wear, and staff being present in communal areas.

Nursing and care staff were visible in each unit throughout the inspection visit over two days. A visitor said, "You never need to hunt for staff, they always greet you, and always welcome you, and you know you can ask them anything". People told us that staff responded quickly to their call bells, and we observed this in practice. The registered manager used a 'print out' in her office to determine how long people needed to wait for their bells to be answered, and this provided confirmation for any concerns raised. The service used a dependency tool (a method of determining how much assistance people needed) as a way of deciding how many staff were needed on duty in each unit. There was one nurse on duty on the ground floor and one nurse on the first floor during the day shifts; and one nurse for the whole service at night. The registered manager and deputy manager were also registered nurses, and were on duty most days.

Care staff numbers included five care staff in the morning and four care staff in the afternoons for Windmill Lodge on the ground floor (up to 24 people); four care staff all day for the first floor unit for people living with dementia and nursing needs (Memory Lane, for up to 21 people); and two care staff all day for the unit on the first floor for people living with dementia and residential needs (Rose Court, up to 12 people). Night shifts included five care staff for the whole service, with two on the ground floor and three for the first floor units. One of these was allocated to Rose Court. The deputy manager provided a staffing rota for four weeks in advance. If there were changes in people's needs which meant that additional staff were needed, extra care staff were added to the shifts. There were suitable numbers of staff employed to cover for additional shifts, and for holidays and sickness.

There were sufficient numbers of administrative, catering, housekeeping and maintenance staff. A full-time activities co-ordinator oversaw the activities and entertainment for the service, and was mentoring a part-time activities co-ordinator who had recently joined the staff team. All of the staff had a holistic approach to care, and would spend time talking with people, supporting them, and helping them to find their way around. There were sufficient numbers of staff to meet people's assessed needs, and spend time with them, meeting their emotional, cultural and psychological needs, as well as their physical needs.

Staff recruitment procedures were thorough, and included required checks, such as ensuring the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. A record was kept of the interview process. One of the people living with dementia enjoyed taking part in the interview process with the registered manager, and this helped to assess if applicants related appropriately to people living with dementia. The registered manager told us that a decision had been made not to employ a candidate as a result of this person's helpful input.

Nursing staff administered medicines on the nursing units, and senior care staff administered medicines in the residential unit. Checks were carried out to ensure they had completed required training, and they were required to attend training updates during the year. Medicines were stored in locked metal cupboards in locked rooms and in medicine trolleys. Liquid medicines were kept separate from tablets so that any leakage from bottles would not cause damage. Bottles of medicines and eye drops were dated on opening as a reminder that these items had a limited shelf life. External medicines and creams were stored separately from internal medicines to promote safety. Room and fridge temperatures were recorded daily to check that medicines were stored within the required temperatures. The service had policies and procedures readily available to refer to, including the action to take in the event of any medicines' errors. There had been no errors during the past year.

Homely remedies were only provided to people when their GP had agreed to this, and had signed to confirm the medicines which could be given. There were clear protocols in place for giving medicines as required ('PRN'

medicines), which gave clear directions about what these medicines were for and when they could be given (for example, for pain relief). Some people living with dementia did not wish to take medicines which they needed. These had been assessed by the GP to check the importance of having their medicines, and were discussed at a meeting with nurses, social care professionals and the person's next of kin or their representative to decide if the medicines should be given covertly within the person's best interests. Directions on the charts included 'Will take this if put in with porridge'.

Medicines were recorded on administration records (MAR charts), and on topical application forms for external creams. Records included a photograph of the person to confirm their identity, and highlighted any allergies. MAR charts had been clearly and accurately completed. Changes to medicines or their doses were sometimes written directly on the MAR charts by the person's GP to avoid possible errors. If a doctor decided to change a medicine and needed to contact staff by phone, there were procedures in place for two nurses to listen together on a speaker phone, and check back with the doctor they had heard correctly before receiving confirmation of the medicine change through a fax or prescription. There were suitable procedures in place for destroying medicines which were no longer required, and records were correctly maintained.

Good

Is the service effective?

Our findings

People and visitors told us that they thought staff were well trained and cared for people. Some of their comments included, “It's very happy here, they look after us so well”; “The staff are always welcoming and there are always people about”; and, “She is well looked after and I can seen an improvement” (in her health).

All new staff were taken through a detailed induction programme by the service’s in-house trainer. This started with a ‘taster’ morning, and then an afternoon covering the initial priorities of fire safety, and staff’s duty of care. There was a structure in place to cover all of the training programme, which involved written tests and answering questions after receiving training in required subjects. Staff were not allowed to commence any duties until they had completed moving and handling training and safeguarding adults. The induction included other essential subjects such as infection control, food hygiene, the Mental Capacity Act 2005 and dementia awareness for all staff. Staff were supervised throughout their probationary period, and had meetings with the registered manager or their line manager during the first week, half way through the induction, and at the end of the induction. A meeting was carried out to discuss if they had successfully completed their probationary period, and this was confirmed in writing.

Staff training records confirmed that all staff kept up to date with essential training, and received additional training in subjects relevant to their job roles. Care staff were encouraged to carry out formal training in health and social care, such as Qualification Credit Framework (QCF) training or diplomas to levels 2 or 3. (QCFs are work based awards that are achieved through assessment and training, and show that staff have the ability to carry out their job to the required standard). Staff working in units for people living with dementia were being provided with advanced training to support them in understanding and caring for people. This followed the company’s own training resource called ‘So Kind’ which was an 8 week course, and was similar to training provided by the Alzheimer's Society.

Nursing and care staff had taken part in end of life training provided by a local hospice. Nurses were given training and refresher courses to update their skills, and this included catheterisation, venepuncture (taking blood samples) and use of syringe drivers (a method of delivering a continuous low dose of medicines to people, for example, for pain relief). Training was obtained from external sources as well as in-house so as to gain the maximum benefit from training available. This included training from the Clinical Commissioning Group’s (CCG) Elder Nurse Specialist who provided nurses with training in accountability, wound care, and early recognition of symptoms.

All staff received regular individual supervisions, and these were recorded on the company’s IT system and showed when next supervisions were due. Staff told us these were usually every three months, but said they also had group supervisions and lots of staff meetings for different departments to ensure they kept up to date with any changes. Supervisions included discussions about best practice. All staff had been given an annual appraisal during November and December 2014 at which time a Personal Development Plan was agreed with them, to be worked through during 2015. Staff said they welcomed the opportunity to think about their development and receive support to achieve their goals. The manager provided supervision and appraisals for all heads of departments, and received her own supervision and appraisals from the Regional Director.

Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and understood how to apply these. The Act protects people who lack mental capacity, and assesses their ability to make decisions or participate in decision-making. Staff demonstrated that they gained people’s consent to giving them care and support, and carried this out in line with people’s own preferences. For example, people who lacked capacity to make difficult decisions were involved in their day to day choices about the food they ate, the clothes they wore, and the activities they preferred. People who were unable to understand or retain information to make difficult decisions were supported by their family members or representative, and by health and social care professionals, so that decisions were taken together according to the person’s best interests. The registered manager had made applications to the DoLS office for all of the people living with dementia, as keypad locks for their security also affected their liberty to leave the building unaccompanied. Staff ensured that people who wished to go out of the premises or into the garden were supported to do so.

Good

Is the service effective?

People and their relatives said that staff communicated with them well, always informing them of any changes. People were given written information when they were admitted to the home, and were given individual copies of information such as weekly activities programmes.

People were provided with menu choices and said that the food was very good. Some of their comments included, "The food is good and there is plenty of it", and "The food is first class!" One person told us they did not like the menu choices for the day, but spoke cheerfully and said "I can ask for something else". A four week menu planner showed that main meals included a meat or a vegetarian option, with two choices of dessert; and supper included a hot meal or a cold platter with the choice of two desserts. There was a wide selection of breakfast choices, and snacks were available at any time. Mid-morning and mid-afternoon drinks were served with a choice of home-made biscuits or cakes.

People were able to sit where they wished, and could eat in their own rooms or in the dining rooms on each unit. Dining tables were attractively presented with clean tablecloths, napkins and fresh flowers. Staff were allowed to eat meals with people, especially on the first floor units. This provided a homely atmosphere for people living with dementia, and enabled staff to assist people calmly and discreetly. We observed that people at risk of choking were assisted to sit upright before meals, and staff ensured that they had the right consistency for their food, for example, soft diets or puree diets, and thickened drinks. People living with dementia were shown an example of the two dishes for each course, and chose which one they preferred. Staff were familiar with people's likes and dislikes, and knew if they preferred tea or coffee and if they took sugar. Staff spoke to people by name and asked if they wanted assistance. One person living with dementia did not eat all of their food and was told "Don't worry, you don't have to eat it all".

People's weights were recorded on admission and then monthly. Any significant weight gains or losses were reported to the nurses and to the deputy manager and registered manager. Each person had a nutritional assessment, showing their body mass index, and any specific dietary needs. The chefs were familiar with people's different diets, and regularly discussed the meals and the food with people in each unit, so that they were aware of people's preferences. The kitchens were well organised, and the Environmental Health Officer had awarded the highest rating of five stars for food hygiene.

Nursing staff referred people to see their GP as needed, and referrals were made to other health professionals if a need was identified. People had been visited by opticians, dentists, occupational therapists (for specialised equipment), dieticians, psychiatrists and the mental health team. For example, a person with a 'PEG' feed had regular visits from a dietician to monitor their food and fluid intake. (A 'PEG' is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person's stomach when they cannot maintain adequate nutrition with oral intake). Support was obtained from hospice nurses for giving end of life care. Outcomes of visits from health professionals were clearly recorded, and care plans showed that treatment was given according to their directions. A health professional told us that nursing staff were "Professional" and "Very competent". They said that the deputy manager who led the clinical team was "Well organised, informed, and an excellent advocate for the residents". A family member told us, "My relative is well looked after and I can seen an improvement" (i.e. with her health). They went on to say that they thought this was due to the care she was receiving.

Nursing staff showed a wide knowledge of the people in their care, and could discuss details of their progress. Care staff demonstrated good knowledge on how to set and monitor the effectiveness of pressure-relieving air mattresses, and the importance of using barrier cream on pressure areas as part of the preventive management. Where people needed wound care, wound assessments and dressing changes were thoroughly recorded. Photographs were taken with the person's permission, and demonstrated wound healing. Each wound was documented separately so as to provide clear records.

Bedrooms were all for single use and had en-suite toilets and wash basins. Specialist nursing 'profiling' beds were provided, which supported people with their care and comfort. Assisted baths and showers were available for each unit, and disabled toilets. Hand rails were strategically placed in corridors and in people's own rooms. The premises had been purpose built, and had wide corridors which easily accommodated equipment such as mobile hoists. Each unit was self-contained with dining rooms,

Good

Is the service effective?

lounge areas and kitchenettes. A passenger lift between floors enabled easy access to the rear garden for people on each floor. The rear garden included seating and walking areas.

Good

Is the service caring?

Our findings

People told us that staff really cared about them. This was expressed by people that we spoke to, and we observed staff's caring attitude and behaviour for people who could not express themselves clearly. People were spoken to by name, and staff took an interest in what they were doing or saying. People were offered choices, for example about food and activities, and staff respected their choices and responded to them with consideration and respect. People told us, "They take good care of me"; "The staff are friendly and nice"; "It's very happy here, they look after us so well"; and "I love it here, they take good care of me". Another person said, "They are lovely here".

Visitors thought that the care was good. "It's a happy place" one person said, "and the staff are so kind and welcoming". The welcome people received when they visited the home was exceptional. All the visitors that we spoke with commented on this and said they were "Always given a warm welcome"; "The reception staff are always so friendly"; and "We are always made to feel welcome and offered drinks and biscuits." A relative said she could "Not fault the care" both she and her relative had received. She said, "It's like being with good friends, they have fully involved me. I visit every day and they let me take home some of the laundry because I want to feel involved. I don't really need to as it could be done here".

Staff showed understanding of people's equality and diversity. They responded to people throughout the service with the same caring manner, and actively enabled people to pursue their choices. People said, "I do not feel pressured to join in activities if I don't want to"; and, "I am not afraid to voice my opinion". Staff were mindful of maintaining people's privacy and dignity and ensured that assistance with personal care was offered discreetly, and carried out in people's own rooms or bathrooms. Care staff answered people's call bells promptly, and knocked on the bedroom door before entering the room. The care staff were not task oriented, and did not rush people, but attended to them with a gentle and caring manner. Staff offered people explanations about the care they wished to give, and reassured people if they became agitated or upset. Staff gave people lots of eye contact and acknowledged people as they went past them. They responded readily to people's requests, for example, for another cup of tea, or to be taken to a different room.

Staff showed attention to the details of care, and people had their hair nicely arranged, were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. People's rooms characterised their preferences and included their own personal items. People living with dementia had 'memory boxes' attached to their bedroom doors. These included photographs or items which brought back special memories. One person showed us that their memory box included a photograph of their wedding day. Bathrooms and toilets in units for people living with dementia had attractive signs on them that identified the purpose of the room without the signs looking childish. The corridors contained wall art and imaginative items to stimulate people's memories. These included accessible chests of drawers and rummage boxes with interesting items that people could find or be invited to use.

Staff promoted people's independence, and allowed them to carry out tasks for themselves if they wished to do so. For example, one person wished to take their time eating a late breakfast each day, with minimal support. The chef agreed to delay lunch times for this person, and to offer a variety of other foods that they might wish to try, including finger foods. A chart was maintained so that the staff and the person's family members could review this situation together. Another person said they did not usually need any help with personal care or mobility "But if I do need help I will ask. I like being able to do things for myself".

People expressed a sense of their well being. One person spoke about being able to go to bed when they wished and said, "And I can get up at a reasonable time, which is not too early". Another person was involved with an activity with other people, which was making and decorating biscuits, and told us "I love the company". This person chatted easily with staff and other people, while helping with the biscuit mixture. Other people were quite absorbed in the activity, and spent time talking to each other and to the staff member helping them. There was a good rapport with lots of joking and helping each other. We observed six people in another unit playing card games together with a staff member, and then dominoes. There was lots of fun and laughter. Some people were invited to join in, but said they preferred to watch. Another person decided to go and wash cups up in a small kitchenette. Staff said this person enjoyed doing this every day, and it had been risk assessed for the person's safety.

Good

Is the service caring?

The care plan for a person on a different unit showed their preference to spend time alone in their room during the afternoons. Staff had established how they liked to spend their time and what resources they liked to have available, and we observed these were put in place. Another person had withdrawn from activities for a while after a bereavement, and the care plan showed that staff had spent individual time with them and had given them bereavement support. At lunch time, one of the people living with dementia slipped in and out of orientation from the past to the present day, and could be quite confused. All the staff demonstrated understanding of this and gave the person reassurance when they expressed a worry about their family. When one of their relatives visited unexpectedly, they were immediately able to sit with the person at their table, and were made welcome and offered a drink.

Each person was allocated with a member of the care staff as a 'key worker'. This role included liaising with the person's family members if they needed more toiletries or new clothes; keeping their clothes and room tidy, and checking details of care such as helping people with their nail care. The service had implemented a system whereby each key worker spent a minimum of 15 minutes, three times per week, talking with people as their key worker, or spending individual time with them. This provided a valuable opportunity to get to know people at a deeper level.

Information was provided for people when they were admitted to the home, called 'Celebrating Life'. This was in a clear format with large print which was easy to follow. It included details of the staff, services provided, care planning, emergency procedures, and obtaining people's views. Each week people were given an updated list of pre-planned activities, and a copy of the home's newspaper, the 'Weekly Sparkle'. This contained past information about the same week in previous years, as well as quizzes, and articles of interest, and up to date information about the service. The paper was used extensively as an aid to discussions and talking-points throughout the week.

Good

Is the service responsive?

Our findings

People's care plans included their life histories, details of their previous lifestyles, and their likes and dislikes. This enabled staff to care for them in ways that were applicable for them. Staff ensured that people were called by their preferred names, and checked if they preferred male or female care staff for assisting them with personal care. People said they could stay in their own rooms or go to the lounges as they wished, and said, "Staff are really kind and supportive". Personal life histories were written from the person's own viewpoint and started with 'Please call me..' (name of choice); and went on to include their family names, relatives, family traditions, occupation, special memories, spiritual needs and social groups.

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. These included all aspects of their care, and formed the basis for care planning after further checks on admission. Care plans included people's personal hygiene care, moving and handling, nutritional needs, continence, sleeping, skin care, breathing and pain management. They contained details such as if people preferred a bath or a shower; if they needed help with dressing and undressing; when they liked to get up and go to bed, and preferences about their food, their clothes, and their social activities. People's care plans were discussed with them, and their family members if this was their wish. Care reviews were carried out each month, and people were invited to write their own comments on the form for the care review. Comments had included, "The care I get is good"; and "I am well looked after". A family member commented, "I have the opportunity to be involved in decisions about my relative's care".

Staff ensured that people's specific needs were followed. For example, when a person came in with a hearing impairment staff discussed with them if an audiology referral was needed. People who had catheters had care plans with details of their catheter care; people with mobility concerns had care plans about how staff should supervise them with walking, or how they should be supported with moving and handling. People who required the assistance of a hoist were measured for the correct sling size, and were provided with their own sling.

The service had a 'Resident of the day' scheme, which was the day the nurse and key worker went through the person's care plan with them; the chef visited to see if any food changes were needed or requested; and the domestic staff gave their room a deep clean. Any maintenance issues identified in their room were attended to. People knew when they were the 'Resident of the day' and one person said this made them feel "Quite special". All shifts started with a staff handover. A member of the care staff said, "The nurses keep us up to date, and if someone has a doctor's visit the nurse tells us the outcome straight afterwards. We are kept in the loop with everything".

Care plans identified if people could communicate their needs clearly, and how much people living with dementia suffered from confusion. Staff said that if people had behavioural issues, they understood that people were trying to communicate their needs. For example, if a person was shouting, it may be because they wanted help to find the toilet, or because they were thirsty. Staff recognised that it was important to obtain as much information as possible from people's relatives if the person was unable to communicate clearly, so that they could familiarise themselves with the person's character and treat them appropriately. This included their past history, such as war times, as well as their interests such as music, cooking, and gardening.

The service employed an activities co-ordinator who kept individual records of the activities people had engaged in, and was directly involved in writing people's care plans for activities. She was assisted by a care staff who worked two days a week as an activities assistant. They led resident/relative meetings on alternate months, to obtain people's feedback and ideas. These were attended by people from all units. People's suggestions were listened to and used, and in the last week this had resulted in having a fish and chip meal served in 'newspaper' (printed cones checked as suitable), and a 'pie and mash' meal. People discussed if they wanted to go out, and went to places such as garden centres, shopping and country rides in the service's own minibus. These always included a staff member for each person, and staff often volunteered to help with these trips in their own time. Records enabled the activities staff to ensure that the opportunities for going out were shared out between people. An activities programme was provided to each person each week, and was on display in each unit. This included games such as skittles and dominoes, carpet bowls, cooking, film afternoons and singing.

Good

Is the service responsive?

The activities organiser arranged entertainers to visit, such as singers and musicians, and obtained feedback from people as well as observing their reactions. This ensured they only re-booked those that people really enjoyed. A new lunch club initiative had been started for people living with dementia. This provided a more intimate dining experience, and could include their relatives if they wished. Other initiatives had included World War 2 memories, and items from the 1950's.

The company arranged developmental meetings for activities staff six times per year, and the activities organiser had learnt there about music therapy and taught her assistant. They had found a good response using this individually with people in their own rooms. They had also introduced 'Music for health' group sessions, which included gentle exercises and quizzes (for example, 'Guess the singer'). The 'Weekly Sparkle' newspaper was used in groups and with individuals to trigger reminiscence and conversations. Sensory items were used for stimulation, and scrapbooks with different themes. The staff actively used information from the care plans, for example, for people who liked cooking, they were invited on the day of the inspection to make shortbread. Some of the men liked specific activities such as shoe cleaning. Units for people living with dementia featured accessible chests of drawers and rummage boxes, with items that people could use, such as clothes, hand bags and musical instruments. All of the nursing and care staff saw it as their responsibility to help people to take part in things that they enjoyed, and the activities organiser said that she saw other staff making plentiful use of these. The garden was accessible to everyone, and a raised bed had been made at people's request. People living with dementia were escorted to the garden as they wished, and staff stayed with them to provide supervision for their safety.

The service had a complaints procedure on display in the entrance hall, and this was also included in the information given to people when they were admitted. The procedure was clearly written and was in large print to make it more easily accessible. It contained details of different contacts, but people were encouraged to raise any concerns or complaints with the staff or registered manager in the first instance. The registered manager had an 'open door' policy and made herself available to people and their relatives. This included an evening when relatives out at work could come in to see her.

There was a system for people to write down any concerns using a form provided in the reception area. This was passed on to the nurse on duty, and followed up by the registered manager or the most senior person on duty the next day. This provided a fast response to people's feedback, and provided people with confidence that any concerns were dealt with quickly. A separate complaints form was used for any serious complaints. People were offered face to face meetings to discuss issues wherever possible. Documentation showed that all concerns and complaints were taken seriously, were investigated, and were responded to in a timely manner. People were confident that they could raise any concerns with the staff or the registered manager, and said they would not hesitate to complain if they needed to, but that they did not have any complaints.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the registered manager and the deputy manager. A survey carried out in 2014 showed that 100% of people who responded were overall satisfied with the service, and were happy with the care and support they received. They told us that they often saw the registered manager in the dining rooms, when she stopped and chatted with people.

A relatives' survey from 2014 had very positive results. 100% of relatives who responded said they thought the service was "A happy place to live", were "Happy with the atmosphere of the home and the physical environment"; were "Happy with the management of the home" and were "Happy with how the service followed up any concerns or issues".

The registered manager and heads of departments attended quarterly meetings with people when they could give their opinion on the service, and ask about anything. At a recent meeting, the registered manager had thanked people for their responses to a survey, and said it had led to an action plan. One of the points on this had been a wish for meeting minutes to be distributed to all of the people living at the service, and this had been put into place. There was a discussion about changes to the garden. People had previously requested a raised bed and a sensory garden, and these had been put in place. The raised bed had been completed the previous week, and already had vegetables growing in it. Individual people's requests were followed up, such as arranging carpet cleaning for one person; and adding baked apples to the menu. The minutes noted that the chef carried out regular walk rounds at meal times to check the presentation of meals on plates. A relative commented to us, "I must say the staff are prompt to react to things".

The registered manager and the deputy manager worked closely together, so that people had confidence in approaching the deputy manager if the registered manager was absent. The registered manager led the staff team and had a visible presence in the service. Staff said they felt well supported and were happy working in the service. They were motivated, and were calm and relaxed when caring for people. Nursing staff told us that they had advanced training in subjects to help them to enhance their practice. One said, "The manager is very supportive, approachable and helpful especially on professional issues. She is very knowledgeable and organises training that suits staff training needs. I have done phlebotomy (taking blood), a leadership course, catheterisation and PEG feed management". Another nurse said, "Our manager is very good but firm; she is very proactive and supportive. I have training to help me perform my job role".

Clinical governance records were carried out every month, and included checks for numbers of any acquired pressure sores, numbers of falls and medicines errors. The records showed overall improvements with target reductions which had been met and exceeded. There had been increased individual interactions between people and their key workers, which people felt was a benefit to them. The registered manager and deputy manager carried out weekly checks which followed key areas, such as checks for people's nutrition pathways to ensure they were correctly delivered; accidents and incidents and how these had been dealt with and minimised for the future; infection control; hospital admissions; and DoLS applications and any safeguarding concerns. These checks were reported to the company's senior management, who reviewed them and advised on any additional action which could be carried out for further improvements. Any trends (for example with falls) were shared with the staff, so that staff were fully informed and included in necessary changes. Numbers of falls and their impact had lessened due to proactive management, such as ensuring staff knew the people who were most at risk; ensuring staff were always sited in communal areas; and making sure people who were assigned hip protectors were wearing these.

The registered manager and deputy manager carried out care plan reviews every week, and these checked that care plans had been reviewed by nurses and key workers; if relatives had been invited to attend review meetings; if risk assessments were in place and followed; if the care plans were person-centred; and if the care plans and risk assessments were up to date. They also looked for evidence that staff had liaised appropriately with external health and social care professionals. The follow up from these processes had enabled nurses and care staff to develop their abilities with care planning.

Staff said they were given the opportunity to improve, and recognised that the service had a continual striving for improvement. Care staff were able to enrol for the company's 'Care Practitioner' training, which enabled them

to carry out increased duties and work alongside the nurses. Four nurses had been included in leadership training, and this had given them increased confidence in leading teams.

Staff meetings were carried out separately for each unit as well as general staff meetings, meetings for heads of departments, and brief daily 'stand-up' meetings for senior staff. These kept staff up to date with changes, and provided the opportunity to listen to staff and their opinions. Feedback at one of the meetings had encouraged staff that the care plans were more person-centred; and people were being offered a bath or shower on a daily basis. A general staff meeting was carried out every two months, and this included information for staff about any applications made for people for DoLS authorisations. Staff said they could "Ask anything" at meetings. Minutes from a recent meeting showed that one of the care staff had asked if manicure sets could be purchased for people, and this had been taken up as a good idea which would further benefit people, and enhance their wellbeing.

Health and safety meetings were held to identify any concerns and check that action had been taken about previous items raised. These meetings always had specific subjects on the agenda, including infection control, food hygiene, the environment, risk assessments, accidents and incidents and staff training.

Monthly audits were carried out for a range of subjects, including medicines audits, infection control, equipment, laundry and catering. The registered manager had additional monitoring responsibilities which included checking staff manners and attitudes, meal delivery, people's weights records, daily charts (for fluid intake, hourly checks, and positional changes), accidents and incidents, and blood pressure monitoring. Any trends found were discussed with the heads of departments so that action could be taken accordingly. No emerging trends had been found over the previous few months. The registered manager said that the regional director was very supportive, and carried out her supervision. He also carried out 'provider visits', which included further checks for all aspects of the service. These included the environment and décor, staff training and recruitment, numbers of staff, and talking with people about their experiences of living at the service.

The registered manager or deputy reviewed environmental risk assessments with the regional director as part of monthly monitoring programmes. There was an on-going plan for redecoration and refurbishing the premises. This had included replacing carpets and furniture during the last year, as well as redecorating many areas.

It was evident that people's views were at the heart of the service, and staff were very motivated about ensuring that 'People came first' and to check they were happy living there. The activities co-ordinator told us that she did not feel alone in providing activities, but was very much part of a team where all of the staff had "Lots of interaction with residents" as well as carrying out personal care duties. Staff told us they had "Good team work", and "Everyone helps out". They told us, "We take time with new residents, and get to know them. Care is based on what people need and say they want, and how they want it, and we tell the nurses as we learn from them". They demonstrated confidence and knowledge about their responsibilities, and one said, "People know we're not just their carer, this is their home and we're all comfortable together." This was especially evident in the units for people living with dementia, where staff sat and ate meals with people so that people felt they were in a homely environment. Staff said they felt valued and listened to, and they had no problems in putting forward any ideas or raising any points for discussion.

Relatives often nominated staff for care awards given by the company. This was due to how they "Spent time with people, had a cheerful attitude and gave consistently good care".

The registered manager and appropriate staff attended the company's 'Quality First Divisional Conferences' at which there were presentations and updates of current practice. Quality First conference calls were attended by registered managers who could arrange for other relevant staff to listen in to what was being said. The registered manager attended bi-monthly regional managers' meetings at which updates on current issues were provided by relevant specialists across all areas relating to management of the services. The deputy manager attended company deputy meetings and the local CCG Clinical Focus Group. In the last year the registered manager had enrolled four nurses to participate in the NHS Leadership and Management Programme in order that they would be aware of current issues. This included group work with professionals working in other care settings to give them a broader view of health and social care.

Good

Is the service well-led?

The registered manager liaised with other regulatory bodies in order to maintain good practice. This included liaising with the Clinical Commissioning Group (CCG). The registered manager told us that a local CCG Elder Nurse Specialist provided staff with valuable training in 'Accountability', 'Wound Care' and 'Early recognition of symptoms'. Also a senior registered nurse in the home had recently composed a short training session for staff regarding the ageing process which was very well received by staff. A clinical lead from the CCG stated, "The home participates in the Ashford care home forum and also submits data around hospital admissions and attendances. I have always found the manager to be helpful and approachable. She has contacted me whenever she needs support or guidance. There is a good rapport between residents and the staff. I have always found the staff to be friendly and attentive at any training or coaching sessions". A Social Services safeguarding lead said, "I find the manager to be upfront and will contact me for advice and guidance".