Sanctuary Care Limited

Ashgreen House Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 and 15 March 2018 and was unannounced. At our last inspection on 1 and 7 December 2015 the service was rated Good. At this inspection we found the service remained Good and continued to meet the regulations and fundamental standards.

Ashgreen House Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides care for up to 52 older people requiring residential or nursing care. The service is provided over four floors and within five units. At the time of this inspection the home was providing care and support to 46 people.

There was no registered manager in post. The registered manager had resigned from their post prior to this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new home manager had been appointed and had started work at the time of this inspection. The deputy manager was in charge of the day-to-day management of the home and was being supported by a registered manager from the provider's other home and a regional manager.

There were sufficient numbers of staff available to support people's; however staff felt additional staff were required on some units to promote safety. The provider had safe recruitment practices in place and had vetted staff before they were employed to work in social care. People were protected from the risk of abuse because staff were aware of their responsibility to safeguard them.

Risk to people had been assessed, identified and had appropriate management plans to prevent or reduce the risk occurring. The provider had procedures in place to protect people in the event of an emergency and had carried out regular health and safety checks including the maintenance of equipment to ensure they were safe for use. People were given their medicines as prescribed by healthcare professionals and there were safe systems in place for acquiring, storing, administering and disposing of medicines. Staff had received medicines training and their competencies had been assessed to ensure they had the knowledge and skills to manage medicines safely. People were protected from the risk of infection because staff had followed the provider's infection control protocols. Accidents and incidents were recorded, managed and monitored regularly to prevent future occurrences.

Before people started using the service, their needs were assessed to ensure they would be met. Staff received an induction when they started work at the home and were supported in their roles through training in areas the provider considered mandatory. Staff were also supported with regular supervision and an annual appraisal of their performance. People were supported to eat and drink sufficient amounts for

their well-being and people's preferences were taken into consideration and respected. People had access to healthcare services to ensure they received safe care and treatment. Where required staff had made prompt referrals to health and social care professionals to ensure appropriate support was in place for people.

Staff understood the requirement of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted in accordance to this legislation. People were supported in an environment that was suitable and met their needs.

People were treated with kindness and compassion and had built relationships with staff. People and their relatives were involved in making decisions concerning the care and support they received. People's privacy and dignity was respected and their independence promoted so they would maintain their life skills. Staff understood the need to promote equality and diversity and supported people without any discrimination. People were provided with information about the service.

People were offered a range of activities to participate in; however more could be done to engage people in activities that interest them. Each person had a care plan in place which provided guidance for staff on how to care for them. People's care plans were reviewed regularly to ensure that their needs were met. People were supported to maintain relationships with their family and friends. People and their relatives knew how to make a complaint and were confident their complaints would be handled appropriately. Where required, people received appropriate support at the end of their life.

All staff did not speak positively about the home's culture; however the provider was taking action to improve staff relationships and maintain a healthy work environment. . There were appropriate arrangements in place for monitoring the quality and safety of the service provided. The provider took into account the views of people and their relatives and where required took action to improve the quality of the service. The provider worked well with other organisations such as the local authority to plan and deliver an effective care and support.

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.

There were sufficient staff available to support people; however staff felt additional staff on some units would be more appropriate.

The provider had safe recruitment practices in place to ensure that staff employed were suitable to work in social care.

The provider had a safeguarding policy and procedures in place and staff knew how to raise concerns of abuse. The provider also had a whistleblowing policy which staff had used when they had concerns.

Risks to people had been assessed, identified and had appropriate management plans in place. The provider had procedures in place to deal with foreseeable emergencies.

Where accidents and incidents occurred, lessons were learnt and improvements made to the quality of the service.

There were safe medicines practices in place and safe infection control practices to prevent the spread of infections.

Is the service effective?

Good

The service was effective.

Before people moved into the home their needs were assessed to ensure they would be met.

Staff were supported through induction, training, supervision and annual appraisals to ensure they had the skills and knowledge to perform their role efficiently.

People were supported to eat and drink enough and to maintain a balanced diet.

People were supported to access healthcare services such as GP and hospitals. Staff teams made prompt referrals to health and social care professionals when required.

The premises was suitable to people's diverse needs.

The service acted in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

Staff were knowledgeable about people's needs with regards to their disability, race, religion, sexual orientation and gender and supported them in a caring way.

People and their relatives were involved in making decisions about their care and support.

People's privacy and dignity was respected and their independence promoted.

People and their relatives were provided with information about the home in formats that met their needs.

Is the service responsive?

Good

The service was responsive.

People using the service had a care plan in place which provided staff with guidance on how their needs should be met.

People were supported with various activities; however more could be done to get people involved in activities that interest them.

The provider had a complaint policy in place which provided guidance on how to make complaints and how complaints would be handled.

Appropriate support was in place for people at the end of their life and to ensure their wishes were respected.

Is the service well-led?

Good

The service was well-led.

The home did not have a registered manager in post. The registered manager had resigned from their post and a new

manager had been recruited and was in the process of registering with CQC.

Staff told us they were not happy working at the home because of a management culture. However a new manager was in post and had started working with people, their relatives and the various staff teams.

People's views were sought through regular residents' meetings and an annual survey.

There were appropriate arrangements in place for monitoring the quality and safety of the service that people received.

The provider worked well in partnership with other organisations such as the local authority.

Ashgreen House Residential and Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 15 of March 2018 and was unannounced. The inspection team consisted of one inspector, a specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority that commission services from the provider to gain their views about the home. We used this information to help inform our inspection planning.

During the inspection, we spoke with 16 people and their relatives for their views about the home. We spoke with three managers and the assistant manager about how the home was run. We spoke with four nurses and six care staff to gain their views about the home. We looked at the care records of seven people, eight staff recruitment files and other records relating to the management of the home such as policies and procedures, minutes of meetings, audits, health and safety checks and surveys. We also spoke with a visiting healthcare professional to seek their views about staff and care delivery.

Good

Is the service safe?

Our findings

There were sufficient staff available to support people's needs. People told us they were attended to promptly by staff. One person said, "They come in three seconds." The management team told us the staffing levels were planned using a dependency tool based on assessment of people's needs. The staffing rota showed that the number of staff on each unit was reflective of the numbers planned for. Staff absences were covered by permanent staff as overtime, staff from the provider's other homes or internal bank staff. We observed staff being attentive to people's needs and no one had to wait for long when they needed staff support. We tested two call bells which were responded to promptly. We also reviewed call bell logs and found people were being attended to promptly.

However we had mixed feedback from staff about staffing levels. Staff said additional staff support would be appreciated on some units during both day and night times. We could not evidence the direct impact these staffing levels were having on the care and support people received. However, we raised this issue with the management team and they told us they would review the staffing levels on these units to ensure they were appropriate. We would check on this at our next inspection.

There were safe recruitment practices in place. Each staff file we reviewed contained a completed application form which included employment history. Where there were gaps in employment these were explored and accounted for. Staff files also contained proof of identity, criminal records checks and the right to work in the United Kingdom to ensure staff employed were suitable to work in social care. We saw that two staff did not have two references in place as required; however there were risk assessments in place to mitigate this risk and the records showed they were long serving staff. Nursing staff were supported to maintain an up-to-date PIN which confirmed their professional registration with the Nursing and Midwifery Council.

People told us they felt safe and were protected from the risk of abuse. There were safeguarding policies and procedures in place and staff had a clear understanding of actions they should take to report abuse. Staff said they would report abuse to their line manager. Where there had been a concern of abuse, the provider had notified both the local safeguarding team and CQC and carried out investigations promptly. At the time of this inspection, there was one safeguarding allegation that was being investigated. Following our inspection, the local authority safeguarding team informed us the outcome of the investigations were inconclusive. Staff knew of the provider's whistleblowing procedure and had used it where required. Information on whistleblowing was displayed in the communal areas and was discussed at staff meetings to encourage staff to report any concerns they had. Training records confirmed that all staff had completed safeguarding adult's training.

Risks to people had been assessed, identified and had appropriate management plans in place to help keep them safe. Risk assessments were individualised and covered areas such as medicines, skin integrity, eating and drinking, moving and handling, falls and behaviours that challenged. For each risk identified there were management plans to mitigate the risk occurring. For example one person was at risk of falls due to poor eyesight. The guidance in place for staff included ensuring they had fitted and suitable footwear, had their

call bell working and within reach, lower their bed to the minimum height and ensure the bed area was free from hazards. For another person who was at risk of pressure sore, management plans included the use of air mattress, regular repositioning and involving the tissue viability nurse (TVN) in their care. People's health conditions and allergies were included in their care plans and where required risk management plans were in place with input from appropriate healthcare professional. Staff were aware of people's individual risks and the support to provide to manage identified risks safely.

Accidents and incidents were recorded, managed and monitored regularly to reduce the risk of reoccurrence. Records showed that where issues were identified, lessons were learnt and improvements were made when things went wrong. For example where medicines errors were identified, these were fully investigated and appropriate action was taken such as supporting staff through supervision and/or additional training to prevent repeat occurrences.

There were procedures in place to help protect people in the event of an emergency. People had personal emergency evacuation plans (PEEP) which provided both staff and emergency services with information about the level of support they required to evacuate safely. There was a fire strategy plan which provided guidance on actions staff should take in the event of a fire and staff we spoke with knew of actions to take in an emergency. There were regular fire tests and fire drills to ensure both people and staff knew of actions to take in the event of a fire. Tests had been carried out on fire detectors and alarm systems, emergency lighting, lift, boiler, gas, portable appliance and legionella. Call bell, wheel chair, hoist and sling safety checks had also been completed to ensure that equipment was safe for use.

Medicines were managed safely and people said they received their medicines on time and when needed. The provider had a medicines policy in place which provided guidance for staff on how to manage medicines safely. There were safe systems in place for acquiring, storing, administering, disposing and for monitoring controlled drugs. Medicines were kept securely in lockable medicines trolleys which were stored in a locked medicines room. Daily room and fridge temperatures were taken which were of appropriate range to ensure medicines remained effective for use.

All staff responsible for administering medicines had completed medicines training and had their competency assessed. We observed staff support people's medicines at lunchtime and we saw that they followed appropriate protocols and respected people's wishes on how they would like their medicines administered. Where people's medicines were administered covertly, there were mental capacity assessments and best interest decisions in place. There were no gaps evident in the medicines administrative records (MAR) and stock level of medicine correlated with information in the MARs. People's allergies and any food they could not consume due to medicines they were taking were recorded and staff we spoke with were aware of this. People's medicines were reviewed regularly to ensure they were effective and meeting their needs.

There were safe infection control practices in place. The provider had an infection control policy in place which provided guidance to staff on actions to take to prevent or minimise the spread of infections. The home was clean and free from odour. The domestic team were responsible for maintaining the cleanliness of the home and cleaning products were stored securely. Cleaning equipment such as mops were colour coded to prevent the risk of cross contamination. Staff said they washed their hands regularly and wore personal protective equipment (PPE) to prevent the spread of infection and we observed this at our inspection. Staff had received training in infection control and food hygiene to ensure they had appropriate skills and knowledge in minimise the risk of infection.

Good

Is the service effective?

Our findings

People's needs were assessed appropriately to ensure they received effective care and support. Before people started using the service, their needs were assessed by the home manager, the clinical lead or the team leader to ensure they would be met. Assessment covered areas such as nutrition, skin integrity, medicine, personal hygiene and communication needs. Information from these assessments were used to draw up individual care plans and risk assessments.

People were cared for by staff that had been well-trained and competent. All new staff had completed an induction when they started work and were up to date with their training. Staff said they received regular supervision and appraisals. Records showed that new staff were inducted into the home and staff were up to date with their mandatory training. Training covered areas such as first aid, infection control, Mental Capacity Act 2005, safeguarding, health and safety and food hygiene. Staff had also received training in areas specific to people's needs such as end of life care, dementia care and falls. All staff we spoke with said there was sufficient training that kept their knowledge and skills up to date. Records showed that staff were supported through regular supervision and where required their performance appraised and new objectives set for a new year. Nursing staff told us and records showed they were supported by the clinical lead with supervision and training sessions specific to their role to maintain their professional development.

People were supported to eat and drink sufficient amounts to help maintain a good health. People told us adequate support was available to enable them eat and drink sufficient and nutritious amounts for their well-being. People's care records included assessment of their dietary needs and included food allergens, likes or dislikes and the level of support required to eat safely. Both kitchen and care staff knew of people's dietary requirements and told us of how specific needs were being met. For example, people who were diabetic were offered reduced sugar diets, those at risk of malnutrition or weight loss were given fortified diets and pureed food for those with difficulty swallowing. People's cultural, religious and/or medical needs were also taken into consideration and special meals were prepared to meet individual needs. The chef told us that healthy eating was promoted at the home and food such as fish were baked rather than fried.

We observed how people were being supported and cared for at lunchtime. There was a menu available and people were given a choice of two meals and were served their preferred meal. One person requested a meal that was not on the menu and this was provided. Most people ate independently whilst some required support with feeding. People were not rushed to eat their food and the environment was relaxed with music playing in the background. We saw that water and/or juice were available to people throughout the day and there were bowls of fruit available in the dining areas. People's weight was checked monthly to ensure that prompt action was taken to mitigate any nutritional risks.

People had access to various healthcare professionals when needed to help maintain good health. People's physical and mental health needs were monitored regularly and where concerns were identified, prompt referrals were made to appropriate healthcare practitioners. The home had a designated GP practice who visited twice a week or when urgently required to treat people. Records showed people were supported to

attend hospital appointments and had received care and treatment from healthcare professionals such as district nurses, TVN, speech and language therapists, chiropodists, dentists and opticians to ensure their needs were met. A visiting healthcare practitioner commended the staff team and said staff had good clinical sense, made appropriate referrals promptly and knew people well.
People's individual needs were met by the adaptation, design and decoration of the home. The home had both stairs and lifts to support people access various floors. The home had been recently refurbished and new carpets fitted in the communal areas. The home was well lit and hand rails were available throughout to support people's mobility. People's bedrooms were decorated with their own personal furniture, photographs and ornaments of importance to ensure the environment was suitable to them.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The management team and staff were aware of how the MCA applied to their roles. They told us that many people had capacity to make decisions for themselves and care staff said they sought consent from people before supporting them. However, where people lacked capacity to make specific decisions for themselves staff adhered to the principles of the MCA and completed mental capacity assessments and best interests decisions regarding specific areas of their care, for example for the use of bed rails and covert medicines.

The home had submitted applications to the relevant local authority seeking authorisation to deprive some people of their liberty where this was in their best interests. We reviewed a sample of the DoLS authorisations which was currently in place and found that any conditions placed on them were being met.

Good

Is the service caring?

Our findings

People were treated with respect and kindness by staff who were caring. People and their relatives told us that staff were kind and caring towards them. When asked how people felt about staff one person said, "They do support me, I enjoy living here." Another person said, "The staff are friendly." A third person commented, "Yes they are kind, if you correct them they don't get upset." Another person also said, "I ask questions and they don't get angry." Yet another said, "Kind, careful, with dignity and respect." We observed that staff had relationships with people; they called people by their preferred names and interacted with people with respect. We observed positive interactions between people and staff. Staff were attentive to people's needs and regularly checked on their well-being. Staff responded promptly to people's request and we saw them offering encouragement and reassurance to people. We saw a member of staff chatting, laughing and sharing jokes with one person.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and religious belief and supported them in a caring way. People told us they were supported to practice their faith. One person said, "A Catholic woman from church comes every Tuesday and gives Holy Communion." Another said, "There is a service downstairs by a Baptist preacher." The home had visiting ministers that supported people with their religious needs. However people with no religious beliefs were also respected. Staff respected people from ethnic minority backgrounds including their daily routines and food choices. There was also a hair dressing salon at the home which was opened to people twice a week to support them maintain their appearance.

Staff knew people well including their backgrounds, family involvement, interest and preferences and provided support that met their needs. We found that most staff had worked in the home for a long time and had built relationship with people they cared for. This was reflective in the feedback we received from people, their relatives and healthcare professionals.

People and their relatives were involved in making decisions regarding the care and support they or their loved ones received. Staff told us people were involved in making day-to-day decisions about the food they ate, clothing they wore or activities they participated in because people were given choices and opportunities to make those decisions for themselves. Staff said people's preferences were taken into consideration and their wishes respected. Records showed people and/or their relatives were involved in planning the care and their preferences including their likes and dislikes were included in their care plan to ensure their needs were met.

People were treated respectfully by staff who maintained their dignity and respected their privacy. Staff told us of actions they took to promote privacy and dignity. One staff said, "I make sure the door is closed when supporting people with personal care." Another staff said, "I make sure the bedroom door is closed when supporting someone and I always ask them if they needed support first." Staff also said they would knock on people's doors, shut the curtains when supporting people with personal care, cover body parts not being washed with towel and maintaining confidentially by not discussing information relating to people in communal areas or with people that did not need to know.

People's independence was promoted. Details of thing people could do and those that they needed support with were recorded in their care plan. There were instructions in care plans on how staff should continuously promote independence when supporting a person for example with personal care. We observed people moving around the home independently some with walking aids to promote their independence.

People and their relatives were provided with information about the home in the form of a 'resident information guide'. This included the type of care available, facilities in the home and what to do if you were unhappy to ensure people were aware of the standard of care and support to expect when they moved into the home. Staff told us that this information was given to people and their relatives when they started using the service. Information was also available to people in formats such as large prints to support their understanding.

Good

Is the service responsive?

Our findings

People received personalised care that met their needs. People and their relatives told us they were consulted about they or their loved ones care and support needs to ensure their needs were known and would be met.

Before people moved into the home, their needs were assessed to ensure they would be met. The provider told us a further assessment was carried out as soon as people moved into the home and information from these assessments were used to develop a person-centred care plan. All the care plans we reviewed were specific to people's needs and covered areas such as eating and drinking, mobility, communication, personal care and medicines. Care plans also included a list of people's medical conditions and where required there were specific guidance for staff to enable them support people appropriately. Care plans contained people's daily routines and covered individual preferences of waking-up or bed times and preferred choice of clothing. All the care plans we reviewed were up to date and reflective of people's current support needs. Daily care notes showed that the care and support provided was in line with what had been planned for.
Care plans contained information about people's life histories and this included their professions and family relations. The staff team knew people well and provided us with information about specific individuals which was consistent with information in their care plans. Staff knew people's medical conditions, histories and preferences and supported them appropriately.

Staff were responsive to people's needs. On the first day of our visit, we found that one person had just returned to the home after a hospital admission. Staff noted their needs had increased and that the residential care and support would no longer be appropriate for them. Prompt referrals were made to appropriate health and social care professional to ensure the person was transferred to a suitable nursing unit. On the second day of our inspection this person had been transferred onto a nursing unit and was receiving care and support that met their needs. A visiting healthcare professional told us the staff team were always responsive to people's needs and had made prompt referrals to their team for safe care and treatment and to ensure people's needs were met in a timely manner.

People were supported to take part in various activities to stimulate them; however these were not always appropriate in meeting their needs. One person told us, "I like to do quizzes." Another person said, "I enjoy knitting." However some people told us they were, "not interested" or found the activities "enjoyable". The weekly activities programme included activities such as name the music, word search, snakes and ladders, dominos, puzzle building and knitting. There were two activities coordinators who job shared the post and care staff were also responsible for engaging people in various activities. There were both group activities and one-to-one support for people who were unable to join in the group activities. Children from a local school also visit the home on regular basis to engage with people.

However during our visit we noted the home to be mostly quiet and majority of people did not wish to participate in the activities that were being provided. For example we saw a creative session of rock-

painting which less than eight people participated in. Staff told us it was difficult sourcing materials and more suitable activities due to funding. All staff we spoke with said more could be done to improve the quality of activities available in the home including taking people out into the community or to places of interest. Therefore, more could be done to get people involved in activities which were of social and of cultural relevance and were more appropriate to them.

We raised this issue with the management team and they told us they would review and improve the standard of activities provided. Following our inspection, the new management team sent us various types of activities they would be implementing in the home to ensure the activities provided were effective and meeting people's needs. We will check on this matter at our next inspection.

People were supported to maintain relationships with people who mattered to them. Relatives we spoke with told us they were free to visit their loved ones without restrictions. There were visiting relatives and friends on both days of our inspection. Staff told us relatives could visit at their convenience and were encouraged to be actively involved in the planning and delivery of the care.

Complaints were responded to appropriately and used to improve the care provided to people. People and their relatives said they knew how to complain and were confident their complaints would be taken seriously and dealt with appropriately. People said they would report to care staff, the nurse in charge, the manager or the director. The provider had a complaint policy in place which provided guidance to people and their relatives on how to raise a complaint. The policy also contained information on how the provider would respond to their complaint including timescales. Records showed that where people or their relatives had raised a complaint; the provider took action to resolve the matter. We saw that formal investigations were conducted into complaints to ensure people were satisfied with the outcome. Where staff were found responsible, disciplinary actions were taken and/or additional support provided to prevent repeat occurrence.

People were given appropriate care and support by staff at the end of their life. Care plans included capacity assessments and discussions held with the person and their relatives where appropriate about their advance care plan and end of life wishes. People who did not want to be resuscitated at the end of their life had a Do Not Attempt Cardiopulmonary Resuscitation (DNACR) forms completed which included the person, their relatives where appropriate, staff and the GP. People's advanced care plans were reviewed annually by the home's GP to ensure their end of life wishes had not changed. The palliative care team were also involved to ensure people's end of life wishes was met.

Good

Is the service well-led?

Our findings

The registered manager of the home resigned from their post a week before our inspection. A new home manager had been appointed and started work at the time of our inspection. The manager had applied to CQC to become the registered manager of the home. The new manager was being supported by a registered manager from the provider's other home, the regional director and an assistant manager who was also the clinical lead. The management team were aware of their legal responsibility under the Health and Social Care Act 2008 and had sent CQC statutory notifications where required.

We had mixed feedback from staff regarding management. All staff did not speak positively about the culture of the home. They told us of issues of favouritism, racism, lack of transparency and rostering which affected their work ethics and prevented them from working as a team. Two staff said they did not feel supported in their role; however, all other staff felt adequate support was available and there were opportunities available to develop and progress in their role. A member of staff told us, "Here [Ashgreen House Residential and Nursing Home] they develop care staff to become home managers depending on the person's attitude." This information was consistent with what we knew about the provider. The staff grievances were mostly in relation to the previous management team.

We raised this issue with the current management team including the area manager. We found this issues had recently been brought to the attention of the management team and the provider's human resources team had been contacted to support staff and address these issues. Following our inspection the provider told us an HR personal had been deployed to the home and had been available to support staff and improve the home's culture. The new home manager had also held one-to-one and group meetings with staff, people and their relatives to ensure these concerns and grievances were addressed and to create a better working environment.

The provider had incentives in place to retain staff. At our visit, a staff member had received acknowledgment from a senior manager at the provider's head office regarding their long serving contrition to the organisation and was given incentives to motivate them to continue working at the home. The staff we spoke with was very elated and appreciative that their hard work was being acknowledged by senior managers.

There were systems in place to ensure people views were sought to improve the quality of the service. There were regular relatives meeting and annual satisfaction survey as well as day to day feedback which was encouraged as the manager operated an open-door policy. The result of an annual satisfaction survey which was undertaken in June 2017 was mainly positive. For example100 percent of people felt treated with kindness, a further 100 percent was awarded to the care and support people received, 98 percent said their privacy and dignity was respected and overall 100 percent of people said they were happy with where they lived and would recommend to their family and friends. However areas such as laundry care which scored lower had been identified for improvement and people and their relatives told us that improvements had been made.

There were systems in place to actively involve staff in the developing the service. Various staff meetings were undertaken to cascade information and gather feedback from staff to drive improvement. This included meetings with nursing staff, care staff and the maintenance team. The minutes of meetings showed areas discussed included training, punctuality, staff engagement, policies and procedures and delivering an effective service. Where staff performances had improved in areas such as training, staff teams were commended for it. Staff were also given the opportunity to question practice and make suggestions to improve the service delivery. All staff we spoke with told us they felt team meetings were good and provided them with opportunities to feedback where required.

Daily handover meetings were held between shifts to enable staff to share relevant information about people's needs and any other information required to provide safe care and support. We also sat in on a daily morning meeting which discussed the day-to-day needs and support required on each unit. Representatives from each unit provided updates in areas such as accident and incident, activities, hospital admission, staff sickness, equipment and any other concerns. Staff told us they found the daily meetings useful as it updated them on what was happening in the home.

The provider had system in place to monitor the quality and safety of the service. Regular internal audits were conducted in areas such as care plan, health and safety, medicines and infection control. Where issues were identified for example with medicines and or a fall, actions were taken and learning shared with staff to improve on the quality of the service.

The provider worked well with other organisations such as the local authority to plan and deliver an effective service. The local authority that commissioned the service conducted an audit in December 2017 in areas such as care quality, healthcare, medicines, food and drinks, activities, the home environment and staffing levels. The report of the quality visit showed that where issues were identified in the previous quality visit in February and March 2017, the provider had taken action and implemented all the recommendations. The Commissioning and Quality Team told us Ashgreen House Residential and Nursing Home was one of their well-managed good care homes.