Alliance Home Care (Learning Disabilities) Limited

Ashgrange 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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Ashgrange House on 16 and 17 December 2014 where we found improvements were required in relation to maintaining people's records and quality assurance. The provider sent us an action plan and told us they would address these issues. We undertook an inspection on 10 and 12 February 2016 to check that the provider had made improvements and to confirm that legal requirements had been met. We found improvements had been made however, further improvements are still required to ensure the changes are fully implemented.

Ashgrange House is a care home that provides accommodation for up to eight people who have a learning disability and require a range of support associated with living with autism and mental health needs. Accommodation comprised of seven individual bedrooms and a single flat. On the day of the inspection there were six people living at the home.

At the time of the inspection there was no registered manager at the home. However there was a manager in post but they had not submitted an application to register with the Care Quality Commission (CQC). 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.

This was an unannounced inspection which took place on 10 and 12 February 2016.

Although there were systems in place to assess the quality of the service provided, these had not identified some of the shortfalls we found in relation to people's support plans and further improvements are required to ensure they reflected all the support people received and required. The audit system had not identified the lack of 'as required' (PRN) guidance for people's medicines. This did not impact on the care and support people received because staff knew them well.

Staff had a good understanding of people as individuals, their needs, interests and hobbies. They were committed to ensuring people lived happy and enjoyable lives. They worked with people to help them reach their goals and achievements and supported to maintain and improve their independence.

Staff had a good understanding of the risks associated with supporting people. They knew what actions to take to mitigate these risks and provide a safe environment for people to live. They understood what they needed to do to protect people from the risk of abuse. There were enough staff on duty to ensure people's needs and choices could be met. Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

Staff received the training and supervision they needed to meet the needs of people who lived at Ashgrange House. There was a training and supervision programme in place to ensure staff maintained current

knowledge and skills. Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people in the decision making process if someone lacked capacity to make a decision. People were supported to have access to healthcare services and maintain good health on a day to day basis or when there was a change in their health.

The manager was approachable and supportive and took an active role in the day to day running of the service. Staff were able to discuss concerns with her at any time and know they would be addressed appropriately. Staff and people spoke positively about the way the service was managed and the open style of management.

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

Ashgrange House was safe.

People's medicines were stored, administered and disposed of safely.

There were risk assessments in place and staff had a good understanding of the risks associated with the people they supported.

Staff understood the procedures in place to safeguard people from abuse.

There were enough staff who had been safely recruited to meet people's needs.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work at the home.

Is the service effective?

Good

Ashgrange was effective.

There was a training and supervision programme in place to ensure staff maintained current knowledge and skills.

The manager and staff had a good understanding of mental capacity
assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choice about what they wanted to eat and drink and received food that they enjoyed.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Good

Ashgrange was caring.

Staff knew people well and displayed kindness and compassion when supporting them.

Staff treated people with respect and their dignity was maintained. Staff communicated with people in a way that met their individual needs.

People were involved in day to day decisions and supported to maintain their independence.

Is the service responsive?

Good

Ashgrange was responsive.

People received support that was responsive to their needs because staff knew them well.

People were able to make individual and everyday choices and we saw staff supporting people to do this.

People had the opportunity to engage in activities of their choice and staff supported them to participate if they wanted to.

A complaints policy was in place and people approached the manager or staff with any concerns.

Is the service well-led?

Requires Improvement

Ashgrange was not consistently well-led.

There were systems to monitor the quality of the service and they were used to respond to how people wanted the service to run. However they did not identify shortfalls within the service including those within record keeping and PRN medicines.

The manager was seen as approachable and supportive and took an active role in the day to day running of the service.

Staff and people spoke positively about the way the service was managed and the style of management.

Ashgrange House

Detailed findings

Background to this inspection

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

We told the manager the day before our visit that we would be coming. We did this because they were sometimes out of the home supporting people who use the service. We needed to be sure that they would be in. We carried out the inspection on 10 and 12 February 2016. It was undertaken by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records, staff files including staff recruitment, training and supervision records, medicine records, complaint records , accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at three care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with five people who lived at the home, eight staff members including the manager and deputy manager.

We met with people who lived at Ashgrange, we observed the support which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. We had difficulty understanding some people's verbal communication so we spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People were comfortable in the presence of staff. We observed them approaching staff freely and discussing concerns with them. One person told us, "I feel very safe here, I know the staff will look after me." Another person said, "When I wake at night I get scared and the staff come to my room till I fall asleep again. I don't like being on my own."

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in locked cupboards in their own rooms. This enabled staff to spend time with people and discuss their medication needs in a confidential and relaxed manner. We observed medicines being given at lunchtime, these were given safely and correctly as prescribed and in the way people chose to take them. There was information within the Medicine Administration Record (MAR) about how people would like to take their medicines. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or were agitated. Prior to administering PRN medicines staff would discuss the need with a team leader or manager to ensure this was the most appropriate treatment for the person at the time. If people experienced pain staff asked them if they required any pain relief. Not everybody who experienced pain was able to express this verbally, and there was information in people's care plans about how they may express they were in pain. If people declined medicines this was recorded and advice sought from the person's GP or on-call doctor. One staff member told us, "We then know what to look out for if a medicine hasn't been taken, we know what the symptoms are and what we should do next."

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references, photographic identification and a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. The manager had undertaken an audit of the recruitment folders and had identified where information was missing. For example one application form did not have a full employment history, the manager had recorded a discussion with the staff member and identified the reason for the gap.

There were enough staff working each shift to ensure people received the support and care they required. Some people required one to one or two to one support and we observed there were enough staff on duty to ensure this happened. People had access to staff when they needed them. We observed people going out to college and shopping with the appropriate support they needed. One person's health needs had changed and they required extra support. This had been arranged through the use of agency staff who were supported by regular staff. Staff told us regular agency staff worked at the home which meant they knew people and the support they required.

People were protected against the risks of harm and abuse because staff knew what actions to take to protect people if they believed they were at risk. Staff told us they had received training on safeguarding adults. They told us about different types of abuse and what actions they would take if they thought someone was at risk. They said in the first instance they would speak to the manager or other senior staff

within the organisation. We asked staff if they knew how to report concerns to appropriate external organisations. They told us they could report to the local authority or CQC. They were confident that any abuse or poor care practices would be quickly identified and addressed by any of the staff team.

Specific and environmental risks associated with supporting people were identified in the care plans and risk assessments. The risk assessments identified the risk, who was at risk and what actions were required to minimise the risk. For example the risk assessment for one person demonstrated they may display behaviour that could challenge others and potentially hurt or injure themselves or someone else. The risk assessment contained guidance and informed staff what actions to take to mitigate the risks. This included talking to the person in short sentences and the need to avoid crowded situations. Staff demonstrated a good understanding of the risks associated with supporting people. We observed throughout the inspection staff supporting people who lived with behaviours that challenged others in a calm, appropriate and safe way.

Regular health and safety checks were in place and these included water and fire safety checks. We saw staff had received fire safety training and undertook regular fire drills where the home was evacuated. There was regular servicing for gas and electrical installations. Day to day maintenance was recorded and signed when completed. There were cleaning schedules and checks to highlight any areas which required attention, for example carpets that may need cleaning. There were systems in place to deal with emergencies which meant people would be protected. There was guidance for staff on what action to take and there were detailed personal evacuation and emergency plans in place for everybody. The home was staffed 24 hours a day with an on-call system for management support and guidance.

Good

Is the service effective?

Our findings

Staff knew people well. One person told us, "Staff know when I'm not well, when I'm feeling low they will help me." One person told us they had a choice of meals which they enjoyed. We asked others if they enjoyed the food. They told us, "Yes."

There was an ongoing training and supervision programme and staff received essential training which included learning disability awareness, conflict management and risk assessment. In addition they received training specific to the needs of people they supported for example, autism awareness, diabetes and epilepsy. The provider had identified staff had not received recent training in some areas which included safeguarding and moving and handling. To ensure staff remained up to date with current knowledge this was being provided as online training. The manager was aware of who needed to complete this and we saw details had been provided to staff to remind them to complete the courses. We saw further classroom based training for a range of areas was booked throughout the year. Staff told us the training they received was good and it was mainly face to face. One staff member said, "Training is really good, it doesn't matter what it is I can always relate it to one of our residents."

When staff started work at the home they received a period of induction where they were introduced to the home, people, policies and day to day routine. They then shadowed staff for a week before they supported people on their own. There were supervision agreements in place and we saw staff received regular supervision. These looked at a range of areas including the individual, their performance and personal development. Staff confirmed they received regular supervision and it was useful and they felt supported by the process. One staff member told us, "I like supervision, it's my chance to talk about me, I can talk about things I want to do."

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There was currently one DoLS authorisation in place and applications had been made for other people as they were under constant supervision by staff. There was information in people's care plans about their mental capacity and how the support they received may deprive them of their liberty. When specific decisions were being considered for people who lacked capacity staff involved relatives, health and social care professionals to support this process to ensure people's rights were fully considered. Care plans reminded staff to ensure people were given choice and involved in making decisions and this is what we observed throughout the inspection.

Nutritional plans were in place and these provided staff with guidance about people's dietary needs and choices. Staff knew people well and understood these needs and preferences. Where people had specific dietary needs for example in relation to their weight, diabetes or fluid intake there was information to guide staff. One support plan reminded staff the person should not eat too much sugary food. Another person liked to drink a lot throughout the day and there was guidance place about how staff should support this person. This included a regular routine of supporting the person to have a drink whilst ensuring their fluid intake was not excessive. People were able to get involved with preparing their own drinks and meals if they chose. One person was responsible for buying, preparing and cooking their own meals each day. This person told us this was something they enjoyed and were supported by staff throughout. They were able to decide what they wanted to eat and planned their weekly menu with staff. They also told us they joined other people in the home for a roast dinner on Sunday which they didn't have to cook. There was a weekly menu on the wall which was developed with people and reflected their choices. Staff told us if people didn't like what was on offer they were able to have alternatives. We saw people having breakfast and lunch at times that suited them. Staff supported them to make choices for example by showing them what was available. People liked to go out for drinks and snacks and where this may impact on their diet this was documented in their support plan and where appropriate was included in people's weekly planners. We were told that although people had their breakfast and lunch at times that suited them and fitted in with their individual plans, most people chose to eat their main meal together in the evening.

People were supported to maintain good health and received on-going healthcare support. We saw from records people were supported to maintain good health through ongoing support from the appropriate healthcare professionals. People regularly saw the dentist, optician and chiropodist. Where people had specific health needs for example diabetes we saw they received regular checks and advice from the diabetes nurse at the GP surgery. Where people's health changed they were supported to obtain appropriate care and treatment. One person had a deterioration of their mental health and had received the care and treatment they needed from the mental health team, their social worker and the learning disability team. One person told us how they managed their health need and told us they were supported to do this by staff.

People had hospital passports in place which they took with them if they needed to go into hospital. Hospital passports are communication booklets which provide important information about the person. They include information such as: "Things you must know about me," "Things that are important to me" and "My likes and dislikes." These were clear and provided hospital staff with a straightforward guidance about supporting the person.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received at the home. From what people told us and through our observations we saw people were able to choose what they did during the day and staff supported them to maintain their independence. Some people had weekly planners in place. This was a daily timetable which showed people what they were going to do each day. People told us they planned their week together with the staff and were involved in making decisions and planning what they done. We saw people attended college, work and took part in a range of activities. We saw people's planners included activities that were important to them for example, placing a bet or going out for a coffee and a cake. Staff explained that one person enjoyed shopping and this was recorded on their planner which meant they knew when their next shopping trip would be. The planners were presented in a pictorial format for people who needed it. One person had recently become unwell and had been unable to complete their planner or take part in their usual activities. However, staff told us how the important things in the person's life had been included on the planner. We were told, "X might not be well but we make sure he doesn't miss out on what X enjoys." Staff told us how they supported this person and by doing this helped to reduce the person's anxiety.

Staff knew people well and treated them as individuals; they were able to tell us about their choices, personal histories and interests. People were involved in decisions about their day to day care and support and were able to decide what care and support they required. We observed people getting up at a time that suited them. People were dressed in clean clothes and were supported by staff to dress according to their individual tastes. People looked well-presented and well cared for. We observed staff treating people with kindness and respect. Most staff had completed equality and diversity training and we observed they respected people and helped them to maintain their uniqueness and individuality. People's bedrooms were decorated in their own style and furnished with people's own photographs and ornaments.

Staff told us and we observed their knowledge of people enabled them to communicate effectively with people. We observed staff chatting with people throughout the day. Where people were unable to communicate verbally, staff were able to communicate in a way that met their needs. Some people used Makaton or an adapted form of Makaton to suit the individual. Makaton is a language programme which uses signs and symbols to help people to communicate. Where people had developed their own signs these had been documented in their communication passports. Communication passports are a tool which clearly explains the unique ways in which a person communicates. It is used to assist any staff member or professional to communicate effectively with them. They are a person-centred way of supporting people who cannot easily speak for themselves.

Staff listened to people and made sure they understood what people wanted. We saw people were relaxed in the company of staff and approached them freely when they wanted support or a chat.

People were treated with dignity and their privacy was maintained. Staff knocked before they entered people's bedrooms and spoke to them privately and quietly when they needed to. We observed staff supporting one person who was displaying behaviour that may challenge others. This was done with

kindness and understanding which enabled the person to maintain their dignity and reduce their distress. When people displayed behaviour that may challenge others one staff member said, "I don't make a big deal of it." The staff member went on to say they knew people well and would manage the behaviour whilst continuing to support the person.

People told us they were able to continue relationships with those who mattered to them. We saw people received visits from their friends and this was included in their support plans and planners. People had developed friendships within the home and were supported to maintain these. We saw people with similar interests attended physical activity classes together. One person told us about the friends they had made and how they looked forward to seeing these people.

Good

Is the service responsive?

Our findings

People received support that met their needs and was personalised to their individual choices and preferences. They chose how they spent their day, what time they wanted to get up and what they wanted to do. We saw people were involved in decisions about their day to day support.

People had individual support plans in place. These were called 'My plan' and were completed as far as possible with the individual. We saw one person had declined to be involved or participate in developing their own plan. Staff had recorded this person was happy for the manager to complete on their behalf. When completed we saw the plans had been signed by the person to show they agreed with the information. Support plans were updated every three months and when people's needs changed. We saw one person had undergone a recent change in the care they needed and their support plan had been updated to reflect this.

Staff knew people well and had a good understanding of the support they needed. This and important information about people's lives had been recorded. The support plans contained detailed information about people, what they liked and disliked and how they liked to be supported. For example one person was at risk of falling if they didn't dress appropriately or if they lost concentration. There was guidance for staff to encourage the person to dress appropriately and information about what this included. Guidance also reminded staff to encourage the person to concentrate and not to rush when undertaking tasks. Another support plan informed staff to 'prompt' people for example to maintain their oral hygiene. There was guidance to ensure staff knew how to support people who may display behaviour that could challenge others. This included how to minimise the risk for people for example avoiding crowded situations which may upset one person. There was information about how to de-escalate the incident for example speaking in short, clear sentences and using Makaton to re-inforce verbal communication. Staff understood the importance of maintaining a consistent approach with people. One staff member told us, "When we deal with challenging behaviour we need to make sure in managing it, we don't create a new behaviour. It's important we all do the same thing."

Routine and structure were important for some people whilst others were able to choose what to do each day. For some people this was achieved through the use of their planners which showed them what they were doing each day. One person told us about their planner and how these were completed, which included time spent with staff to develop the plan. Another person's support plan stated they liked to have their planner completed. For people who wanted them, we saw their planners were in place and they used them to tell us what they were doing throughout the day. One person who chose not to have a planner and was unable to communicate verbally had a clear support plan in place to inform staff about their routine. Staff knew the person well and were able to support them appropriately.

Support plans guided staff about how to communicate with people. One person's communication passport reminded staff to keep sentences short and speak clearly. Other people used a form of Makaton and there were photographs of these individual Makaton signs within their support plan to guide staff. Support plans reminded staff to continue to offer choices and informed them how to support people to make choices. This

included speaking with people using their preferred communication method. For some this included objects of reference. We observed staff asking people if they would like to watch television or a DVD. When DVD was chosen staff placed a number of DVD's on the floor to enable people to choose what to watch. Where a specific object of reference was required for example, a toiletries bag to prompt a person with their personal hygiene, this was recorded.

People were supported to continue with their hobbies and interests and take part in work and social opportunities. We saw people were busy throughout the day, they attended a range of college classes which included art, music and flower arranging. When staff went shopping they asked people if they would like to accompany them. Two people did not attend college or work. They were offered a range of activities in the home, we observed one person writing a letter. Staff explained these people were reluctant to go out however they were continually reminded and given opportunities. Staff told us and we saw through photographs, what people had done throughout the year. We saw one person had gradually increased the range of activities they would participate in. For example, There was a weekly club which people attended and were able to meet people from other homes. There was information about what people hoped for and wanted to achieve. The manager told us one person was interested in first aid and it had been arranged for them to attend a first aid class. Another person told us about pets that visited the home and this was something they enjoyed. Some people had specific goals they wished to achieve for example managing their own money. One person had developed a booklet which showed what they would like to achieve and what they had achieved. They told us about their achievements which included baking and preparing their own meals.

People were asked for their feedback continually on a day to day basis, at support plan meetings and monthly meetings. At monthly meetings people were asked for their feedback about the support they received and about activities they may like to take part in. One person said they would like to go swimming. This person told us they would be doing this when the weather was warmer. People were asked about their menu choices and two people had made specific requests. One person had requested fried eggs and another, mince pies. Staff told us people's requests had been met.

There was a complaints procedure in place. People had been asked about complaints in a recent feedback survey. Not everybody was able to understand the questions even when presented in a picture format however when asked if problems were sorted out they were able to say the manager would do this. Through observation and discussion with people it was clear they would approach the manager and staff if they had any concerns. One person told us, "If anything's wrong I'll tell (the manager) or (deputy manager)." They told us the manager or deputy manager would always deal with any problems they had.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 16 and 17 December 2014 the provider was in breach of Regulation 10 and Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17(1)(2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accurate records were not in place in relation to the care and treatment for all service users and the provider did not have an effective system to regularly assess and monitor the quality of service that people received.

An action plan was submitted by the provider that detailed how they would meet the legal requirements. At this inspection we found that improvements had been made however, further improvements are still required to ensure the changes are fully implemented.

At the time of this inspection there was no registered manager at the home. They had left their position in August 2015 however they had not been working at the home for some months before this. There was a manager in post who had been appointed in December 2014 but they had not submitted an application to register with the Care Quality Commission (CQC). They told us that they were leaving this post and that a new manager had been appointed and would apply for registration in due course.

Staff were able to tell us how they supported people, they could tell us about people's goals and objectives and how they were helping people to achieve these goals. However, this had not been recorded consistently and records did not demonstrate how people were achieving their objectives or show what progress people had made. For example in relation to going out and participating in activities. Some people had very busy lives and had structured activities whilst others had less structured activities. Often their planner related to drives out. There was no planning in advance to assess what could be achieved or demonstrate people's choice. For example drive to the seafront, a walk and café. Daily records showed people had watched films or gone out for a drive but did not record what film people had watched or where they had driven to. Therefore people could have visited the same place at each drive.

Care plans, risk assessments and communication passports contained a lot of information but this was not always consistent. Information was recorded across a number of folders and although this had improved since our last inspection it would be easy for staff to miss the key or most up to date needs of a person. One person's communication passport said they used objects of reference and Makaton but their support plan did not refer to either. Staff told us this person was able to communicate verbally however other means of communication could be used for example if the person was distressed or upset. Other support plans did not contain all the detailed information staff may need to ensure consistent support. One person's plan stated they were a diabetic and informed staff to monitor their sugar intake and promote healthy decisions. However, there was no guidance about how much sugar this person could have each day and no record of what they had eaten. Staff told us they were mindful of what this person ate and prompted them to make healthy food choices such as fruit. They said this person liked to eat sweets and this was planned into their weekly planner and this helped them maintain a healthy diet. Another person's plan stated their religion and informed staff to support the person to follow their religious beliefs but there was no information about

these beliefs. Staff told us they sought guidance from the person's family. This is an area that needs to be improved to ensure guidance is consistent and demonstrates that people's needs were met. Although staff knew people well new staff may not be aware of people's needs.

Where areas for improvement had been identified they had not always been addressed. For example, one person was who was unable to communicate verbally did not respond to drawn pictures however, staff had identified they were able to respond to 'real' pictures or photographs. Staff told us they had taken photographs of places this person liked to visit on a drive out to enable them to make a choice. However, the photographs had not been printed out to assist the person make choices.

There was a system in place to monitor the management and quality of the home however, this was not always effective. Although improvements had been made since our last inspection we found there were areas that still needed to be improved. The audit system had not identified there was no PRN guidance for medicines. Staff told us how they identified when people required PRN medicines. One person required medicine periodically for constipation. Staff were able to tell us when this was required. Whilst this did not have an effect on people because staff had a good understanding of people and the medicines they may require to take PRN. There was no evidence to demonstrate these medicines were given consistently or demonstrate evidence that people's care needs were met. Support plan audits had not identified the issues we found and for example one person had experienced a change in their family support network. This was causing the person some distress and although staff supported this person appropriately there was no support plan to reflect the support provided. The manager had analysed incidents and accidents for individuals however there was no analysis of incidents across the home to identify any patterns or themes. For example if incidents were occurring at certain times or on certain days.

The audit system included audits by the area manager and quality assurance staff. There was an action plan in place which had been identified by the audits as areas that needed to be addressed. We saw work had taken place whilst other areas were still ongoing. The provider had highlighted in the PIR that feedback questionnaires were being updated and we identified at the inspection that due to people's individual needs a range of questionnaires were required to ensure everybody's opinion could be obtained.

The manager told us she was moving to another post within the company and a new manager had been appointed. They said this person worked for the company and had previously worked at the home so knew some of the people who lived there. The manager told us she planned to work with the new manager to ensure they received an appropriate induction and introduction to the home.

People were asked for their views and were involved in developing and improving the service. Regular staff meetings and resident meetings were held and minutes confirmed that they were used to gain people's views and to share information. For example, the appointment of the new manager was discussed and people were kept informed of how this would affect the service.

People liked the relaxed and friendly atmosphere in the service and spoke fondly of the staff especially the manager and deputy manager who they had regular and close contact with. Both people and staff told us they were sorry to see the current manager leave but were happy with the choice of new manager. One person said, "I'm glad it's X it's good to have someone I know."

We saw from the previous staff survey of January 2015 staff had said they did not feel valued and spoke of a poor staff culture. We asked staff about this and they told us there had been improvements at the home and issues raised had been dealt with. All staff we spoke with were positive about working at Ashgrange House and told us how much they enjoyed their work and felt supported and encouraged in their roles. One staff

member told us, "I love it, it's not like coming to work." Another told us the staff team was, "Like an extended family." They told us they had regular supervision and time to talk about their work and their individual roles and expectations. Staff told us the manager was approachable and worked with them for the benefit of people. Staff repeatedly told us there was an open door policy and they could speak to the manager whenever they wanted to. The culture was open with staff and people able to share their views in an open way.