Care Quality Commission

Ashgrove House Care Limited

Ashgrove House Care Limited

Inspection report

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Tel: 01616812183

Date of inspection visit:
08 November 2016
09 November 2016

Date of publication:
15 December 2016

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

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.

The inspection took place over two days on 8 and 9 November 2016. The first day was unannounced. The home was last inspected in November 2014. At the last inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not always check the suitability of newly recruited staff to work with vulnerable adults. There was a breach of Care Quality Commission (Registration) Regulations (2009) as the service did not notify us of how they responded to certain specified situations, such as injuries, illness or safeguarding concerns. During this inspection we saw that the service was now compliant in these areas.

Ashgrove House is a large Victorian house, which has been extended and refurbished to provide 32 single rooms, 28 with en-suite facilities. It is situated in a residential area of Chadderton, and is close to local amenities such as shops, churches and schools. Bedroom accommodation is provided on the ground and first floor. There is a passenger lift to the first floor. The service is registered to provide accommodation for persons who require nursing or personal care. At the time of our inspection there were 31 people living at Ashgrove House.

The home had a manager registered with the Care Quality Commission (CQC), but this person was not present when we inspected. However there was an interim manager in place who was available throughout the time we were at the home. A registered manager is a person who has registered with CQC 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 and associated regulations about how the service is run.

Ashgrove had a warm and friendly atmosphere and people told us they felt safe there. When we spoke with staff they were able explain how they ensured people were protected from abuse or harm.

People were supported by a long-standing, stable staff team. Staff were knowledgeable and knew the needs of the people who used the service. Procedures for recruiting new staff were sufficiently robust to help ensure that people were protected from the risk of unsuitable staff being employed, and the level of staff was sufficient to meet the needs of the people who used the service.

We saw from looking at the training records that staff received appropriate training to meet the identified needs of people who lived at Ashgrove, such as dementia training, capacity and consent, and end of life care. We saw that where specialist equipment was required, staff had received instruction on its use, and the property and all equipment was well maintained.

Care records gave a good indication of people's abilities and provided a good description of their individual likes and dislikes. Where risk was identified, plans were in place to minimise the risk of harm occurring. Senior staff were trained to administer medicines and we saw procedures were in place to ensure the safe management of medicines.

When people were being deprived of their liberty, the correct processes had been followed to ensure that this was done within the current legislation. Staff understood issues around capacity and consent, and offered people choices to support their independence. People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest.

Staff communicated well with each other and we saw that information was exchanged between staff informally throughout the working day, and a detailed handover meeting took place at the start and finish of every shift to ensure that care and support was provided in accordance with people's changing needs.

People enjoyed the food provided. One person commented, "All the food is good; the cook is very fussy about food and it always looks and tastes nice".

We saw that staff monitored people's physical and mental health needs, and ensured they had good access to healthcare staff. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments.

People were treated in a caring and compassionate manner, by cheerful staff. One person who used the service told us, "This is a happy home. Staff are always smiling. A relative who was visiting Ashgrove during our inspection told us, "When I came here, I got a good feeling. The staff were friendly and pleasant and I saw how well they cared for residents. Nothing has changed my opinion; I can't find fault". Care was person centred and delivered by cheerful staff who understood how to interact with the people who used the service. We saw people were comfortable and looked well cared for. Staff were vigilant to people's needs and were able to respond in a timely way to people's requests for assistance. They respected people's need for privacy, but understood the risk of social isolation and did not leave people unattended. Staff spent time talking with people on a one to one basis or in small groups so that people felt like they were included. We saw that people's belongs were treated with respect, and personal information held about individuals was securely stored.

Staff provided care for people at the end of their lives in a sensitive, manner and recognised the need to treat people with dignity and compassion. The home achieved accreditation from Pennine Care NHS Foundation Trust in the Six Steps to Success Programme. We saw that that people's wishes for care at the end of their lives were respected.

Information contained in care plans gave a good outline of the individual, actions to take to support the person to maintain their independence, recognition of personal preferences, and actions to take to minimise risk. We saw care records were thorough and gave a good chronology of interventions with individuals, which indicated any changes in the person's presentation or needs. People's preferences and wishes were taken into consideration in the day-to-day delivery of care and support.

The service was well led by an experienced management team committed to service improvement and providing a high quality of care. Regular checks were made by the entire management team to measure and improve the delivery of good quality care to the people who lived at Ashgrove.

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.

The building was secure, clean and well maintained.

There were enough staff who were safely recruited and knew how to protect people from harm.

Care records informed staff how to minimise risks in relation to people's health and wellbeing.

There were appropriate systems in place for the effective ordering, control, management and administration of medicines.

Is the service effective?

Good

The service was effective.

Staff were well trained, and knowledgeable. They communicated well with each other to ensure care needs were met in a consistent manner, and had regular supervision.

People enjoyed the food provided, and had good access to healthcare. Staff monitored their physical and mental health needs.

Staff showed an understanding of capacity and consent issues. Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

Is the service caring?

Good

The service was caring.

People were very well cared for at the end of life.

Staff were friendly, welcoming and patient, and spent time sitting and talking with people who used the service,

Privacy and dignity were respected.

Is the service responsive?

The service was responsive.

People told us that staff responded to their needs and provided them with support when they required it.

Care plans gave a good outline of the individual, actions to take to support the person to maintain their independence, recognition of personal preferences, and actions to take to minimise risk.

Systems for recording gave staff time to respond to the needs of the people who used the service.

The service listened to what people had to say and responded positively.

There was a complaints policy, but people told us that they did not need to make any complaints.

Is the service well-led?

The service was well led.

Systems were in place to assess and monitor the quality of service provision, and the service had developed good systems to audit the quality of care provision.

The manager and registered provider understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Staff were encouraged to raise concerns and take responsibility where mistakes had been made.

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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 8 and 9 November and was unannounced. The inspection team consisted of one adult social care inspector accompanied by an inspection manager. Before this inspection, we reviewed the information we had about the home including the previous inspection report and notifications about incidents which affected the service that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

During this inspection, we spoke with three people who used the service, and relatives of another three people. We had general conversations with other people who used the service and their visitors. We spoke with the registered provider of the service, the interim manager, area manager, four care staff, two housekeepers and a chef.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us.

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

We looked at the care records for four people, three medicine administration records, three staff personnel files, and other documents related to the management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe. One person who used the service said, "I'm well looked after here. They keep me very safe" and another told us "I'm very pleased, they make sure I'm safe. If I need anything I'll shout and they arrange it for me, like an extra blanket to stop me getting cold, but generally I want for nothing".

Staff had received training in safeguarding adults, and were able to explain how they ensured people were safe, and tell us how they would respond if they suspected a person who used the service was at risk of harm. The home had a safeguarding policy, which met the requirements of the local Adult Safeguarding Board. Staff had reported all incidents that may constitute a safeguarding concern to the local authority. We looked at the monthly safeguarding logs, which the service returned to the local authority safeguarding team. These showed that where a person was at risk of abuse, appropriate steps were taken to protect the individual, and to investigate incidents to avoid any future reoccurrence. Most of the incidents reported related to disagreements between people who used the service, and reported actions indicated that prompt action from staff meant that these incidents did not escalate. One visiting relative observed, "People living with dementia can have their moments, people get agitated. The staff cope really well though. Things just seem to get done; there is an easy pace, so things never get too heated". We saw that staff were vigilant, and would use distraction techniques to avoid any possible incidents between people who used the service who did not always get on with one another.

All staff respected and protected people's rights. For example, people were free to walk throughout the building and in a secure garden to the rear of the building, with the only exceptions being to areas where it may not be safe to do so, such as the laundry and kitchen. There were no restrictions on visiting times. One person who used the service smoked, and was supported to smoke outside the building in a covered area. Their cigarettes and lighter were held in the main office, but staff wanted to give the person some control so they ensured that the person always had more than one cigarette on their person so that they could choose when to smoke.

We saw that the home was secure. The entrance was kept locked, with access via a secure key code; this ensured that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time. A visitors book was also available in the entrance hall which allowed all staff to be sure who was in the building.

Some people who used the service required assistance with moving and handling using mechanical aids, such as hoists or stand aids. We saw that equipment was clean and well maintained. We observed staff were able to use this equipment effectively, and took care to ensure that transfers were safe.

We looked at four care records, which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication and hygiene. Risks identified had corresponding detailed care plans to help reduce or eliminate the identified risks, which were reviewed on a regular basis. When we looked around the home, we saw measures were in place to prevent injury or harm. For example, crash mats were placed next to some

people's beds, so if a person were to roll out of bed the risk of injury would be reduced. Call bells were accessible to allow people who used the service to summon help.

We found systems were in place to enable staff to respond effectively in the event of an emergency. There was a fire risk assessment in place, and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker; and when full checks were needed for water temperatures and legionella testing.

When we last inspected the service in November 2014, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not been vetted as thoroughly as the law requires. This meant that the service provider did not gather all the information from applicants to enable them to make a reasonable judgement about their suitability to work with vulnerable people. However, during this inspection we saw that the service had made improvements. We looked at the recruitment procedures in place and saw that this gave clear guidance on how staff were to be properly and safely recruited. We looked at three staff files. These included proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, interview notes, a job description, and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and these checks were updated every three years. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Ashgrove.

We saw that there was a good ratio of staff to people who used the service. The area manager informed us that they used a dependency tool to determine how many staff would be required. The staff rota showed that there were four care staff on duty during the day with three waking night staff, who began work at 9:00 p.m. and finished at 8:00 a.m. There was some flexibility should needs change, for example, if more staff were needed due to illness of people who used the service or end of life care. In addition, the manager and assistant manager worked each day of the week with alternating weekends off. The service operated a 24 hour on call system to provide cover for any emergencies.

We were told that regular staff would generally cover any sickness or annual leave. One care worker told us that staff were happy to pick up any gaps, saying, "I love caring and I love the staff. We are a great team, and we all help out". People who used the service and their relatives told us they believed there were enough staff on duty to ensure that people received the care and support they needed in a timely manner. Our observations supported this view. We saw that call bells were responded to promptly, and staff were seen spending time talking with people who used the service either quietly on their own or in small groups.

We saw that there were appropriate systems in place for the effective ordering, control, management and administration of medicines at Ashgrove. Three senior care workers were responsible for ordering medication and would complete a weekly check of all medicines and reordering any stock required.

Medicines were delivered by the pharmacist, and before being booked in both the pharmacist and a senior care worker would check to ensure the correct medicines and correct quantities had been received.

We saw that there were robust systems in place to minimise risk of medicine errors, including weekly stock checks and regular audits by the manager and area manager. Medicines were provided using a monitored dosage system. This minimised the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Staff noted any unused medicines and tablets which they stored in a returns box for returning to the pharmacy.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines are stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form that records the details of any medicines prescribed, when they are taken, and if they are refused. Staff recorded all newly delivered medicines on the MAR, which also included details of the medication and dose required; details of the general practitioner (GP), condition, and any known allergies. Senior care staff administered medicines. We spoke with one senior carer who informed us that they completed regular medication training and confirmed that they were happy with the training received.

We noticed that one person had consistently refused to take their medicines, so staff had arranged a review of her medicine regime with the person's GP. They recorded the actions taken, which included a reduction in the prescribed medication, so instead of being offered four different medicines per day this was reduced to just one.

We were told that nobody received medicine covertly. Medication given covertly is the administration of any medical treatment to a person in a disguised form, such as sprinkled over food. We asked a senior carer what they would do if someone refused to take medicines which they needed. They told us that this would be their choice, but if they lacked capacity to understand the consequences, then they would organise a best interest meeting to determine the correct course of action, and that if it was agreed to provide this without the person knowing they would need written authorisation from the person's GP.

We looked around all areas of the home, and saw that it was clean, free from any unpleasant odours and well maintained. One relative told us, "It's all good. Always clean and tidy, staff are well presented and hygienic and there are no smells".

Bedrooms had matching furniture and were personalised with people's own belongings. Bedrooms had suitable locks on the doors to help ensure people's belongings were protected and they could have some privacy. The locks had a mechanism to ensure that people could not be locked in their rooms.

Communal bathrooms were clean and hygienic. They were decorated in pastel shades with pictures on the wall that gave a homely feel to them. Thermometers in each bathroom allowed the staff to ensure the water temperature was not too hot or cold. Communal areas and walkways were clear of obstacles to minimise the risk of accidents. We saw that where dangerous or hazardous equipment was stored, doors displayed warning signs and 'keep locked notices'. When we tried these doors, we found that they were locked. This promotes a safe environment.

We checked the kitchen and saw that it was clean, and that kitchen staff regularly monitored the fridge temperatures and stored food safely to prevent any risks of cross contamination or food wastage. The kitchen was awarded the highest food hygiene rating from the Food Standards Agency.

In the laundry, we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

We saw that toilets had posters detailing safe hand washing techniques, and that soap; paper towels, disposable aprons and hand gel were available, further reducing the risk of cross contamination.

Staff we spoke with understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Staff had attended infection prevention and control training.

We spoke to two housekeepers, who informed us that they received regular training, and demonstrated a sound knowledge of how to minimise the risk of infection and use of specific cleaning materials to ensure the environment was safe from the spread of infections such as MRSA and Clostridium Difficile. We were shown cleaning schedules were in place for all areas of the home, including the kitchen, and we saw that staff completed a deep clean of a room in preparation for the admission of a new person to the service. This included purchase of a new carpet for the room.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. Discussions with the manager, observations and conversations with staff showed they had an in depth knowledge and understanding of the needs of the people they were looking after.

Prior to working with people who used the service all new staff received training in essential aspects of the job, such as moving and handling, infection control, first aid, food hygiene and fire safety awareness. They were shown equipment used and instructed on how to operate it. They would then spend time 'shadowing' a more experienced member of staff before they were allowed to work on their own. This enabled them to meet the people who used the service, understand their specific needs, and how best to respond.

We saw staff files included copies of certificates to demonstrate that they had attended training, and included evidence of any training completed prior to starting work at Ashgrove, such as National Vocational Qualifications (NVQ) or Health and Social Care accredited qualifications. New care workers were enrolled on the 'Care Certificate'. This is a nationally recognised qualification for people working in the caring sector.

The registered manager gave us a copy of the training matrix, which showed oversight of the level of training undertaken by staff. We saw that all staff had completed essential training with dates when refresher training had been completed either annually; such as training in moving and handling techniques; bi-annually, for example, dementia care and mental capacity, or three yearly, such as food hygiene and first aid. Nine members of care staff, including night care workers, had completed further training in end of life care.

Staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervisions included a review of performance, future work targets, training, support and development, and any other matters arising. This meant staff were fully supported in their role. Staff also had a yearly appraisal conducted by a director of the service, which allowed further exploration of opportunities for development.

Staff communicated well with each other and we saw that information was exchanged between staff informally throughout the working day. A detailed handover meeting took place at the start and finish of every shift. We observed one handover meeting, and saw that staff coming on duty were informed of any change in people's care needs and of any tasks, which might need to be completed. This ensured continuity of care. Notes were kept in a handover book and we saw staff referring to this and making regular updates throughout our inspection.

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.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Ashgrove 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 manager told us, and we saw information to show that applications to deprive people of their liberty had been authorised by the supervisory body (local authority), or were awaiting authorisation. We had been informed where authorisations had been granted. Capacity assessments had been completed as part of the process to determine whether people needed a DoLS authorisation.

Paper copies of all requests and authorisations were kept in the person's care record file, and the electronic records used on a daily basis highlighted that the person was subjected to a deprivation of liberty. This would ensure staff would deliver care in line with any current restrictions in place. However, there was no central file to show when the request had been made, authorised or due to expire. This posed a risk that the authorisation could expire without the knowledge of the manager or staff. When we raised this, the registered manager agreed to compile a central list to act as a reminder to seek renewals when necessary.

From the training matrix, we saw that all staff had received training in mental capacity and deprivation of liberties. The care staff we spoke with were able to demonstrate a good understanding of capacity and consent issues to help ensure that people's rights were protected, including pathways to reach best interest decisions. We were told that care staff asked for the person's consent before carrying out care and support tasks. One person told us, "They won't do anything for me without asking first, and I can do as I please, within reason of course." We observed this in practice, for instance, we saw a care worker knock on someone's door and wait for permission to enter, we overheard them asking the person if they required assistance to dress, and what clothes they would like to wear. At lunchtime, care workers asked people if they wanted help to eat their meals.

People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest. Where this was the case, we saw information in care records that advocates were consulted before decisions were made. There was also evidence in one care file we looked at that the service would act to protect people's rights when they were involved in disagreements between family members about provision of care, and we saw that the service ensured that the needs and wishes of the person using the service were uppermost in any decisions about their care.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. A visitor told us that her relative had a poor appetite, but said, "The staff keep an eye on what [my relative] is eating. She's never been a sandwich person and that is accommodated, they always offer her an alternative". We saw that people liked the food offered and had enough to eat and drink. Another person visiting their relative told us, "The food is good and [my relative's] appetite is so much better. They look after her diet really well. Since coming here, [my relative] is the healthiest she's been for a long while."

We looked at four care records. All included an eating and drinking care plan and recorded that people were weighed on a weekly basis where necessary. We saw that attention was paid to people's food and drink and people received a nutritionally balanced diet. The kitchen displayed information about specific dietary needs and staff understood the specific requirements of people living at Ashgrove.

We saw residents had a choice of meals. Breakfast normally consisted of cereals, porridge and toast, and we

were informed that if required people who used the service could have a cooked breakfast or boiled egg if they requested. The main meal of the day was served at lunchtime, and a choice of hot or cold meals was available at teatime. Supper was offer before people retired for the night and tea, coffee and biscuits were available in between meals.

We observed the lunch-time meal. There was a menu on display, but this had not been updated from the previous day, and did not reflect the choice on offer. Care staff would ask each person what they would like for their meal a short time before it was served and people had a choice of two main courses and a desert. On the first day of our inspection, most people had chosen cottage pie, but some preferred sausage and mash, which was the alternative option. People who were able to feed themselves were encouraged to do so, and the service made use of special cutlery and drinking cups to maximise people's independence. Staff provided one to one assistance for people who were unable to feed themselves, sitting with the person, talking with them, establishing eye contact and helping them to eat and drink at their own pace. Lunchtime was a sociable, relaxed and happy occasion, with staff engaging well with residents, for example, and there was a light hearted discussion about the difference between cottage pie and shepherd's pie. Portions were of a good size, and second helpings were offered to people if they required.

People told us that they enjoyed the food on offer. Finishing their meal, one person commented, "That was fantastic, cooked just the way I like it". We asked another person about the food and they told us, "All the food is good; the cook is very fussy about his food and it always looks and tastes nice". The chef, who was relatively new to the service, told us, "Standards here are very good; as good as some of the hotels I have worked in".

People had good access to healthcare and staff monitored their physical and mental health needs. Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

Good

Is the service caring?

Our findings

One visitor told us, "it was a big thing coming into care; it had to be the right place for [my relative]. I looked at a few places but when I came here, I got a good feeling. The staff were friendly and pleasant and I saw how well they cared for residents. Nothing has changed my opinion; I can't find fault. All the staff are lovely, and they really welcome me. It's [my relative's] home, and everyone who works here respects that".

The registered provider told us, "I want staff to be proud of where they work and if they are it goes all the way through the home. We are here to help people, and if staff do not like it, they should not be in the job. It's about caring. I am proud of the home and the staff."

Throughout our inspection, we saw that people were treated with care and compassion by all the staff, who were without exception warm, friendly and open. For example, we saw the registered provider notice a person who used the service and went over to speak to them. When she came back she informed us, "[Person] was here when I first came eighteen years ago. She doesn't know me anymore but I always pop over and say hello". We saw the housekeepers would stop and talk with people who used the service, showing patience and kindness, and they assisted them, for example, to safely get out of a chair or to walk across the corridor by linking arms and walking with them a short distance. We saw that staff had time to sit and talk with people who used the service, we observed care workers sitting quietly with people, making eye contact and chatting quietly, or sitting with groups and supporting conversations. All showed positive regard for people who used the service. One care worker told us "I really like the residents, and the best part of this job is being able to sit and talk to them."

We saw an empty noticeboard marked 'thank you cards' and when we enquired why there were no cards we were informed by a member of staff, "Oh, that will be [person], she likes to take things, and put them in her pram". The care worker told us that this person is living with dementia and has been provided with an empathy doll which she enjoys looking after, and will take items to give to her 'baby'. They told us that this person liked to collect items, mostly harmless, but some items could be dangerous, such as items of cutlery. However, they informed us, "They are her treasures, what she has collected that day. We will sit back and watch, to make sure they are safe. We will get them back later". This was an example of the good understanding of people, and how staff had developed genuine affection, and understanding of how best to interact with them to ensure that they were safe and well cared for.

Person centred care was reflected in work with other people who used the service. We were told about one person who would refuse assistance with personal care. The service had developed strategies to ensure that the person was well groomed and dressed without affront to their dignity. If the person refused, staff would leave them for a short while before returning, or would ask for a different worker to speak with the person, who would often choose a person to help them. Staff showed patience, tolerance and understanding.

Similarly, when people were not ready for their meals, they would be asked if they would like the meal to be kept warm so they could eat at a later and more convenient time. When we observed people being given medicines, we saw that the senior carer giving out medicines would ask if the person was ready to take them

and they offered a drink to help swallow, but would not stand over them or rush them to take their tablets. Instead, they would withdraw and discreetly observe that the medicines had been taken, and check by offering a refill of the drink before recording this in the medication charts. We observed people being transferred using mechanical equipment. This was done by two care staff who ensured the equipment was clean, spoke clearly and calmly to the person being transferred to reassure them and explain what they were doing and ensured the safe transfer, checking the person was comfortable in their new position.

Lunch was provided in a calm and unhurried manner. Staff brought people their preferred meals and checked that they were happy and had drinks. Several people needed assistance to eat and drink, and staff sat beside them and engaged appropriately with them, establishing eye contact, and talking with them. People receiving assistance and those who had difficulties were offered aprons to prevent spillage onto their clothes.

There were no organised activities on the days we inspected Ashgrove, but staff ensured that people were not bored, providing stimulation and activity throughout the day. We saw that people were occupied, and staff initiated conversations and supported people to join in. At the same time, they respected people's wishes for quiet time and solitude. People's need for privacy was respected, and they were free to retire to their rooms. Similarly, there was a quiet lounge where people who used the service could entertain their guests. We spoke with one relative about this and they informed us that normally when they visited their relative, they were content to sit in one of the busier lounges, but if they needed to talk privately they could retire to the person's room or use the quiet lounge.

We were able to retrieve the thank you cards on the second day of our inspection and saw that these were unanimous in their high praise. One card, for example, read, "We would like to thank you for all the care, compassion and empathy you have given to [our relative]. We could not have asked for anything more or better. The staff at Ashgrove are a credit and fulfil the meaning of carers". Other cards spoke of kindness, patience, love, compassion and care shown to people who used the service. Other relatives we spoke with echoed these sentiments. One relative told us "I would recommend this place to anyone, the carers are all so friendly and so caring, it's such a safe and friendly place to be."

Relatives we spoke with also told us that they were made welcome when visiting the home. They informed us, and we saw that staff knew them and addressed them by their preferred name and were always welcoming. A relative told us that the staff were always available, friendly and knowledgeable. They told us, "There is always someone around and I can go to any one of them. They all know who I am. My [relative] is on a lot of medication, but they are always so patient, and they tell me what they are all for." There were no restrictions placed on visiting times. "I can come anytime I like and they always have a smile for me.

Care records for people documented their interests and what they enjoyed doing. People and their representatives told us that they were offered choice in the delivery of their care and support. One person told us, "I always get a choice, from when I get up to when I go to bed. They'll always ask me what I want, and I'm never rushed to make a choice". We were told that there were no set times for people to get up or go to bed. When we spoke with night staff, they told us that some people who used the service liked to stay up very late, and that they would support this recognising that some people enjoyed the quiet of the night.

Staff we spoke with recognised that most of the people who used the service would end their life at Ashgrove, and so care at the end of life was an integral part of the care provision. We saw that nine members of staff had completed training in end of life care, and the service had achieved accreditation from Pennine Care NHS Foundation Trust in the Six Steps to Success Programme. This is the care pathway for people who are near the end of their life, and looks to provide a compassionate and dignified death.

Some of the staff had had relatives who had lived at Ashgrove previously, and were drawn to the care profession because of the quality of care provided to their relatives, particularly at the end of their life. One person told us how their relative was treated with the utmost dignity and compassion. They said, "The staff were unbelievable! There was such attention to detail, so the care was always there".

We spoke with staff about how they delivered care at the end of life. They told us how the care and support they offered would be in line with the person's wishes, and included details such as the person's choice of bedding, pillows and blankets; music; smells, such as perfumes and room scents, or flowers. Further details included personal care and how they would like to be presented. Attention was paid to care needs such as mouth care, fluid intake, and position, so turning charts and fluid charts would be kept to inform staff of any needs, and relatives would be kept fully informed or made welcome if they wished to stay.

We looked at the care records for a person who had been placed on the care pathway. We saw that there was a signed DNAR form (do not attempt resuscitation: this is document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation) and a current statement of intent. This is a form signed by the person's GP to say that they have reviewed the person and they are likely to pass away. It lasts for two weeks and then requires renewal. Medicine records showed that all non-pain relieving medicines had been stopped and a supply of medicines to relieve pain had been prescribed, with information about when and how they were to be used. Case notes reflected compassionate care, with hourly entries showing interventions to maintain the person's comfort. A revised care plan, which reflected the person's wishes was evaluated on a daily basis to ensure that the care provided was respectful, dignified and in accordance with the person's wishes. We noted regular turns to minimise the risk of developing pressure sores, mouth swabs to keep the mouth moist as part of the oral regime, and application of topical creams to minimise the risk of infection. We found that the quality of care for people at the end of their lives was dignified, compassionate, person centred and extremely sensitive to the needs and wishes of the person.

We saw that people's belongings were treated with respect. When we looked in bedrooms, we saw that a high standard of cleanliness was maintained, and clothes were folded in people's drawers or hung appropriately in wardrobes. Information held about people who used the service was locked in the manager's office when not in use, or stored on secure electronic systems to prevent unauthorised access.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs and provided them with support when they required it. One visitor told us, "We never get the impression anyone is being ignored. During our inspection, we saw that staff were vigilant to needs and people were never left unattended for long periods. A visiting relative told us "they are always responsive and always seem to have time."

The manager told us that before a person is admitted they complete a pre-admission assessment to determine if they can meet the person's needs and to find out how best to respond. A visiting relative said that, prior to admission, the manager visited their relative, and, "Went through everything, so they had really good background information about her history, likes and dislikes. They got to know her, so when she came here they were ready, and were able to meet her needs. I am quite happy with how she is looked after here."

We asked people and their visitors about their care plans. One relative told us, "I have never seen a care plan, but the staff tell me what they are doing, and I have seen progress. I know they do what is right and meet her needs and wishes".

Information contained in care plans gave a good outline of the individual's needs and preferences, and the actions staff should take to support the person to maintain their independence, meet their personal preferences, and reduce any potential risks.

For each person a paper file, which was stored in the main office, contained useful information about the person including a pre-admission assessment, personal details and contacts, local authority reviews, best interest decisions and a transfer to hospital summary, which was reviewed on a regular basis. In addition, there was an electronic system which contained detailed information to guide staff on how to provide care and support. Staff could update daily records using electronic tablets, and a series of prompts which described the activity. These records gave a good chronology of interventions with individuals and an indication of any changes in the person's presentation and health. They could be further cross-referenced to activities charts such as bathing charts, weight records, updates to MUST Score (Malnutrition Universal Screening tool: this identifies if a person is at risk of malnutrition or obesity) and Waterlow score (reflects the risk of developing pressure sores).

They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury, for example, from falls. Where a risk was noted action to reduce or eliminate the identified risk was recorded in detail. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records.

Staff told us that they found this system of recording simple, efficient and quick, and believed that it reduced the amount of time spent completing records allowing more time to spend with the people who used the service. However we noted that the prompts did not reflect the person-centred way care was delivered, for example, "[A] needed assistance getting up" did not describe how the person was given time to come around after sleep, was helped with toileting and personal care and given choices about what to wear.

The records were password protected to prevent unauthorised entries or leaking of information, and were reviewed on a three monthly basis to ensure the information was fully reflective of the person's current support needs.

People's preferences and wishes were taken into consideration in the day-to-day delivery of care and support. We saw a number of the people who used the service had been encouraged to develop their own friendships groups, whilst staff were mindful that not all got on well, so were vigilant to prevent any flashpoints. The service employed an activities co-ordinator who was on leave at the time of our inspection, but people we spoke with told us they enjoyed the organised activities provided. One person told us, "There is usually something to do, so we can get involved, or they will have people around to entertain us. We just had a party for Halloween, which was good fun."

We were told that some of the people who used the service did engage in organised activities but would spend much of their time in their own rooms. People came into the dining rooms for their meals and we saw that they would initiate and join in conversations. We spoke with one person, who told us that they had always been a private person, and content with their own company. They told us, "There is plenty for me to do and I keep myself occupied. I get regular visits from my family and they all feel at home when they call".

The service had a complaints policy that was displayed in the entrance area for relatives and people who used the service to see. There was a system for logging complaints but the manager told us the service had never received any, and when we asked people if they had cause to complain, they told us they did not. One person told us, "Everything is very nice. I would say if it wasn't" and a visiting relative told us that they had never needed to raise a complaint, saying, "If there is anything, they've always got time. They will listen and put it right. Quite often they are already on to it before I let them know, for instance, there was a leak in [my relative's] room, but they had already asked the maintenance man to look at it." The manager told us that she kept an open door and wanted to listen to any ideas to improve the service, and that the service would try to rectify any issues before they became an official complaint.

Visitors told us that the staff and manager would keep them informed and there was a monthly newsletter available to residents and their families. They told us that they were always informed if anything out of the ordinary happened to their relative. One person told us "The staff are brilliant, they will always let me know, and if I need to know anything I have never felt nervous about asking". Another said, "they will always phone me if my relative isn't well, and keep me informed all the time".

Good

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. At the time of our inspection the registered manager was on long term leave, but the service providers had informed CQC that they had appointed an interim manager who had been working in that position for five months at the time of our inspection.   The provider was in the process of agreeing a return to work date with the Registered Manager.

People we spoke with, including staff, visitors and people who used the service, thought that the home was well led. They told us that the interim manager was available and we saw that she maintained a visible presence within the home, not confined to the office. For example, at lunchtime she would eat her meal in the dining room with the people who used the service, and interacted with them whilst they ate their meals. She was familiar with all the people who used the service and would spend time talking with them. This ensured she was familiar with their needs and could identify and quickly remedy any concerns. Staff we spoke with told us that the registered manager, interim manager and area manager were supportive. One care worker told us, "In and out of hours, they are there for us, and always willing to listen. They make us feel like a part of the family".

When we last inspected Ashgrove the service had not always notified us of certain specified changes, events or incidents as required by the Care Quality Commission Regulations. The registered manager and interim manager were now keeping us informed by submitting the relevant notifications. This meant we were able to see if appropriate action had been taken to ensure people were kept safe.

We saw that the service had developed a homely atmosphere. A member of staff told us "I love everything here. I feel like I'm home". We saw staff were friendly and polite, people who used the service were happy, and they and their belongings were treated with respect. A visitor said to us, "The staff are so friendly, they know whose home it is, and they are always so welcoming". We noticed that a large proportion of the people who used the service had been living at Ashgrove for six years or more, with two people having been resident for more than fifteen years.

When we spoke with the registered provider they told us they were proud of Ashgrove, because, "It's so homely. I promote an atmosphere of being homely. Residents' families always comment about how jolly it is, we all get on, there is no arguing". One of the people who used the service agreed with this telling us, "This is a happy home. I don't want people to be miserable and they are not here. Staff are always smiling. Everyone moans a bit, but it's the exception here, not the rule".

Staff told us that they enjoyed working at Ashgrove and many had worked at the home in excess of five years ensuring that the staff group was a stable one. One care worker told us, "Everyone is nice; we are a genuinely nice bunch. It's not always a pleasant job and the pay isn't good, but we love doing it".

Ashgrove had a statement of purpose, to "Strive to provide the highest quality of care available to our residents and make their stay as comfortable and as enjoyable as possible." We saw that when the directors were present during our inspection, staff and people who used the service were familiar with them. We saw that they took an active role in the day-to-day management of the service, for example, assisting with staff reviews and completing a number of audits and spot checks on specific aspects of service delivery.

We looked at two audits completed earlier in the year; a health and safety and Quality audit of the building, and a care plan audit that reviewed information within four care plans chosen at random. Both audits noted issues for action and checks to show the required action had been taken before being signed as complete. When we spoke with the registered provider, they told us that they also undertook quality assurance checks of the service at night, but these were not recorded. They agreed to make a record of any future night-time checks they undertook.

The service kept a record of all other audits undertaken, and we saw that in addition to the directors, the area manager and manager would complete at least one audit each month on medication, care plans, health and safety, standards and staffing. Issues would be followed up at team meetings and through staff supervision and were recorded in action plans. We looked at the most recent audit of medication completed the previous month. This was a twenty- point audit covering administration, deliveries and stock control and management of medication, and showed that there were no issues or concerns.

The service had appropriate policies and procedures, which were accessible to all staff who signed to say when they had been read. The area manager reviewed all policies and procedures annually.

Staff told us that they were involved in discussions about issues in service provision during team meetings. Minutes demonstrated that staff were encouraged to raise concerns and take responsibility where mistakes had been made. Staff felt supported to raise issues and suggest changes they felt needed to be made and were confident that if they spoke to managers they would be listened to. We saw that the staff worked together as a team, and responsibilities were shared.

The service was aware of the importance of maintaining regular contact with people using the service and their families. We saw that questionnaires were distributed asking people to comment on the service. Areas covered included first impressions, meals, standards of care, and housekeeping, with opportunity to comment if people were not satisfied. We saw that where respondents made comments these were seen as positive and action points were taken and acted upon to improve the quality of care provided. We reviewed the questionnaires and saw that comments were positive, with the majority of respondents marking either 'good' or 'excellent' in response to questions.

Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about Ashgrove and were satisfied with the level of care provided.