New Care Projects Sale (OPCO) Limited

Ashlands manor Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 completed this inspection on the 9 and 11 May 2018 and the first day was unannounced. This was the first inspection at Ashlands Manor (known as Ashlands) since the service first registered with the Care Quality Commission (CQC) on 28 April 2017.

Ashlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashlands is a purpose built home which can accommodate up to 57 people over three floors. All rooms are en-suite and each floor has its own separate facilities. The ground floor is a residential household, the first floor supports people living with dementia and the second floor supports people who need nursing care. There were 49 people living at the service at the time of our inspection.

There was a manager in place who was registered with the 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.

People and their relatives thought they were safe living at Ashlands. The staff said they enjoyed working for the service and felt very well supported by registered manager.

People received their medicines as prescribed. A new electronic medicine administration record (eMAR) system had been introduced which prompted when medication was to be administered. Quantities of stock were checked each week; however we found stock balances on the eMAR system did not always tally with the physical stock held due to an issue with duplicate records in the eMAR system. The training manager was going to work with the dispensing pharmacist and eMAR supplier to identify the cause of the duplicate records.

Senior care staff differed in how they responded to any differences in stock balances found, with one investigating the reason for the discrepancy and one altering the quantity noted in the eMAR system. Additional training was to be provided on the eMAR system so all discrepancies were looked into.

Protocols for when any 'as required' medicines were to be administered were not sufficiently detailed. Additional information was added to the system during our inspection. Topical creams were applied by the care staff and recorded on a cream chart. However this chart had not been distributed to the rooms that needed one on the nursing unit in May. Cream charts for previous months had been completed on all floors.

Person centred care plans and risk assessments were in place. These provided guidance and information about people's support needs, their likes, dislikes and preferences and how to mitigate the identified risks.

The guidance for staff to distract people who had behaviours that may challenge the service varied in its detail. Staff we spoke with knew people and their needs well. Care files were reviewed each month. People and their families were involved in these reviews.

People were supported with their health and nutritional needs. Ashlands was part of a scheme where a GP visited the home each day. This meant any minor ailments could be raised with the GP with the aim of preventing them becoming more serious and reducing hospital admissions. Two health professionals we spoke with were complimentary about the support provided to maintain people's health.

Staff thought there were sufficient staff on duty to meet people's needs; although they thought a hospitality member of staff would be beneficial on the first floor as well as the ground and second floors. People and relatives we spoke with said they felt additional staff should be on duty. During our inspection we found sufficient staff were on duty and call bells were responded to in a timely manner. Daily checks on the call bell response times were made.

Advanced care plans were available if people wanted to discuss their end of life wishes. A GP who visited the home told us they had been involved in discussing end of life care with people, their families and the home. We saw evidence of where the home had supported people to stay at Ashlands at the end of their life as they had wanted.

The service was working within the principles of the Mental Capacity Act (2005). A capacity assessment tool was used and applications made for a Deprivation of Liberty Safeguard (DoLS) if a person lacked capacity.

A safe recruitment process was in place. Staff had completed an induction programme when they joined Ashlands and also received refresher training on an annual basis. A programme of additional training in dementia awareness and distress reaction (managing challenging behaviours), dysphagia (choking) and falls management was being introduced. Training for specific needs, for example catheter care was provided by District or Community nurses when required.

Staff had regular supervisions with a named senior carer or the registered manager. Regular staff meetings were held, which were open discussions.

Residents and relatives meeting were held and a survey had been completed with the responses being positive.

Ashlands had a complaints policy in place. No formal written complaints had been received at the time of our inspection. Issues raised verbally had been recorded and responded to.

An activities programme was in place, including a gardening group and external entertainers. The majority of these activities took place on the ground floor which meant it was more difficult for people living on the other floors to get involved. Links had been made with a local nursery and school who visited the home.

People's cultural and religious needs were being met by the service.

The service was clean and well maintained throughout. On the first floor, where people living with dementia lived, tactile memory items were in place along the corridors to stimulate memories and to orientate people within the home. Doll therapy was in place if people wanted and a lifelike robotic cat had been purchased which people enjoyed petting and talking to.

A quality assurance system was in place. Incidents and accidents were monitored to identify if there were any patterns or trends. The provider had recruited a new quality manager who would undertake monthly quality audit visits to the home. Provider quality assurance visits had been on a quarterly basis before.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines as prescribed; however some stock balances were not correct and when found were not always investigated.

Additional guidance for when as required medicines were needed was added to the eMAR system during our inspection so they contained sufficient information. Guidance on how people communicated was available in their care plans. A topical cream chart was not in place for May and had not been raised by the staff members.

Clear risk assessments and guidance to mitigate the risks were in place. Guidance for supporting people if they become anxious was variable in the level of detail provided.

Sufficient staff were on duty to meet people's assessed needs. A robust recruitment process was in place.

Is the service effective?

Good

The service was effective.

The service was working within the principles of the Mental Capacity Act (2005). Capacity assessments and best interest meetings were completed where required.

Staff received the training and support through supervisions and team meetings to effective undertake their role. A programme of additional training was being implemented.

People were supported to meet their nutritional needs and maintain their health. A GP visited the home each day.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in developing and reviewing their care plans.

People said the staff were kind and caring. Staff knew people's likes, dislikes and needs.

Staff knew how to maintain people's dignity and privacy when providing personal care and prompted people to complete tasks independently.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place that provided guidance for staff in how to meet people's needs. People's wishes for their support at the end of their lives were respected where possible.

A programme of regular activities for people to take part in was in place; however most of these took place on the ground floor. Links with a local nursery and school had been made.

The service had a complaints procedure in place. All complaints received had been responded to appropriately.

Is the service well-led?

Good

The service was well led.

A quality assurance system was in place; although issues with the medicines had not been identified through this system. The provider had appointed a quality manager to complete monthly quality audits at Ashlands.

Staff said they enjoyed working at the service and felt the management team were very supportive and approachable.

Feedback was obtained from people and their relatives through meetings and a survey.

Ashlands manor Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 11 May and the first day was unannounced. On the first day the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. One inspector returned for the second day of the inspection.

Before our inspection the provider completed a provider information return (PIR). The PIR 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 service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. We also reviewed Share Your Experience' forms from relatives of people living at the home. Share your experience forms allow people to provide feedback about a service directly to the Care Quality Commission.

We contacted the local authority safeguarding and commissioning teams. They did not raise any concerns about Ashlands. We also contacted Trafford Healthwatch who said they did not have any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed people's mealtime experience and interaction between people using the service and staff throughout the inspection.

During the inspection, we spoke with six people who used the service, four relatives, 14 members of care staff (including three agency staff members), the training manager, two visiting health professionals, an activities co-ordinator and the registered manger.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, four staff recruitment files and training records, six care files, meeting minutes and auditing systems.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe living at Ashlands. One person said, "Yes I do feel safe here."

People received their medicines as prescribed. The service used an electronic medicines administration record (eMAR). The dispensing pharmacist entered the records of the medicines prescribed for each person and the prescribing instructions. These were checked at the service when medicines were delivered.

We observed the medicine round on each floor of the service and saw staff patiently spending time with people to ensure they had taken all their medication. We saw they asked people if they needed their 'as required' (PRN) medicines, for example pain relief, before preparing them. The eMAR did not always have person specific details about when and why individuals might need a PRN medicine, or how they could communicate a PRN was required, either verbally or non-verbally. Communication plans in people's care files gave clear information about how people communicated their needs. Good practice guidelines state information about how people would communicate they needed a PRN should be readily accessible and the eMAR system had the capability to record this information.

A list of people's medications was in each person's care file and included specific details about how they wished to take their medicines. Full details about when people needed their PRN medicines and how they would communicate this been added to the eMAR system by the second day of our inspection. The staff we spoke with were able to describe when people needed their PRN medication to be administered. When people received PRN medication, the eMAR system required the administrator to enter the reason why they needed it and the number of tablets given. An eMAR system report showed the PRN's administered and this was seen to show PRN's had been administered appropriately.

A stock check of medicines was completed each week; however one senior carer told us if they found the actual stock held did not tally with the eMAR stock amount they manually altered the eMAR stock record. Other seniors told us they would investigate why the actual count did not tally with the eMAR and record the reason for the discrepancy on the eMAR system. We completed a stock check for eight medicines and found the quantity of tablets held by the service did not tally with the computer records for three of these. We discussed this with the training manager and the registered manager. It was found that on occasion the same medicine had been entered twice on the eMAR system. The service had deleted one of these entries so as not to cause confusion when administering medication; however this also removed any stock balances from this entry, causing a discrepancy in the count of actual stock held and the eMAR system. The training manager said they would follow this up with the dispensing pharmacist to ensure double entries were not made for the same medicine. The registered manager confirmed that the procedure for any discrepancies found in the tablet count was to investigate and record the cause and all staff would be re-trained in this procedure.

Where required topical creams were applied by the care staff and recorded on a cream chart kept in people's rooms. However the cream charts on the nursing unit had not been put in place for May. This had not been raised by the staff team. We saw they had been completed for previous months. The registered

manager told us the charts had been given to an agency nurse but had not then been put in the rooms where they were needed. The charts were in place on the second day of our inspection.

The new deputy manager received a daily summary from the eMAR system of any missed entries and was able to address these straight away.

Comprehensive risk assessments had been undertaken for all the people whose files we reviewed. These included moving and handling, falls, pressure ulcers and malnutrition. Pre-admission assessments listed a timescale for all risk assessments to be undertaken once the person arrived at the home. Key risks were assessed within six hours of arrival. Guidance was recorded for staff to follow to manage the identified risk.

Where people might have behaviour that challenges, details of the potential behaviours was recorded and guidance for staff in how to manage the behaviours was provided. We found this guidance varied in detail. For example for one person it was very clear the different distraction techniques that re-assured the person, for example putting their favourite music on in their room and giving them some time alone. However another person's guidance was to distract the person, without providing any details on what this distraction may be. We discussed this with the registered manager who said that the guidance for staff when supporting people whose behaviours may challenge would be reviewed and additional support provided for the senior care staff and nurses when writing this guidance. All the staff we spoke with were able to explain how they would support and re-assure people when they became agitated.

Staff we spoke with were aware of the safeguarding procedures at the home. They understood how to report any safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the management team and were confident they would deal with any issues promptly and appropriately. They were also aware they could report concerns to other relevant agencies, for example the local authority or Care Quality Commission.

All incidents and accidents were recorded and reviewed by the registered manager. Any actions or changes to the support provided to reduce the risk of a re-occurrence were recorded.

Ashlands had a robust recruitment procedure in place. All pre-employment checks were completed and a full employment history recorded. The reasons for any gaps in employment history were recorded.

All the staff we spoke with thought there were sufficient staff on duty to meet people's needs, although acknowledged that there were some busy times, especially in the morning. A hospitality member of staff was employed on the ground and second floors to serve meals. They also cleaned and set tables and ensured there were stocks of snacks and drinks available on all three floors. Staff on the first floor thought a hospitality staff member should also be employed for the first floor. Currently the senior member of staff based themselves in the dining area of the first floor and supported people with their breakfast whilst administering the medication. This enabled the care staff members to concentrate on supporting people to get up. People and relatives we spoke with felt that additional staff were needed, with one person saying, "I think the staff are overworked; there's too much to do."

On the days of our inspection we found there were sufficient staff on duty to respond to people's needs in a timely manner. Call bell response times were monitored daily and we saw that the call bells were responded to within five minutes, even at busy times of the day. The registered manager said they had flexibility with the staffing numbers so that if people's needs increased, for example if someone was ill and required more support, the number of staff on duty could be increased.

Agency staff were employed to cover any staff vacancies or annual leave. We spoke with three agency staff who had all worked at the home previously. They knew the people they were supporting and were able to explain their needs to us. The registered manager confirmed that the home used one agency for care staff and requested regular staff were allocated to the home.

The home was clean throughout. A local authority infection control audit in November 2017 had awarded a green rating (high compliance). The actions identified during this audit had been completed.

We saw evidence that equipment was maintained and serviced in line with national guidelines and the manufacturer's instructions. Weekly checks were made on the fire alarm, emergency lighting system, call bells, wheelchairs and hoists. Legionella water checks were completed each month.

Personal emergency evacuation plans were in place for each person. These detailed the support a person would need in the event of having to leave the building in an emergency. Regular fire drills had been completed. Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak.

Good

Is the service effective?

Our findings

Staff told us they felt well supported in their role by the management team. They said they had completed relevant training and had completed an induction when joining the service. We spoke with the training manager who had formulated a spreadsheet to record all the training completed. This identified when refresher training was due.

An induction programme was in place for new staff. This included three days of training, including moving and handling, fire awareness, safeguarding, infection control and food hygiene. Staff also worked supernumerary in the home to get to know people and their needs. Probation meetings were held on a planned basis to review how the staff member was settling in to their role.

Where staff were new to working in a care role they were enrolled on the Care Certificate, which is a nationally recognised set of principles that all care staff should follow in their working lives. Staff were then encouraged to enrol on a diploma in health and social care.

The training manager had developed training courses for dementia awareness and distress reaction (managing challenging behaviours), dysphagia (choking) and falls management. We saw that these courses had started to be held and a training plan was in place to roll these courses out to all the staff team. We will check this has been completed at our next inspection.

Staff we spoke with confirmed they had received training in catheter care, pressure area care and PEG (Percutaneous endoscopic gastrostomy) feed care directly from the district nurse team or community nurses. They were all able to talk easily about these topics and demonstrated they had up to date training and skills.

Staff had regular supervision meetings with a named senior or nurse. This enabled the staff member to receive feedback on their performance and also raise any ideas or concerns they may have.

Staff meetings were held for each floor. Minutes showed that these were open forums where items were raised and discussed by the registered manager and the staff team.

This meant the staff received the training and support to carry out their roles, with additional training also being planned. The home had been accredited by Investors in People (IIP). IIP is a recognised standard for managing, supporting and training a staff team.

Staff told us they had enough information to meet people's assessed needs. We observed staff handover from night staff to day staff on two floors of the home. Any changes or issues in people's health or wellbeing were recorded and discussed. Staff said they were encouraged to read care plans, and sign to show they had done so after returning to work from holidays or days off and this helped them keep up to date on any changes in people's needs. We observed staff communicate with each other during the day of our visit, for example, when a person chose to remain in bed.

A pre-admission assessment was completed for all new referrals. This assessed the person's needs and involved the person, their relatives where appropriate and other medical or social care professionals involved in their current care and support. Initial care plans were written from this information. Staff told us they were given a verbal handover of this information and were also able to read the assessment and initial care plans and risk assessments prior to the person moving to the home. This meant staff had the information they needed to support people when they first moved to the home.

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).

The service was meeting the principles of the MCA. Capacity assessments and best interest decision meetings were seen in people's care files. Applications for DoLS had been made where it had been assessed that people lacked capacity.

Each person was registered with a GP. We saw referrals had been made to district nurses, the dementia crisis team and other medical professionals when required. One visiting health professional told us, "I get all the information I need, staff come with me to support (the person they were seeing) and they follow all the guidelines I give them." The home was involved in a new initiative whereby a GP visited the home every day. The aim was to reduce hospital admissions by addressing any health concerns early to try to prevent them from developing further. The GP was very positive about Ashlands and the staff knowledge of the people they supported, saying, "They (the staff) have all the information I need to hand and their follow up is excellent. They always call with updates when I've asked them to do this." The home were also positive about the initiative as any person who was feeling unwell could be seen by the GP straight away.

People's care files included details of any medical diagnoses and the support required for each medical condition. When people's care plan called for frequent changes of position to reduce the risk of developing pressure area sores, we saw these had been recorded on charts noting the time and their position. Whilst we saw some gaps in these positioning charts, no one at the service had any pressure area sores at the time of our inspection.

Each floor had a de-choker device that created suction to clear a person's airways in the event of them choking. We were told this had been used for one person and had cleared their airways. This meant that people's health needs were being met by the service.

We observed lunch on all three floors of the home. The dining experience was seen to be calm and unhurried. People received the support they required to eat their food. People told us they enjoyed the food and they had a choice of meals. One person said, "You pick what you want for lunch from the menu at lunch-time and select what you want for tea at the same time." Drinks, fruit and cakes were available throughout the day and we were told, "There's always fresh fruit available for you to help yourself."

We looked at how people were protected from poor nutrition and supported with eating and drinking. People were weighed either weekly or monthly and we saw referrals had been made to the speech and

language team (SALT) and dieticians when people were seen to be at risk of malnutrition or were having difficulty swallowing. Where required the quantity of food and fluids consumed was recorded. The home also had a stock of large handled cutlery and plate guards if people needed them. This would support people to continue to eat independently. This meant people's nutritional needs were being met.

The chef was knowledgeable about individual people's needs for a soft or fortified diet and had a list of people's requirements in the kitchen. The care staff informed them if a person's dietary requirements changed. The most recent inspection from the environmental health department in December 2017 had awarded the service a 5 (Very Good) rating.

Ashlands Manor is a purpose built home and is fully adapted to meet people's needs. All rooms had a walk in shower and an adaptable bath was available on each floor. On the first floor, where people were living with dementia, there were memory boxes outside each room. These enabled photographs or small mementos to be placed in them so people who were living with dementia were able to recognise their own room, although not all memory boxes were being utilised at the time of our inspection. Tactile items were also located along the first floor corridor, for example old cotton bobbins and sewing memorabilia or old tools and tape measures. These were for people living with dementia to touch and fiddle with as well as being reminiscence items that may stimulate memories and orientating people to where they were within the home.

Different areas of the home had distinct decoration which helped people to orientate themselves within the home. There were also tables and comfy chairs located by windows in alcoves along the corridors if people did not want to sit in the larger lounge or dining areas.

We saw some people on the first floor held dolls. Doll therapy is a recognised therapy that can reduce people's anxieties. We were told a crib and pram had been ordered for people to use if they wanted to do so.

A 'robotic cat' had been bought for use on the first floor. This was a realistic looking cat which was able to move, purr and meow. We saw one person affectionately sitting with the cat on their lap stroking and talking to it. Staff told us people enjoyed having the cat around and it seemed to give them an interest and had a calming effect. We were told a robotic dog had also been purchased and the home was currently waiting for delivery. This showed new methods of providing stimulation for people living with dementia had been introduced at Ashlands.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and caring and took opportunities to ask if they wanted anything and to have general conversation. One person said, "The staff are reasonably good, if I ask for anything they do their best to get it" and another told us, "The staff are lovely; really good." However another person told us, "Agency staff are not necessarily as good as the permanent ones." A relative said, "The staff are good, especially at mealtimes, helping those who need help."

People said that the staff knew them well, with one saying, "They remember not to bring me cake with a cup of tea; I don't like cake." Staff were able to talk about different people and showed they knew them well and treated people as individuals, knowing what was important to different people, such as wearing perfume or the way they liked to dress. Care files contained information about people's life histories, including their families, work and hobbies on the first floors. People living on the ground floor were able to chat with staff about their lives and so formal life histories had not been written. Life histories were not always in place on the second floor nursing unit. We discussed this with the registered manager who said the nursing unit had opened in February 2018 and so the life stories had not all been completed. In addition the activities co-ordinator was on maternity leave. A temporary activities co-ordinator was due to start the week following our inspection and would provide more opportunities for the life stories to be completed.

We saw and heard positive interactions between members of staff and the people they were supporting throughout our inspection. Staff spoke calmly with the people they were supporting to explain what they were doing and providing re-assurance. For example we saw one staff member patiently encouraging one person to walk at their own pace to the dining room for their lunch.

People and relatives told us that staff listened to them, did what they asked and respected their privacy and dignity. For example, staff always knocked on doors and waited for a response before entering, used people's preferred names, made sure that residents were always covered during personal care and supported people to go at their own pace.

People's confidential information was stored in locked cupboards on each floor. People told us that the staff didn't discuss their affairs in front of other people.

We also observed staff prompting people to do things for themselves where possible, for example when eating or mobilising around the home. One person told us, "They don't help me too much." People's care files contained information about the things people were able to do for themselves and where they needed assistance.

This meant staff maintained people's dignity and privacy, supported them with respect and prompted them to maintain their independence where possible.

We found people's equality, diversity and human rights were being met. People's cultural and religious needs were noted in their care files. Assessments and care plan documentation also prompted assessors

and reviewers to consider people's communication needs, preferences and characteristics protected under the Equality Act such as gender, religion, sexual orientation and disability.

At the time of our inspection we were told that no one currently at the home had requested a specific cultural diet. The chef told us they did prepare vegetarian meals for a relative when they requested a meal and were able to source culturally appropriate food, for example kosher or hallal, if required. We saw representatives from three local churches visited the home to offer blessings and communion for people who wanted this. Some people also went to the local church on a Sunday. All staff completed training in equality and diversity.

Where people did not have the capacity to make their own decisions and did not have relatives who could be involved in decisions about their care and support referrals were made for an independent mental capacity advocate (IMCA). This meant that an independent person would be involved in any best interest decisions about the person's care, to ensure their rights were protected.

Good

Is the service responsive?

Our findings

We viewed six care plans in detail. These contained details of people's assessed support needs and provided guidance for staff in how to meet these needs. For example information was provided regarding people's personal care, mobility, falls management, skin integrity, sleeping, communication, eating and drinking and health. Care plans also included details of people's likes and dislikes and information about their life history.

Care plans were reviewed each month or following an incident or accident, such as a fall. The review contained a one sentence summary of each care plan and highlighted any changes made to the care plans. The home used a 'resident of the day' system on each floor for reviewing people's care needs. This meant that as well as reviewing the care files people were asked about their food preferences and about the activities they liked to participate in and if there were any changes they would like to the menu or activity programme. We saw that people's relatives were involved in the reviews, either being asked when they visited the home or consulted via telephone or email. One person said, "Yes, I was involved in writing my care plan" and a relative told us, "[Name's] daughter was involved in writing the care plan and probably in reviewing it as well."

Where there was an assessed need we saw that technology, such as bed or motion sensors, were used to reduce the risks for people. The sensors were linked to the call bell system and alerted the staff when triggered. We also saw that one person who had the capacity to make their own decisions had decided they did not want the sensor to be used in their room as it disturbed their sleep. The service balanced people's wellbeing with their right to choose and make their own decisions.

The staff we spoke with knew people's care needs well and were able to describe the support they required. Staff offered day to day choices to people, for example what they wanted to wear, eat or drink. People told us they were able to get up and go to bed when they wanted. On the first day of our inspection we arrived before 7am. We found there were few people up at that time and observed people being supported to get up and have breakfast throughout the morning when they were ready to do so.

Advanced care plans were available in people's files; however they were not always completed. The registered manager said some people were not willing to discuss an advanced care plan. We did see some people had 'do not attempt resuscitation' (DNAR) forms in place. These were completed by their GP and involved people's families. The GP we spoke with confirmed to us the home had involved them in advanced care planning for some people living at Ashlands.

At the time of our inspection one person was approaching the end of their life. Anticipatory drugs, to manage pain at the end of a person's life, had been prescribed and a blank end of life care plan prepared in their file. However staff said the person, while frail, still had a good appetite and was not in pain and so their current care plan was still appropriate. This meant the person's needs had been carefully considered and preparations made in order to ensure when the time came the person would have a dignified and pain free death.

We saw cards and letters thanking the staff team for the care and support provided for their relative during the last days of their life, including being able to stay at Ashlands rather than go into hospital. This showed the service supported people and their families to meet their expressed wishes at the end of their lives.

A weekly timetable of activities was arranged at the home. This included entertainers visiting the home each month, exercise sessions, bingo, quizzes and arts and crafts. A gardening club had been started, with a herb garden having been planted. Trips out were also arranged each month for a small number of people using the home's minibus. A TV sized iPad was available and the first floor had a 'magic table' where interactive games could be projected on to the table. This could be used to stimulate memories and also hand / eye co-ordination as the table was touch-sensitive. Staff on the first floor supported people to use the magic table.

14 out of 18 organised activities took place on the ground floor as this had more space; however this did mean that people on the other floors needed support to get to the activities. We saw one of the visiting entertainers and this was well attended by people from all floors and also people's relatives; however we were told if people from the other floors needed staff to stay with them during the activity it would depend on how many people wanted to go to the activity as to whether the staff would be able to leave their own floor. This meant that a programme of activities was in place, but the activities were not always accessible for everyone living at the home.

The home had trained five staff in a programme called 'Oomph' which aims to enable staff teams to be involved in organising different activities to promote people's wellbeing. Five more staff were due to undertake this training. At the time of our inspection we did not see activities being arranged on the individual floors outside of the planned programme, with the exception of the magic table. One relative told us, "Staff need to be encouraged to engage actively with the residents when they are supervising them in the lounges." The home hopes the Oomph training will stimulate additional interactions and activities for those people who don't want to or can't attend the planned activity programme.

We saw there was a formal complaints policy in place. The home had not received any formal written complaints since opening. Verbal complaints raised with the registered manager were recorded, including the responses given to the complainant. People and relatives also told us they would speak directly to the staff or manager if they had an issue, rather than using the formal complaints procedure.

Good

Is the service well-led?

Our findings

The service had a registered manager in place as required by their registration with the Care Quality Commission. A deputy manager had recently been appointed to support the registered manager.

A quality assurance system was in place at the home. This included a monthly analysis of all accidents and incidents, changes in people's weights and the environment. Daily checks of call bell response times and weekly medicines checks were also completed; however as noted previously discrepancies in the medicine stock balances were not always investigated. The new deputy manager was also now reviewing the electronic medicines system each day to identify and follow up any possible errors or missed doses. The monthly care plan review summary for each person was signed off by the registered manager. A short daily managers meeting was held to discuss any current issues and share any changes in people's wellbeing or health. This meant the registered manager had an overview of the service.

The provider also completed audits for health and safety, infection control, catering and housekeeping in April 2018. These had been completed by the provider's quality assurance manager and were now due to be completed monthly. Prior to this the Nominated Individual for the provider had completed quarterly quality assurance visits. Actions taken when issues had been found were noted. This meant the quality assurance system had been strengthened by the appointment of the provider quality assurance manager.

We were aware of an incident at the home where an agency member of staff had not been fully aware of how to use a 'syringe driver'. A syringe driver helps reduce pain symptoms by delivering a steady flow of injected medication continuously under the skin. We discussed with the registered manager what lessons had been learnt from this incident. They told us that they informed the agency of all the equipment and procedures used at the home when booking the agency staff and asked for a profile for each agency staff member to ensure they had the correct training before confirming the booking. This meant the home had reviewed the incident and put measures in place to reduce the risk of it happening again.

We saw evidence that resident and relative meetings were held quarterly. Minutes of the latest meeting showed that people and their relatives were able to raise any issues they may have, for example asking that towels are replaced in people's bathrooms straight away when they are taken to be washed. One person told us, "The outcome was that they now do this when they remember."

A resident and relative survey had been issued with 20 being returned. These had been analysed in April 2018 and the responses were seen to be positive. Everyone said that they were very likely to recommend Ashlands to other people.

Staff meetings for each floor were also held on a quarterly basis. The meetings were used to provide information about developments at the service and also for staff to raise ideas and concerns they may have. Minutes again showed that the staff team were able to contribute to these meetings.

The staff we spoke with all said they enjoyed working at Ashlands and that the registered manager was

approachable and visible within the service. People and their relatives felt they could talk to the manager; most thought she was polite and helpful and would try and sort any problems out.

The home had established links with local community organisations. Children from a local nursery visited twice a month, although this was dependant on the weather as the children had to walk to Ashlands. A local school choir had also sung for people at Christmas and Easter.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.