brighterkind (Blair) Limited

Ashbourne Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 22 and 23 November 2016 and was unannounced.

Ashbourne Court Care Home, to be referred to as the home throughout this report, is a home which provides residential and nursing care for up to 64 older people. The home is situated over three floors. People who receive residential care live on the ground floor, people who have nursing needs live on the first floor and those who require nursing needs who are also living with dementia live on the third floor. Some people living at the service also had additional health conditions such as epilepsy, diabetes and Parkinson's Disease. Each floor of the home comprises of single accommodation with en-suite wet rooms with washing and toileting facilities. Separate bathrooms are available for those who prefer to use a bath to meet their bathing needs. Each floor has their own communal lounge with a separate quite lounge for people to entertain guests on the Charlton Unit. A kitchenette area with a sink, fridge, toaster and hot and cold drink making facilities is available on each floor as part of the communal dining rooms. The home has its' own secure rear garden and is situated in a residential area approximately a mile from the town of Andover. At the time of the inspection 58 persons were living at the home.

The home has a registered manager in post. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Relatives of those using the service told us they felt their family members were kept safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. Appropriate risk assessments were in place to keep people safe.

People were kept safe as the provider ensured sufficient numbers of staff were deployed in order to meet people's needs in a timely fashion. In the event of unplanned staff shortages the provider sought to use existing staff including the registered manager to deliver care. Agency staff were not used in the home to ensure familiarity and continuity of care for people living at Ashbourne.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as large scale staff sickness or accommodation loss due to fire or floods.

People were protected from the unsafe administration of medicines. Nurses and senior staff responsible for administering medicines had received additional training to ensure people's medicines were administered, stored and disposed of correctly. Staff skills in medicines management were regularly reviewed by managerial staff to ensure they remained competent to administer people's medicines safely.

The provider used robust recruitment processes to ensure people were protected from the employment of unsuitable staff.

New staff induction training was followed by a period of time working with experienced colleagues to ensure they had the skills and confidence required to support people safely.

People were supported by staff who had up the most relevant up to date training available which was regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

People, where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager showed an understanding of what constituted a deprivation of person's liberty. Appropriate authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted.

People were supported to eat and drink enough to maintain their nutrition and hydration needs. We saw that people enjoyed what was provided. People's food and drink preferences and eating support required were understood and appropriately provided by staff.

People's health needs were met as the staff and the registered manager had detailed knowledge of the people they were supporting. Staff promptly engaged with healthcare agencies and professionals when required. This was to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff had taken time to develop close relationships with the people they were assisting. Staff understood people's communication needs and used non-verbal communication methods where required to interact with people. These were practically demonstrated by the registered manager and staff.

People received personalised and respectful care from staff who understood their care needs. People had care and support which was delivered by staff using the guidance provided in individualised care plans. Care plans contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. People were encouraged and supported by staff to make choices about their care including how they spent their day within the home.

Relatives knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. Relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager.

People were supported to participate in activities to enable them to live meaningful lives and prevent them experiencing social isolation. A range of activities were available to people to enrich their daily lives. Staff were motivated to ensure that people were able to participate in a wide range of activities and encouraged them to participate where possible.

The registered manager fulfilled their legal requirements by informing the Care Quality Commission (CQC) of

notifiable incidents which occurred at the service. Notifiable incidents are those where significant events happened. This allowed the CQC to monitor that appropriate action was taken to keep people safe.

Relatives told us and we saw that the home had a confident registered manager and staff told us they felt supported by the registered manager. The registered manager provided strong positive leadership and promoted the providers values. These were promoted on a daily basis with each floor of the home selecting a value they wished to evidence that particular working day. These values were known by staff and evidenced in their working practice.

Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff that encouraged them to raise concerns with them and the registered manager. The provider routinely and regularly monitored the quality of the service being provided in order to drive continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

People were supported by sufficient numbers of staff who had been subject to a robust recruitment procedure ensuring their suitability to deliver care.

Medicines were administered safely by senior staff and nurses whose competence was assessed by appropriately trained managerial staff.

Is the service effective?

Good

The service was effective.

The provider ensured that staff had the relevant induction, on-going training and support to be able to proactively meet people's needs and wishes.

People were assisted by staff who demonstrated they offered them choices in ways that could be understood and responded to. Staff evidenced that they understood how to support people effectively so their needs were met.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. People who had specific needs in relation to eating and drinking were provided with the additional support required to protect them from any associated risks.

Staff understood and recognised people's changing health needs and promptly sought healthcare advice and support for people whenever required.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring in their approach with people, supporting them in a kind and sensitive manner. Staff had developed companionable and friendly relationships with people.

Where possible people were involved in creating and reviewing their own personal care plans to ensure they met their individual needs and preferences.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to. The service responded quickly to people's changing needs or wishes.

People were assisted by staff who actively encouraged people to participate in activities to allow them to lead full, active and meaningful lives.

People's views and opinions were sought and listened to. Processes were in place to ensure complaints were documented, investigated and responded to appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which was based on being open and ensuring care provided was given honestly and with genuine affection. Staff knew these values and this was evidenced in their working practices.

The registered manager provided strong leadership fulfilling the legal requirements of their role. Staff were aware of their role and felt supported by the registered manager. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The registered manager and provider sought feedback from people and their relatives and acted upon this. They regularly monitored the quality of the service provided in order to drive

continuous improvement.

Ashbourne Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 22 and 23 November 2016 and was unannounced, it was conducted by two inspectors and an Expert by Experience.

An Expert by Experience is someone who has personal experience of using or caring for someone who use this type of care service, on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, a relative, observed meal time sitting and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We did not request a Provider Information Return (PIR) from this provider prior to the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with 10 people living at the home, one relative, the regional manager, registered manager, deputy manager, three nurses, the assistant chef and six care assistants. Following the inspection we spoke with a social care professional.

We viewed seven people's care plans, seven of these people's daily care records and six medicine administration records. We reviewed seven staff recruitment files, six supervision and appraisal records, staff

training records and staff rotas for the dates 24 October to 20 November 2016. We also reviewed other documentation relating to the running of the home, these included quality assurance audits, policies and procedures relating to the running of the home, complaints, compliments accident and incident forms and maintenance records.

This was the first inspection of the home since the new provider was registered to deliver care on 11 May 2016.

Good

Is the service safe?

Our findings

People we spoke with all said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. They told they felt safe as staff were available to meet their needs. One person told us "I feel very safe here as the staff are so good". Another person said, "I feel that living here is safe and it's such a homely place to be".

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse. Staff were aware of their responsibilities to report any safeguarding concern. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert which included contacting the local Adult Services Safeguarding Team. Staff were able to identify that they would speak to the manager in the event of any concern being identified and could contact the Care Quality Commission if they felt appropriate action was not being taken. Where staff felt unable to raise concerns in person the provider had a whistleblowing policy to support staff to raise concerns anonymously. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if any concerns were identified.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, regarding falls, moving and handling needs and any identified nutritional or hydration risks. Risk assessments included information about the action staff needed to take to minimise the possibility of harm occurring to people. For example, some people had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. Additional risk assessments were completed when required to manage new risks identified to people's safety, for example, when it had been identified that people were at risk of choking. These risk assessments were reviewed monthly. This ensured that all current risks were identified and appropriate action documented for staff to take to mitigate this risk as soon as this change in need had become known. A social care professional told us, "There are always up to date risk assessment in files and staff on the floors can also tell me aspects of the care plans". Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety.

Accidents and incidents were documented, reviewed and actions taken as a result to mitigate the risk of future harm occurring. Staff demonstrated their understanding of risk management and keeping people safe whilst not restricting people's freedom. One staff member told us, "We don't stop someone doing something for themselves if they can. We let them go where they like in the home". Another staff member said, "If someone has (mental) capacity and they want to do something risky or not do something we advise, that's up to them. We'll discuss it with them to make sure they understand the risks and then get them to sign a form saying they understand. We need to keep people safe but not so much we take away their freedom. If someone doesn't have capacity then we can discuss their care with their family if possible and come to the right decision". Our observations on the day confirmed staff were mindful of people's rights to take risks.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been completed including obtaining written previous work and personal character references. The provider also completed a Right to Work form in all staff files which included up to date immigration status for overseas staff and professional registration for registered nurses. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care service. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue. The nursing staff we spoke with were aware of their professional responsibilities, including the maintenance of professional registration and of the recently revised revalidation process. People were kept safe as they were supported by staff who had been assessed as suitable for the role."

People told us there were enough staff deployed in the home. One person told us, "Staff are always nearby whilst I have a shower, they are terribly caring", another person said, "Staff here are so good…it gives me comfort knowing they are around to assist should I need it." Throughout the inspection call bells used by people to request assistance were answered promptly. We could see sufficient numbers of staff were deployed to deliver care at the time it was needed. The registered manager routinely assessed whether sufficient numbers of staff were deployed to meet people's needs. As a result they had identified the number of staff required to enable each person to receive the care they required. These consisted of one nurse and five carers on duty during the day in each of the two nursing units and two to three carers in the residential unit, plus the deputy manager and registered manager. There were a total of two nurses and six carers on night duty. There was no significant reduction of staffing at weekends. There was also kitchen, domestic, administration and maintenance staff on duty. The provider did not use agency staff; existing 'bank 'staff of the management of the home were used to fill any identified last minute staffing shortages.

People living at the home received their medicines safely. Nurses and appropriately trained senior care staff were responsible for administering medicines. Records showed that medicine administration records (MARS) were correctly completed to identify that people received their medicines as prescribed. Nurses and senior care staff were also subject to regular competency assessments as part of the provider's quality assurance processes to ensure medicines were managed and administered safely.

There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance. Some people living at the home were receiving medicines which are known as PRN or 'as required' which includes analgesics, sedatives and other medicines to manage people's pain. These are medicines that are not routinely required and may only be needed occasionally. Peoples MARS included a PRN protocol for nurses so they were able to see when PRN medicines were most appropriate, and the dosage that could be given. For example, people's MARS showed when they were in receipt of medicines for pain relief, clear guidance was provided as to when it could be administered and the levels of which could be given and for how long. We observed a medicines round where the nurse appropriately supported people to take their medicines as required. The nurse also routinely asked if people were experiencing any pain and wished to take any PRN medicines.

A number of people living in the home had been identified as having the need for the medicines to be administered covertly; this meant they were not always aware that they were being given their medicines. We could see a fully documented decision making process was in place to ensure medicines were suitable to be given in this way. During the medicines round we could see people were provided with an explanation

of the medicines they were due to take, including those people due to receive them covertly. People were provided with the information to allow them to make the decision as to whether or not they would take their medicines. People were offered choice in taking their medicines and as a last resort covert administration was provided in people's best interests.

Medicines were stored, administered and disposed of correctly which included those which required refrigeration to remain safe. The temperatures of drugs storage locations were routinely completed and documented to ensure they remained suitable for use. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented daily by the nurses to check that records and stock levels were correct.

There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood. The business continuity plan was situated in an emergency 'grab bag' situated by the front door to allow for easy access by staff and emergency personnel. This provided guidance of the steps to take in the event of an emergency to ensure people were kept safe.

Good

Is the service effective?

Our findings

People we spoke with were positive about the ability of staff to meet their care needs. People said they felt staff had sufficient knowledge and skills to deliver their care. One person told us, "The Staff can't do enough for you, they have to help me with all my personal care, they do everything for me, how could I complain about that". Another person said, "I couldn't think of a better place to be…all my needs are met, I'm happy". A social care professional told us, "They (the provider) provide a good robust training and on-going supervision and support".

People were assisted by staff who received a thorough and effective induction into their role. New staff were required to complete an induction which followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised within the first 12 weeks of their employment. These inductions were then followed by a period of shadowing to ensure they were competent and confident before supporting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their role. This allows new staff to see what is expected of them. Staff were provided with sufficient training to enable them to conduct their role with confidence. We spoke with staff about their experiences of induction when first coming to work at the home. One staff member told us, "It was very good. I never felt left alone and I shadowed staff until I felt comfortable". Another staff member told us, "I've worked in care before but I still had an induction and a probationary period". We noted from staff files the provider extended some staff's probationary period if issues remained at the end of the formal process.

Staff were able to access training in subjects relevant to the care needs of the people they were supporting, these were provided 'in-house' by senior staff. The provider had made training and updates mandatory for all staff in a number of key areas which included infection control, health and safety, food safety and dementia awareness for example. Staff were also encouraged to undertake additional training to meet the requirements of their role which included, pressure ulcer and skin tear management, nutritional and hydration and the care of people with dysphagia (those who experienced difficulty in swallowing). Staff spoke positively about the training provided. One staff member said, "Yes, there is training which we do regularly. If you need it, you can do it". Another staff member told us, "There is quite a lot of training now". We spoke with the registered manager about staff training who told us they were switching away from online e-learning to an 'in-house', face to face programme which was to be conducted by senior staff trained by the provider. This was felt to be a more complete way of ensuring that staff were able to actively participate in the training sessions and ensure that their confidence and ability were tested appropriately. We spoke with registered nurses about training and updates specifically for them. They confirmed specific training was available. One nurse told us, "Yes, I've done quite a lot of training over the past year. I've done training for male catheterisation and venepuncture and I know there are updates available".

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member

said, "Yes, we have one to ones. They're very good and the management team is very supportive". Another staff member told us, "Yes, the manager is very good. It's open and honest. I supervise staff too and I've had a lot of support doing that". We looked at the 2016 supervision matrix and planner and six supervision records. We noted that supervision sessions and yearly staff appraisals for all staff had been planned, in line with the provider's policy.

We asked staff whether team meetings were held as a way to ensure that updates and new information about the home was shared amongst staff. One staff member told us, "We have 'flash' meetings every morning for fifteen minutes. The nurses and senior carers go as well as the chef and other staff. It's just to catch up on the day and decide what needs doing. There's a longer one on Wednesdays. That's for discussing things in more detail". We saw that these meetings were held with the nurses and heads of department and were a useful way of ensuring that information was shared amongst the teams. This included identifying the 'Resident of the Day' who would then be spoken with by the chef, have a deep clean of their room and would have a full review of their care plan completed by nursing staff for example.

People's freedom was not unlawfully restricted without the appropriate authorisation being sought. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and deputy manager showed a detailed understanding of the DoLS which was evidenced through the appropriately submitted applications and authorisations.

Staff had all undertaken recent training in the MCA and evidenced they had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. All staff members could tell us the implications of DoLS for the people they were supporting. One staff member told us, "Some people without (mental) capacity have to have decisions made for them in their best interests. There is a process around this which is part of the Mental Capacity Act". Another staff member told us, "We have to keep people safe if they can't make decisions for themselves".

Records showed that decision specific mental capacity assessments and accompanying best interest decisions were made in relation to a number of aspects relating to people's personal care needs and wellbeing. Best interest decisions are made when people no longer have the capacity to make a specific decision about their life or care. This included best interest decisions regarding the administration of covert medication where appropriate and the use of bed rails to keep people safe.

Consent to care and care plans were agreed with people, their relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves. This process included involving those with a POA in assessing people's care needs before moving into Ashbourne, in care plan reviews and assisting in making best interest decisions. People were supported to have their views known and the provider ensured those with appropriate POA were involved in all aspects of people's care.

People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. Records were accurately maintained to detail what people ate to inform staff if people had had adequate food and fluid during the day. People's weights were monitored regularly and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example where a person had lost weight more frequent checks of their weight had been carried out and their diet reviewed and a fortified diet considered. This approach, along with actively catering for specific dietary preferences, ensured that people's dietary and fluid intake improved their wellbeing and they put on a maintained a healthy weight.

People were complimentary about the food provided. One person told us the food had not been to their liking when they first moved to the home however, "The food has improved a lot…its lovely now". Another person said, "I love the food, today we had lemon meringue pie which was wonderful". We carried out observations at lunchtime. Food was both nutritious and appetising. People could choose their meals from a daily menu and alternatives were available at each meal time. To help with providing choices for people living with dementia there was a pictorial menu available if required. We could see that people were also being shown two plates of food when being asked to choose what they would like to eat. This helped people to understand what foods were available as some people living with dementia are able to more easily recognise images rather than words. Some people ate in their rooms whilst others ate in the dining areas. People were asked and encouraged to sit in the dining rooms to create a social environment at lunchtime. We saw positive interactions such as staff asking where people wanted to sit, people being given consistent one to one support, plate guards offered for people that required them and some people having clothing protectors. Special diets were catered for. The assistant chef showed a detailed knowledge of people's specific dietary needs and this information was openly displayed in the kitchen and updated when required. They told us, and we saw, alternatives to the meals were available and were always offered to ensure people ate and drank enough to support their health and wellbeing.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of potential illness could be identified by regular review of people's risk assessments and care plans. Where required people were supported to seek additional healthcare professional advice which included seeing dieticians, for example. When advice from healthcare professionals had been provided we could see this had been documented and staff had taken appropriate action to ensure this guidance was followed A social care professional was asked if the professional advice they provided was followed by staff, they told us, "It is always followed, when I raise a concern or issue it is documented, acted on and then management will email me to confirm this has been completed". Care plans detailed how to recognise the signs of an impending health related issue and what action to take as soon as one of these incidents were recognised. For those living with catheters we could also see that guidance was provided for all staff on how to make sure these remained operational and how to treat any problems identified during their use in order to minimise the risk of infection for people using. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included Tissue Viability Nurses, social workers and hospital consultants. We found evidence that advice and guidance given by these professionals was followed and documented.

Ashbourne had been designed to meet the needs of older people and specifically decorated to support those living dementia. We saw that the environment had been adapted to support people to live as independently as possible. The corridors were wide and naturally lit with the addition of wall lighting to

ensure people with limited eyesight often associated with dementia could see clearly. Handrails were in place and in contrasting colours to the walls to aide people to find physical support as they mobilised. Toilets, bathroom doors and doors leading to communal areas such as the lounge/dining rooms had pictorial signage to make identification easier for people. People were supported by a living environment that was adapted in accordance to meet their needs.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that support was delivered by caring staff. One person told us, "The Staff here are as good as gold, they respect the fact that this is my home and always knock on my door". Another person said, "The staff are excellent I really can't fault them. They are so happy, yes that's it summed up they are all so happy. I rely on them 100% for everything from my personal care to helping me get into my chair and they treat me with such dignity, they never make me feel uncomfortable. I'm fully aware of what I need assistance with and they have listened to me all the way".

People experienced relaxed, companionable and caring relationships with staff. We observed staff being engaging with people, lowering themselves to people's level, ensuring eye contact, listening and responding accordingly, smiling, being polite with terms of endearment being used where agreed and appropriate. During the inspection the maintenance man chatted to lots of people as he went about his work. He asked them how they were and engaged with people in an appropriate manner which made them smile and engage with eye contact. Conversations were not just task orientated. Staff took time to speak with people engaging in talking about the weather, activities and relatives that were coming to visit them. Staff spoke to people in a warm and caring manner, and spent time to chatting with them about issues they were interested in. One member of staff was discussing relatives that were coming to see the person that afternoon. There was a calm and friendly atmosphere at the home. Staff interactions between people and staff were caring and professional in their approach when supporting people.

We observed care in communal areas throughout the day, we saw excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistently high standard.

Staff knew the people they were supporting because care plans included information about what was important to them such as their family relationships and what help they required to support them and when. People's care plans detailed their personal history, what activities interested them, relationships which were important to them as well as the name people preferred to be called by. This information assisted staff by enabling them to have an understanding of people's needs, preferences and the support they needed to remain happy. For example, one person's care plan contained information regarding their personal preferences for topics of conversation and the activities their preferred to participate in. This person was frequently engaging with staff and we could see that staff were aware of the types of conversations she wished to have with them. We could see that people's needs were known and people supported in the way they wanted. We could also see, for example, that people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked.

Care plans provided staff with a detailed insight into people's wants and needs which we could see were

followed during the inspection. As you entered people's rooms on the dementia floor a 'Pen Profile' was displayed on the wall. This detailed information about the person, their family history as well as topics of conversation which they would engage with. This was a positive way of ensuring that all staff, and visitors, had a conversation topic available to them which was comforting and reassuring to the person allowing for a comfortable rapport to be created.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. All the staff we spoke with were able to describe how they would support people in a caring way giving people the time and reassurance they required until they were no longer feeling unhappy. During the inspection one person became quite upset in their room; we could see that both a member of staff and a nurse were able to identify the cause for this persons unhappiness. They spent time reassuring them and encouraging them to participate in the afternoons activities until they were smiling and engaging in the friendly interaction. Staff told us they had the time to be able to spend with people if they were feeling sad or upset and we could see this was the case. People were supported in periods of low moods and offered comfort and reassurance until they felt better within themselves.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people to engage with them. When communicating with people staff would lower themselves to eye level to ensure that people were engaged in conversation. Staff would also often gently place a hand on people's arms to communicate that they were being spoken with in reassuring way. We saw that people were comfortable and actively sought this physical contact with staff.

People were supported to express their views and where possible involved in making decisions about their care and support. Care plans and risk assessments were reviewed monthly and signed by staff and relatives or representatives. We found evidence that people or their representatives had regular and formal involvement in on-going care planning or risk assessment. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

People and relatives told us they were treated with respect and had their privacy maintained at all times. Staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. People's care plans provided specific guidance on how to support people in a way that was mindful and respectful of people's dignity which was followed. Staff were able to provide examples of how they followed this guidance. Staff were seen to ask people before delivering or supporting them with the delivery of care. One staff member told us, "Yes, we always knock before we go into people's rooms". Our observations on the day confirmed this. Another staff member said, "We know this is their home. We always try to make sure we remember that".

We saw that people's differences were respected. We were able to look at all areas of the home, including people's own bedrooms. We saw rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. People were supported to live their life in the way they wanted in a homely environment which respected their individuality and met their needs.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. A social care professional told us, "(there is) evidence that people are consulted in their plans and is evident by talking to them". People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. People mainly spoke positively about the activities provided and were comfortable to raise concerns with management should they have a concern or complaint about the service they were receiving. One person told us, "I've never had reason to complain but if I did I would feel able to do so as the staff are so good, I know my problem would be listened to and action taken if necessary". Another person said, "I never have problems to discuss but the staff are very proactive and I'm sure if I had any issues the staff would listen and address the issue".

People's care needs had been assessed and documented by the managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met.

People's care plans and daily documentation were legible, person centred and securely stored. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's choices and preferences were documented. Care plans contained detailed information about people's care needs and actions required in response to changes in their health and wellbeing to ensure the care met their individual needs. For example, we noted one had an extensive pressure ulcer, acquired before admission to the home. We noted appropriate risk assessments were in place to anticipate and manage potential complications of these issues. These were regularly reviewed to ensure appropriate action was taken in response to any change. For example, attention had been paid to possible contributory factors, such as nutrition, hydration and risks associated with manual handling. Specialist equipment such as a pressure relieving mattress was in place. The pressure ulcer was being treated by registered nurses and was slowly improving.

Another person's care plan showed they had a supra-pubic catheter in place. This is a tube that drains urine directly from the bladder. It is inserted through on opening (stoma) made in the abdomen above the pubic bone. We noted this person's care plan contained specific guidance and action planning around the management of the person's care in this area. For example, the person received a continence assessment and had been recently reviewed by the person's GP. We noted advice and guidance given by them had been followed; risk factors such as possible infection of the catheter site had been recognised and preventative measures put in place.

People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in these reviews to ensure people received personalised care. Relatives with the relevant POA to assist in the decision making process were informed when reviews were happening to ensure their views could be taken into consideration. When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. When healthcare professional advice

had been sought the information provided had been used to update people's care plans accordingly.

The provider sought to engage people in meaningful activities however there had been a period of two weeks prior to the inspection where the home's two activity coordinators had left their employment. Recruitment had already commenced and one new member of activities staff had been employed at the time of the inspection however were waiting their full recruitment documentation to be received. In this interim period staff and the management were aware of the need to ensure people remained active and had activities available to them. During the inspection we saw people were being encouraged to participate in games of skittles with staff and movie afternoons. The registered manager and staff were aware of the need for people to receive personalised interaction when they did not wish to or could not participate in group activities. A social care professional told us, "Activities are always well attended and lively".

A typical week activities rota was viewed which had defined activities twice a day, 7 days a week. These activities included one to ones with people in their rooms, 'knit and knatter' sessions, sing-alongs, sensory activities such as feeling and experiencing new sensations, puzzles, cupcake decoration, live music, memory games and arts and crafts. The provision of activities on each day were reviewed to ensure they remained appropriate. During the inspection a newspaper group was to be held to discuss the headlines of that day. On that particular day there was a lot of negative and potentially inappropriate and upsetting content being widely reported. As a result it was discussed by staff that people would potentially become upset at the content of the discussion and a sing-along session was held with people as an alternative activity.

External organised activities were not regularly included in the activities programme. A lack of available transport for use by the home meant that this was not always possible for people to participate in such activities. However the registered manager had made arrangements with another local care home to start operating a system where they would share that home's minibus to enable people to participate in external activities such as visits to the local garden centre for example. Internal larger organised activities included professional musicians performing in the home, Christmas shows and singing groups. People's spiritual needs were also catered for, the home invited the local church to conduct a service at the home once a month for those who wished to attend. One person told us, "I enjoyed going to church, I helped a lot with my local church. Here we have a service once a month which I like".

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. The provider's complaints policy was available in the home's foyer which was accessible to visitors and relatives. This listed where and how people could complain and included details of how to complain. The provider's complaints policy included information on how to raise concerns with the Local Authority Ombudsmen if the complainant remained dissatisfied with the outcome of their complaint. It also included website contact details for the Care Quality Commission, Parliamentary and Health Service Ombudsman and the Independent Sector Complains Adjudication Service. This information was also included in people's welcome packs which were available in their rooms.

Complaints made in writing and verbally received were documented and recorded on the registered manager's computer system. This enabled the provider to maintain an overview of the complaints and concerns raised by people, relatives, visitors and staff. This was then reviewed monthly by the regional manager to ensure that appropriate action was taken to investigate, respond and put measures in place to ensure the original cause of the complaint was not repeated. Three formal complaints had been received in the last year. We saw that the complaints raised were investigated by the registered manager and steps taken to address the causes of the complaints. The complainants were then responded to appropriately in accordance with the provider's policy. Staff we spoke with were aware of the provider's complaints policy

and were able to describe to us the correct procedures for handling complaints and concerns.

Good

Is the service well-led?

Our findings

People we spoke with were confident in the registered manager's ability to manage the service and address concerns. People were able to recognise the registered manager and demonstrated they visited them regularly. The registered manager visited one person when we were speaking with them to see how they were. This person told us, "This is the Manager, he comes to see me and we have a chat and lots of friendly banter". People told us they were happy with the quality of the care provided, one person said, "I'm very happy here, the Staff are wonderful". Another person told us, "I couldn't think of a better place to be, I can't think of any way in which the home could be improved, all my needs are met, I'm happy". A social care professional told us the management of the home was "Excellent".

The registered manager and provider had developed an open and inclusive culture by meeting and working with people's relatives, staff and external health and social care professionals. We observed throughout the inspection the registered and deputy manager taking the time to speak with every person they met. People looked pleased to see them and there was good rapport between them. The deputy and registered managers office was next to the front door so they were a visible and recognisable presence to those who entered the home. The registered manager also sought to make themselves visible by completing a walk of the home on a daily basis. This was in order to see if there were sufficient levels of staffing to meet people's needs and to interact with people and staff visiting the home. The registered manager was keen to ensure that people living, working and visiting the home were aware that their door was always open and they were available to speak with people as and when they wanted.

The registered manager promoted an 'open door' policy and was available to people and support whenever required. Staff felt that they were subject to consistent and valued support from the registered manager. Relatives told us they could always speak to the registered manager if required and were confident that action would be taken if they raised any concerns. A written compliment from a relative supported this feeling, 'I should like to take this opportunity to thank you both registered manager and deputy manager for your professionalism and support over the past few months since mum came to Ashbourne Court. It has been a great comfort to know that I could knock on your door and be assured of a kind ear and prompt response to any concerns I might have had.' We asked staff if they thought the home was well led. One staff member told us, "This is by far the best run home I've ever worked in". Another staff member said, "The manager and the team are great. They're firm but fair. If you need anything, like equipment for example, it's there". Several of the staff we spoke with had been able to express their views formally by completing a staff satisfaction survey issued by the provider.

Staff demonstrated the values of the service. The registered manager promoted the visions and values of the provider. These included, choose to be happy (staff), sort it (concerns or complaints), doing it (care delivery) from the heart, love every day and make every moment matter. These were discussed with staff as part of their supervision process and at the daily flash meetings within the home. Each floor would then select the value of the day that they were going to evidence how that value was being shown during care delivery. We saw that the vision of the day was displayed on each floor and observations showed that staff demonstrated placing people at the heart of the care delivery within the home. Staff worked well together and were

friendly, helpful and responded quickly to people's individual needs. One member of staff told us the values of the service included, "We (staff and people) choose to be happy, we sort things (concerns or complaints), we treat people from our heart, we treat them with respect, dignity and are loyal to whatever their needs are".

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Staff had submitted notifications to the CQC, in a timely manner, about any events or incidents they were required by law to tell us about. They were aware of the new requirements following the implementation of the Care Act 2014, for example they were aware of the requirements under the duty of candour. This is where a registered person must act in an open and transparent way in relation to any specific incidents.

People, their relatives and healthcare professionals were actively encouraged to be involved in developing the service. The registered manager actively sought feedback from people to identify how the service people received could be improved. The last completed annual quality questionnaire survey had been completed between May and June 2016 and 25 out of 63 questionnaires had been completed and returned. This questionnaire asked for feedback in key areas such as people's satisfaction with the home and environment, the food and dining, recreation and activity and the care and the home team. Most responders answered positively about the all aspects of care delivery in the home. Written comments included, 'On the whole the staff are excellent and look after my husband very well', 'I am very happy with the care my mother receives, she is treated with care, respect and friendship' and 'All my worries and concerns about mum going into care have been dealt with in a caring, kind, selfless manner, nothing is too much trouble'.

Where areas for improvement had been identified actions had been documented and completed to ensure that the service provided was meeting people's needs. For example, it was identified that the maintenance of the grounds and garden was not at a level people had expected. We could see that action had been taken and a gardener had been employed to ensure the grounds and the patio areas were well kept and accessible to all. Residents and relatives had also commented activities staff should be available at the weekends. We could see this had been happening prior to the recent staff change. The home had employed a new member of activities staff and were attempting to recruit another both of whom would work alternating weekends to ensure this coverage was available seven days a week.

People and their relatives were also involved in meetings which were held every three months. During these meetings changes which were affecting the home such as recruitment, activities and any other services available to people such as home visit dental services were discussed. People were also provided with the opportunity to provide feedback in a safe environment and told us this was a useful process to put forward ideas/suggestions and raised any concerns. One person told us, "The meetings are great so we can all get together, I never have any need to complain but it's a good way to meet any new residents and get to know people and relatives". The last three meeting minutes were reviewed and people discussed sensory activities being introduced to the home especially for those living with dementia, a summer fete which was being held at the home and recruitment updates for new staff. Positive feedback was received during these meetings and the deputy manager actively encouraged relatives to come and meet the management and participate in people's monthly reviews of their care plans.

There was a robust system in place to monitor the quality of the service people received through the use of regular provider and registered manager audits as well as daily observations of staff in their role. Regular quality checks were completed on key areas such as care plans, staff records, and MARS. The provider also completed mock CQC inspections reviewing documentation and speaking with staff, relatives and people living in the home. These were also unannounced visits in order to review the quality of the service provided

on a daily basis.

Reports following the audits detailed any actions needed prioritised timescales for any work to be completed and who was responsible for taking action. For example, an audit was completed in April 2016 by the regional manager who identified that there was a temporary issue with the securing of one of the treatment rooms. A risk assessment had been put in place to manage the situation whilst a long term solution was being sought to enable the room to be secured appropriately. However it was identified during this audit that there was a risk to people being able to access the treatment room and medicines stored within. We saw action had been taken to secure this room safely on the day of the audit and appropriate security measures were in place by the time of our inspection. The same provider inspection also identified that people's fluid targets were not always recorded on the appropriate forms. This meant that staff would not always be able to immediately identify whether or not people were drinking sufficient amounts to maintain their hydration needs. An action was identified to ensure this information was available on these forms and we could see these were in place at the time of the inspection.

Staff identified what they felt was high quality care and knew the importance of their role to delivery this, we saw interactions between staff and people were friendly and unobtrusive. Compliments had been received in the home which identified that high quality care had been provided to their loved ones. A selection of these were viewed, one relative said, 'My sister and I had chosen Ashbourne for her (mother) as we felt it was well managed, had good facilities, and most important that our mother would receive excellent care there, we were never disappointed. The Watermills Team were all truly wonderful and showed such professionalism, kindness, respect and compassion towards our mother at all times. Her medical needs were quite complex and challenging but the staff enabled our mother to end her life in a peaceful and dignified way and for that we are truly grateful.' A social care professional had written to the home, 'I truly believe that the registered manager and all his staff have worked so hard to make a different in (person's) life and to give him the best ending that he could have had in the circumstances. (Registered manager) has also been a great support to me as well and I am comforted that I made the right decision in asking (the registered manager) to assess (the person).' Another relative had written 'What can we say that you are awesome, amazing, kind and caring. Be proud of what you do thank you for everything you did to help make (family members) last few years comfortable and she saw you as family and I did too, thank you so much.' People were assisted by staff who were able to recognise the traits of good quality care, ensured these were followed and demonstrated these when supporting people.