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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Ashlands Manor Care Centre (Ashlands Manor) on 09 and 11 May 2018. Since this inspection we received concerns in relation to staffing levels, and management of end of life care. As a result, we undertook a focused, unannounced inspection to look into those concerns. This report only covers our findings in relation to the key questions of whether the service was safe, responsive and well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashlands Manor Care Centre on our website at www.cqc.org.uk

This inspection was carried out on 18 and 19 December 2018. At our last inspection in May 2018, we found the service was meeting the fundamental standards, and we rated it good overall. At this inspection, the service continued to meet the fundamental standards, and the rating remained good overall, and the rating for safe improved from requires improvement to good.

Ashlands Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is a purpose-built home which can accommodate up to 57 people over three floors. All rooms are en-suite and each floor had its own separate facilities. The ground floor supports people requiring support with personal care, the first floor supports people living with dementia and the second floor supports people who need nursing care. There were 55 people living at the home at the time of our inspection.

There was a registered manager in post. 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. There had been no change in registered manager since our last inspection.

No-one was receiving end of life care at the time of our inspection. However, we found there were systems and procedures in place to help ensure the service was prepared to provide effective end of life care when needed that followed good practice guidance.

Nurses employed by the home had received training in how to use specialist equipment that might be needed when providing end of life care. At the time of our inspection, staff had not received any general end of life training. However, we found they were aware of good practice and procedures and were aware of where they could seek additional support and advice from, if needed.

The service regularly used agency nurses, and occasional agency care staff. The registered manager had information about their training and qualifications that allowed them to check they had the appropriate skills and experience to meet the needs of people living at the home.

Where possible, the service used the same agency staff to improve consistency. However, at the time of our inspection, the regular agency nurses were on leave, and the nurse on duty on both days of the inspection had not worked at the service before. We spoke with the agency nurses who told us they felt they had received adequate handovers and inductions to the service to allow them to understand their responsibilities and the needs of people living at the home.

We found there were sufficient staff on duty to meet people's needs. Some staff said they could be 'pressured' at certain busy times of the day, which was also our observation on the first-floor household that supported people living with dementia. However, we saw there were no significant delays to people receiving the care and support they needed.

The service used an electronic system to help manage medicines and record the administration of medicines. Staff told us they found the system worked well, and we saw it had a number of safety measures built into it to help ensure medicines were given safely. For example, the system alerted staff if someone required their medicine at a specific time, or if there had not been a sufficient time gap since the last dose of medicines.

The service was of a modern design and was clean. The service had recently received 100% in an infection control audit completed by the local authority area infection control lead.

Required servicing and maintenance of utilities and equipment at the home had been undertaken. However, we found the passenger lift had not had a required safety inspection. The provider sent us evidence that this was completed shortly after out inspection, and the lift was found to be safe to use.

Care plans were person-centred and contained the information staff would need to provide people with care that met their needs in a safe way, and in-line with their preferences. Although few people told us they had been involved in reviews of their care, people were happy with the information they received about their care and the level of their involvement.

Some people had DNACPR's (do not attempt cardiopulmonary resuscitation) directions in their care files. We found this information was not always accurately reflected on people's profile sheets or on the electronic medicines system. Whilst staff we spoke with were aware which people had a DNACPR in place, this would increase the risk that staff or other health professionals would not be aware of this information.

People were happy with the activities on offer. They were able to access the community and go on trips out as often as they wished. Since our last inspection, the service had started to hold scheduled activities on different floors of the home to help increase opportunities for engagement. The provider spoke about wanting to have conversations with people about their aims and aspirations when they moved into the home. One person had been supported to attend a surprise visit to the football stadium on the team they were a keen supporter of.

Staff told us they felt they received sufficient support. They said they were confident that they could raise any concerns with the management team and that they would be listened to. Several staff we spoke with demonstrated a clear commitment to the role and providing good quality care.

There were systems in place to help the provider and registered manager monitor the quality and safety of the service. This included audits of medicines, care plans and health and safety. The accident reporting system had recently moved to an electronic system, which provided opportunities for increased monitoring of themes and trends.

We noted the registered manager's check of service and maintenance records had not been completed in November 2018, and had not picked up the lack of a required safety inspection of the passenger lift.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The rating for safe has improved from requires improvement to good.

The service took pro-active steps to help keep people safe. For example, the service had purchased and trained staff in the use of 'de-chokers' that could be used if other methods to clear obstructions had not been successful if someone choked.

Although there were points in the day when staff were 'pressured', we saw there were sufficient staff to meet people's needs.

Staff assessed risks to people's health, safety and wellbeing. There were clear plans in place to guide staff how to minimise the likelihood of people being harmed.

Improvements had been made to ensure medicines were managed safely.

Is the service responsive?

Good

The service was responsive.

Staff were aware of and followed good-practice guidance in relation to the provision of end of life care.

Complaints were investigated and responded to appropriately. People who had raised complaints told us they had been dealt with promptly and to their satisfaction.

There were a range of activities on offer, including trips out from the home. Activities were scheduled to run on each floor of the home to help increase the number of people who were able to take part in them.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt they were listened to and could approach the registered manager with any concerns they might have.

There were systems in place to help the registered manager and provider monitor the quality and safety of the service.

We saw evidence that the provider had made changes and acted on the feedback of people living at the home.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a focussed inspection that was prompted in part by concerns raised with us relating to the competence of nursing staff, the provision of end of life care and staffing levels. We referred the concerns relating to the provision of end of life care to the local authority safeguarding team prior to our inspection. We did not investigate these specific allegations, but considered the management of end of life care, staffing levels and other relevant concerns as part of the inspection. We inspected the service against three of the five key questions we ask about services: Is the service safe, responsive and well-led? No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

This inspection took place on 18 and 19 December 2018 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor who was a clinical nurse specialist in palliative and end of life care 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.

Prior to the inspection we reviewed information we held about the service to help us plan the areas we would focus on during our site visit. This included the last inspection report, any concerns or complaints about the service we had received since the last inspection, and statutory notifications. Statutory notifications are information that services such as Ashlands Manor are required to send us about serious injuries, safeguarding, deaths and other significant events.

We sought feedback from the local authority quality and contracts team, Trafford Healthwatch, Trafford Clinical Commissioning Group (CCG) and a social worker with recent involvement with the service. We received feedback from Trafford quality and contracts team, which did not raise any concerns about the service. Healthwatch told us they did not hold any relevant information.

This was an unscheduled inspection carried out due to concerns raised about the service. Therefore, on this occasion we did not request a provider information return (PIR). A PIR is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 11 people who were living at the home and two people's visitors. We spoke with 13 members of staff, which included; two agency nurses, eight care staff, the deputy, the registered manager and the nominated individual for the provider.

We looked at records relating to the care people were receiving, including; 11 care plans, daily records of care and medication administration records (MARs). We also reviewed documents related to the running of a care home. This included personnel files for three staff members recruited since our last inspection, records of servicing and maintenance and quality assurance and audit records.

Good

Is the service safe?

Our findings

Despite mixed feedback about staffing levels from people and staff, we found there were sufficient staff to meet people's needs. Comments from people using the service included, "There's plenty of people about. There's always somebody there if I need them", "I can generally find somebody", "There aren't enough [staff] to go around, but it doesn't affect me" and "there's not a lot of them, but I think they've got enough". People's concerns tended to relate to periods when staff could be busier and appear 'stretched', such as in the morning when supporting people to get up and serving breakfasts. This was particularly the case with the household that supported people who were living with dementia. This household did not have the support of hospitality staff to serve meals. However, no-one we spoke with felt that staffing levels had a negative impact on the care they received.

Despite some staff feeling additional staff would be beneficial, most staff felt there were sufficient numbers to meet people's needs and provide people with the level of support and supervision they needed. During our inspection, our observations supported staff reports that they could be very busy at certain times of the day. For example, on the household supporting people living with dementia, we saw a member of senior staff was completing the medicines round in the morning. They were also interrupted by requests to provide people with support or serve people breakfast whilst other staff were supporting people to get up from bed. They handled such interruptions appropriately to help reduce the likelihood that a medicines error could occur. Staff did not leave people without support other than for short periods, and during our inspection we observed that people received the support they needed in a timely way.

The registered manager used a dependency tool to help them work out how many staff were needed to safely meet people's needs. This showed that the home was staffing above the level the tool indicated was needed. We also saw staffing levels had been changed based on the changing needs of people living at the home. For example, the number of staff on duty during the day on the household supporting people who had nursing care needs had reduced from five to four care staff since the last inspection due to a reduction in the needs of people living there. We saw the reasons for this change had been explained to staff at a recent team meeting. The registered manager and staff told us shift patterns were being changed on the household supporting people living with dementia to introduce a 'twilight shift'. This would result in more staff being on duty at the time people had greater need for support.

The registered manager told us there was one full-time vacancy for nurses on day shifts, and one or two vacancies for care staff. The service used agency staff regularly to maintain safe staffing levels. The registered manager told us the service only used one agency, and where possible the same staff from that agency. This included using two regular agency nurses, although both these staff were on leave at the time of our inspection. Two different agency staff were on duty during the day on each day of our inspection whom had not worked at the home before. We spoke with both agency nurses who told us they felt they had received an adequate handover and induction to the service. Induction checklists had been completed for both staff, which covered key things those staff would need to know about the service including procedures, documentation and emergency contacts for example. The registered manager showed us they had profiles for these agency staff listing their training and qualifications. This would help the registered manager ensure

these staff had the skills needed to meet the needs of people living at the home.

Procedures were followed to help ensure only staff with the required skills and who were of good character were employed. Required checks, such as a Disclosure and Barring Service (DBS) check had been completed, and proof of staff identity was held on file. DBS checks provided detail about any convictions and, dependent on the level of check, whether the applicant is barred from working with vulnerable people. Staff had provided a full employment history as required, and the provider had explored the reason for any gaps in such records. Staff had been interviewed, and we saw this process included exploring applicant's experience, skills and judgement. Nursing staff were asked to answer questionnaires based on clinical scenarios to help determine their competence and suitability for the role.

At our last inspection in May 2018 we found shortfalls in the way medicines were managed. This included issues relating to procedures followed when stock checks were not correct, and staff not consistently keeping records of the application of topical creams. We found the provider had made improvements and medicines were being managed safely.

Medicines were kept securely in locked medicines trollies that were kept in clinic rooms on each floor of the home when not in use. Controlled drugs were kept safely in a separate controlled drugs cabinet, and two staff members had signed for the administration of these medicines as is good practice. Controlled drugs are medicines that are subject to additional requirements in relation to their safe storage, administration and destruction due to their higher risk of misuse.

The service used an electronic system to record the administration of medicines. We observed staff using this system and saw the electronic medication administration records (MARs) displayed a recent photo of each person the record related to, along with details about their medicines. Staff showed us that the system had a number of built in safeguards to help reduce the risk of errors occurring. For example, the system would not allow staff to administer paracetamol without the required four-hour gap between doses, and the system flagged if someone was due medicines that were due at a specific time of day, or if updated instructions relating to the administration of warfarin were required, for example. We saw the system prompted staff to record details such as the quantity of medicine administered for people prescribed variable doses of medicines, and details such as the outcome of administering 'when required' (PRN) medicines. Staff now recorded the application of cream medicines on the electronic system, rather than on separate paper records.

There were protocols on the electronic system to inform staff when and why they should administer people's prescribed PRN medicines. This information was supplemented by more detailed information in people's care plans about their medicines. We saw evidence that people were administered pain relief as they required it, and also found evidence of good practice being followed, such as the use of standardised scales to help staff assess the level of pain people were experiencing.

Staff assessed risks to people's health, safety and wellbeing. We saw risk assessments in people's care files that related to hazards such as choking, pressure ulcers, malnutrition, falls and moving and handling. Risk assessments had not consistently been reviewed monthly. However, everyone's risk assessment we saw had been recently reviewed, and staff had reviewed risk assessments following any significant changes or events. For example, we saw staff re-assessed people's falls risk if they had sustained a fall.

People's care plans cross-referenced their risk assessments, which would help staff understand people's needs and the measures in place to keep them safe. We saw staff had identified appropriate steps to help reduce risks, which included making referrals to other professionals such as tissue viability nurses and

speech and language therapists when required.

The registered manager told us there had been no pressure ulcers that had developed whilst people were living at the home since the service opened in April 2017. During our tour of the home we saw there were 'de-chokers' located in the dining areas on each floor of the home. Staff had been trained in the use of these devices, which could be used to help clear a person's airway if other methods had not been successful. We saw records that one of these devices had been used successfully since the last inspection to help a person who had been receiving the correct care and support, but had choked. This showed the home was acting pro-actively to explore ways to keep people safe.

Staff were aware of the home's procedures in case anyone had a fall or suffered an injury. This included assessing the person, calling for help and completing an accident/incident form. We saw accident forms were checked by a member of management staff, and recorded any actions taken to help ensure a repeat incident did not occur.

At our last inspection we found care plans relating to how staff should support people with behaviour that challenged were not written with a consistent amount of detail. At this inspection, we found care plans provided sufficient information for staff to understand how they should support people effectively. In some cases, we saw the service had worked with others including GPs, psychiatrists and other mental health professionals to help them identify ways in which they could meet people's needs, and hopefully reduce incidences of behaviour that challenged. The registered manager told us that if people had more significant needs in relation to behaviour that challenged, they would ask relevant professionals to carry out an assessment of their needs. They would also consider whether the home was still able to meet that person's needs, as it did not provide a dementia nursing service.

People we spoke with told us they were treated with respect and felt safe living at Ashlands Manor. Notifications sent to the CQC demonstrated that staff at the service were identifying and reporting and escalating potential safeguarding concerns appropriately. Staff we spoke with were aware of potential signs of abuse or neglect to be aware of, and how to report any concerns they might have. We saw the registered manager had carried out investigations into safeguarding incidents when required and taken actions to help ensure people were safe.

The service managed risks relating to the prevention and control of infection. Ashlands Manor is a purpose-built care home. The environment appeared well-maintained and clean throughout the home. Since our last inspection, the home had received 100 percent in an infection control audit carried out by the infection control lead within the Trafford local authority area. The service also received the highest rating (level five) in a food hygiene inspection carried out under the food standards agency rating scheme in December 2018. The registered manager told us they had encouraged staff to get the annual flu vaccination, although there had been a low take-up. We also saw signs displayed in the home's lift asking that relatives or friends did not visit the home if they had flu like symptoms, and advising them that they could request vaccination through their GP.

Environmental risk assessments had been completed, and identified potential hazards and the control measures in place to reduce any potential risk. We saw on the morning of the first day of our inspection that a soup cauldron and hot-plate were accessible to people in the dining area, which presented a potential risk. We saw there was an environmental risk assessment for the kitchenette and that these items should have been placed on the opposite side of the kitchenette where they would have been out of reach. We brought this to the manager's attention, so they could remind the staff team of the correct procedure. Third parties contracted by the provider had completed required risk assessments relating to legionella and fire

risk. We saw the provider had acted on recommendations made in these risk assessments and had appropriate management procedures in place to help control these risks.

Certificates evidenced that required tests and servicing of equipment such as electrical appliances, gas appliances, the syringe driver and lifting equipment (such as hoists) had been completed. Whilst we saw evidence that the passenger lift had been regularly maintained, with the most recent maintenance/service visit taking place in November 2018, the provider was unable to show us a certificate to evidence it had had a thorough examination within the past six months. These checks are required to confirm that the lifting equipment was safe to use. The provider sent us a certificate to show us this check had been carried out after our inspection on 24 December 2018 and talked to us about how they had learnt from this incident and applied this learning across the homes they operated.

Good

Is the service responsive?

Our findings

The home had systems in place to enable them to provide effective end of life care. At the time of our inspection no-one at the home was receiving end of life care, although the registered manager told us two people were thought to be within the last 12 months of their lives. We saw evidence that staff had considered people's wishes in relation to their end of life care, and recorded this in their care plans. These plans had been regularly reviewed and updated in accordance with people's changing needs. As there was no-one receiving end of life care at the time of our visit, staff had not completed advanced care plans relating to people's end of life care needs. However, we saw there was a standard format document for staff to use that covered aspects of care and people's preferences including considerations around organ donation, making a will and 'putting things in order'.

Some people had DNACPR's (do not attempt cardiopulmonary resuscitation) decisions documented within their care files or within ReSPECT plans that had been completed when some people had been previously admitted to hospital. ReSPECT plans detail people's priorities and preferences for end of life care, along with agreed clinical recommendations. We noted that in five cases, people had DNACPR's in place, but this was either not accurately reflected, or had not been completed on their profile pages. Whilst staff we spoke with were aware of whom had a DNACPR in place, this would increase the risk that staff or other health professionals would not be aware that a DNACPR was in place. Staff told us they would update people's records as required to address this issue.

Staff had not received training from the provider in end of life care, although the registered manager told us they had recently sourced some suitable training. The registered manager told us the home followed the accredited 'six steps' programme in relation to delivery of end of life care, and this was supported by our findings in relation to procedures relating to end of life care planning. Permanent nurses had received e-learning in specific procedures that might be required when delivering end of life care, such as setting up and managing syringe drivers. We also found evidence of good practice in relation to managing syringe drivers such as using recommended equipment, and having a check-list to ensure syringe drivers were monitored once running. The registered manager told us that if a member of agency nursing staff was on duty, either they, or another member of permanent nursing staff would take responsibility for checking that syringe drivers were operating correctly. Profiles of agency staff training also allowed them to check that such staff had the appropriate training and experience to manage this equipment. Syringe drivers are small battery powered pumps that can be used to deliver a continuous dose of medicines through a needle under the skin.

The registered manager told us people's families would be involved in the planning of their relative's end of life care where this was the person's wish. They told us they also made guest rooms available to people's relatives if required to facilitate an overnight stay. Staff were aware of other professionals they could approach if they needed support in relation to the delivery of end of life care, including people's GPs, MacMillan nurses and district nurses.

People's care plans contained a good level of detail about their needs and preferences. This would support

staff to provide appropriate and person-centred care. The exception to this was in relation to the care plan completed for a person who was staying in one of two allocated 'discharge to assess' beds, where there were limited details about their care preferences. The discharge to assess placements are intended to support people to leave hospital, with the aim of the placement being time limited to around four weeks. We discussed this with the registered manager and deputy who told us it was hard to know at what point to put further care plans in place as people could move on at short notice.

We recommend the provider reviews procedures to help facilitate the provision of person-centred care for people staying at the home on a temporary or short-term basis.

Everyone we spoke with was complimentary about regular staff at the home, although some people commented that they felt agency staff did not know them so well. Staff had reviewed most care plans monthly or when they recognised a change in that person's needs. There was a 'resident of the day' system in place, which involved staff carrying out a full review of people's current care and support they received in conjunction with other professionals, the person and their family when possible. We saw the standard format of care plan contained space for the person or their representative to sign to show they had been involved in the care planning or review processes. Few of these had been signed. However, people told us they were involved as much as they would like to be in care planning.

Everyone we spoke with told us they received information from staff about their care in an appropriate format. One person who had a visual impairment told us staff or a family member would read information to them if required. Staff had assessed people's abilities and support needs in relation to their communication. Care plans noted how any health conditions the person had could impact on their ability to understand information or communicate their needs and preferences. They also provided staff with guidance on how to support effective communication with that person.

A range of activities were offered to people living at the home. Staff told us that since our last inspection, planned activities had started to be held on different floors of the home on different days. This was to help staff engage as many people as possible in activities who might otherwise have missed out due to previous barriers relating to the need for staff supervision when activities were run on the ground floor.

People were generally positive about the activities offered at the home. Comments included, "I enjoy the activities. There's a wide variety", "I'm not bored, there's always something going on" and "There's a lot of good things going on". We saw there was an activity timetable displayed in communal areas, which included quizzes, visiting entertainment, pet therapy, yoga and meditation and one to one's. Staff were also encouraged to undertake training in a structured activity programme that was delivered at the home. The first-floor household had a table that worked with an interactive projector and allowed people to play games on it. Whilst we did not see anyone using this equipment during the inspection, the registered manager told us it was used, and that they had found it to be good way of encouraging interaction between people living at the home and others including staff and younger visiting family members.

People told us they were able to get out of the home as often as they wished, either with family or on organised trips out. On the second day of our inspection a group of people living in the ground-floor household went out to a local garden centre. We saw communal areas were arranged in a way that would encourage people to interact socially. There were also areas on each floor where people could sit in a more private area with friends or family members, or take part in quiet activities such as completing jigsaws. Prior to our inspection we saw an online article about a person living at Ashlands Manor. Staff had arranged for this person to visit the football stadium of the team they were a keen supporter of as a surprise as they had not been for around 10 years. The nominated individual talked to us about wanting to have conversations

with people about what they wanted to achieve and supporting them to meet their goals. This demonstrated a person-centred approach to supporting people living at the home.

Complaints were managed effectively. The majority of people we spoke with told us they had not had any need to raise a complaint, but would feel confident to raise any concerns with a member of staff if they felt this was necessary. One person told us, "I've not complained, I've suggested things to do. You can talk to people here". Two people told us they had raised complaints and that they had been dealt with promptly and to their satisfaction. We saw evidence that the registered manager or provider had acknowledged, investigated and responded to complaints appropriately. This included making changes to put things right, and offering an apology if required.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who was registered with the CQC to manage Ashlands Manor in February 2018. The registered manager was supported by a deputy manager and team of senior care staff.

Staff told us they felt listened to by the management team and told us they would feel confident to approach them and discuss any concern they might have. Staff we spoke with were positive about their job roles, and several staff demonstrated a strong commitment to the role. One staff member told us, "You don't come into this job lightly" and highlighted the core values of the service as being to support people in a way that treated them with dignity and respect.

The provider told us they investigated and learned from any concerns, as well as reporting any incidents to relevant authorities such as the local authority and the CQC. Staff told us they were confident they would be treated fairly if they made any mistakes and would learn from any such incidents.

We saw staff team meetings were held, which gave the registered manager opportunity to update staff on any developments or planned changes, and for staff to raise any concerns they might have. We saw the registered manager had given staff a copy of their job descriptions at one staff team meeting to help re-enforce expectations and understanding about staff member's responsibilities. During the inspection we observed that staff were well organised and they understood what their duties were. The deputy manager told us there had not been a staff survey, but that one was being arranged at the time of the inspection.

We received mixed feedback about meetings held for people living at Ashlands Manor and their relatives. Comments included, "They're not regular, just on odd occasions. I've been to some", "Yes, I've attended them and things change" and "When I can I go to them because you learn a lot." We saw minutes from meetings that had taken place in April and June 2018. There was a further meeting advertised on posters in the home due to take place in December 2018.

Resident's meetings included representation from the different teams working within the home, such as maintenance, care and catering. We saw that this had enabled people to raise any issues directly with the relevant team so that actions could be agreed to make improvements. There had been a resident's survey in April 2018 and we saw there was a 'you said, we did' board displayed on the ground floor of the home. This recorded actions the provider had taken as the result of feedback, such as the purchase of a plate warmer and arranging more frequent trips out.

There were a range of audits and quality assurance checks completed by the registered manager and provider to help them monitor the quality and safety of the service. This included audits of care plans, medicines, health and safety, risk of malnutrition and call-bell response times. Whilst the provider acted promptly to address any concerns we raised, their audit and governance procedures had not effectively identified issues relating to recording of DNACPR orders in people's care documentation, and the lack of a required thorough examination of the passenger lift to ensure it was safe to use. The provider contacted us

following the inspection and told us they had completed a 'lessons learned' exercise in relation to the issue of a having a thorough examination report in place for the passenger lift, which they had shared with the company's board.

The provider had recently moved the accident and incident reporting system from a paper based to an electronic system. They demonstrated how this system 'flagged' if the manager was required to complete further actions or investigation before closing accident reports. The system also allowed the registered manager to run a range of reports to check for trends in accidents/incidents. For example, they could monitor the total number of accidents over time, or could break down this information to look for trends relating to each individual living at the home, or by time of day/location of the accident. This would help them identify where further actions could help them improve the safety of the service.

The provider completed audits of the service based on the five key questions CQC ask, which are whether the service is safe, effective, caring, responsive and well-led. The last audit had been completed in July/August 2018 and included feedback from staff, and whether they thought the service met the 'mum test', which is whether they thought the service was good enough for one of their relatives or another loved one.

It is a legal requirement that services such as care homes display their most recent CQC performance rating both on any website they have and within the home itself. Ashlands Manor was meeting this requirement.