Resicare Homes Limited

Ashton Lodge

Inspection report

Ashton Road
Dunstable
Bedfordshire
LU6 1NP

Tel: 01582673331

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 June 2016 and was unannounced. When we inspected the service in November 2013 we found that the provider was meeting all their legal requirements in the areas that we looked at.

Prior to this inspection we had received concerns in relation to the infection control procedures in the service and the care people were receiving. We had also received concerns regarding the environment and the cleanliness of the kitchen.

Ashton Lodge provides accommodation and care for up to 54 people with a variety of social and physical needs, some of whom may be living with dementia. At the time of our inspection there were 40 people living at the service with one person having recently been admitted to hospital.

The service has a registered manager. 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.

An appropriate level of cleanliness was not maintained throughout the service.

People's needs had been assessed and care plans took account of their individual needs but lacked detail with regards to their preferences, choices and individuality. Care plans and risk assessments had been regularly reviewed to ensure that they were reflective of people's current care needs.

There were personalised risk assessments in place however they did not offer robust guidance to staff on how individual risks to people could be minimised and the care provided to some people was not consistent with the assessments in place.

There were mixed opinions with regards to the activities provided at the service. There were limited activities on the day of our inspection and some staff we observed did not engage people in social conversation.

People told us there were sufficient numbers of staff on duty. However we observed there were significant periods of time when people were not supported by having a member of staff available. This was mainly observed during early morning, within the communal lounge areas of the service.

The registered manager completed quality monitoring audits and it was clear how these were used to drive improvements in the service however they did not routinely consider the experiences of people living in the service.

Staff understood their responsibilities with regards to safeguarding people and they had received effective

training. Referrals to the local authority safeguarding team had been made appropriately when concerns had been raised.

Medicines were managed safely and medicines audits were completed regularly.

Safe recruitment processes were in place and had been followed to ensure that staff were suitable for the role they had been appointed to prior to commencing work.

Staff were trained and had the skills and knowledge to provide the care and support required by people. New members of staff received an induction.

People's consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People were supported to make choices in relation to their food and drink and a varied menu was offered. People's health care needs were being met and they received support from health and medical professionals when required.

Staff were friendly and respectful. People's privacy and dignity was promoted throughout their care. People were provided with information regarding the services available.

The management team were approachable and staff felt supported in their roles.

People and staff knew who to raise concerns with and there was clear line of accountability amongst senior staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Appropriate standards of cleanliness were not maintained throughout the service.

Care provided was not consistent with the risk assessments in place which identified the actions to be taken to reduce the risk of harm to people.

There were systems in place to safeguard people from the risk of harm and staff had an understanding of how to use these processes.

Safe recruitment processes were followed.

Systems were in place for the safe management of medicines.

Is the service effective?

Good

The service was effective.

Staff were trained and had the skills and knowledge to provide the care and support required by people.

People were asked to give consent to the care and support they received.

People were supported to meet their health needs and had access to a range of health and medical professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff spent little time engaged with people in social conversation or activities.

The interactions observed between people and staff were mainly task focussed or to enable day-to-day decisions.

People were supported by staff that were friendly and respectful.

People's privacy and dignity were promoted by staff.

Staff were aware of people's needs and respected their choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans which reflected people's needs were in place and were consistently reviewed however they lacked personalisation.

We received mixed opinions on the activities provided at the service. There was a limited amount of activities available.

There was an effective system to manage complaints.

Is the service well-led?

Good

The service was well-led.

Quality monitoring systems were in place and were used effectively to drive improvements in the service however they did not consider the experiences of people living in the service.

There was a registered manager in post. People and their relatives knew who the manager was and found them approachable.

There was a clear management structure and there was an open culture amongst the staff team.

Ashton Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 30 June 2016 and was unannounced. The inspection was undertaken by two inspectors.

Prior to this inspection we had received information of concern. We reviewed all the information we held about the service, including data about safeguarding and statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. We also spoke with the local authority to gain their feedback as to the care people received.

During our inspection, we observed how the staff interacted with the people who used the service and how people were supported during meal times, individual tasks and activities. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people who lived at the service and two relatives to find out their views about the care provided. We also spoke to three care workers, three senior care workers, one member of housekeeping staff, the medicines co-coordinator, the deputy manager and the registered manager of the service.

We reviewed the care records and risk assessments of six people who lived at the service, and also checked medicines administration records to ensure these were reflective of people's current needs. We also looked at six staff records and the training records for all the staff employed at the service to ensure that staff training was appropriate and up to date. We reviewed additional information on how the quality of the service was monitored and managed to drive future improvement.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we had received information of concern regarding the infection control procedures in the home and the cleanliness of the kitchen.

During this inspection we found that ample supplies of protective equipment were available for staff use throughout the service. We observed staff wearing personal protective equipment (PPE) for the task they were carrying out, for example, disposable gloves and aprons when assisting people with personal care. We saw that PPE items were promptly and appropriately disposed of once used. We also saw that any waste from the delivery of personal care was disposed of correctly and there were ample disposal units in the communal toilets and bathrooms. Pest control checks were carried out by an approved contractor and there was no evidence of vermin in the service. We found the kitchen was clean and well maintained and cleaning schedules were in place. We were therefore unable to substantiate the concerns raised.

Appropriate standards of cleanliness were not maintained throughout the service. People told us that their bedrooms were cleaned to a good standard. One person told us, "I have my own room. It's very nice, it's kept clean." We conducted a tour of the service and found that communal areas including toilets and bathrooms had been cleaned and they contained ample supplies of soap and handtowels. We found that although on-going cleaning was in operation, there was a need for more robust deep cleaning in some areas and further attention to detail. On the second floor there was one bathroom where there was a noticeably unpleasant odour with staining and debris within the bath. The visitor's toilet was dusty and there was a build up of limescale and discolouration within the sink. One bedroom on the ground floor which had been prepared for person being admitted to the home was also dusty; debris was found on the carpet and there was staining to the headboard of the bed. We spoke to the registered manager regarding these concerns who confirmed this would be addressed with housekeeping staff.

Housekeeping staff had access to sufficient equipment and materials required to complete tasks and a schedule was in place to ensure areas of the service were cleaned regularly. Records we viewed indicated that cleaning tasks had been completed in accordance with the schedule in place but additional tasks required inclusion so as to ensure all areas of the service were thoroughly cleaned. This would ensure the maintenance of appropriate standards of cleanliness and hygiene. The training plan for the service confirmed that staff had undertaken training in infection control procedures to protect people from the risk of acquired infections.

A weekly health and safety checklist was completed to ensure that the condition of the environment was monitored and action taken to address any concerns. The registered manager told us that any concerns found were recorded for attention by maintenance personnel who visited the home twice a week. The registered manager described how repairs and improvement works had been discussed with the provider and how they were to be completed in the future throughout the service. We saw that repairs had been completed when identified.

Risk assessments were not always effective and did not provide staff with sufficient guidance. We observed

the care people received and found that this was not always consistent with the risk assessments in place. For one person, who was at risk of social isolation, the assessment completed stated that they should 'have all comforts to hand' including their call bell. We saw that this person remained in their room and was unable to reach their call bell; therefore unable to summon the assistance of staff should they require it. We took action to address this by bringing it to the immediate attention of the registered manager.

Another person's risk assessment stated that staff should check the electrically operated air flow mattress in place was working correctly on a daily basis to reduce the risk of harm from pressure; however the correct pressure setting was not recorded. This meant that staff were unable to check if the person was receiving the correct support from the equipment in place. This concern was shared with the registered manager who confirmed they would include this information on the checklist that staff completed. We also noted that a number of people had bedrails in place and, whilst a risk assessment had been completed, there was no evidence that there had been an assessment of the compatibility of the bedrails with the bed that they were being used with. We raised this concern with the registered manager who confirmed they would seek the advice of the company who provided the bedrails and an assessment would be completed.

Risk assessments and management plans were in place for each person who lived in the service. They addressed identified hazards they may face and included any actions that staff should take to reduce the risk of harm. The registered manager told us that risk assessments were reviewed monthly to ensure that the level of risk to people was still appropriate for them taking into account any changes in people's needs. This included identified support regarding nutrition and hydration, personal care, communication, emotional and physical well-being, falls and mobility. For some people, these also identified specific support with regards to their skin integrity and pressure care. Detailed steps that staff should take and the equipment to use to keep people safe were recorded and included the involvement of the district nurses, where required.

Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of ways. These included looking at people's care plans and their risk assessments and by talking about people's needs at staff handovers. One member of staff told us, "Handover is when we find out what area of the home we will be working in and find out if there have been any problems that we need to know about." Another member of staff told us, "We can always access people's risk assessments and plans on the computers so can always check for information if we are unsure." We observed the morning handover where the senior member of staff informed the staff on duty of changes in people's needs, any incidents that had occurred and highlighted concerns with regards to people's health and well-being. This meant people received continuity of their care and staff were provided with up to date information.

People said that they felt safe and secure living at the service. One person said, "I feel completely safe." Another person told us, "I'm settling in well and feel safe here." A relative told us, "The staff are ever so good. I am 100% sure [Name of person] is safe living here." Other relatives we spoke to confirmed they had no concerns about the service, the conduct of staff or their ability to provide care safely to their relative.

People were safeguarded from the risk of harm by knowledgeable staff. All the members of staff we spoke with told us they had received training on safeguarding procedures and demonstrated a good understanding of these processes. They were able to explain to us the types of concerns they would raise and were also aware of reporting to the local authority or other agencies. One member of staff said, "I have done safeguarding training that also covers the whistleblowing procedures. I know what to do if I ever suspected anybody was at risk of abuse." Another member of staff said, "I would speak to the senior or [Name of deputy manager] if I was worried that someone had been harmed." Training records for staff confirmed that they had undergone training in safeguarding people from the possible risk of harm. There was a current safeguarding policy in place and information about safeguarding including the details of the

local safeguarding team was clearly displayed in the entrance hallway. Records showed that appropriate referrals had been made to the local authority where required.

A computerised record of all incidents and accidents was held, with evidence that these had been analysed by the registered manager and appropriate action had been taken to reduce the risk of recurrence. Where required, people's risk assessments were updated to reflect any changes to their care as a result of these so they continued to have care that was appropriate for them.

The registered manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments, the maintenance and inspection of mobility equipment and the security of the building. People living at the service had Personal Emergency Evacuation Plans (PEEP's). Information and guidance was displayed in the entrance hallway to tell people, visitors and staff how they should evacuate the service if there was a fire.

People, relatives and staff told us there was enough staff to meet people's needs. One person told us, "There always seems to be staff around." A relative told us, "There seems to be enough staff, but they always seem very busy. They do their best." One member of staff told us, "I think we have enough staff. We cover for each other when anybody is off sick or on leave." We observed that staff were available to meet the needs of people living in the service when required or requested but there were prolonged periods of time when people in the communal lounges had no staff to attend to them and there were delays in the answering of call bells.

A formal staffing level assessment which considered the needs of people whilst considering the layout of the building was not in place. The registered manager explained to us that they used a dependency tool to assess the level of need of all the people living in the service and the support they required. They told us this was reviewed on a monthly basis to determine staffing levels for the coming month prior to completing the staff rota and took into account any changes to people's needs and new admissions to the service. We reviewed past rotas and found that there was consistently the required number of staff on duty that the registered manager told us was determined by the dependency tool however they were unable to share with us the most recent dependency assessment they had completed for comparison. This was not available as it had been completed online and a copy had not been saved.

Robust recruitment and selection procedures were in place and were followed consistently. One member of staff told us, "I had to complete a DBS and give the names of people to be contacted for references. I know it is very important that these checks are carried out." We looked at six recruitment files for staff including one care worker that had recently started work at the service. Relevant pre-employment checks including obtaining references from previous employers, checking the applicants previous experience, and Disclosure and Barring Service (DBS) reports had been completed for all staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. This meant that steps had been taken ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

People we spoke with confirmed they received their medicines as prescribed. One person told us, "The staff give me my medicine. I am on morphine, the doctor has been in to review it and it is getting tapered down, so that I can come off it." There were effective processes in place for the management and administration of people's medicines and there was a current medicines policy available for staff to refer to should the need arise. We reviewed records relating to how people's medicines were managed and they had been completed properly.

Medicines were stored securely and audits were in place to ensure these were in date and stored according to the manufacturer's guidelines. The medicines co-ordinator explained to us how regular audits of medicines were carried out so that all medicines were accounted for. These processes helped to ensure that medicine errors were minimised, and that people received their medicines safely and at the right time. We observed a senior member of staff administering medicines for people at breakfast and at lunchtime and they demonstrated safe practices.

Good

Is the service effective?

Our findings

People told us that they thought that staff were well trained and had the skills required to care for them. One person said, "The staff seem to know what they are doing; I think some of them have worked here for a long time." Another person told us, "They know what they need to do. I'm well cared for." Our observations of staff interacting with people confirmed that they knew and understood people's care needs and used their knowledge to deliver care appropriately.

There was an induction period for new members of staff and an ongoing training programme in place for all staff, which gave them the skills they required for their roles. One member of staff told us, "I have worked here for a long time. I have done lots of training and refresher training is mostly done through e-learning." Another member of staff told us, "[Name of senior staff] acts as a mentor for new staff; they are trained in supervising staff." A third member of staff told us, "When I first started working here I had to read through all the policies and procedures. I then worked alongside another member of staff until I felt more confident." Staff explained the variety of training courses they attended or completed online and were positive about how this supported them to carry out their role and responsibilities. The registered manager explained to us that the induction training that was completed by new staff was in line with the requirements of the Care Certificate. This was also supported by the records we checked.

Staff told us that they felt supported in their roles and received supervision, formally and informally. One member of staff told us, "We have supervision monthly." Another member of staff told us, "I can always talk to the one of the seniors any time not just in a supervision meeting." Some staff we spoke with confirmed that they had received an appraisal. Records showed that members of staff received formal supervision on a regular basis and that annual appraisals had taken place or were planned in line with the provider policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the MCA and the associated DoLS and we saw evidence that these were followed in the delivery of care. Where it had been assessed that people lacked capacity, best interest decision meetings had taken place involving relatives and health professionals. The outcomes of the best interest decisions were documented within people's care plans.

Authorisations of deprivation of liberty were in place for some people who lived at the service as they could

not leave unaccompanied and were under continuous supervision. We also saw the registered manager had made appropriate applications for other people living at the home and was awaiting the outcome of these applications from the relevant supervisory bodies.

People told us that staff sought their consent before they provided them with care or support. One person told us, "They have to ask my permission and they do. I'm old enough to know now." Members of staff told us that they always asked for people's permission before providing them with care. Our observations confirmed that staff obtained people's consent before assisting them with personal care or supporting them to transfer. Where people refused, we saw that their decisions were respected.

People told us that they had a good variety of food at mealtimes and were complimentary about the meals that were provided at the service. One person told us, "The food is nice. The cook works hard. We always get plenty and plenty of drinks." A relative told us, "The meals always look and smell very nice." A member of staff told us, "We ask people what they want for their meals every day. They have a choice of three main meals." There was a menu programme in place which had been completed considering the likes and dislikes of people and offered people a variety of meals, in line with their dietary preferences. Regular alternative meals were also available.

We observed the lunchtime meal in two dining areas and found that the meal time was relaxed. Where people required specific equipment or assistance to eat their meals we saw that this was provided. We observed staff encouraging people to eat at their own pace and chatting with people in a friendly manner. We observed that people were provided with regular drinks of their choice.

People had been asked for their likes and dislikes in respect of food and drink prior to moving to the service during the pre-admission assessment. One person told us, "I'm a fussy eater. I don't like carrots, onions or gravy. I lost a lot of weight before I came to live here. They try and encourage me to eat, they know the things I like and don't like." We spoke with the cook who told us that all food was prepared at the service and people were given at least three choices for each of the meals, with snacks available throughout the day. Members of kitchen staff were notified of people's dietary requirements and were informed of any changes. There was no-one living at the service at the time of our inspection that required a special diet for cultural or religious reasons but the cook confirmed that cultural diet choices could be catered for. Some people had been assessed at risk of poor nutrition and hydration and the cook was able to explain how changes were made to meals for these people to increase the calorie content and that additional fortified drinks were made. Members of care staff were aware of people's dietary needs and this information was documented in the care plans and risk assessments. Records held in the kitchen detailed people's preferences and specific dietary needs such as allergies or consistency requirements for example, a soft or pureed diet.

People were supported to maintain their health and well-being and were assisted to access healthcare services, if needed. One person told us, "I'm feeling well and they [staff] are looking after me well but I've been checked out by the GP." The care plans and records confirmed that people had been seen by a variety of healthcare professionals including the GP, speech and language therapists and district nurses. Referrals had also been made to other professionals, such as dietitians and physiotherapists where required. Daily records that we reviewed confirmed that the advice from healthcare professionals was being followed in the delivery of care.

Requires Improvement

Is the service caring?

Our findings

Prior to this inspection we had received information of concern regarding the care people received and the staff working in the home.

In response to the concerning information we arrived at six o'clock in the morning to begin our inspection. We found that seven people had received support with their personal care, were dressed and in the communal lounge on our arrival. People that we spoke with confirmed that they preferred to be supported early in the morning. One person told us, "I've always got up early. It's just my way. I was in the army." Another person told us, "I was out with my daughter last night but still always get myself up early." A third person we spoke to explain that their husbands past occupation required them to start work at four in the morning and had always been "an early riser." Our conversations with people and observations confirmed that people were making the choice to wake early.

Staff knew people and understood their preferences. One member of staff told us, "You get to know people after a while. They tell us about themselves." Information in the care plans enabled staff to understand how to care for people in their preferred way and to ensure their care needs were met however they lacked personal detail about people's individuality such as past occupations, social and leisure interests and people that mattered to them.

People we observed appeared comfortable and relaxed in the company of staff and staff engaged people in conversation however these interactions were mainly task focussed and to enable people to make day-to-day choices. One person told us, "The staff are working hard. Backwards and forwards they go. They don't seem to stop." Staff spent little time engaged with people in social conversation or activities and appeared consistently busy in meeting people's care needs. We saw that staff were moving from task to task, unable to stop and spend time engaging and socialising with the people they were caring for. We did however observe one member of staff who interacted with people in a warm, caring and thoughtful manner and took the time to engage people with kindness and affection.

People were positive about the staff and the care they received. One person told us, "I like it here. The staff are nice and looking after me very well." Another person told us, "We have a good laugh and a crack together." A relative we spoke to said, "The staff are very caring. They are always able to say how [Name of person] is when I phone." We saw a record of compliments that had been received by the service and comments with regards to staff were positive.

We observed interactions between staff and people that lived the service and found these to be polite and respectful. Where concerns had been raised regarding the behaviour of one member of staff we saw that the registered manager had taken action, investigated the concerns thoroughly and disciplinary action had been taken in accordance with the provider's policy.

People's bedrooms were personalised and had been furnished in the way they liked. One person told us, "I have my room. It's mine and has all my things in it." Many people had brought their own furniture, pictures

and decorations with them when they came to live at the service. There were numerous areas throughout the service where people could go to spend time quietly or have privacy to meet with their family members if they wished. We also saw that there was also an outdoor area in the garden with seating for people and their relatives to spend time together outdoors if they wished.

The promotion of people's privacy and dignity was observed throughout the day. Staff members were able to describe ways in which people's dignity was preserved such as knocking on doors before entering, making sure they offered assistance with personal care to people in a discreet manner and ensuring that doors were closed when providing personal care in bathrooms or in people's bedrooms. Staff all clearly explained that information held about the people who lived at the service was confidential and would not be discussed outside of the service.

There were a number of information posters displayed within the entrance hallway which included information about the service and the provider organisation, safeguarding, the complaints procedure, fire evacuation procedure and the aims and objectives of the service. We also saw contact details available for the local authority and the Care Quality Commission. This meant that people and their relatives had information regarding the services available to them.

Information on how to access the services of an advocate should this be required and support from charitable organisations that provide services to older people and people living with dementia was available on request from the management.

Requires Improvement

Is the service responsive?

Our findings

People, and their relatives, told us that they felt involved in deciding what care they were to receive and how this was to be given. One person told us, "My children were involved in me coming to live here. We had a meeting about what care I needed." Another person told us, "I have a care plan. My daughter comes to the meetings, she is very involved." Records showed that pre-admission assessments were undertaken to establish whether the service could provide the care people needed.

People's care plans lacked personalisation. There were computerised care plans for people living in the service which were accessible to all staff via computers in the main lounge or in the manager's office. The care plans followed a standard template which included information on care needs but lacked detail on people's background, their individual preferences or their interests. The plans reflected people's needs and included clear instructions for staff on how best to support people. We found that the care plans had been updated regularly with changes as they occurred.

We received mixed opinions from people regarding the activities provided at the service. One person told us, "Sometimes there's something going on during the day. I'm not sure about today though. I enjoyed the church service the other week when the priest came." Another person told us, "There's not much to do here." A third person told us, "I like to go out. I go out most days with my daughter."

Activities were provided by two activities coordinators who shared the responsibility of providing activities during the week. Members of staff we spoke with were able to describe some activities that people enjoyed, for example, completing crosswords, listening to music, spending time with relatives. They also explained difficulties the service had in providing meaningful activities for everyone, due to the range of needs experienced by people living in the service. Photographs of recent events and activities that had taken place were displayed in a wall mural in the corridor on the ground floor.

There was an activity schedule available so people and their relatives knew the activities that were on offer or any future events that were planned, however the activity co-ordinator was absent on the day our inspection and no alternative activity arrangements had been made. During our inspection we saw limited activities being completed by people with the support of staff on duty and visiting relatives. We saw one person being supported to play a game, one person receiving assistance to complete a word search and group of people being supported to sit outside in the garden. People who chose to remain in their rooms had no social interactions or activities recorded in their daily notes.

People we spoke with were aware of the complaints procedure and knew who they could raise concerns with. One person told us, "If I wasn't happy I could call my daughter at any time. I never had any reason to complain; the staff do the best they can for you." Another person told us, "Everything is ok here. I've got no complaints. I'd speak to someone if I did." Formal complaints that had been received in the past year were recorded. There was an investigation into each concern and the actions to be taken in response included. Each complainant had received a written response to their concern and the registered manager had recorded the outcome from each. There was an up to date complaints policy in place and a poster

displaying the complaints procedure available in the entrance hallway.

Good

Is the service well-led?

Our findings

The registered manager at the service was also the registered for another service within the provider organisation. They explained they were supported by a deputy manager at Ashton Lodge and how they divided their time equally between the two services.

Most people knew who the registered manager was. One person told us, "I think I know who the manager is, if it is who I think it is." Another person told us, "I know who's in charge here." A relative told us, "The manager seems very friendly and the staff keep in touch with us." A member of staff told us, "I love working here. Everyone is really good." The registered manager was knowledgeable about the people living in the home, the staff team and the systems in place within the service.

During our inspection we saw that both the registered manager and deputy manager spoke with people and staff to find out how they were and was actively involved in the running of the service. We saw that the deputy manager was regularly approached by senior staff regarding the support and wellbeing of people living in the service and the experiences of the staff on duty and they responded in a positive, supportive manner.

Staff on duty told us that there was an open culture and they would be supported by the management team. One member of staff told us, "The manager and the deputy manager are always available if ever you need to speak with them." Another member of staff told us, "We know what we need to do on the floor and the manager supports us to do that." Staff were aware of their roles and responsibilities and were clear on the lines of accountability within the staff structure but were not always clear on the visions and values of the provider organisation and the direction of the overall service development. Staff told us their focus was the day to support of people living in the home.

We found that there were a range of audits and systems in place by the provider organisation to monitor the quality of the service provided. These included reviews of care plans, daily records audit, medicines audits, incident audit and health and safety checklist. Any issues found in the audits were recorded in an action plan for the service and there was information as to how they would be addressed by the registered manager. We also saw the registered manager had taken appropriate action following recent Local Authority and Environmental Health inspections of the service. This demonstrated how the manager used feedback from a variety of sources to drive improvements at the service.

We noted that whilst the audits completed had highlighted some of the concerns raised during our inspection, and action was being taken, the audits completed were records focussed and did not consider the experiences of people living in the service. Therefore they did not highlight the concerns we found with regards to the observations of interactions with people or the lack of staff presence within the communal areas. We saw that questions relating to the satisfaction of people was included during the review of care plans. This meant that the quality of the care provided and the satisfaction of people living in the service was not routinely evaluated as part of quality assurance.

Staff were encouraged to attend team meetings at which they could discuss ways in which the service could be improved and raise any concerns directly with management. Previous discussions at meetings had included rota patterns and weekend working, pay, equipment provided for use and concerns noted by staff in the environment. We also saw that compliments and feedback for staff was shared. Members of staff we spoke with confirmed that they were given the opportunity to request topics for discussion.

We noted that records were stored securely within the computerised system or within the manager's office. This meant that confidential records about people and members of staff could only be accessed by those authorised to do so.