

## Ashley Grange Nursing Home Limited

# Ashley Grange Nursing Home

### Inspection report

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Good



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



### Overall summary

Ashley Grange Nursing Home provides accommodation which includes nursing and personal care for up to 55 older people. At the time of our visit 51 people were using the service. The bedrooms are arranged over two floors. There are communal lounges with dining areas on the ground floor with a central kitchen and laundry.

A registered manager was employed by the service. 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.

We looked at eight care plans and found some guidance did not always identify how care and support should be provided. This meant that people were at risk of not receiving the care and support they needed.

We found the service was not meeting the requirements of the Mental Capacity Act (2005). Where people were

# Summary of findings

deemed as lacking capacity assessments were not always completed and sometimes gave conflicting information. In response to this, the provider has contacted its software provider and arranged for an amendment to the software to enable it to record greater detail in these assessments”.

People were supported to eat a balanced diet. There were arrangements for people to access specialist diets where required. There were snacks and drinks available throughout the day during our inspection. However, monitoring charts were not being used in a proactive way and concerns about poor fluid intake were not being shared or communicated with the team.

People and their relatives spoke positively about the care and support they or their relative received. People and their relatives said they felt comfortable with raising concerns and had confidence that action would be taken where appropriate.

People were supported by staff that understood how to respect people's privacy and dignity. Staff had the knowledge and skills to carry out their roles. Staff told us they had access to training that was appropriate to their role. They said if they required any additional training, they could ask and had confidence it would be provided.

Staff knew how to identify if people were at risk of abuse and what actions they needed to take should they suspect abuse was taking place. The registered manager dealt with and responded to all safeguarding concerns.

Medicines were managed safely. Nursing staff managed medicines and ensured people received their medicines as prescribed. We observed two medication rounds and found nurses to be knowledgeable about the people they were supporting.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours.

Health and social care professionals spoke positively about the care and support people received and praised the management team. They said they found the staff and management team approachable and told us they sought advice and guidance where appropriate regarding changes in people's care and support.

There were systems in place for monitoring the quality of the service to ensure people received a high standard of care and support. The service had a clear set of values which included treating people with dignity and respect and promoting independence.

There were plans in place to respond to emergencies such as fire. There was a business continuity plan in place to cover emergencies such as loss of utilities or flooding.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

This service safe.

Medicines were managed safely. People received their medicines as prescribed.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

There were enough staff available to ensure that people received appropriate care and support.

There were systems in place to reduce the risk and spread of infection.

Good



### Is the service effective?

This service was not always effective.

The service was not meeting the requirements of the Mental Capacity Act (2005). Where people were deemed as lacking capacity, assessments were not always completed and sometimes gave conflicting information.

People were supported to eat and drink enough and had access to specialist diets where required. However, monitoring charts were not being used in a proactive way and concerns about poor fluid intake were not being shared or communicated with the team.

People had access to healthcare services and received on-going healthcare support.

People were supported by staff who had the knowledge and skills to carry out their roles.

Requires improvement



### Is the service caring?

This service was caring.

People were treated with kindness and compassion in their day to day care and support.

Staff knew the people they were caring for including their preferences for how they would like to receive care.

People were supported to be as independent as they wanted to be.

Good



### Is the service responsive?

This service was not always responsive.

We looked at eight care plans and found that some guidance did not always identify how care and support should be provided. This meant that people were at risk of not receiving the care and support they needed.

Requires improvement



# Summary of findings

People were supported to take part in activities.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. People were confident their concerns would be listened to and appropriate action taken.

## Is the service well-led?

This service was well-led

Staff told us they understood the values of the provider, which included keeping people safe, promoting their independence and ensuring people received care which met their needs.

The provider had systems in place to monitor the quality of service.

People and their family were regularly involved with the service and their feedback was sought by the provider and the registered manager.

**Good**



# Ashley Grange Nursing 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.

This inspection took place on 29 September and 1 October 2015 and was unannounced. Two inspectors carried out this inspection. During our last inspection in December 2013 we found the provider satisfied the legal requirements in the areas that we looked at.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service.

This included talking with seven people, nine relatives and two visitors about their views on the quality of the care and support being provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included eight care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we observed how staff supported and interacted with people who use the service. We spoke with one of the directors, the registered manager, and 11 staff including registered nurses, the training officer, housekeeping staff and the chef. We also spoke with a visiting health professional. Prior to our inspection we contacted health and social care professionals who work alongside Ashley Grange. We received positive feedback from all seven professionals spoken to.

# Is the service safe?

## Our findings

Medicines were managed safely. We observed parts of two medication rounds. On both occasions, the nurses administering the medicines were knowledgeable about the people they were caring for, the medicines they were receiving and the reasons why. People were asked if they were ready to take their medicines and when they weren't, for example, because they were having a wash, the nurse returned later. People were not rushed and nurses spent time ensuring people were comfortable and free of pain. One nurse said "Even though X is unable to communicate, we could see from their face and eyes they were in pain when they received personal care, so we asked the doctor to prescribe some analgesia." All bottles and fridge items had been clearly labelled and signed to indicate when they had been opened. This ensured that medicines were not used past their expiry dates.

The MAR charts were all signed to indicate when staff had given medicines. There were no missing signatures on the charts we looked at. Topical medicines were signed for on the medicine administration records (MAR) by nurses, or they ticked, to indicate they had been applied correctly. Medicine trolleys were locked when not in use, and kept in a locked room, with a code that only necessary staff had access to. This ensured medicines were stored safely.

Nobody using the service was self-administering their medicines. Some people were receiving their medicines covertly. This is when medicines are disguised within food or drink without the person's knowledge. Other people had their medicines crushed. For example, one person was having their medicines crushed. A relative had given verbal consent, and staff had documented this. The GP had also signed. The pharmacist had signed to confirm there was no reason why the tablets should not be crushed, however this was not dated. There was also no review date recorded. Other covert medicine forms we saw had been fully completed.

Medicines were disposed of safely. Medication audits were undertaken on a monthly basis. Missing signatures on MAR charts had been noted. The provider had implemented a checklist for staff to sign at the end of each medication round for them to confirm they had signed where necessary. There was no system in place for monitoring stock levels of medicines, which is a recommendation by the Royal Pharmaceutical Society. This meant there was no

clear audit trail available to monitor medicines into the service against what was used and what was disposed of. We discussed this with the provider during our inspection and they advised they were planning to implement a system in the near future.

People and their relatives and visitors told us they or their relative or friend felt safe living at Ashley Grange Nursing Home. Comments included "Staff will come if I need help", "They always come when I press my bell and check I'm ok" and "The care here is very good, it's a relief I can leave him here."

Staff told us they had received training in how to protect people from abuse and avoidable harm. Through conversations with staff they demonstrated their knowledge and understanding of safeguarding, including how to recognise signs of abuse and report them. One staff member said "If I saw anything wrong I would report it straight away. I've never had to but I am sure I would be taken seriously." Any concerns about the safety or welfare of a person were reported to the registered manager who investigated the concerns and reported them to the local authority safeguarding team as required.

Assessments were undertaken to identify risks to people who used the service. When risks were identified, appropriate guidance was in place to minimise them. For example the provider had carried out risk assessments in relation to falls prevention, malnutrition and moving people safely. Personal evacuation plans had been completed for people using the service. These took into consideration people's understanding of what an emergency was, their cognitive needs and mobility requirements during a fire evacuation.

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people receiving a service. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the staff member's past work performance. Staff were subject to a Disclosure and Barring Service (DBS) check before they started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

## Is the service safe?

There was enough qualified, skilled and experienced staff to meet people's needs. The training officer explained they were responsible for completing the roster to ensure there were always sufficient staff members on duty. We looked at the home's roster which indicated there was a consistent level of staff each day. Staff said there were sufficient staff to meet the needs of the people they were supporting and that cover for staff sickness and annual leave was always provided. One staff member said "We tend to have enough staff around. Occasionally people go off sick but we always pull together and people always get the care and support they need." A visiting health professional told us "There always appears to be enough staff on duty."

Measures were in place to maintain standards of cleanliness and hygiene in the home. There was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. People and their relatives told us they were happy with the standard of cleanliness in the home.

# Is the service effective?

## Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

During the inspection we found the service was not meeting the requirements of the Mental Capacity Act (2005). Where people were deemed as lacking capacity, assessments were not always completed and sometimes gave conflicting information. For example, although people's care plans stated people had been deemed as not having capacity to consent to some or all aspects of their care, there were no completed mental capacity assessments in place. Some care plans gave conflicting information about people's capacity. For example, in one person's plan, staff had stated the person was able to consent to care; however, the bedrails consent form had been signed by the person's relative. There was nothing documented to indicate if the person had been involved in the decision making process, despite being able to consent to their own care. Another person's plan stated they were able to make informed decisions. However, their bed rails consent had also been signed by a relative with no detail of whether the person had been involved. In another person's plan there was nothing to indicate the person had consented to their care. Staff had documented they were unable to communicate, but there was no mental capacity assessment completed and no evidence of any best interest meetings having taken place. It was not always documented why the person had been assessed as requiring bed rails to be in place, or whether alternatives had been looked at first. We asked staff where mental capacity assessments were kept within people's care records, but staff did not know. One staff member said "If a resident doesn't have capacity to consent, we speak to a relative."

It was not clear if mental capacity was assessed because there were no completed assessments in people's care records. This contradicted the provider's policy which stated that staff should 'Make sure the mental capacity assessment form is completed fully, that it is signed by the assessor and that it is dated. The test detail should be recorded in Caredocs'. Caredocs is the electronic system used to record people's care and support needs. An example of this was where the person receiving covert medicines. The provider's policy stated that 'An assessment of mental capacity must be completed', but there was no record of this being completed within people's records in relation to covert medicines administration.

In response to this, the provider has contacted its software provider and arranged for an amendment to the software to enable it to record greater detail in these assessments".

These concerns were a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of documented evidence of capacity assessments and consent, staff were seen throughout the inspection asking people before they assisted them with their care. Staff were seen asking people where they wanted to sit, what time they wanted to get up, what time they preferred to have their medicines and whether they wanted to go to one of the lounge areas.

The registered manager told us they had made the necessary applications for DoLS authorisations. Applications had been submitted to the local authority and they were awaiting a response.

People had access to food and fluid throughout the day during our inspection. Where people had been identified as being at risk of malnutrition or dehydration their intake was being monitored by staff. Although the fluid intake was supposed to be totalled at the end of each shift, as a method of highlighting when people may require further encouragement to drink, this did not always happen. Despite this, staff knew which people were being monitored, and we observed staff encouraging and assisting people to drink throughout the inspection. We looked at the daily record for one person who was having their intake monitored. The nurse on night duty on 27/09/2015 had noted "X had 200 mls yesterday". They had documented that the day staff should encourage the person to have more drinks. However, there was nothing



## Is the service effective?

similar documented on other days. The same person's chart stated they had only received 200mls of fluid the following day. We asked staff how they knew how much people should be drinking and one said "They're meant to have one litre of fluid a day." We could not find this information within the person's care plan. This meant there was a risk that the monitoring charts were not being used in a proactive way and that concerns about poor fluid intake was not being shared or communicated with the team.

Where staff had documented in care plans that people had care needs in relation to nutrition, there was not enough guidance in place to inform staff how to meet these needs. For example, in one person's plan staff had documented 'Consider likes and dislikes when providing food', but there was no detail available on what the person liked or disliked. In the same plan, staff had documented 'Consider completing a food record chart', but later in the plan staff had documented 'Document daily dietary intake'. This meant there was a risk that staff may not know which guidance to follow.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to specialist support, such as dieticians and speech and language therapy (SALT). Where people had difficulties swallowing, the specialist guidance was on the wall of the person's room to assist staff. We overheard a conversation between the registered manager and one of the nurses about someone who had just been referred to the SALT team and the reasons why. The referral had been made as soon as concerns had been raised. This meant that people had access to specialist services in a timely manner.

We observed the lunchtime meal on the first day of our inspection. Staff were patient and polite when supporting people. Staff checked that people had enough to eat and asked people if they wanted any more when they had finished. People who required assistance were offered this at a pace appropriate to their needs and in a sensitive manner. Staff sat down with people and gave them time to eat the meal. People were offered a choice of two main courses. People had access to specialist diets where required. This included wheat or sugar free meals or meals design to help those people trying to gain weight. However where people required a pureed diet they only had one

option. We spoke with the chef about this. They explained they were new in post and had recognised this was an area of nutrition which needed addressing. They were currently looking at how they could offer people on pureed diets more choice.

The chef told us they were given information about people's dietary needs by the care staff and nurses. They had information in the kitchen about people's particular likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu, they were able to request alternatives. The kitchen was clean and tidy and had appropriate colour coded equipment to ensure that food was prepared in line with food handling guidance.

People we spoke with said they enjoyed the food. Comments included "Food is really good here and there's always plenty" and "Food is marvellous. I may have put on a little weight since I got here." One relative told us "I feel he gets enough to eat. Availability of food is spread out throughout the day."

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed, such as dentists, doctors and specialists. Concerns about people's health had been followed up and there was evidence of this in people's care plans. The service had good links with organisations for specialist support and advice. For example, the tissue viability nurse was regularly contacted for advice and the local speech and language team (SALT) were involved in planning care for people with swallowing difficulties. One nurse said "I am the tissue viability lead here and have just started a course to help me with this." A relative told us "X had the best care towards the end of their life. The GP was always called and we were always kept up to date." Another relative said "When X was not well recently they called the GP straight away. The attention they got was marvellous."

One health professional told us "I have assessed a number of residents. The staff are always accepting of my advice and do appear to carry out the prescribed treatment and care regime I prescribe. There have been a number of very successful outcomes with residents and their health needs. A regime is only as good as the people carrying it out".

Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. Care staff had the skills and knowledge to support

## Is the service effective?

people effectively and this was supported by core training they had completed, such as mental capacity, health and safety, safeguarding, moving and handling and more condition specific training such as dementia awareness. Once completed training was recorded and this was monitored to ensure training was completed as required by the provider. All staff we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service.

Regular meetings were held between staff and their line manager. These meetings were used to discuss progress in

the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meeting would also be an opportunity to discuss any difficulties or concerns staff had. Staff said they felt supported by the registered manager and other colleagues. They said they could approach the registered manager at any time to seek guidance and support. They also said they could seek support and advice from other staff members.

# Is the service caring?

## Our findings

People and relatives spoke positively regarding the care and support they or their relative received. Comments included “Staff are terrific, extremely caring which is very important”, “Staff are absolutely brilliant, they always have a smile for you” and “I enjoy it when staff come round and speak with me.”

One relative explained how staff treated their family member as a “Friend”. They said staff were always talking with their family member, telling them what they were doing when completing care. They said “Staff always sought permission before carrying out any care. Even when X wasn’t able to talk they still asked.” They said if they had any questions about the care their family member was receiving they could ask staff at anytime.

People’s privacy and dignity was maintained. Personal care was delivered behind closed doors. Staff explained how they maintained people’s dignity when carrying out personal care. They said doors and curtains would always be closed. They would always seek permission before doing anything and explain what they were doing. One staff member said how it was important to ensure that if they were hoisting someone in the communal area who was wearing a skirt, they made sure the person was covered at all times.

Staff knocked on people’s doors before entering, and asked before they assisted them with anything, from medication, to eating and drinking and personal hygiene. We observed one staff member asking a person “Shall I give your hair a brush for you? That way you will look smart.”

Throughout the inspection we saw people being treated with kindness and compassion. For example one person was sat in the communal area in their night wear. A staff member got down to their level and asked if they would like them to help them put some “Day wear” on. They explained to the person they would be warmer in their day clothes and would perhaps be more comfortable. They then noticed that the person was not wearing their hearing aids and could therefore not hear what they were saying. They got a piece of paper and wrote their request down for the person to read. The person then got up and accompanied them back to their bedroom to get dressed.

We observed another person being hoisted from their wheelchair into a lounge chair. Staff told the person what

was happening at all times. They encouraged the person to “hold on” and offered them reassurance when lifting them up. Once in the chair staff asked if they were comfortable and “Would you like a cup of tea now”. They also said “Well done, you did wonderfully.”

Staff knew the people they were caring for, and treated people as individuals. They knew their preferences. For example, during the medication round the nurse said “I will just get X a drink, they prefer orange juice, it’s their favourite.” When another person asked a member of staff if their newspaper had been delivered, the staff member said they would check, and if not, they would arrange for someone to go and buy one for them.

We saw that staff were gentle with people, and did not rush them. On one occasion we observed a member of staff gently waking someone who had fallen asleep in the lounge. They reminded them about their cup of tea, and offered them a napkin “Just in case you spill some”. They checked people had finished their drinks, and offered refills. They also asked if people wanted more biscuits.

People's preferences were taken in to account when adaptations or decorating took place in the home. At people's request a forest wall had been painted in the lounge area where people liked to sit and wanted a view. This part of the lounge did not have any windows so the forest scene gave people the feeling of being outside.

The home had recently purchased a large beanbag for a person with Parkinson's so they had choice of where they would like to sit or lie around the home. Some people used equipment, such as walking frames, to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it.

One visiting health professional said “There is a real sense of nurturing and respect here that you don’t often see in care homes” and “The people here are so well cared for; I would live here.” Feedback from other health and social care professionals included ‘Ashley Grange is a very good nursing home and care for people extremely well’, ‘The home always feels welcoming and there is a lovely atmosphere’ and ‘People were always treated with dignity and respect during my visits’.

We saw many complimentary letters received from family members about the care and support their relative received. Some letters were from family members of

## Is the service caring?

people who had passed away. They expressed their gratitude for the care and kindness they and their relative had received during the final days at Ashley Grange Nursing Home.

# Is the service responsive?

## Our findings

The provider was using an electronic care planning system called Caredocs. We looked at eight care plans. The quality of care plans was variable and was not always person centred. They did not always contain the detail required for staff to be able to care for people consistently. The system generated statements based on the information staff put into the system. This meant several plans contained the same statements meaning they were not person centred. For example two plans we looked at informed staff to ensure the person was positioned appropriately for eating and drinking but did not provide any detail of what the position was. Where people had been assessed as being at risk of developing pressure ulcerations, care plans informed staff to 'Introduce a repositioning schedule'. Again there was no detail of what this schedule looked like. Plans for people with dementia contained the same statements on how to care for them, such as removing mirrors from bedrooms. Although the system generated statements for care, these were generic and had not been developed by staff to create person centred care plans relevant to the people they were caring for.

We found that information in one section of a care plan contradicted information in another section. For example one section of a person's care plan stated 'Sometimes finds it difficult to remember family and friends'. Within the mental health section this was contradicted as staff had documented 'It is unknown if X recognises their visitors'. In the same plan, staff had documented the person was unable to communicate. In the personal care section, they had documented 'Wishes to have hair cut by the home stylist'. It was not clear how the person had communicated this wish. Within the action plan it was documented 'Staff to encourage exercise programmes to strengthen the muscles that control the bowel'. Again, there was no further detail of what the exercises were, or how staff should encourage them.

In another person's plan, staff had documented the person had no intrinsic factors which could affect skin viability. However, the person had diabetes, which meant there was a risk. In the same plan, staff had documented in the neurological risk section the person had experienced a stroke previously. In the stroke section of the plan, staff had documented the person had not had any strokes. In the nutrition section, staff had documented 'full support

needed', but there was no detail of what that support was. They had also documented 'Some supplements needed', although there was no detail of what the supplements were. Later in the plan, staff had documented 'Eats well and no need for any supplements'. The conflicting information meant it would be difficult for staff to gain a full understanding of people's medical conditions and the care they required.

We observed one person at lunchtime. Staff explained that due to anxieties with eating this person did not like to sit at the communal dining table and chose to sit in a quiet area of the lounge. They also told us about distraction techniques they used to help reduce this person's anxieties and support them to eat. We observed this included reading a magazine with the person whilst offering food. However when we looked at the person's nutritional care plan this information was not included. This meant staff might not be supporting this person in a consistent manner.

The likes and dislikes sections within plans were either limited or incomplete. Life story sections contained very minimal information, which meant staff would not be able to read about people's life histories. In one person's plan staff had documented 'Lived alone, no children'. This meant staff caring for people with dementia, may not be able to talk about people's past, or their interests or engage them in meaningful conversation.

People's religious and spiritual needs had not been assessed fully. Statements in people's plans included for example, 'Religious needs, is Christian'. There was no information for staff on whether or not people wanted to attend the church services available at Ashley Grange.

Despite the overall lack of detail within the care plans, staff did demonstrate through conversation they knew people well and understood their needs. For example, one member of staff talked through the care needs of one person. When we asked them to show us this detail within the plan, the detail they had spoken about was not available. However, although many staff had been in post for several years, the service was also undertaking a recruitment campaign, which meant that new staff would soon be commencing employment at Ashley Grange. There was therefore a risk that new staff, and temporary agency staff would not have accurate detailed information available to them.

## Is the service responsive?

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had two activity co-ordinators who organised activities throughout the week. They also offered people activities on an individual basis. Activities included arts and crafts, quizzes and day trips out. They also invited outside entertainment to come in to the home to perform. People were supported to have as much choice and control as possible over activities. The activities co-ordinator told us it was people's choice if they wished to join in.

There was a procedure in place which outlined how the provider would respond to complaints. We saw that all complaints had been dealt with in a timely manner. Where people and/or their relatives had raised their concerns

informally, these had been recorded in people's daily notes. The registered manager explained this was so they could be addressed immediately and to stop concerns then escalating unnecessarily into formal complaints.

People and their relatives told us that whilst they had not needed to make a complaint they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the directors, registered manager or a member of staff. One relative said "Never had to complain, but I know who to speak to."

Care plans informed staff when people might need support to read and understand the provider's complaints procedure. The provider had a Residents and Family Liaison officer in post, whose role included being the first contact for any concerns people had. They were visible within the home and their desk was at the main entrance so they could be easily seen and were accessible to visitors.

# Is the service well-led?

## Our findings

There was a registered manager in post who was supported by a deputy manager. The company directors also played an active part in the running of the home. People and their relatives knew the management team and told us they felt comfortable speaking with them. Staff said they felt there was an open and transparent culture. They told us their managers were approachable and they felt part of a team. They said they could raise concerns with their managers and were confident any issues would be addressed appropriately. Staff told us they felt well supported in their role and they did not have any concerns. One staff member said “It’s very friendly here, very homely” and “I came because of the manager, they’re so good and have really high standards”.

Staff were aware of the organisations visions and values. They told us their role was to maintain people’s dignity, promote independence and provide consistent care. Concerns or issues could be discussed in staff’s one to one meetings or raised at team meetings. All staff spoken to provided positive feedback about the management team.

Staff were supported to question the practice of other staff members. Staff had access to the company’s Whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff’s care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

Health and social care professionals spoke positively about the open management culture and staff. A visiting health professional said “This place is really well run with strong management. The manager knows everyone and everything” and “The manager goes above and beyond.” Comments from other health professionals included “The staff follow my advice and outcomes for care have been very positive” and “All staff at Ashley Grange are very approachable.”

The provider had systems in place to monitor the quality of the service. This included audits carried out periodically throughout the year. Previously this had included health and safety, infection control and the safe management of medicines. The provider showed us new audits which they

were in the process of implementing. These audits would now include care plans, dignity, falls and catering. We saw records of recently completed infection control and health and safety audits. The audits showed the service was meeting standards at the time of our inspection and where required actions had been identified. There was evidence that learning from incidents / investigations took place and appropriate changes were implemented.

The provider showed us their action plan for the coming year. They had reflected on past innovations and what had been put in place over the past year. They also had a plan for future innovations which included offering training to families to help them understand and support their relative, working with the pharmacy on medicine audits and working with other providers looking at best practice when supporting people who were on pureed diets.

Staff members’ training was monitored by the training officer to ensure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles. They said if they felt they required additional training, they could request this from the registered manager or training officer.

The registered manager and director attended the registered nursing homes association forum. This gave them the opportunity to meet with other providers to share best practice and discuss challenges they may be facing with service delivery. One of the directors also attended the Wiltshire quality safeguarding board.

People and their family were regularly involved with the service and their feedback was sought by the provider. Relative and resident meetings were held periodically throughout the year. We saw relatives had fed back about activities for people who were not as able as others and how they did not feel there was enough on offer. The home had listened and introduced one to one activities for these people. Families also received a newsletter to help keep them up to date and involved with what was going on in the home. The home had access to a local advocacy service to support people to share their views.

Management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was available 24 hours a day to manage and

## Is the service well-led?

address any concerns raised. There were procedures in place to guide staff on what to do in the event of a fire. There was a contingency plan in place to cover emergencies such as loss of utilities, flooding or fire.



This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent  <b>We found the service was not meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards. Where people were deemed as lacking capacity assessments were not always completed and sometimes gave conflicting information. (1)</b>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance  <b>The provider did not ensure monitoring charts were used in a proactive way to ensure people's food and fluid intake was being monitored correctly. Concerns about poor fluid intake was not being shared or communicated with the team. (c)</b>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care  <b>Care plans were not always completed to reflect people's preferences and how they wished to receive care and support. They did not always contained detailed information on how staff could ensure the person's needs were met. (1)(a)(b) (3)(b)</b>