HC-One Limited

Ashington Grange

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

Ashington Grange provides residential and nursing care for up to 59 people. At the time of the inspection 43 people were accommodated at the home, some of whom were living with dementia.

This inspection took place on 21 and 22 July 2015. The inspection was unannounced.

The provider, HC-One, had two services on one site, Ashington Grange which is a nursing home and Moorhouse Farm which is a residential home. We inspected both services at the same time. The same staff were used across both services and the same management structure was in place. Our findings for Moorhouse Farm are discussed in a separate report.

The last inspection we carried out at this service was in April 2014 when we found the provider was not meeting one of the regulations we inspected. This breach of regulation related to assessing and monitoring the quality of service provision. At this inspection we found improvements had been made to the systems in place to monitor the quality of the service and this breach in regulation had been met.

Summary of findings

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they were safe in the home. Staff had undertaken training in how to respond to safeguarding issues and concerns and were able to describe to us the correct process to follow. We saw where concerns had been raised these had been shared promptly with the local authority safeguarding team.

Risks had been assessed and where possible action had been taken to reduce the likelihood of the risk occurring. Accidents and incidents were monitored to ensure staff response had been appropriate.

People, their relatives and staff told us there were enough staff to meet people's needs. We saw staff were able to respond to people's requests quickly. Recruitment processes were in place to ensure checks on candidates' character were undertaken before staff began working in the home. Checks were in place to check nurses' qualifications and registration were up to date.

Medicines were managed appropriately.

Staff training was up to date. The manager monitored essential training to ensure any refresher courses were booked before training expired. Staff had received a range of training in care and welfare subjects in addition to training specific to the needs of people they supported, such as dementia, end of life and mental capacity training. Nursing staff attended training relevant to their experience. Care workers and nurses received regular supervision sessions and a yearly appraisal.

The principles of Mental Capacity Act 2005 (MCA) were not always followed. Some people had capacity assessments completed which were not decision specific and had been carried out by only one nurse. Where decisions had been made on people's behalf, documentation had not been completed to evidence that their capacity had been assessed or that the decision had been made in their 'best interests'.

Do not attempt to resuscitate documentation within some people's care records were out of date, meaning they were invalid.

Where restrictions were in place to keep people safe, applications had been made to the local authority to grant Deprivation of Liberty Safeguards.

People spoke highly of the food in the home. A choice of food was available at every meal and food was on offer throughout the day.

The home was spacious and considerations had been made to improve the environment for people living with dementia. Some areas of the home were tired looking or impersonal. A large scale refurbishment plan was in place and due to commence in the months after our inspection. The manager told us improvements would include better signage, bringing the home up to date and making it more homely. People and their relatives were to be consulted on the improvement plans and included in decision making about colour schemes and decoration.

All of the people we talked with, and their relatives spoke highly of the staff and how well they cared for them. Staff had good relationships with people, they responded with a gentle and kind manner when they were distressed.

During mealtimes staff were attentive, caring and considered people's individual needs. People were encouraged to be independent by staff who recognised their needs and responded in a personalised way with practical solutions. Where people did need help from staff with their meals, this was provided in a dignified way. The manager told us considerations had been made to make mealtimes as enjoyable as possible, such as thinking about different ways to present the food. For example, by using traditional boxes and people eating 'on their knee' rather than at the table when having fish and chips.

Activities staff showed creativity in devising an activities schedule planned to meet the different interests of all of the people in the home. We saw busy and louder activities brought people together in the main lounge of the home, whilst staff engaged with people one to one or in smaller groups in other areas of the home, either playing games, chatting, or gardening outside. People were given the opportunity to travel to the nearby coast

Summary of findings

where they home had hired a beach hut for two days a week over the summer and a caravan for a week at the start and end of the summer for people to go out and enjoy their local area.

Staff told us they enjoyed working at the home and we saw they treated people with dignity and respect. Staff knocked on doors and waited to be invited inside before entering people's bedrooms and addressed people politely.

Staff supported people to reach their goals. Staff had helped one person to manage their own care needs. Spending time talking through their medicines and equipment they used in preparation for them returning to their own home. Plans were in place to ensure that people were cared for as they wished as they approached the end of their lives.

People, relatives and health professionals told us that the home was responsive to people's needs. Care records were detailed, specific and individual to the person receiving care. Assessments had been carried out to determine people's needs and were regularly reviewed. Staff we spoke with were knowledgeable about people needs and how best to support them.

People and relatives' feedback was encouraged through regular meetings and a yearly survey. Complaints had been investigated and responded to. The home had received nine compliments since January 2015.

Improvements had been made to systems in place to monitor the quality of the service since our last inspection. People, relatives and staff spoke highly of the new registered manager and told us about the improvements she had made to the home.

Staff we spoke with told us they felt valued. They explained how communication between the three units in the home had improved.

Audits and checks were carried out regularly to monitor the quality of the service. The manager assigned some of these checks to care staff and nurses so all staff were aware of the standards which were expected.

We found one breach of regulations. This related to the Need for Consent. 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?

Good

The service was safe.

People and their relatives told us they were safe in the home. All staff had undertaken safeguarding training. Staff we spoke to knew the correct process to follow if they had any concerns.

There were enough staff to meet people's needs and recruitment checks were in place.

Accidents and incidents were monitored and risks were assessed to minimise the risk of harm to people.

Medicines were managed appropriately.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training was up to date. Staff undertook a range of training including training specific to people's needs.

The principles of Mental Capacity Act 2005 were not always followed. Capacity assessments were not decision specific. Documentation was not in place where 'best interests' decisions had been made to show the process had been followed. The provider had applied for authorisation for Deprivation of Liberty Safeguards where people's movement was restricted.

Do not attempt to resuscitate documentation within some people's care records were out of date, meaning it was invalid.

People spoke highly of the food in the home. A choice of food was available at every meal and food was on offer throughout the day.

Is the service caring?

Outstanding

The service was caring.

People told us staff were kind and treated them well. We observed good staff interactions where people were treated with dignity and respect and encouraged to be independent.

Mealtimes were person-centred. Staff enabled people to enjoy the dining experience by being very attentive to their individual needs and responding in a personalised way.

Activities staff had been innovative in planning a range of activities which took into account people's choices and preferences. The home had hired a beach hut and a caravan, so people were able to enjoy the summer-time in their local community.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People, relatives and health professionals told us that the home was responsive to people's needs. Care records were personalised and contained clear information about how staff should support people. Assessments had been carried out to determine people's needs and were regularly reviewed.

Staff we spoke with had read people's care records and were aware of their needs and how to support them.

People and relatives' feedback was encouraged through regular meetings and an annual survey. Complaints had been investigated and responded to.

Is the service well-led?

Good

The service was well-led.

Staff we spoke with told us they felt valued. They explained how communication between the three units in the home had improved.

Audits and checks were carried out regularly to monitor the quality of the service. The manager assigned some of these checks to care staff and nurses so all staff were aware of the standards which were expected.

Ashington Grange

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 improvements had been made to the service provided and if the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. In addition, this inspection was carried out 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 21 and 22 July 2015 and was unannounced.

The inspection was carried out by an inspector, a specialist advisor and an expert-by-experience. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection was a registered nurse who specialised in nutrition. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who was part of this inspection team had expertise in older people and those who had a dementia related condition.

Before the inspection the provider completed a 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 any improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We reviewed information we had received from third parties. We contacted the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch. We spoke with two members of the challenging behaviour team from the local Mental Health Trust and a care manager. We used the information that they provided us with to inform the planning of this inspection.

During the inspection we spoke with seven people who used the service and six people's relatives. 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. Throughout the inspection we also spent time in the communal areas of the home observing how staff interacted with people and supported them.

We spoke with the registered manager, the regional manager, three registered nurses, four care workers, a kitchen assistant and a domestic. We reviewed eight people's care records including their medicines administration records. We looked at five staff personnel files in addition to a range of records in relation to the management of the service.

Good

Is the service safe?

Our findings

We spoke with seven people who used the service who all told us they felt safe living at the home. One person said, "The staff will do anything I ask of them, I feel safe and cared for." Relatives we spoke with told us staff put them at ease, one relative said, "The staff are very good, she is as safe as she can be here." Another relative said, "Yes I feel he is very safe here and I am notified if they see any changes in him."

Systems were in place to minimise the risk of potential abuse. Staff had been trained in how to identify and respond to any safeguarding concerns. Policies and procedures were accessible to staff describing what potential abuse may look like and the actions they should take in response. This information detailed that staff should share any concerns with their manager, but also provided contact information for the local safeguarding team. All of the staff we spoke with, including domiciliary and kitchen staff, confirmed they had undertaken safeguarding training within the previous 12 months. They were able explain the correct course of action they would follow, and all told us they felt any concerns raised would be acted upon by the registered manager of the home. We reviewed the safeguarding records and saw any concerns raised had been shared promptly with the local safeguarding authority. Concerns had been investigated, action taken and the outcomes of investigations had been fully recorded.

Information was also available for staff about how they could raise any issues through the company. A telephone number was available where staff could raise any concerns anonymously if they wished. The manager told us she had an open door policy and all of the staff we spoke with confirmed this. We reviewed disciplinary records following concerns regarding staff conduct. We saw detailed records had been kept of investigations and outcomes.

Risks to people's safety and welfare had been assessed. Care records showed assessments had been undertaken, to determine any risks people may be subject to when living in the home and receiving care. For example, assessments monitored risks associated with moving and handling people, the likelihood of them falling over, or of them choking on food. Where a risk was identified, information was provided to staff about how to mitigate the risk.

Where accidents or incidents had occurred, detailed information had been recorded by staff and reviewed by the manager to ensure appropriate action had been taken. Documentation prompted staff to answer specific sections depending on the nature of the accident or incident. Where a person had sustained an injury, this was recorded within a body map on the accident and incident forms and staff were required to state where the accident had occurred, whether it was observed and what factors had contributed to it. Forms were reviewed by the manager and submitted to the provider's head office for monitoring. Documentation prompted the manager to record whether the incident should be reported to various external organisations such as the local authority or CQC. We saw records detailed the action taken to prevent accidents recurring or to minimise the risk of harm in the future.

Systems were in place to monitor the safety of the building and the equipment in use within the home. Records showed the boiler and lift were serviced regularly to ensure they were in good working order. The call bell system was checked to make sure it was working properly and records were kept of any maintenance work carried out and services undertaken of equipment such as hoists so they were safe to use. Emergency evacuation plans were displayed throughout the home so staff were aware of the process to follow in the event of a fire. Each person who used the service had a personal emergency evacuation plan within their care records. These detailed people's individual needs, such as their mobility or communication needs in the event of an emergency. Fire alarms and fire doors were tested on a weekly basis.

Throughout our inspection we noted there was a good staff presence in the home. The home was divided into three units. We spent time within all three units and saw staff were available to respond to people's needs and requests. When people pressed their call bell for staff attention, these were responded to promptly. People who used the service, their relatives and staff told us there were enough staff to meet people's needs. One person said, "I am looked after, the staff come when I call them." Another person told us, "The staff are kept very busy with the other residents, but they still have time to chat with me."

A relative and a member of staff told us the number of care workers on shift had been reduced when there were fewer people living at the home; however they noted that following new admissions to the home the staffing

Good

Is the service safe?

numbers had not increased. We discussed this feedback with the manager who told us that staffing numbers were determined by an assessment of people's needs, as opposed to the number of people accommodated. She acknowledged that the staff numbers had reduced and had not been increased following admission of three new people to the home. She told us that was because the people who had recently moved into the home did not have high needs and were able to manage most aspects of their care themselves. We viewed the dependency assessment for the home, in addition to staff rotas from four weeks before our visit and saw staff numbers were consistent with the dependency assessments.

Robust recruitment processes were in place to determine that staff were of good character before they started working within the home. We viewed personnel files for four care workers and two nurses. We saw all staff had been subject to two references, at least one of which was from a previous employer, and a Disclosure and Barring (DBS) check had been carried out before new staff started in their roles. Nursing staff files showed their registration had been checked with the Nursing and Midwifery Council (NMC) to ensure their registration was up to date and that nurses were fit to practice.

Medicines were managed appropriately. Nursing staff dispensed medicines. They undertook yearly training in medicines management, and assessments, including observations and knowledge checks had been carried out to ensure their competence in administering medicines. We watched staff administer medicines. People were told what their medicines were before they were given them. People were asked if they needed any medicines prescribed 'as required' such as pain relief. Protected time was available on a monthly basis for one member of the nursing team to check stocks, order and dispose of any unused medicines. We looked at medicine administration records for eight people. Records were fully completed detailing when people had taken their medicines, and if they had not the reason why.

The home was clean and infection control processes were in place. The service employed two full time domestic workers who cleaned the communal areas and people's bedrooms, another member of staff worked in the laundry. Throughout our visit we saw staff wear personal protective equipment to minimise the risk of spreading infection. One staff member had been assigned the role of infection control lead who was in charge of carrying out a monthly infection control audit to identify and address any areas for improvement.

Requires improvement

Is the service effective?

Our findings

People we spoke with and their relatives told us the care they received was effective and that staff were well trained. One person said, "All the staff are good." A relative said, "Yes I think they have had enough training. They look after [my relative] brilliantly." We reviewed the compliments records within the home and one received in April 2015 stated, "The staff are all well trained and sympathetic. The food is outstanding. The manager is capable and very friendly. The rooms are being updated, but to me it is more important to keep a good level of trained staff than to worry about walls and carpet."

We looked at training records for six staff, in addition to the training overview for all staff in the home. We saw staff had undertaken a wide range of training. All staff were up to date in training required for their role, such as moving and handling, health and safety and safeguarding. We saw the manager monitored training dates to ensure required training was booked before it went out of date.

The service provided care to people living with dementia. All staff who delivered care had received training in dementia awareness, which provided staff with an understanding about the needs people living with dementia may have. We saw more than half of the care workers had also undertaken more in depth dementia care training.

We spoke with four care workers who told us they felt the training they had received equipped them to carry out their role. They told us they were given opportunities to discuss their development and training needs at regular supervision sessions with the nursing staff. Care workers had all received an annual appraisal with the manager of the home. We saw staff were asked to take time to consider their performance before they met with their manager to discuss development areas for the following year.

Nursing staff received regular clinical supervision sessions with the manager who was also a registered nurse. Nurses we spoke with were positive about the benefits of meeting with the manager to discuss the care they delivered and best practice. One nurse told us, "They [clinical supervision sessions] are aimed at our level of experience, it's good to sit and talk things through with [Name of manager].

Staff were able to develop their skills and knowledge. Two staff we spoke with had undertaken a Level 3 diploma in Health and Social care whilst working at the service and another staff member was working towards their Level 3 qualification. Nursing staff told us they had access to training to maintain their registration. Registered nurses need to undertake 35 hours of learning activity within a three year period in order to meet the requirements to renew their registration. One nurse told us they were currently studying towards a university module in end of life care, while two other nurses told us about training they were undertaking in pressure damage and wound care. A community matron had delivered practical training to nursing staff in areas such as taking blood and catheter care.

Staff and the manager told us about a new role of nursing assistant which was being introduced by the provider. Six staff from the home had been selected to undertake the training to become nursing assistants. The training was to consist of face to face training with the provider's head office in addition to online learning. Staff would then work closely with nursing staff towards achieving a number of competencies in modules such as medicine management and administration, wound care, infection control and nutrition. Once they had been assessed as competent they would be able to assist the nursing staff with tasks such as administering medicines, applying dressings and writing care plans.

We reviewed records in relation to the Mental Capacity Act 2005 (MCA). The MCA protects and supports people who may not be able to make decisions for themselves. Where people lack the mental capacity to make their own decisions related to specific areas of care, the MCA legislation protects people to ensure that decision making about these areas is made in people's 'best interests' in the form of best interest discussions. We looked at eight people's care records and found mental capacity assessments had been undertaken for three people; however the assessments were not decision specific. The assessments covered 'receiving care' and stated that due to people's dementia related needs they were unable to make decisions about their care. These assessments had been carried out by one nurse and did not include information from a multidisciplinary team or from the person's family. We spoke with the manager of the service about this who acknowledged that these records did not follow the principles of the MCA. She told us that whilst they were in people's care records no decisions had been made in people's 'best interests' and that people were still

consulted and their consent sought before their care was delivered. We spoke with staff about the care these people received and they confirmed that they asked for people's consent before delivering any care.

Where decisions had been made on people's behalf assessments of their capacity were not available. We saw a decision had been made to give one person their medication covertly. This person frequently refused their medicine, which could have a major impact on their health. We saw a GP, pharmacist and the person's family had been involved in the decision to give medicine within the person's drink without telling them.. A detailed care plan and risk assessment were in place so staff had information about how to administer the medicine, as well as clear information that they should always attempt to get the person to accept their medicine first before putting it in the drink. However, whilst a multidisciplinary team had been involved in making a decision in the person's behalf, assessment documentation not been completed of the person's capacity to understand the implications of refusing their medicine. The manager could not evidence how they had come to the decision that the person did not have capacity to make that decision, or that the decision had been following the principles of 'best interests'.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the manager removed the non-decision specific assessments from people's records. She also completed the MCA assessments and 'best interests' documentation where decisions had been made on people's behalf. She told us she would arrange for all care records to be reviewed to ensure appropriate MCA documentation was in place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider acted in accordance with DoLS. At the time of our inspection the manager had applied for DoLS authorisation for 26 people. Care plans were in place detailing how staff should support people who did not have the capacity to leave the home unaccompanied. We saw where people had been assessed as not requiring these safeguards they were able to come and go from the home as they wished. During our inspection we saw people left the home to go to the local shops or to leave the grounds of the home for fresh air.

All staff had received training in MCA, DoLS and in managing behaviour that may be seen as challenging. This training was delivered online. In addition to this, one third of the staff team had undertaken training from the challenging behaviour team at the local Mental Health Trust. We spoke with two members of the challenging behaviour team who told us that staff at the home had a very good grasp on supporting people who may be anxious or distressed due to living with dementia. They said, "The service is very engaged. We've offered training which they have accepted and their staff have been very keen to learn. They support one person who does not like to receive any personal care. We've worked with their staff and developed their skills about how to work with this person and engage with them to encourage them to receive personal care. They've managed to avoid having to restrain them and as far as I know they've never had to restrain anyone, and instead can get people on board by encouragement." Staff and the manager confirmed that they had never restrained anyone within the home.

Where people had made advance decisions to refuse resuscitation in the event of a cardiac arrest, or their medical team had determined resuscitation would be futile, this documentation was kept within people's care records. However, we saw documentation in three people's files detailed their previous addresses. This meant this documentation was invalid. We fed this back to the manager who contacted people's GPs to arrange new documentation. She also advised she would check through care records to determine if any other documentation needed to be requested.

People spoke highly of the food served in the home. One person said, "The food is brilliant, every time there is a choice of about three meals. I have put on three stone, but I needed to and I feel better for it." A visitor told us they sometimes ate meals with their relative and that the food was 'very good'. We observed lunchtime in three of the four dining rooms and saw that the food was served hot and was well presented. Food was available throughout the day. People were able to choose a cooked breakfast or something lighter for breakfast, a choice of hot meals for lunch, and then sandwiches or another hot meal for dinner.

Requires improvement

Is the service effective?

There were also a range of snacks available in the reception all day, such as cakes, crisps and fruit. Staff offered people cakes or biscuits regularly when serving them hot drinks. We spoke with the cook who was knowledgeable about people's dietary requirements. They told us they had information within their kitchen records of people's allergies or food they should avoid due to medicines they took. We saw from records that most people put weight on when they came to the home. Weight records showed the last time people had been weighed of the 43 people receiving care at the home, only two had lost weight and this was due to them being unwell.

The home was a purpose-built care home so the corridors were wide to enable access for people with mobility needs and the rooms were large with plenty of space. The communal areas and bathrooms and toilets were very impersonal. The walls were painted cream throughout and there were no homely touches such as paintings, photographs or cushions on chairs. However, the manager advised us that shortly after our inspection the provider was planning a major refurbishment of the home. People had been invited to an open day as they were to be involved in the design of the home.

We saw some considerations had been made to enable people living with dementia to move about the home. The handrails were a contrasting colour to the wall so people could see them easier. Individualised memory boxes had been installed outside people's doors where their family could put photographs or items which may help a person with dementia to recognise their room. One wall on the upper floor of the home had been used as a reminiscence space with a rock and roll mural and black and white images of the stars of the 1940s and 1950s. We noted that there was poor signage in the home. Lounges, dining rooms and bathrooms were not signposted in corridors. The manager told us signage would be improved as part of the planned refurbishment.

Outstanding ☆

Is the service caring?

Our findings

All of the people we spoke with, and their relatives praised the staff within the home. They told us staff were caring, kind and attentive to their needs. One person said, "They will do anything for me it's like living in a hotel". A relative told us, "All the staff care a lot about [My relative]." Another relative said, "They [the staff] obviously do this job because they care, it's certainly not for the money." An entry from the home's compliments files read, "[My Relative] has been a resident for six months. He's being well cared for, the staff are lovely and nothing is too much trouble. They are always there to give [My relative] anything he wants. He has improved greatly under their care and always seems happy." We saw that staff were very warm towards people. Staff laughed and joked with people and showed their affection by giving people a hug or holding their hand when they were upset.

During our inspection we observed the lunchtime experience in three of the four dining rooms. We saw staff were very attentive to people's needs. People who needed staff support to eat were helped in a dignified way. Staff sat with people and gave them their full attention. Staff told people what they were eating and fed people at an unrushed pace. Where people did not need support to eat staff encouraged and prompted people to eat their meals. Staff seemed to know people well and responded in accordance with people's needs. We saw within one dining room, where people who were being supported were living with dementia, some people struggled to eat their meal with a knife and fork. People seemed disinterested in their food. The meal was a pie, and one member of staff asked everyone if they would like to hold their pie to eat it rather than use cutlery. All of the people accepted and we saw that when they were using their hands they were able to eat their meals much more comfortably and appeared to be enjoying it. Another member of staff shared a table with a person and ate their lunch with them. They talked to the person about their day and about what they were eating. We saw this person ate their whole meal. The staff member told us that at one point this person had left most meals, but they had worked out that by staff sitting with the person, talking to them and sharing the mealtime it prompted them to eat much more of their meals.

The manager told us that mealtimes were very important in the home. She said, "Meals are the one thing everyone looks forward to, so we like to do as much as we can to make them special." The cook showed us traditional fish and chip boxes which the home had bought to serve fish and chips in when they were on the menu. They told us that when people were given fish and chips in the boxes they ate it on their knees rather than at the table and that people really enjoyed this.

During the two days we visited the home we saw there were a range of activities on offer. The manager told us that these were planned to meet the varying interests of people who used the service. She said "We put as much as we can on, we know not everyone enjoys bingo or flower arranging, so we consider the fact we have men, women and varying ages here at the home." During our visit the two activities coordinators performed with a guitar and other instruments, encouraging people in the main lounge to take part in a sing-a-long. Other quieter activities took place such as engaging people in games, such as darts or bowling from their seats and staff offered people manicures and hand massages. People were able to help out in the garden, including a vegetable patch. Staff told us this activity was mainly enjoyed by the gentleman in the home, and the produce was proudly prepared by the kitchen staff and served to people involved in the gardening whenever it was ready to be eaten. On the second day of our visit a professional performer put on a music show, for all the people from the three units of the home, and people from the sister home based on the same site were invited to attend. We saw people and staff sang a-long to songs they recognised and laughed amongst each other.

The home had hired a beach hut for two days a week for the summer. Four people were able to go each day and people from both of the homes took part. Both people and staff told us they had really enjoyed the days they had spent at the beach hut, visiting an ice cream parlour and dipping their feet in the water. The home had also hired a caravan on a nearby campsite for a week at the start of the summer, and had another week planned for the end of the summer. Staff told us that whilst people had not stayed overnight, they had been able to take lots of people up to the caravan for the day, where they had spent time going for walks or eating their packed lunches in the sun.

Outstanding ☆

Is the service caring?

Staff we spoke with told us they liked working at the home and told us how they had come in on their days out to be able to attend trips with people. One staff member said, "I just love it here." Another staff member told us, "I can't leave here; I love the residents too much."

People told us that staff treated them with dignity and respect. One relative told us how the staff maintained their relative's privacy and dignity. They told us staff always closed the curtains when they were supporting their relative to get dressed and that they were asked to step outside of the bedroom when staff supported their relative with personal care. We saw that staff knocked on doors, and waited to be called in, before they entered people's bedrooms. Information about advocacy services was displayed in the reception area. The manager told us no one was currently accessing the service, but that they had referred people to an advocate in the past to support them with decisions about their care.

People's care plans included information about their life histories, choices and preferences. We saw information had been included about people's previous working lives, family situation and hobbies they had enjoyed. We saw staff knew people well and used this information to engage them in conversation. For example, we saw one person was very interested in motorcycles. We saw staff sitting with this person looking through photographs of them with their motorbikes. People had been asked their preferences to a male or female carer when being supported with personal care. We saw where people had indicated a preference this had been incorporated into care plans. Daily records showed these preferences had been respected.

Care records and observations showed people were encouraged to be independent. We saw people were supported to use mobility aids to walk around the home. Extra-long call bells were in place next to the main door, which enabled people to spend time sitting outside whilst still able to contact staff if they needed them. One person was looking forward to returning to their own home. They had come to the service from hospital and had been supported by staff to manage their own care needs. Care plans were in place which described how staff should teach the person how to manage their equipment and medicines. We saw staff had spent time showing them how to use their nebuliser (a machine which dispenses asthma medication) and their oxygen supply. We spoke with this person who said, "I feel like I've been on holiday whilst I've been here. I'll miss it, but I am ready to go back to my own home. The staff have been brilliant."

Relatives told us that they could visit the home at any time and always felt welcome and comfortable. One relative told us how they were offered meals whenever they visited over lunchtime. Another relative told us that it meant a lot to them that staff welcomed them and their family whenever they visited. They said, "The staff are all so friendly. They don't just see to [My relative] but they check I am okay too. They'll ask after me and after the family. I bring the grandkids in quite often and they can be a bit noisy. I've never felt anything but welcome though. This is [My relative's] home and they've made me feel like it's fine to make as much noise as we like. They'll get juice for the kids and ask if I want a tea. They are lovely."

Care records included an end of life care plan, where people had been asked if they would like to discuss the plans they would like to put into place at the end of their life, such as where they wished to be cared for and if they wanted to be buried or cremated. All staff had undertaken training in basic end of life care and the manager told us a community matron had also delivered sessions on end of life care for care staff and use of a syringe driver (a small, battery-powered pump that delivers a continuous dose of medication) for nurses meaning people could receive the care they needed without having to go into a hospital. Nursing staff had undertaken training delivered by the local hospital trust in a new end of life care pathway. The manager told us that whenever possible they provided a room for families as people approached the end of their lives, so that they were able to rest, whilst still being close to their relatives. We saw staff were allowed time off to attend funerals of people who used the service who they had been close to. The manager said, "We know people so well, and staff really care for them, so we make sure we can cover so that staff can go to the funeral. I think it's nice for the families too, to know that we'll miss them."

Good

Is the service responsive?

Our findings

People told us they were well cared for and that they felt their needs were met. One person said, "The staff know me and understand me." A relative said, "I cannot fault it here. [My relative] can't really communicate now, but they understand what he wants and what he needs." During our visit we saw a member of staff was always present in the communal lounges and they regularly checked with people to see if they needed anything from them. We saw that staff were aware of where people were in the home and visited people in their rooms regularly to check they were well.

We spoke with three health professionals who told us that the home was responsive to people's needs. One health professional said, "I think that staff recognise and respond to people's needs. When we carry out reviews they know people well and input a lot." They continued, "When people have nursing needs they are managed well." Another health professional said, "When I visit and ask how people are, the care staff are well informed. They seem to be on top of things."

We reviewed eight people's care records. Records were individual and personal to the person receiving care. Assessments had been carried out to determine people's needs and the support they required from staff. For example, a range of assessment tools had been used to determine what support people needed with mobility, continence and skin integrity. Nursing staff had carried out the assessments and where they determined that the person needed staff support, they had written care plans which described how staff should deliver their care. Plans of care were clear about which staff were responsible for carrying out the plans. Information detailed how care workers should help people with their personal care needs, such as the support they needed to bathe or shower, or to get dressed. Where people required more complex care, for example for Percutaneous Endoscopic Gastrostomy (PEG) feeding tubes, management of catheters or wound care, this was planned and delivered by the nursing staff.

We spoke with four care workers and three nursing staff and asked them about the care people received. Staff knew people well. All staff told us they had read people's care records. They were able to tell us how they managed people's needs and delivered their care. Staff descriptions of the care they provided matched the information provided in people's care plans.

People, their relatives and staff told us there was a good range of planned activities. One person said, "There is always something going on in here." The home employed one full time activities coordinator, who worked closely with the activities staff member from the sister home. They planned activities which people from both homes could take part in. We saw an activities board was on display in the reception area which provided information for all planned activities. People were able to take part in activities both inside and outside of the home, as the homes had access to a mini bus to take people on day trips.

People and their relatives were invited to attend a monthly meeting to discuss their views on how the home was run. One relative told us they attended the meetings and found them useful, they said, "It showed us that all relatives and residents have similar issues." They told us that they felt that the staff acted upon comments made at the meetings. We looked at the minutes from the meeting and saw people had been asked their opinion on things like future activities planned and the menu in the home.

The home was due to carry out major refurbishment work shortly after our visit. The manager showed us a letter sent to all of the people who used the service and their families inviting them to attend an open day to discuss the refurbishment. People were to be asked to vote on the colour scheme of the communal areas and were going to be fully involved in the decoration of their bedrooms.

Satisfaction surveys were sent to people who used the service and their relatives yearly. People had responded positively to the last survey carried out in March 2014, although some negative feedback had been received about the décor in the home. We saw these comments had been discussed at the next residents and relatives meeting, as well as information about the upcoming refurbishment.

Complaints records were well maintained. We saw two complaints had been made in the previous year. We saw the original communication had been recorded, investigations had been carried out and the person who had complained had been kept up to date with the progress of their complaint as well as any outcomes. Nine compliments had been received since January 2015. People spoke of how happy they had been with the service

Good

Is the service responsive?

they had received. Comments included, “Ashington Grange is a clean and friendly well run care home, my father is very happy there and never complains about the staff, food or condition, overall a well-run establishment.”

Good

Is the service well-led?

Our findings

At our last inspection of the service in April 2014 we identified a breach of regulations relating to how the provider assessed and monitored the quality of the service it provided. Following that inspection the provider sent us an action plan detailing how they would make improvements. We checked on the progress made in relation to the action plan and found systems were in place to assess and monitor the quality of the service.

At the time of our last inspection a registered manager was not in place. Since our last inspection a new manager has been employed by the service and registered with CQC in February 2015. People, their relatives, staff and health professionals spoke highly of the manager and the improvements to the service since she started working at the home. One person said, "I have seen lots of changes since the new people took over, all for the better." A relative told us, "I am really happy with the new manager she is easily approached." A health professional said, "The present manager has improved things. It is much, much better than it was. That's reflected in the staff attitude. They have good leadership and know what is expected of them."

Staff we spoke with told us they felt valued and listened to. Staff described a relationship of trust with the new manager. One staff member said, "She is open and acts on things." Another member of staff told us how the manager worked alongside them when needed so had an understanding of their role and the people they supported, they said, "She is there for us and the residents." We saw minutes from staff meetings and staff confirmed they attended these regularly. Staff had been assigned champion roles in areas such as dementia, wound care and nutrition. The manager told us, "Staff are encouraged to take active leadership in these areas and will inform me if the standards are not met."

At our last inspection some staff had described issues with communication between the staff teams working in the different units within the home. During this inspection staff described how they now rotated around the different units within the home and worked with all staff rather than in specific teams. One member of staff said, "It used to be quite them and us, between the upstairs units and downstairs but it isn't like that anymore. We all work together rather than sticking in groups of staff so everyone has an understanding of people's needs and it means there aren't any cliques any more. It's made for a much better atmosphere."

We found that improvements had been made to the systems for monitoring accidents, incidents and complaints. The manager was responsible for two services on the site; Ashington Grange and Moorhouse Farm. We had previously found that information and analysis relating to accidents, incidents and complaints for the two homes had not been recorded separately, but managed together. This meant it was difficult to analyse any trends or to learn from previous events. We saw systems had been put into place to ensure management information for each home was recorded separately to enable the manager to monitor any factors which may contribute to accidents or complaints.

Systems were in place to monitor the quality of the service provided. We saw a range of audits and checks were carried out to ensure that standards in the home were maintained to the provider's expected standard. Audits were carried out by staff of all designations. The manager told us this was so all staff understood the importance of monitoring the home and that providing a quality service was everyone's responsibility. A sample of care records was audited on a monthly basis by the manager who checked they were up to date and accurate. In addition to this each day staff focussed on a 'resident of the day'. 'Resident of the Day' was scheduled by the manager and communicated to the staff member involved about which person it would be. Nurses or senior staff would check through their care plans on this day to make sure everything was in place; that reviews had been carried out and that records reflected people's current needs. Domestic staff would do a deep clean of their room, the maintenance staff would check that everything in their room was in working order and the cook would speak with the person to get their individual feedback on the food they received.

A dining experience audit was also completed daily by a different member of staff. This audit looked at the atmosphere in the dining room, such as whether music playing was at an appropriate level to allow people to carry on a conversation and whether it was to people's tastes. It checked that the dining tables were set, whether people had access to condiments, that their meals were appetising and that they were appropriately supported. The manager

Good

Is the service well-led?

explained the importance of all staff taking part in this, she said, “There is no point in me filling it in each day. I could think things are fine but they might not be. We get everyone to take part. One person might pick up on something that another person doesn’t. It also helps staff to think about how important meals are for people and helps them to keep in mind good practice when they are serving people.

Regular audits were carried out to monitor the health and safety and maintenance of the home, to check that medicines records were properly completed and that medicines stock tallied with the records of how many medicines had been administrated and a domestic audit to check that the home was cleaned to a high standard. Records had been kept of the audits carried out, along with any actions which audits had highlighted needed to be taken. For example, we saw the manager had noted that a care plan was not in place stating how staff should respond if one person, with a deprivation of liberty order in place, tried to leave the home. We saw this had been fed back to staff, a care plan put into place and the audit action updated to state it had been carried out.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Principles of the Mental Capacity Act 2005 (MCA) were not followed. Capacity assessments were not decision specific. Records were not in place to show that capacity assessments and 'best interests' decisions had been made in accordance with the MCA. Regulation 11 (3).