Sheval Limited

Asheborough House Care Centre - Saltash

Inspection report

St Stephens
Saltash
Cornwall
PL12 4AP

Tel: 01752845206
Website: www.asheboroughhouse.co.uk

Date of inspection visit:
05 January 2017
06 January 2017

Date of publication:
31 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 5 and 6 January 2017 and was unannounced.

At the previous comprehensive inspection on 27 and 30 October 2015 there were breaches of legal requirements. For example, we found risk assessments were not always reflective of people's needs and care plans were not reflective of the care being given. There were not always suitable numbers of staff deployed to meet people's needs, people did not have end of life care plans in place and although accidents and incidents were recorded, they were not always audited to look for themes to reduce the likelihood of a reoccurrence. We asked the provider to send us an action plan on how they would meet these requirements. We also found the provider's systems to monitor the quality of service people received were not effective. Enforcement action was taken on this issue. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to our enforcement action. We undertook a focused inspection on 29 February 2016 to check they had followed their plan and to confirm they now met legal requirements. We found the legal requirements were being met.

Asheborough House Care Centre is a nursing and residential care home which predominately provides nursing care and support to people who have been diagnosed with a form of dementia. The home is registered to accommodate up to a maximum of 31 people. At the time of the inspection, there were 27 people living at the service.

There was a registered manager 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 were well cared for at Asheborough House. One staff member told us; "I can one hundred percent say that every resident here is so well looked after". Staff were exceptionally kind, caring and compassionate and the interactions we observed were warm, affectionate and caring. People's dignity was upheld and their confidential information was securely stored.

Without exception, people and their relatives told us the service was very caring. One relative said; "They go above and beyond their duties all the time". Staff were extremely caring and treated people with kindness, compassion and affection. The service was committed to delivering outstanding end of life care, in which people's wishes were respected and where people experienced a pain free, dignified death.

There was a strong focus on delivering innovative, personalised activities for people. There was a commitment to forging links with the local community and ensuring people remained visible and active whether in the service or in the community.

Relatives were made to feel important and were always warmly welcomed at the service. Staff and

managers were considerate towards them and ensured that they felt looked after and valued. Relatives were kept informed of any changes and were able to have an open and honest dialogue with staff and managers. Relatives felt able to approach the managers with any issues and their feedback was sought and valued.

Systems were in place to deal promptly and appropriately with any complaints or concerns. The registered manager promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the Duty of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to care and treatment. Feedback on the service was sought in creative ways to ensure everybody had their voices heard.

The service was well led. The registered manager valued their staff, paid attention to detail and led by example. They were committed to continuous improvement and development. All of the staff said they felt valued and supported by their colleagues and the managers. Other agencies were very positive about the leadership of the service.

The provider had a robust quality assurance system in place and gathered information about the quality of the service from a variety of sources including people who used the service, relatives and other agencies. Learning from quality audits, incidents, concerns and complaints were used to help drive continuous improvement across the service.

People were kept safe within the service, they had their medicines as prescribed and on time. People were cared for by staff who had undergone checks to ensure they had the correct characteristics to work with vulnerable people. Staff understood their role in safeguarding people and in recognising and reporting signs of abuse.

People were supported by staff who were skilled. They had received training to carry out their roles which was regularly updated and refreshed. Staff were supported by an on-going programme of supervision, competency checks and an appraisal.

People's consent was sought prior to staff providing them with any assistance. Staff had a sound knowledge of the Mental Capacity Act (MCA) and understood how to apply this to the care and support they provided to people. Staff understood that capacity could change over time and was decision specific. This was reflected in people's care records and in the way staff interacted with people.

People's health and social care needs were addressed holistically through access to a range of health and social care professionals. People's care records were personalised, contained the correct guidance for staff and recognised the person as a whole, including their social history, choices, aspirations and goals.

The service was visibly clean and infection control practices were robust. The environment was comfortable and people's bedrooms were spacious, bright and personalised to suit their preferences. People enjoyed the meals and were offered choice. People had enough to eat and drink and feedback on the meals was extremely positive, from both people and their relatives.

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 felt safe.

People were supported by suitable staffing levels. There were sufficient numbers on duty to meet their needs.

People's medicines were stored, administered and disposed of safely.

People were supported by staff who understood how to recognise and report signs of mistreatment or abuse.

Is the service effective?

Good

The service was effective.

People had access to a range of health and social care professionals in order to meet their needs.

People had enough to eat and drink and any dietary needs were met.

People were supported by staff who understood the Mental Capacity Act (MCA) and how it applied to their role.

People's bedrooms were individually decorated and personalised.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Interactions between staff and people were positive, warm and compassionate.

People had comprehensive end of life plans in place.

People's dignity was protected and their confidentiality was

maintained.

Is the service responsive?

Good

The service was very responsive.

People had detailed social support plans in place which were written by the person and those close to them.

Personalised, bespoke activities were arranged for people which reflected their preferences and choices.

Activities were innovative and staff went above and beyond their duties in creating opportunities for people to engage in them.

The service had a proactive approach to managing complaints. Any concerns raised were dealt with promptly.

Is the service well-led?

Good

The service was well led.

People, relatives and staff spoke highly of the registered manager and felt they were supportive and approachable.

Feedback on the service was sought using a variety of methods and was used to drive improvements.

There were a number of audits in place to monitor the quality of the service.

The registered manager promoted the ethos of openness, transparency and honesty and led by example.

Asheborough House Care Centre - Saltash

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 5 and 6 January 2017 and was unannounced. The inspection was undertaken by one adult social care inspector.

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 improvements they plan to make. We also reviewed information we held about the service such as notifications and previous inspection reports.

Prior to 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 they do well and improvements they plan to make. We also reviewed information we held about the service. This included notifications we had received. A notification is information about important events, which the service is required to send us by law.

Some people were unable to verbally communicate with us to give us their views about the service, so we observed how people responded and interacted with staff. We observed care and support in the lounge and dining rooms, and watched how people were supported during lunch. During the inspection we spoke with ten members of the staff team. This included management and care staff as well as the cook and domestic staff. We also spoke with two people who lived at Asheborough House, five relatives and one professional who was visiting the service. After the inspection we contacted three health and social care professionals who were employed externally.

We looked around the building including people's bedrooms. We looked at training records for all staff. We looked at five records relating to people's care. We also looked at medicine administration records (MARS), as well as documentation relating to the management of the service. This included policies and procedures, audits, staff rotas, four staff recruitment files, and quality assurance and monitoring paperwork. We also assessed and reviewed the safety and cleanliness of the environment.

Good

Is the service safe?

Our findings

At the comprehensive inspection on 27 and 30 October 2015 we found people's falls and accidents were recorded. However, the information about people's accidents and falls was not robustly recorded and effectively used to identify themes, to help keep people safe, and prevent it from happening again. At this inspection, we found this issue had been fully resolved. Accidents and incidents were recorded in detail and, this information was then audited by the registered manager on a monthly basis to look for any themes or patterns. This was then used to formulate plans to mitigate future risks of reduce the likelihood of a reoccurrence.

At the last inspection, we also found risk assessments were not always in place as necessary and that risk assessments were not always reflective of people's individual needs. This issue had been addressed at this inspection. We found people had detailed risk assessments in place in order to mitigate risks associated with their condition. For example, there were risk assessments in place for community access, which balanced people's need to remain safe with their right to freedom and independence. These assessments covered factors such as suffering cold or sunburn, absconding and becoming agitated in an unfamiliar environment. One person had been assessed as a high falls risk. A falls assessment had been completed and this was linked to the person's care plan and risk assessment. There was detailed information for staff about reducing the risk of future falls, including looking out for underlying causes for an increase in falls such as a urinary tract infection (UTI). The risk assessment directed staff to report any concerns or anomalies to the person's GP.

At the comprehensive inspection on 27 and 30 October 2015 we also found concerns relating to staffing. We found people's individual needs were not always being met because there were not sufficient numbers of staff deployed. At this inspection we found this concern had been fully addressed. The registered manager used a dependency tool in order to calculate the amount of staff required to keep people safe on each shift. This was audited on a monthly basis, and where people's needs changed and they required a greater number of hours from staff, this was reflected on the rota. We observed safe staffing levels. Staff were available to meet people's needs in an unhurried way, with time to stop and talk to them. Staff told us they felt there were enough of them on duty to keep people safe, and people agreed staffing levels were sufficient. One person said; "Oh yes there always seem to be enough staff on duty to help you when you need them".

People and their relatives told us they felt safe living at Asheborough house. One person told us; "Yes, I feel safe living here". Comments from people's relatives included; "It's a very safe place. [relative's name] used to fall a lot, and they put a one to one carer in place and a special chair to help him get up. They have been like a godsend" and "Oh yes, it's a safe place. I can recommend it thoroughly".

People had their medicines as prescribed and on time. There were systems in place to ensure medicines which required stricter controls were safely and effectively managed. When people were prescribed creams, the opening dates were recorded and body maps were completed. MAR (medication administration records) were completed to ensure medicines were correctly administered. Some people were administered

their medicines covertly (crushed in food or drink). Where this was required, there were clear care plans around the use of the medicines and a best interest decision had been recorded with the person's doctor and staff at Asheborough House. This helped ensure the person's rights were protected. These were kept under review. Were people had been prescribed medicines which required refrigeration, they were stored in a medicines fridge and the temperatures of the fridge were recorded daily. We noted some, infrequent instances, were the fridge temperatures had been slightly colder than guidelines suggest, to ensure the efficacy of the medicines. For example, there were some recordings of the temperature being 3.9 degrees Celsius. The lower limit for medicines is 4 degrees Celsius. This was highlighted to the nursing staff who said it would be immediately addressed.

People were protected by staff who understood how to recognise and report signs of abuse or mistreatment, including which external agencies they should alert. Staff had undergone training on safeguarding adults and there was a policy in place to underpin their practice. Staff comments included; "I would report to the nurse in charge, or the manager. If I wasn't satisfied I would ring the safeguarding team, or even the police". Recruitment practices were safe. People were supported by staff who had undergone checks prior to commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

People's medicines were stored, managed and disposed of safely. People had their medicines as prescribed and on time. MAR (medicines administration records) were completed accurately. Where people were prescribed creams, body maps were completed to ensure the creams were applied as prescribed.

The service was visibly clean and free from adverse odours throughout, The service employed a domestic team who were knowledgeable about infection control practices and who had undergone training in this area. There was a laundry team and processes were in place to manage any laundry which was soiled or infectious in line with guidance. There were appropriate levels of PPE (personal protective equipment) throughout the service. We observed hand gel, aprons and gloves situated on all floors and witnessed staff using these as required. There was also signage around the service and by the front door, prompting staff and visitors to wash their hands and use the antibacterial gel.

People who were at risk of become unsettled or agitated had detailed care plans which contained guidance for staff on how to help them remain calm. They also contained helpful advice for staff on how to manage their own feelings, when working with people who could present with behaviours which were challenging. One person's records stated; "Before you react, take a deep breath to give the person space and take some time. Don't take the behaviour personally". The plan went on to say; "After the incident, don't punish the person for their behaviour, take some time out and discuss your feelings with other members of staff, bottling up your feelings may make it harder to care for the person".

Assessments had been completed in relation to risks associated with the environment. People had personal evacuation plans in place, which helped ensure their individual needs were known to staff and other services in the event of an emergency. A fire risk assessment was in place, and regular checks undertaken on fire safety equipment. A maintenance person was employed and undertook regular checks to help ensure the environment was safe and fit for purpose. There was an on-going programme of refurbishment taking place at the service, and some bedrooms were being updated at the time of the inspection.

Good

Is the service effective?

Our findings

At the previous inspection on 27 and 30 October 2015 we found that people's needs at mealtimes were not effectively met as there were not enough staff deployed to meet their needs. We told the provider to take action to make improvements to how they ensured sufficient staff were deployed to meet people's needs effectively. The provider sent us an action plan detailing how they would make improvements. At this inspection, we found that the issues had been fully resolved.

We observed the lunchtime experience. The atmosphere was pleasant and relaxed. The tables were laid with cloths, flowers and condiments and music was playing in the background. There were sufficient staff on duty to assist people who required help with eating and drinking in an organised and timely manner. Some people required one to one support, and we saw staff took the time to chat with them whilst offering assistance, to make the mealtime a pleasant and sociable experience." One staff member sat quietly holding a person's hand and offering gentle encouragement for them to try to eat a little more. The person looked content. The food looked plentiful and appetising and people were seen to finish their plates. The cook brought the meals into the dining room and explained to people what the individual dishes were. They also asked for feedback. People were offered a variety of drinks. Staff paid attention to detail. One person had requested lemonade with their meal. The staff member poured the lemonade and was heard to say, "I think this is a little bit flat. Let me go and open a fresh one". The staff member returned with a new bottle of lemonade and apologised. There was a drinks station with hot and cold drinks which people could access independently or with staff support throughout the day.

At the comprehensive inspection on 27 and 30 October 2015, we found people living with dementia were not supported or empowered by their environment, this affected people's stimulation and independence. We set a recommendation for the provider to consider research and published guidance in relation to the design of the care home environment and its connection in providing an enhanced level of care for people living with dementia.

At this inspection, we found improvements had been made. People's bedrooms were bright, clean, spacious and personalised. Thought had been given as to which bedroom people occupied, dependent on their needs and characteristics. For example, if a person valued a quiet environment the registered manager ensured their room was not close to people who would call out frequently. There was appropriate signage around the service to help those living with dementia to orientate themselves. There was also a dementia friendly notice board, which reminded people of the date, season and weather outside. There was a pleasant and well maintained garden and seating area, which we were told was enjoyed by people, particularly in warm weather. Staff told us people would sometimes choose to eat their meals in the sunshine and play games on the lawn. We saw people had care plans and risk assessments around ensuring their skin was protected whilst enjoying time in the sun.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lacked capacity had capacity assessments in their records which were decision specific and regularly reviewed and updated as appropriate. Staff were knowledgeable about the Mental Capacity Act and how it applied to their role in practice. For example staff had a clear understanding of the use of restraint. One person's records stated; "Restraint is anything that prevents someone from doing something". Their records went on to say; "Usually restraint would be unlawful if not conducted using agreed procedures. It may be unlawful not to use restraint where it is necessary to act in someone's best interest, either under the mental Capacity Act or common law". This demonstrated staff understanding of the principles of the MCA and how to apply it to those they supported.

People can only be deprived of their liberty so they can receive care and treatment, when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where people's liberty was restricted in their best interest, applications had been submitted to the supervisory body to authorise the restrictions. The registered manager sought advice from the supervisory body when required and ensured they were kept informed of changes that might have affected the person's liberty or freedom.

People had access to a range of professionals to ensure their health and social care needs were met. Records evidenced that people were offered blood tests and medicine reviews. Prompt referrals were made as necessary to specialist services, for example, the SALT (Speech and Language) team, the physiotherapy team and community mental health team when required. Screening tools were used to assess people's level of needs, for example falls assessments were completed and carried through to the person's care plan and risk assessment. MUST (Malnutrition universal screening tool) assessments were also completed and where people were considered to be at risk in terms of their nutritional intake, care plans and risk assessments reflected this.

People were supported by staff who had undergone a variety of training in order to carry out their roles effectively. Staff were up to date with training identified by the provider as mandatory such as infection control, manual handling and safeguarding adults and there was a system in place to prompt staff? that their training needed to be renewed or refreshed. Aside from mandatory subjects, staff also received additional training which was specific to their role, such as dementia awareness, behaviours that challenge and dysphagia and speech. A new food thickener was being introduced to the home and all staff had been booked onto training around its use. One staff member told us; "Training is really promoted here. They are always putting us through new training".

There was a notice board in the office, featuring a detailed display about dementia. This was called; "Dementia the facts". It was created by a community dementia liaison nurse to inform staff at Asheborough House about the specific needs of those they were working with. There was information about the different types of dementia, for example, Lewy Body and vascular dementia and how they affected the person's brain and behaviour. This helped to keep staff informed and raised awareness.

Staff felt well supported in their role. New staff underwent an induction which included reviewing key policies and procedures and shadowing more experienced staff. New staff also undertook the care certificate. All staff were supported by a programme of supervision, appraisal and competency checks. One staff member told us; "I just had my appraisal and it went really well". Staff confirmed the registered manager and senior staff were supportive and that there were always opportunities for informal supervision, advice and sharing of best practice. One staff member said; "I am new and they are very patient with me. I

am never afraid to ask anything".

Good

Is the service caring?

Our findings

At the comprehensive inspection on 27 and 30 October 2015, we found People's end of life care and resuscitation wishes had not always been recorded so staff would know what to do at the end of a person's life to ensure they received the care they wanted. At this inspection, we found this had been fully addressed. Each person had a separate end of life care plan. These plans were written with the person and family wherever possible. They were detailed and comprehensive documents which were regularly reviewed and updated where needed. They gave details such as the person's capacity to make decisions and the person's wishes around being resuscitated. Staff had received training around end of life care and were committed to supporting people to experience a dignified, comfortable and pain free death.

People and their relatives told us the service was caring. One person said; "If they can do a little thing to help you, they will, it's good here". One relative commented about a member of staff; "He's a very special person. Second to none". Other comments from relatives included; "I am very satisfied, they are ever so caring" and "All the staff are caring. I can't fault them at all". One relative we spoke with told us her loved one had been reluctant to accept care when first admitted to the service, but that through the care and attentiveness of two male carers he had a particularly close bond with, this changed and he settled and welcomed their support.

Staff were exceptionally warm, compassionate and kind. Comments from staff included; "Everybody here is right for their job. They have a big heart"; "I love the residents. They are safe, happy and well looked after"; "We care. We want this place to be as nice as our own home"; "We love these residents and it shows" and "Everybody who comes here is treated with kindness. We throw our arms around them and make them feel welcome".

People were made to feel valued and important. One person had been celebrating a significant birthday. A laminated photograph of the person had been placed on the tables in the dining room with the message; "Happy birthday from us all!" one staff member said; "We do our best to make people feel special. We give them choices, ask them what they'd prefer to wear. We respect their choices on who delivers their care. On birthdays we always have cakes and sing happy birthday". People enjoyed pamper sessions at the service with essential oils, heat packs, relaxing music and massages. A staff member said people valued this time and it helped them to feel special.

People living at the service were encouraged to make suggestions and to have their voices heard. They were asked for feedback and given the opportunity to make suggestions at residents' meetings. Additionally, staff looked out for non-verbal signs that people were happy or had enjoyed something, then used this information when making future plans involving the person. People had access to advocacy services to ensure they were represented wherever necessary.

We observed positive and caring interactions between people and staff. One staff member was heard to compliment a person. They said; "This blouse is nice. I haven't seen it before. Very pretty". The person responded positively to the comment. Another person who was not independently mobile was sitting

looking out of the window. One staff member noticed that the flowers in the vase in front of them had started to wilt slightly and said; "Let me get you some fresh daffodils to look at".The staff member changed the flowers and the person appeared pleased. On the day of the inspection, it was particularly cold weather. We saw staff offering people blankets for their knees and asking if they were feeling warm enough.

People were treated with respect and their dignity was upheld. One staff member said; "There is no patronising here. Everybody is treated with respect. We speak to people as humans. With kindness". Throughout the inspection, we observed people's dignity was promoted. Offers of care were discreet and staff knocked and waited to be invited before entering people's bedrooms. People's confidential information was securely stored. Files were kept in locked cabinets and offices were locked when not in use.

People using the service were allocated a key worker and there was a matching process to ensure the right staff member was allocated to each person based on common interests, skills and character. People were able to choose whether they preferred to have their personal care delivered by a male or female member of staff.

Staff were committed to improving the lives of the people they supported and on helping them to achieve happiness and fulfilment. Comments from staff included; "The best thing about this job for me, is getting to know our residents and seeing happy faces".

Good

Is the service responsive?

Our findings

At the comprehensive inspection on 27 and 30 October 2015, we found that people's care plans were not effectively reviewed to ensure they gave guidance and direction to staff about how to meet people's individual care needs. In addition, care plans did not always meet people's needs and preferences and were not effectively reviewed and reflective of the care being delivered. At this inspection, we found improvements had been made. People's care records were extremely detailed documents which were well organised, easy to navigate and regularly reviewed and updated with the person and their family, wherever possible. Care records contained the correct level of guidance for staff to enable them to meet people's needs in a personalised and meaningful way. Care records contained information such as, what people liked to talk about, what helped them to stay calm and what things they were able to do for themselves. One person's record stated; "Hand me my clothes one at a time, explain what you are doing and give me time". These small details helped staff to respond to people as individuals and to help ensure that people retained their skills. Independence was promoted at the service. Wherever possible, people were encouraged to participate in day to day tasks such as laying tables, pairing socks and folding laundry. They were also encouraged to get involved with activities such as mending items of clothing, through sewing, if they had skills and interests in this area.

People had hospital admission packs in their records. This gave the hospital staff important information about the person, such as details about allergies, resuscitation status, details about their diet and any triggers for distress or agitation. One person's hospital pack said; "I rarely become verbally challenging, but if I do it's because I feel my personal space is being invaded".

There was a real focus on communication and enabling staff to understand the needs of people living at the service, some of whom were not always able to articulate themselves verbally, due to their advanced dementia. People had a small laminated booklet in their records. On the cover, it read; "Please read this book to get to know me and how I communicate". It was informative for new staff members and hospital staff, should an admission be required. One person's booklet stated; "Triggers and things I don't like, include; loud noise, unexpected noises and being ignored".

There was an activities coordinator who was committed to providing a range of innovative, personalised and bespoke activities to suit the individual person. People living at the service had a social history file. This contained very detailed information about the person's whole life, including their childhood, family, significant life events and working life. People had a "this is me" document within this file, which people and their families had completed, wherever possible. This document was used by staff to plan personalised and meaningful activities for them. For example, one person with dementia, had enjoyed date nights with their partner at a local cinema which offered dementia friendly viewings. Another person had been attending a local youth centre where they were undertaking an art project with a young person. They were creating a piece about the person's favourite landscape. One staff member told us how important intergenerational links were and how it was vital that people were present and involved in their local community. One relative commented; "Credit must go to the activities coordinator who is going to great lengths to introduce activities to the residents, which make such a difference to their lives".

Each person had an activities recording sheet which detailed not only the activity that they had participated in, but also how they seemed, how it went, and whether they enjoyed it. This helped staff to understand whether the activity was a success and whether to repeat it in the future. This was useful with this particular client group, many of whom had advanced cognitive impairments and could not always give verbal feedback.

In addition to the personalised activities, there was a weekly schedule of planned activities which people could participate in. Examples of activities on offer included; comedy afternoons, films and sherry on Sunday afternoons, arts and crafts, breakfast club and a relaxation group. There were also one-to-one sessions. One staff member commented; "One to one's vary a lot according to the person. One person likes looking through catalogues and having help to order clothes. Some people just enjoy sitting and being able to cuddle up and hold hands, or just chatting. It can be unplanned, dependent on their mood".

Staff were consistently responsive to people's needs and ensured that loved ones were kept up to date with any changes. We observed one relative telephone the service to enquire about a person whose health had deteriorated. The staff member who answered the telephone was extremely well informed about this person's health and provided information to the relative in an extremely kind and compassionate manner. Another person had been experiencing a decline in their mental health. Staff had called the person's doctor who was attending the service for a review. We spoke with the doctor who confirmed that the staff always sought advice promptly and followed any guidance given.

There was a thorough pre-assessment process for new people coming to live at Asheborough House. The registered manager told us that it was important to have the right mix of people living at the service in order to maintain their quality of life. As many people were living with an advanced dementia, the service may not have been the right place for people who were more cognitively aware. The pre-admission process included an in-depth assessment of people's needs such as their behaviour, elimination and personal care needs. Upon admission, screening tools such as Waterlow and MUST (Malnutrition Universal Screening Tool) were used to assess people's level of need and risk.

People and their relatives were given information on how to make a complaint and advice on making a complaint was displayed around the service. If people wished to make a complaint, they were supported to do so. There was a complaints policy in place which was regularly reviewed and updated. If concerns had been raised, these were dealt with promptly by the registered manager and the complainant had been satisfied with the outcome.

People were supported to maintain relationships with people who mattered to them. Relatives were made to feel welcome and there were no restrictions on visiting times. We observed one staff member sitting with a person and their relative and helping them with their meal. It was clear from their conversation that they had a positive rapport and that they knew each other well. One staff member told us; "We look after visitors. They are always offered drinks and food. We keep them included and have conversations with them".

Good

Is the service well-led?

Our findings

At the comprehensive inspection on 27 and 30 October 2015 we found issues relating to governance and Asheborough house. The systems in place to assess and monitor the quality of service people received were not considered to be effective. For example, people did not always receive a high standard of quality care because the provider did not have effective monitoring systems and processes in place. We found breaches in regulation and enforcement action was taken. We followed this up with a focused inspection on 29 February 2016. At that time, the issues had been addressed.

At this inspection we found the improvements had been sustained. The registered manager undertook a range of audits to monitor the quality of the service and to drive improvements. For example, there were regular audits of medicines, accidents and incidents and staffing levels. Any issues identified were promptly addressed and the outcomes were clearly recorded. People living at the service had a key worker, who would also carry out audits relating to the people they supported. For example, they would regularly check their clothing, room and any equipment and report any issues to the registered manager. One staff member had recorded; "[person's name]'s trousers are looking a little worn". This helped ensure any issues were quickly noticed and resolved.

People, relatives, visitors and staff all told us the service was well led. Everybody we talked with spoke very highly of the registered manager. Comments from staff included; "The registered manager listens and understands"; "We have a really good manager here. She is good with the residents and good with the staff"; "I can always speak to [registered manager] about anything" and "The registered manager is brilliant. Caring, easy to approach and easy to speak to". Relatives confirmed the registered manager was approachable and that the service was well led. Comments included; "The manager is very good. If ever we need to talk to her, she's always available" and "The manager is absolutely brilliant".

Feedback on the service was welcomed by the registered manager and a variety of forums were used to ensure people, staff and visitors had the opportunity to have their say. For example, there was a suggestions box in the reception area and quality assurance surveys were sent out every four months. Feedback from the most recent quality assurance survey was positive. Comments included; "[relative's name] is always spotlessly clean"; "All of the staff I have met, I have found to be kind and caring" and "I'm very satisfied with all aspects of the care". There were regular residents' meetings in which people were given the opportunity to raise suggestions, for example regarding meals or activities within the home. Wherever possible these were implemented.

There were regular staff meetings which were well attended and were an opportunity for staff to raise suggestions and share best practice. One staff member we spoke with commented; "Staff meetings are useful. Lots of issues are discussed and it is a good way to get together as a whole team, as we work shifts". There were also senior staff meetings and management meetings attended by the nominated individual, registered manager and director.

There were clear lines of accountability within the home. Staff knew what was expected of them and were

happy in their role. Morale amongst staff was very high. Staff confirmed they felt valued and respected and were committed to providing high quality care. Comments from staff included; "I am trusted to get on with my job here"; "I love working here"; "I wouldn't want to work anywhere else" and "I love my job. I love the team and the residents and I look forward to coming to work".

The registered manager led by example, and would undertake care and nursing duties alongside the staff team, as needed. The registered manager was committed to sharing best practice and to forging links with other professionals. For example, a community nurse had been invited to create a display about dementia to inform staff at Asheborough House.

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the manager, and were confident they would act on them appropriately.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. The manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

There were a range of policies and procedures in place which were accessible to staff. Some of the policies required updating. For example, the DoLS policy predated some new case law which had made significant changes to the deprivation of liberty safeguards. This was highlighted to the registered manager who took immediate action to address this. The policies had been updated by the second day of the inspection.