Archmore Care Services Ltd

Ashdown Nursing Home

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 4 September 2017 and was unannounced.

Ashdown Nursing Home is located in Worthing. It is registered to accommodate a maximum of forty people, as some of the rooms were large enough for dual occupancy. However, rooms had been converted and were single occupancy, therefore the provider was only able to accommodate a maximum of thirty-one people. At the time of our inspection there were thirty people living in the home. The home provides care and support for people living with dementia, some of whom have complex health needs and who may require nursing support. The home itself is a large detached property spread over two floors. People had their own rooms and had access to shared, communal bathrooms. There was a lounge and a dining area. There was a well-maintained garden and paved area as well as a summer house that people could use during the summer months.

There have been another two comprehensive inspection since January 2016. We carried out an announced comprehensive inspection on 6 and 8 January 2016. Breaches of legal requirements were found and the home received a rating of 'Inadequate' and was placed into 'special measures'. The purpose of special measures is to provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example, cancel their registration. Services placed in special measures will be re-inspected again within six months. If sufficient improvements have been made, the service can come out of special measures and the overall rating can be revised. You can read the report from our previous inspection, by selecting the 'all reports' link for (Ashdown Nursing Home) on our website at www.cqc.org.uk.

We carried out another comprehensive inspection on 3 and 13 May 2016. It was evident that improvements had been made and the home received a rating of 'Requires Improvement' and as a result was no longer in 'special measures'. However, the legal requirements in relation to safe care and treatment, the need for consent and dignity and respect had not been fully met. Areas for improvement were also identified in order to further improve some practices in relation to staffing levels, medicines, communication and interaction and providing choice.

At this inspection it was evident that improvements had been made and the providers had ensured that this had been sustained and embedded in practice. The providers were no longer in breach of the regulations, however, although the providers were no longer in breach, we noted that further improvement was needed to ensure that there was a consistent approach to assessing peoples' capacity and making decisions on peoples' behalves.

At the previous inspection on 3 and 13 May 2016 the home had been without a registered manager for seven months. 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. The providers had been responsible for the day-to-day management of the home and peoples' care. A new manager had been in post for one month. Following the inspection the manager left employment and one of the providers had become the registered manager. At this inspection it was evident that considerable efforts had been made to continually improve the service. A clinical lead nurse had been recruited to improve the nursing care people were receiving. In addition, a general manager was in post who had worked hard to improve the leadership and management of the home and had introduced mechanisms to ensure that the service was meeting peoples' needs.

At this inspection people received care that was safe. There were sufficient numbers of suitably trained staff to meet peoples' needs and people told us that when they required support, staff responded in a timely manner. People were assisted to move and position in a safe way. Staff had received training in safe moving and handling and their practice was observed and monitored by the management team as well as senior staff to assure peoples' safety. People received their medicines on time from nursing staff as well as staff who had received the required training. Records showed that relevant healthcare practitioners had been involved in decisions that related to peoples' care and their access to medicines. The home was clean and people were protected from the risk of infection.

People were treated with dignity and respect. Observations showed staff explaining their actions, treating people with kindness and compassion and being sensitive when supporting them with their personal care needs. Positive relationships had developed between people and staff and people and relatives told us that staff were kind and caring. A relative told us, "I can't see how they can do anything else, they're fantastic. I have to trust these people, and I do". People and relatives were involved in peoples' care and able to share their thoughts and suggestions. Regular care plan reviews took place as did residents' and relatives' meetings where people and relatives were kept informed of peoples' care and the running of the home. People were able to stay at the home until the end of their life. People and their relatives had been involved in planning how the person wished to be supported during this stage in their life.

The management team and staff 'knew' people and took time to find out about their life before they moved into the home. People were encouraged to participate in a wide range of activities, external entertainment and meaningful occupation that occupied their time. People received care that was personalised to their needs. Care plans documented peoples' preferences and wishes as well as their healthcare needs. People and their relatives were involved in the development, review and implementation of peoples' care.

The management team welcomed feedback and used various mechanisms to obtain this from people, relatives, staff and external professionals. Feedback was positive and any suggestions that had been made had been recognised and changes made as a result. This related to peoples' choices of activities or the food that they were provided with. There was a positive culture and a warm, calm, friendly and welcoming atmosphere.

People told us that they liked the food. One person told us, "The food is very good, very good, better than at my last place". Observation showed people could choose what they had to eat and drink and peoples' right to change their mind was respected by staff. Communication aids were used to adapt communication for both staff and people. For example, pictures of meals were shown to people to help them to choose food and guidance had been translated in staffs' first language to promote understanding and aid their development.

The home was well-managed and people, relatives, staff and external professionals were complimentary about the leadership and management of the home. Rigorous quality assurance processes audited the care that was provided to ensure that it was meeting peoples' needs and they experienced a service they had a

right to expect. The management team worked with external healthcare professionals to ensure people were receiving good quality care, to promote learning amongst the staff team and the sharing of best practice guidance.

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 home was safe.

Risks to peoples' safety had been assessed and people were supported in a safe manner.

There were sufficient staff to safely meet peoples' needs. People were supported by staff who were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People had access to medicines when they required them. There were safe systems in place to manage, store, administer and dispose of medicines.

Is the service effective?

Requires Improvement

The home was not consistently effective.

Although improvements had been made, there was a lack of consistency when assessing peoples' capacity and involving relevant people to make decisions on peoples' behalves.

People were supported to eat and drink to maintain their health and had a positive dining experience. People were supported to maintain good health. They had access to healthcare professionals to enable them to receive the necessary care and treatment.

Staffs' skills and experience ensured that people received good care. Staff had access to on-going and appropriate training to enable them to carry out their roles.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. People were able to maintain their relationships with family and friends.

People were involved in decisions that affected their lives and their care and support needs.

Peoples' privacy and dignity was maintained and respected. People were able to spend their time as they chose and their independence was promoted.

People were able to stay at the home until the end of their lives and they and their relatives were involved in the planning of their care needs for this stage in their lives.

Is the service responsive?

Good

The home was responsive.

Care was personalised and tailored to peoples' individual needs and preferences.

People had access to a range of activities to meet their individual needs and interests and to minimise social isolation.

People and their relatives were made aware of their right to complain. The management team encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good

The home was well-led.

People and staff were very positive about the leadership and management of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals and their opinions and wishes were taken into consideration in relation to the running of the home.

Ashdown Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 4 September 2017 and was unannounced; this meant that the providers and staff did not know that we were coming. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection the registered manager had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to this inspection included previous inspection reports, feedback that we had received about the home and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people, eight relatives, eight members of staff, one visiting healthcare professional and the two providers, one of whom was also the registered manager. Prior to the inspection we had also contacted the local authority to gain their feedback. We reviewed a range of records about peoples' care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, eight staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area and spent time observing the lunchtime experience for people and the administration of medicines.

The home was last inspected in May 2016, where the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home received an overall rating of 'Requires

Improvement'.

Good

Is the service safe?

Our findings

At the previous inspection on 3 and 13 May 2016, the provider was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns raised with regards to staffs' practice in relation to moving and positioning people. Observations showed staff sometimes undertook unsafe moving and handling practices and therefore placed people at risk of injury. Following the inspection the provider wrote to us to inform us of the measures that they would take to ensure that they met the regulations and to ensure that people were provided with safe moving and handling support.

At this inspection it was clear that improvements had been made and sustained in practice. The provider had retained staff and because of this the use of agency staff, who were sometimes not fully aware of peoples' assessed needs, had decreased. They had also promoted some staff to team leaders and recruited a care coordinator to, among other tasks, oversee and observe staffs' practice to ensure that it was safe and appropriate for peoples' needs.

Staff were knowledgeable about peoples' care needs and demonstrated safe moving and positioning practices. People and relatives told us that they had no concerns with regard to the moving and handling practices of staff and that people were supported in a safe way. The provider ensured that staff had up-to-date moving and handling training that provided them with both theoretical and practical knowledge of how to move and position people in a safe manner. The provider had taken measures to ensure that people, who required assistance with moving and positioning, had risk assessments and mobilising care plans in place. These identified the risks to the person, the potential hazards and the goals to be achieved. They provided advice and guidance to staff on the precautions and actions to take to minimise the risks and ensure peoples' safety. Observations showed staff demonstrated safe techniques, in accordance with risk assessments and mobilising care plans, for example, when assisting one person to move from their armchair to a wheelchair with the use of a hoist. When providing support, staff explained their actions to people and communicated to them throughout the manoeuvre and ensured that they were supported in a safe manner.

People and relatives told us that people were safe. When asked why, one person told us, "We've got two doors before the pavement and they are all locked". Another person told us, "Anyone can't come and attack you". A relative told us, "I am quite happy here, I know my relative is safe here".

At the previous inspection an area in need of improvement related to the documentation and associated guidance provided to staff when people were prescribed 'as and when required' medicines. Documentation advised staff of the medicines that could be offered and what these were for. However, the guidance lacked detail in regards to when it could be offered. For example, records for one person advised staff that the medicine could be given if the person showed signs of agitation, shouting or verbal aggression. However, it did not provide staff with guidance in relation to the steps to follow before administering this medicine. This could have potentially led to a lack of consistency in approaches by staff. At this inspection the management team had ensured that care plans contained information on peoples' 'as and when required'

medicines, informing staff of when to offer the medicines, how long they should wait in-between doses and how much medicine to administer. This, along with the information in peoples' medicine administration records (MAR) ensured that staff were provided with sufficient information on the use of 'as and when required' medicines to ensure consistency in their approach.

At the previous observation staff did not always explain their actions to people when they were being supported to take their medicines. At this inspection it was evident that improvements had been made. It was apparent that staff administering medicines knew people well and that they took time to explain their actions to people. Observations showed staff adapting their approach to meet peoples' needs. For example, one person needed to take their medicines on a spoon. They were supported to do this in a calm and dignified way. People were asked if they were experiencing any pain and were offered pain relief if required. The management team had recognised that some people were unable to verbally communicate their needs or inform staff that they were in pain. They had introduced an Abbey Pain Scale. The Abbey Pain Scale is best used for people who are living with dementia or for those with limited verbal communication and provides guidance to staff to assist them in the assessment of pain in people who are unable to clearly articulate their needs. There were safe systems in place for the ordering, storage and administration of medicines. People and relatives told us that they had no concerns with regards to people receiving their medicines.

At the previous inspection the home had not been occupied to full capacity and therefore despite improvements in staffing levels and the deployment of staff that the provider had made, we were unable to determine if the staffing levels could be sustained over time, should the number of people living at the home increase. At this inspection it was evident that the provider had worked hard to ensure that staff felt valued and this had impacted on the retention of staff and the provider no longer used agency staff. There were sufficient numbers of staff to safely and effectively meet peoples' needs. Peoples' need had been assessed when they first moved into the home and these were regularly reviewed to provide an accurate overview of their needs. The provider used a dependency tool which analysed the amount of support a person needed, this was then aligned with the staffing levels to ensure that there were sufficient staff. People and relatives told us that there were enough staff and that when people required assistance staff responded to their needs. One person told us, "Yes, no problem with that". A relative told us, "There are enough carers who are around whenever they need help". Another relative told us, "They've got more staff, they're fantastic. They don't just come to work, they all know the people".

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed, and their employment history gained. In addition to this, their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Peoples' freedom was not unlawfully restricted and they were able to take risks. Observations showed some people independently walking around the home. Peoples' needs had been assessed and risk assessments were devised and implemented to ensure their safety. These related to peoples' health conditions, mobility, cognitive abilities, social isolation, and access to call bells, wound care and nutrition. Risk assessments provided clear guidance for staff as to how to support people in a safe manner. Accidents and incidents that had occurred were recorded and analysed to identify the cause of the accident and determine if any further action was needed to minimise the risk of it occurring again. For example, risk assessments and care plans had been updated to reflect changes in peoples' needs or support requirements. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans

were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and peoples' ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan. A business continuity plan informed staff of what action needed to be taken in the event of an emergency.

People were protected from harm. Staff had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were mixed responses from staff when confirming their understanding of safeguarding procedures. Some staff who used English as a second language, had difficulty expressing their understanding, however were able to explain that they would report this to the management team. Other staff were able to clearly demonstrate their understanding. One member of staff told us, "For abuse, it could be one of the staff forcing the residents to do something, hurting them, shouting to them, bruises, skin tears, fractures, finger marks on the skin. I would report it to the manager and the safeguarding tem who will investigate. I would report it to colleagues on handover or the police, ambulance or GP". Another member of staff told us, "I would inform the manager or phone the CQC or local authority".

There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. (A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace). The provider had demonstrated an awareness of the importance of safeguarding people from abuse and improper treatment and had made referrals to the local authority when required. Body map charts were used to document and monitor any injuries, marks and bruises to ensure people had not been exposed to harm.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People were supported with their continence needs and to access the toilet facilities regularly. People and relatives were complementary about the cleanliness of the home. A relative told us, "I have never known it to smell of urine". Another relative told us, "The house is very clean and tidy".

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 3 and 13 May 2016, the provider was in continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to gaining peoples' consent when supporting them to take their medicines and when they were using bed rails. Following the inspection the provider wrote to us to inform us of the measures that they would take to ensure that they met the regulations and to ensure that peoples' consent was gained. At this inspection, although improvements had been made and the provider was no longer in breach of the regulation, further improvements are needed to ensure the consistent approach of mental capacity assessments and best interests decision meetings so that care and treatment is consistently provided with the consent of the relevant person.

At the previous inspection there was insufficient guidance for staff when administering covert medicines. As well as a lack of sufficient documentation to ensure that any decisions to administer medicines covertly were being made lawfully. At this inspection the provider had implemented a document to capture this involvement and agreement and there were appropriate protocols in place for the convert administration of medicines.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made appropriate DoLS applications for people who were unable to leave the home without staff support or who had restrictive practices used as part of their care. Records for one person showed that conditions, associated with their DoLS, had been met.

People were asked for their consent before being supported. Staff told us and records confirmed, that staff had received training for MCA and DoLS. The provider had undertaken mental capacity assessments and best interests decisions for some people and was aware of DoLS. Some people had lasting power of attorneys that could make decisions on peoples' behalves when they lacked capacity. The management team had demonstrated good practice as they had ensured that the documents to confirm this had been requested and gathered, this ensured that they had assured themselves that people making decisions on peoples' behalves had a legal right to do so.

However, although improvements had been made there was an inconsistent approach to assessing capacity. Mental capacity assessments should be decision specific, some mental capacity assessments had been completed that stated they were for 'All aspects of care', whereas others had been completed for specific decisions, such as they use of lap belts or bed rails. Best interests decision meetings should only

take place following a mental capacity assessment to assess peoples' capacity and ability to make decisions. If, after undertaking a mental capacity assessment it is deemed that the person lacks capacity then a best interests decision should be made which includes people involved in the person's care to ensure that any decisions made are in peoples' best interests. Records showed that best interests meetings had sometimes been conducted without a mental capacity assessment being in place and therefore peoples' lack of capacity had been presumed. Others showed that decisions had been made by members of staff, without the involvement of other professionals. Despite attempts to involve external healthcare professionals the management team had experienced some difficulties when asking them to sign documentation to confirm that a best interests decision had been made. The management team had taken measures to document that this had been requested but declined.

Although improvements had clearly been made and the provider was no longer in breach of the regulation, the registered manager needs to ensure clarity and a consistent approach to conducting mental capacity assessments. This is an area in need of further improvement.

At the previous inspection an area recognised as in need of improvement related to staffs' interaction with people when supporting them to eat and drink. At this inspection, it was evident that improvements had been made. People had a positive dining experience. Observations showed that the preparation and presentation of the dining room assisted people, living with dementia, to orientate and know that it was time for their meal. Tables were laid with tablecloths, placemats and napkins and contributed to a pleasant environment for people to have their meal. People were provided with drinks and meals of their choice and their right to change their mind was respected by staff. For example, one person did not like the meal that they had chosen; instead they requested a cheese sandwich. This choice was respected and the person was provided with the sandwich. Another person asked staff if they could have mashed potato with their dinner, as well as the type of potato that they had been given, once again, staff respected this decision and the person was provided with mashed potato. Observations of these two people showed that they enjoyed their lunch. For people who required more support to eat and drink, staff ensured that they were patient and calm and supported people with dignity. Staff asked people if they were ready for their food and if they could assist them to wear a clothes protector. Staff then sat alongside people, explaining what the food was and asking if they were enjoying their meals. People and relatives told us that the food was good and that people were happy with the quality, quantity and choice of food. One person told us, "Yes, I like the food", Comments from relatives included, "Food has improved quite a lot", "I am very satisfied with the food" and "My relative wouldn't eat, staff went out of their way to get them to eat, even getting fish and chips as they knew that this was something my relative used to enjoy".

People's risk of malnutrition was assessed upon admission and reviewed monthly, using a Malnutrition Universal Screening Tool (MUST) to identify people who were at a significant risk. These people were weighed each week or month, dependent on advice provided by healthcare professionals, to ensure that they were not losing any more weight. The management team audited peoples' weights to ensure that timely action was taken if people had lost a significant amount of weight. For people who were at risk of malnutrition, food and fluid charts had been implemented that monitored and analysed the food and fluid intake of people. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP and the practice nurse. Advice and guidance provided by these professionals had been followed. For example, some people had been prescribed drink supplements and fortified food to increase their calorie intake.

People's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. Assessments were used to identify which people were at risk of developing

pressure wounds. Care plans for people showed that referrals had been made and measures had been taken to liaise with relevant professionals such as GPs, practice and tissue viability nurses. For people who had pressure wounds, body maps and wound assessment charts were completed that detailed the wound and the treatment plan recommended. Photographs of wounds were taken to monitor their improvement or deterioration. People at risk of developing pressure wounds used equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushions and mattress that was appropriate as well as the setting that the mattress was required to be on.

People, relatives and healthcare professionals told us that they felt that staff had appropriate and relevant skills to meet peoples' needs. Observations demonstrated that staff knew peoples' needs and were able to provide care to meet their needs. The management team had a commitment to learning and development. Staff that were new to the home were supported to undertake a 12 week induction which consisted of familiarising themselves with the providers' policies and procedures, orientation of the home, as well as an awareness of the expectations of their role. The provider was aware of the changes in induction practices since the Care Act 2014 and informed us that any new staff would be undertaking the Care Certificate induction process. The Care Certificate is a set of standards that social care and health workers should work towards. It is the new minimum standards that should be covered as part of the induction training of new care workers.

Staff had completed training which the registered manager considered essential to their roles as well as completing training that was specific to the needs of the people they were supporting, such as supporting people living with dementia. Some staff held Diplomas in health and social care, whereas others were working towards them. There were also links with external organisations to provide additional learning and development for staff, such as external training providers and links with the local authority and external healthcare professionals. Staff told us that they received sufficient training to enable them to provide care to people in a competent and consistent way. Registered nurses ensured that their practice was current; they undertook relevant training courses and were registered with the Nursing and Midwifery Council (NMC). The general manager had taken additional steps to develop staffs' understanding, they had sourced documents and guidance in staffs' first language to promote understanding and ensure that staff had been provided with appropriate guidance to inform their practice.

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss their needs and any concerns they had. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions and appraisals helpful and supportive, however, explained that they could also approach the management team at any time if they had any questions or concerns. One member of staff told us, "The support is there whenever I need it".

Peoples' communication needs were assessed and met. Observations of staffs' interactions with people showed them adapting their communication style to meet peoples' needs. Pictures of food had been introduced for people who experienced difficulties understanding verbal communication, the pictures enabled people to make choices with regards to what they would like to eat and drink. Peoples' communication needs had been assessed when they first moved into the home. People were encouraged to communicate with one another. Observations in the communal lounge showed that people enjoyed having conversations within one another and with staff. Staff encouraged this by engaging in conversations with people, contributing to a friendly and relaxed atmosphere. There was effective communication between staff. Regular handover meetings provided an opportunity for staff who had been working during the

previous shift to provide information about peoples' needs to staff working during the following shift. This, in addition to team meetings and care plans ensured that staff were provided with up-to-date information to enable them to carry out their roles. One member of staff told us, "We have daily handover. We discuss residents' eating and drinking issues, such as fortified drinks". Management meetings were also held to discuss changes in practice and to ensure that the management team promoted a consistent approach amongst the staff team.

People had access to health care professionals. People and records confirmed that they had access to GPs, opticians, tissue viability nurses and chiropodists. The provider had arranged for a practice nurse from the local surgery, to visit the home each week and monitor people who were at risk of pressure wounds, malnutrition or who were unwell. Records showed that referrals had been made in a timely manner to ensure that people had access to relevant health professionals. This was echoed within a comment made by a visiting healthcare professional, who told us, "We get appropriate referrals they'll contact us if needed and staff seem capable and understand what we're saying." This further demonstrated that the provider was aware of the importance of making referrals in a timely manner to ensure that people had access to appropriate healthcare professionals to meet their health needs.

Good

Is the service caring?

Our findings

At the previous inspection on 3 and 13 May 2016, the provider was in continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns related to dignity and respect. Following the inspection the provider wrote to us to inform us of the measures that they would take to ensure that they met the regulations and to ensure that people were treated with dignity and respect. At this inspection it was evident that improvements had been made.

People told us that they were treated with compassion and that their privacy and dignity was respected. The provider had implemented mechanisms to ensure that peoples' privacy and dignity were maintained. They had implemented a system where more experienced and skilled staff were given the roles of team leaders. The provider had also recruited a care coordinator. The team leaders and care coordinator were, among other tasks, responsible for monitoring staffs' performance and providing feedback to them in relation to their practice. Signs were used on peoples' doors and observations showed that these were displayed if staff were assisting people with personal care; this advised other people and staff that the person needed privacy. Observations showed staff knocked on peoples' doors and waited for a reply before entering. Privacy was maintained when assisting people with their personal care. Staff supported people in a discreet and sensitive manner. People were treated in a respectful and dignified way and were supported by staff that explained their actions and showed warmth and compassion. Peoples' right to confidentiality was respected. Records held about them were stored in locked cabinets and offices to ensure that their privacy was maintained.

The providers had a set of values that they strived to achieve, these stated, 'Our residents are at the heart of what we do. We will always strive to provide the highest quality care. We endeavour to fulfil each residents' individual needs'. This was demonstrated in practice. People were involved in their care and in the decisions that related to this. The general manager had introduced a residents' committee where people had different roles in relation to food and drink and activities. People met at these forums, with a staff representative and a relative to discuss the menus and provision of activities as well as other topics that related to the care and running of the home. Peoples' involvement was respected and their suggestions had been used to change practice, such as the type of activities and entertainment that was offered. Relatives told us that they were involved in peoples' care and continually informed of any changes. A relative told us, "I can phone anytime and they'll phone me. They have a system that works perfectly. I have to trust these people, and I do. The other day at 8:30pm the owner phoned me about something, they don't have to do that, but they do". Regular residents' and relatives' meetings provided opportunities for people and their relatives to be kept informed and were a chance for them to share their views and opinions. A monthly newsletter was also produced to inform people and relatives of the forthcoming activities and entertainment, with photographs of people that were providing the activities, to aid peoples' understanding. Events that had taken place were reflected on, such as tea parties or a summer barbeque. There were also excerpts from publications and articles relating to dementia and results of surveys. A 'Come and have a brew' coffee morning had been organised for people and relatives and was going to be a regular occurrence. Staff told us, "It is an opportunity to meet, greet and chat and everyone is welcome".

People appeared to be at ease in the company of staff. They were observed holding hands, having reassuring hugs and engaging in banter with one another. There was a shared sense of humour, laughter and smiles when there was interaction and engagement. People, relatives and a visiting healthcare professional were complimentary about the caring nature of staff. Comments from relatives included, "I am more than happy with what we have got so far, staff are very friendly", "I am very happy they are looked after well" and "They know their name, they keep them happy, people are polite". Feedback from the recent quality assurance survey that was sent to relatives to gain their feedback, contained a comment which stated, 'My relative has their needs met at every level. The quality of emotional care is outstanding. Patience and communication is essential and is extremely apparent at Ashdown'. When people were asked if they would recommend the home to a friend, they told us, "Oh yes I think I would" and "Yes, no reason not to".

People were supported to be independent; they told us that they were able to spend time where they liked in the home. Observations showed people independently walking around the home and expressing their views to ensure they were involved in making decisions about how they spent their time and how they were supported. Staff explained that they encouraged people to be as independent as possible. The provider recognised that people may require additional support to be involved in their care and explained that if people required the assistance of an advocate then this would be arranged. (An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.)

Observations found that one person was tearful and showed signs of distress. Staff recognised this and took time to communicate with the person, reassure and listen to them. At times staff intervened and used distraction techniques to diffuse situations when people were in disagreements with one another. Care was adapted to meet peoples' needs and peoples' equality and diversity was respected. A chaplain regularly visited the home so that people, who chose to, could partake in the service. This was available for people of all faiths. People were able to choose where they spent their time, some preferring to spend time in the communal lounge, whereas others chose to spend time in their own rooms or walking throughout the home. Peoples' rooms were personalised with their belongings, photographs and ornaments and they were supported to maintain their sense of identity. People were supported to maintain their personal hygiene and appearance. Observations showed people were regularly supported to access toilet facilities and to have their personal hygiene maintained. People appeared well cared for and were able to dress in such a way that respected their individual style and identity. This was echoed in some comments made by relatives, who told us, "They are always clean" and "Yes, their hair is cut regularly, very nicely done. Nails well-manicured, they are always smart".

People were encouraged to maintain relationships with one another as well as with family and friends. Observations showed visitors and relatives spending time with people. There was a relaxed, happy and homely atmosphere. Relatives told us that they were made to feel welcome, that they could visit any time and have meals with their relatives. Birthdays were celebrated and people had access to parties with family and friends. One member of staff told us about a party a person had, they explained that the person had invited their relatives and had enjoyed a meal in the garden with staff serving as waiters and waitresses.

People were able to remain at the home and were supported until the end of their lives. Observations showed staff undertook regular checks on a person who was receiving end of life care and ensured their comfort throughout. Staff had involved the person's relatives to ensure that the person's wishes were known and respected. Peoples' end of life care was discussed and planned for. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require

them at the end of their life.

Good

Is the service responsive?

Our findings

At the previous inspection on 3 and 13 May 2016, there were inconsistencies with regards to the degree of choice that was afforded to people, this was fedback to the provider and at this inspection it was clear to see that improvements had been made.

Observations showed that people were provided with choice within all aspects of their lives. People were asked how they would like to spend their time, what activities they wanted to participate in and what they had to eat and drink. Records showed that people had been asked what time they preferred to go to bed and get up in the morning as well as their preferences and dislikes. When people were asked if they were able to choose the clothes that they wore, comments included, "Oh yeah, particularly about what I buy, I always buy good quality clothes", "Yeah, I like expensive clothes and I check it myself" and "I have always chosen my clothes, I like them".
Peoples' social, physical, emotional, and health needs were assessed prior to moving into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed, that they had been involved in the development of the care plans. Regular reviews had taken place in response to peoples' or relatives' feedback as well as any changes in peoples' conditions and care was adapted accordingly. Relatives' comments included, "They have a care plan, a couple of months back I contributed a lot on it", "They do have one, I can ask if I need to see it, I do get involved about it, I can go to the manager if I am not happy" and "Yeah, she has one, we worked on that the other week". A visiting healthcare professional commented about peoples' involvement in their care, they told us, "Staff genuinely seem very good at making the people part of the management of their care as much as they can be, which is increasingly important'.

Care plans contained information about peoples' interests, hobbies and employment history and provided staff with an insight into peoples' lives before they moved into the home. This influenced practice. A dedicated activities co-ordinator ensured that people were provided with dedicated, meaningful activities from staff as well as external entertainers. Observations showed people enjoying various activities, such as reading newspapers and board games. Musical entertainment was provided by one of the providers and it was evident that this was a regular occurrence as people reflected on other days that they had enjoyed the entertainment. This proved a popular choice and it was evident that people, and their relatives, enjoyed this. People were seen singing and dancing with staff and people made various requests for music. This provided further entertainment for people as people and relatives took joy in asking the provider to play and sing sings that they were unfamiliar with as they found this comical. There was banter and laughter throughout the activity and people clearly enjoyed the session. External entertainers were well-resourced and people enjoyed visits from these several times per week, these included, music therapy, acoustic afternoons, sing-a-longs, viola players, keep fit and Frank Sinatra singers. People and relatives told us about events that they had been involved with and photographs showed people enjoying these. These included trips to the local seafront and tea parties. A member of staff told us how popular the activities had proved. They told us, "We only book entertainers that interact with the residents. They chat with the residents before they start and they know the residents' names. If they have a 2pm slot they stay for afternoon tea and have it with the

residents. The residents are all very musical. Some of the residents don't interact at all but one resident sings when Elvis comes on".

For people who chose not to partake in group activities one-to-one sessions were provided to ensure that people were not socially isolated. Records showed that people had enjoyed listening to music or watching television in their rooms, having access to newspapers and reading with staff. A member of staff told us about a sensory activity that they had undertaken with one person, which the person had enjoyed. This had involved playing some music and using scented sprays to match the music. One person who chose not to join in with the group activities was having lessons to learn to play the piano and to develop their computer skills. Volunteers had also been introduced to the home to provide additional one-to-one time and attention for people.

People and relatives told us that the management team were responsive to peoples' needs. A comment within a recent quality assurance survey sent to relatives, stated, 'From my experience my relative has had excellent support and care from the Ashdown team. Who are always responsive and advise of any issues. Really impressed with the service provided'. For people and relatives who were not happy with the care people received there were various mechanisms in place to enable them to make their views known.

The provider had a complaints policy, concerns and complaints that had been raised had been dealt with effectively and in line with the providers' policy. A suggestions box was positioned in the hall way for people to share their views and suggestions. Records showed that people and relatives were encouraged to make their thoughts and feelings known, they had been invited to attend care plan reviews and residents' and relatives' meetings. When people were asked if they felt able to share their concerns and speak to the managers, they told us, "Yes, if I have an issue, I will talk to one of them", "Yes, they do listen" and "Yes, they are very good here". A relative told us, "Yeah, they will deal with all the concerns very quickly".

Good

Is the service well-led?

Our findings

At the previous inspection on 3 and 13 May 2016, the home had been without a registered manager for seven months. The providers had been responsible for the day-to-day management of the home and of peoples' care and a new manager had been in post for one month. Following the inspection, the manager had left employment and one of the providers had become the registered manager.

People, relatives, staff and healthcare professionals were complementary about the management team within the home. Comments from staff included, "If I have any issues I just go to the office. They always say come in and sit down. They are all approachable", "Staff get listened to and management are supportive. There's an open door policy with no restrictions. The manager is always on the floor"; "The support are there whenever I need it. Things are actioned quickly such as improvements or maintenance issues". Staff were complimentary about the registered manager. One member of staff told us, "On weekends you only have to call her. I have got a lot of support. She is always at the end of the phone. She responds well to suggestions. I had a suggestion, she said let me think about it and got back to me and said that's ok. There is a lot of empowering with her. She will give you the training and say go and fly. She has an open door policy, she's excellent".

The management team consisted of the two providers, one of whom was the registered manager. There was a clinical lead nurse who ensured that people were provided with appropriate nursing care and a general manager who ensured that the management of the home, its staff and on-going improvements were implemented. In addition to the management team, to provide role models for staff, other senior roles had been implemented such as team leaders and a care coordinator. These ensured that there was a visible management and senior team presence within the home. It was apparent that the providers, the management team and staff had made considerable efforts to improve the service that was provided.

There was a calm, relaxed, friendly and homely atmosphere. People appeared to be at ease in the presence of the management team and staff and staff told us that they were happy in their work. This was evident and contributed to a positive culture. Relationships had developed and it was apparent that management and staff knew people well. The general manager had devised and implemented innovative and effective systems to continually improve the service. This included devising booklets for peoples' bedrooms, these listed the CQC fundamental standards and informed people and their relatives of the standards people had a right to expect. It asked people and relatives to make their comments and concerns known within the book if they felt that there were ever any occasions when the fundamental standards were not being met. Further mechanisms to gather feedback had been implemented. Quality assurance surveys had been sent to people and relatives as well as external visitors and health professionals. Results of which were displayed on notice boards so that people and prospective residents were informed of others views.

Results from the surveys were complimentary. Comments from external healthcare professionals included, 'The atmosphere, care and attention the residents receive at Ashdown is by far superior. The staff work very well as a team and this can be seen in the care residents receive', 'Ashdown had a very helpful and supportive team. We have no concerns, every aspect we witnessed was excellent' and 'The client we placed

here had significant and complicated needs, the change and transformation in about 6 weeks has been quite amazing'. These positive comments were echoed by relatives. One relative told us, "The investment they've put into this place, both in the decoration and in the staff, is astounding'. The provider had made significant investments into both the staffing and the home itself to ensure that the décor and amenities met peoples' needs. Communal rooms had been refurbished and the external spaces had been landscaped and paved so that people could access outside spaces in the warmer weather. Photographs showed people had enjoyed various activities and tea parties in the spaces.

To ensure that staff were happy within their roles and able to share their views confidentiality, the management team had arranged for an independent audit to be conducted by an external organisation. Staff had been asked for their feedback about the management of the home and how well they were supported. All of the feedback had been positive and it was clear that the staff team felt that the leadership and management of the home was good.

The general manager further demonstrated their enthusiasm and willingness to drive improvement and affect change. Minor, constructive feedback had been provided to the management team at the end of the inspection. The next day the general manager had devised an action plan addressing these minor issues to ensure that measures were immediately put in place to improve practice.

The management team demonstrated their awareness of the implementation of the Duty of Candour CQC regulation and records showed that they had informed peoples' relatives if peoples' health needs or condition had changed. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. This was confirmed by relatives who told us that they were involved in their loved ones care and kept up-to-date when changes occurred.

The providers ensured that links with the local community were maintained. There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local GP practice, local authority, external training providers and dementia crisis team. The provider had plans to liaise with the local hospice to provide additional training for staff. The management team attended monthly forums with the GP surgery and had plans to attend the local authority manager forum meetings to enable them to share best practice guidance. The management team were involved and working with initiatives to enable them to further improve the care that people received and ensure a more personalised approach to care. These included, 'Making it Real' and 'The Social Care Commitment'. 'Making it Real' highlights the issues that are most important to the quality of peoples' lives. 'The Social Care Commitment' is an agreement about improving workforce quality and providing high quality services in adult social care.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. There were rigorous quality assurance processes in place as well as regular audits to enable the general manager and the registered manager to have oversight of the processes in place to identify what was working well, or if there were any trends or areas of improvement required. These included the implementation of audits to monitor peoples' weights, medicines, care plans, wound care and accidents and incidents. A monthly management report was conducted to enable them to monitor the general performance of the home. It included monitoring the frequency of resident, relative and staff meetings, ensuring that audits had been completed, occupancy levels, compliments and complaints, falls, hospital referrals, infections, safeguarding investigations and staffing.