Ashtonleigh Homes Ltd

Ashtonleigh

Inspection report

4 Wimblehurst Road
Horsham
West Sussex
RH12 2ED

Tel: 01403259217

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashtonleigh is a care home without nursing, providing accommodation and personal care for up to 54 People. We inspected the service on 24 and 26 October 2017. On the days of our visits 49 people were living at the service. People living at the service are older people. The service offers care to people living with or without dementia as a primary diagnosis; Some people may also be living with physical illness or disability.

At the last inspection on 5 and 8 May 2015 the service was rated as good in all areas apart from safe, where it was rated as requires improvement. The overall rating was good. At this inspection in October 2017 we found improvements made following the last inspection had been sustained. However we identified some additional areas where improvements were needed. We have rated the service as requires improvement.

Some management or governance systems were not effective in identifying improvements needed at the service. As a result, people did not always receive safe care in an environment where risks had been assessed and addressed. We identified some furnishings that were not stable, and the water supply to some rooms was erratic in temperature. The laundry was cluttered and did not provide an environment that could be kept clean. We did not identify people had suffered harm as a result of these concerns, and the provider took immediate action to address these areas during the inspection.

People received their medicines safely, but some clarification was needed on staff training and accountability in relation to the administration of insulin. As Ashtonleigh is a care home without nursing, the administration of insulin would normally be done by a community nurse if the person was not able to do so safely themselves. The community nurse may decide to delegate the responsibility for this to care staff at the home, if they have assured themselves they are competent to do this. However the accountability would need to remain with the community nurse. At Ashtonleigh the accountability was not clear. Following the inspection we received evidence to show action had been taken.

There were sufficient staff on duty to support people and meet their needs.

Incidents were analysed to identify trends and learning took place to prevent a re-occurrence. Following an incident where a fire had taken place at the service due to building works occurring, the provider had been asked by the fire service to share their experience with other providers in the area. Staff had managed the incident well and no-one had been harmed as a result. The provider had taken steps to provide a sprinkler system in most areas of the home to protect people further.

Effective systems for staff training and support were in place. We saw staff working well with people and they had a clear understanding of people's need and wishes regarding their care. The registered manager ensured staff received appropriate supervision with observation of their practice. The registered provider also regularly monitored staff interactions to ensure they reflected positive outcomes for people.

People received a well-balanced and nutritious diet. People told us the food was very good, and we saw

people enjoying a choice of meals. The cook had worked at the home for many years and was a well-respected member of the care team. They understood about safe textures of meals to support people with swallowing difficulties and special medical diets. We have made a recommendation over ensuring staff have access to information to help them assess risks from poor hydration.

People's rights regarding capacity and consent were understood and supported. Where necessary the service had applied for authorisations to deprive people of their liberty. Staff understood about 'best interest decisions' and these were recorded in people's files where needed. Staff also understood that people had the right to make poor choices where they had capacity, and acknowledged this, for example people wishing to smoke despite significant health problems.

The environment was homely and comfortable, and had been adapted to support people living with dementia. This included help to understand and navigate the environment, with directional signs such as "This way to the toilet". Colours had been chosen to help support people to feel calm and people's bedroom doors had been decorated to look like a front door with a name plate for the person's details. People's care plans recorded the choices they had made of door colours to remind them of where they had lived previously and, they had selected pictures to help them find their own rooms easier. Contrasting colours had been used to highlight areas such as light switches to make them more visible to people. The garden had been levelled the week before the inspection to make it safer for people to access independently.

Staff had built positive relationships with people and supported them to be as independent as they were able. We saw and heard of many positive examples of staff celebrating success and events with people and valuing their contribution to the life of the home. This included respecting choices people made. People's privacy and dignity was respected.

People received individual care in accordance with their agreed care plan. Plans were reviewed regularly, and the person or their representatives were involved in this process. People completed "This is me" forms to help staff understand the person they were caring for in the context of the life they had lived. People and their relatives told us they were very happy with the services they received.

People received healthcare that met their needs. The service had commissioned weekly 'rounds' carried out by a local GP, which meant people had good, consistent access to medical support in a timely way. District and community nurses visited the home several times a week to support people.

The service had activities available for people, based on their interests. We saw people actively engaged in activities such as listening to music, carving Halloween pumpkins, reading and playing games. Staff understood when people liked to be quiet, and listened and responded to their communication effectively.

Systems were in place for the management of complaints, and staff understood indicators and different types of abuse and how to report any concerns they had. The service had a positive and open culture where people were encouraged and able to air their views about the service.

Records were well maintained, and appropriate notifications had been made to the Care Quality Commission or other services as required by law.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive safe care in an environment where risks had been assessed and addressed. The provider took immediate action to address this.

There were sufficient staff on duty, but one person's staff file did not contain information on a full employment history.

We have made a recommendation over ensuring staff have access to information to help them assess risks from poor hydration.

People received their medicines safely, but some clarification was needed on staff training and accountability in relation to the administration of insulin.

Incidents were being analysed to identify trends and learning took place to prevent a re-occurrence. A recent incident was being shared with other services to promote good practice as this had been managed well.

Is the service effective?

Good

The service was effective.

Systems for staff training and support were in place.

People received a well-balanced and nutritious diet.

People's rights regarding capacity and consent were understood and supported.

The environment was homely and comfortable, and had been adapted to support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff had built positive relationships with people and supported

them to be as independent as they were able.

People's privacy and dignity was respected.

We saw many positive examples of staff celebrating events or positive qualities of people living at the service. This told us people were valued.

Is the service responsive?

Good

The service was responsive.

People received individual care in accordance with their agreed care plan. Plans were reviewed regularly.

The service had activities available for people, based on their interests. Staff understood when people liked to be quiet, and listened and responded to their communication.

Systems were in place for the management of complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some management or governance systems had not been effective in identifying improvements needed at the service.

Records were well maintained, and appropriate notifications had been made to the Care Quality Commission or other services as required by law.

People and their relatives told us they were very happy with the services they received.

The service had a positive and open culture where people were encouraged and able to air their views about the service.

Ashtonleigh

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 was 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 was a comprehensive inspection which took place on 24 and 26 October 2017. The inspection was unannounced, and was carried out by one adult social care inspector. The second day visit was by appointment. The inspection visit started at 07.35 am to enable us to meet with the night staff and see how duties were delegated for the day.
Prior to the inspection we reviewed information we held about the service, and notifications we had received. A notification is information about important events, which the service is required by law to send us. Prior to the inspection the registered persons sent us information in a Provider Information Return or PIR about how the service was operated.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring, and over a mealtime. Many of the people living at the service were not able to share their views with us about their experience of care at Ashtonleigh. We spent time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. We also looked at similar observation records carried out by the provider.

During the inspection we spoke with or spent time with 8 people who lived at the service, a visiting GP and two district nurses, 7 relatives, 12 members of staff including care and support staff on both day and night shifts, cleaning and catering staff and the service's plumber. We also spoke with the registered manager and two registered providers.

We looked at the care records for five people with a range of needs. These records included support plans, risk assessments, health records and daily notes, which were maintained on a new customised IT system. We sat in on a handover meeting, to see how information was shared between shifts. We looked at records relating to the service and the running of the service. These records included policies and procedures as well as records relating to the management of medicines, food, and health and safety checks on the building. We

looked at two staff files, which included information about their recruitment and other training records. We also viewed a number of audits undertaken by the service or commissioned by them to identify any concerns to people's health and well-being.

Following the inspection the registered provider supplied us with copies of other audits and quality assurance and management tools.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of Ashtonleigh in May 2015 we rated this key question as Requires Improvement. Although the service had taken action to address the concerns we identified at that time, on this inspection we identified other concerns.

We identified a risk in relation to a lack of clarity over the training and support, monitoring and supervision of staff administering insulin to a person living with diabetes. The registered manager was involved in administering insulin to this person and told us they had received training from the district nurses to do so. However they also told us they thought this allowed them to train other staff to administer insulin. We clarified the situation with both the registered manager and visiting general practitioner regarding the training of staff in the administering of insulin, and the need for this to remain on the accountability and caseload of a registered community nurse. The visiting general practitioner agreed to ensure that this was clarified with the district nurses, and later supplied us with evidence this had been done following the inspection. We did not find that the insulin had been administered by anyone other than a person who had been appropriately trained and supervised to do so. The service's policy on insulin storage needed amending, and this was done while we were at the inspection.

People were not always being protected from harm because risks to their well-being from the environment were not always being identified or mitigated. An audit completed in October 2017 had indicated furniture was 'stable'. We toured the building with the provider and identified wardrobes that were unstable and unsecured to the walls which could have been pulled over onto people. The provider took immediate action to rectify this, and sent us evidence they had done so.

People's care plans contained clear records of the amounts of fluids that people took in; however there was no indication of an appropriate fluid level for each individual to maintain their health. We looked at the records for one person who had been assessed as being at risk of poor nutrition as they had lost over 3% of their weight in the last three months. Their care plan stated "food and fluids monitored." We observed that over the preceding four days the person had taken in less than 1,000 mls of fluid on each day, and on one day only 500 mls. The person had been referred to the GP and had been seen on the day of the inspection, which told us risks were being identified and managed.

We recommend the registered person ensures where people are at risk of poor fluid intake their care plans record a target figure, based on the person's body mass index and historical fluid intake to support staff understand the level of risk associated with the person's intake.

During the tour of the accommodation with the registered provider we found water temperatures at the point of delivery to wash hand basins in some areas was being delivered at over 48 degrees centigrade when the recommended safe level was 43 degrees. Hot water checks had last been carried out on 7 September 2017 when there had been no issues reported. When we returned on the second day of the inspection the provider and their plumber demonstrated to us that the problems that had been identified would not necessarily have shown up in the services regular audits. A new pump had already been ordered for the

older part of the building prior to the inspection which had led to the erratic water temperatures we found. No-one was identified as being at risk in this area, as people would not have used the water independent of staff. The provider told us they would be installing new regulators throughout this area to ensure safety of water temperatures as a precaution.

Best practice in infection control was not always being carried out, which exposed people to the risk of cross infection. The service's laundry contained a build-up of old duvets, and items of clothing where the owner could not be traced. There was no clear separation between clean and potentially contaminated clothing or linens. By the second visit this area had been cleaned and all excess items removed. A system for the safe workflow of soiled or potentially contaminated items had been established. This meant the area was much easier to keep clean and therefore minimise any potential cross infection or contamination.

Staff had access to gloves and aprons and we saw these in use throughout the inspection with supporting people with their personal care. During the inspection, one person suffered an incident of incontinence in the lounge. Staff managed this without any fuss or distress to the person, and ensured all areas were treated with antibacterial cleaner to reduce any odour or potential cross infection. One person had been identified as having been colonised with a specific bacteria and information on this was contained in their file. All rooms had soap dispensers mounted on the wall and paper towels to help people maintain good hand hygiene.

People were being protected from risks associated with their care, because the service had assessed monitored and reduced risks to people. For example we looked at the care records for one person who had diabetes. This person had a specific care plan and risk assessment for their diabetes management, including information for staff on what signs to look for that might signal the person's condition was deteriorating due to a low blood sugar. Another person's records contained a clear assessment of risks to their skin from damage caused by pressure. The person was under the supervision and monitoring of district nurses, and was being supported on an appropriate level of pressure relieving mattress. The person was being repositioned by staff every 2 to 3 hours. We looked at the records for this which demonstrated this had happened. Where people had difficulty swallowing assessments were available in the files and information available in the kitchen on any specific textures of food needed. The cook could show us information on the number of people requiring a soft diet. This told us risks to people were being mitigated.

A system was in place to identify any risks associated with the staff recruitment process. We identified a short gap in one person's employment history, but this had been explored and had not presented a risk to people. Staff recruitment and employment practices ensured any reasonable adjustments that might be needed were identified and put into place, for example to support staff members with a disability or during pregnancy.

Each member of staff had access to a portable tablet computer which contained detail about the person's needs, and any risks regarding their care. Backup systems were in place to ensure this information was available in case of power cuts or other emergency situations.

Staff we spoke with were clear about how people showing distressed or anxious behaviours were supported in a positive way and staff understood this was communication of something the person may no longer be able to express verbally. This helped to reduce any risk of their behaviour being misunderstood.

An analysis of falls and incidents was undertaken on the electronic care planning system. Falls analysis forms were in place, and good practice guidance on falls prevention was in place. We looked at one person who had fallen regularly in January 2017. The analysis included a list of detailed actions taken to support the

person and attempt to reduce falls. This had included the use of a sensor mat and referrals to the falls team.

The tablet computer system could provide audits of all accidents and incidents including staff description and any actions taken. We cross referenced an incident referred to in the analysis with the person's care file. We found the care file contained records of the injury and a body map to identify the wound area. This also included a description of how the event occurred. Photographs could be attached to the tablet computer system to monitor any concerns. The registered manager told us "as soon as we seen the first signs we call in the district nurses." This told us systems to assess and analyse incidents were managed well to mitigate risks.

Other risks to people's well-being from the environment were being managed. Lifts, hoists, and baths were maintained and serviced regularly on a contract and regular tests carried out of fire alarms. People had personal evacuation plans in place to ensure their safety in case of a fire and emergency equipment was regularly tested and reviewed. Risk assessments were undertaken of safe working practices for staff to ensure they were protected, for example during pregnancy, and there were emergency plans and contact numbers in place for staff to use.

Learning from incidents was undertaken and shared within the local care community. For example earlier in 2017 there had been a fire at the service, caused during building work for a new extension. Staff told us "sometimes we feel we have too much training, however it happened and we were ready." The home had been evacuated quickly and there had been no harm to people at the service. The provider and group manager had shared their experience at a local provider meeting at the request of a fire authority to speak with other homeowners. The home had since worked with the local fire service fire service to help reinforce the importance of good fire precautions and practice. The service had also installed a sprinkler system to reduce risks to people from fire throughout the service.

There were enough staff on duty to meet people's needs. Many people at the service got up early, and by 7:50 am there were 34 people up and dressed. We queried this with the night staff on duty who clearly told us that people were not got up until they wanted to do so. Five night staff were on duty, which helped ensure that people could receive care and support to get up when they wanted. A member of the night staff told us people were checked at around 6:30 am and were supported to get up as they wished. They told us one person for example liked to have a cigarette first thing in the morning. We spoke with this person who told us they enjoyed having a cigarette so much they had even gone outside at 2 am to have one on occasions. Night staff told us that some people like to go get washed and dressed and then go back to bed for a while having had a cup of tea, to wait for breakfast. During the day we observed staff were busy and active but able to respond quickly to changes in people's need. We saw minutes of a staff meeting where staff had raised that they felt an additional person would increase flexibility of the morning staff and we saw this had been looked into, using a system to determine staffing levels based on the needs of people accommodated.

Staff understood about abuse and how to report any concerns they had about people's well-being. Policies and procedures were available to detail actions staff should take in case of concern and the service were proactive in supporting people to raise concerns about other agencies, for example healthcare support. The registered manager told us any "safeguarding alerts would be looked at as a way of learning" and improving practice.

People received their medicines safely. We looked at the medicines with the deputy manager, and observed staff supporting people to take their medicines during the day. Medicines practice at the service was audited weekly. Records were completed which showed medicines had been given to people in accordance with the prescribing instructions. Additional records were completed where for example there were variable

prescriptions or where medicines required additional precautions due to their strength or effects. The service had indicated in their PIR there were a high number of medicines errors in the preceding 12 months. We spoke with the registered manager who confirmed that these had been identified during audits and were recording errors. For example if a staff member had failed to record that a medicine had been administered. Following that audit the home had implemented a system of double-checking at the end of each shift. The records that we looked at had been completed thoroughly. Staff concerned had received additional support and where needed training. We saw people being given their medicines, which was done with enough time to enable the person to take them at their own pace. A new air conditioner had been fitted to the medicines room to keep this area cool and ensure medicines could be stored at optimum temperatures.

Good

Is the service effective?

Our findings

Staff we saw had the skills they needed to carry out their role. We saw support staff using equipment such as wheelchairs competently to move people, and demonstrating good practice when supporting people to eat. Staff told us they felt they had the skills and training they needed. One told us they had completed training in their former role, but had repeated when they had started working at Ashtonleigh. Another told us "Training – they are really on it. I'm back on all the courses, I don't think there is anything I have missed out on." People and relatives told us the staff that supported them had the skills to do so. A relative told us they had chosen the home because "It's the staff that make it. We felt confident from day one."

Training and learning was consolidated by the registered manager and senior staff in 'Knowledge shares' and quizzes with the staff team. This helped to ensure learning was embedded and staff were consistent in their understanding and practice. Staff had regular supervision, appraisals and one to one sessions with senior staff where they could share any difficulties or identify training needs. Supervisions included observations of practice, to ensure staff were working consistently and safely.

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's consent to their care and treatment was sought in line with legislation and guidance. We heard staff asking people for their consent when carrying out care tasks and offering them choices. Staff understood about 'best interest decisions' and these were recorded in people's files where needed. Staff also understood that people had the right to make poor choices where they had capacity, and acknowledged this. For example people wishing to smoke despite significant health problems.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made applications where appropriate for authorisation to deprive people of their liberty, ten of which had been approved by the local authority and two others which were awaiting approval. These related to the persons not being able to leave the building unescorted or under the supervision of staff as they were unable to manage their own safety. Staff were aware of the conditions in relation to these authorisations. The computerised planning system ensured staff were reminded on the need to carry out regular checks on people who whose whereabouts were subject to monitoring and supervision under their DoLS.

People were supported to eat, drink and maintain a healthy balanced diet. People, relatives and staff told us the food was good and they ate well. One relative told us their relation had put on weight since being at the service and eating well. They told us this had helped with an improvement in their overall health and

strength. Another relative told us when their relation had been admitted to the service staff had been very worried about their weight loss. Staff had sat with the person and encouraged them to eat at each meal. The person's weight had now stabilised.

On the first day of the inspection the lunchtime meal was sausages and mashed potatoes, fish cakes, ham salad or jacket potatoes. We saw people eating and enjoying their lunch. One person had soup and another had a sandwich because they 'didn't want much'. Cakes and biscuits were available at all times and fresh fruit and vegetables were delivered twice weekly.

Some people needed their food presented in different textures, due to swallowing difficulties and some people needed support to eat and drink or medical diets. We saw this was provided. Information was available for the cook on different textures needed, or people's likes and dislikes.

People were supported to have access to good healthcare. The service had commissioned a local GP service to attend the home each week, for a period of two to three hours to operate as a 'Doctor's round.' The GP or nurse practitioner visiting the home each week ensured people had access to GP services on a regular basis. This offered consistency and a swift review of any issues, even minor ones. People did not have to transfer their services to this GP practice if they did not wish to do so. We spoke with the visiting GP, and two community nurses vising the service. They told us they had no concerns over the quality of services and healthcare support provided to people. A community nurse told us staff called them in early if they had any concerns. We saw evidence of people being supported to attend hospital appointments, having access to podiatry, dental and optical checks as needed. Preparations were under way for people to receive influenza vaccinations if wished, including staff.

Ashtonleigh provided a comfortable environment for people to live in. The service provided accommodation over three floors, with the majority of rooms having ensuite facilities. Some rooms were for shared occupation and screens were provided to protect people's privacy while receiving care. Lounges were available on the ground and first floor, one of which could be used as a cinema room, with large screen projection in place. A hydrotherapy bath was available for people to use, and the service had a dedicated hairdressing salon.

Many of the people living at Ashtonleigh were living with dementia. The service had been adapted to support people to understand their environment with directional signs to support people, for example "This way to the toilet". Colours had been chosen to help support people to feel calm and people's bedroom doors had been decorated to look like a front door with a name plate for the person's details. People's care plans recorded the choices they had made of door colours to remind them of previous houses and pictures to help them find their own rooms easier. Contrasting colours had been used to highlight areas such as light switches to make them more visible to people. The garden had been levelled the week before the inspection to make it safer for people to access independently. The service had also supported people to start growing vegetables. One person told us they had successfully grown some lettuce but had picked it too early for a sandwich, which meant it wasn't crisp enough. They hoped to grow different varieties next year.

Some people had identified to the registered manager they were concerned over people entering their rooms when they were not there. The service had fitted external bolts to these doors as a temporary measure while they explored how this could best be achieved for each individual.

Good

Is the service caring?

Our findings

People and relatives told us the staff were "lovely", "a great bunch" and "staff are positive – always friendly, laughing and smiling." One relative told us "We are very satisfied. We were very lucky to get a place at Ashtonleigh." Another relative told us they always felt welcome at the home and there was a lovely 'busy' atmosphere with something always going on.

The service presented an environment that was tolerant of people's lifestyle choices. For example one person chose not to get dressed in day wear. Staff ensured the person was appropriately covered to protect their dignity, but otherwise supported them to express themselves in the way they felt most comfortable. We asked this person if they wanted to get dressed. They told us "Goodness no. I am very happy." Staff and the management ensured people were not discriminated against or felt excluded because of a health condition or need. For example one person was not able to drink alcohol due to it interacting with a medicine they were taking. The person was supported to enjoy a glass of alcohol free wine with others.

People were valued for their contribution to the life of the home. One person chose to spend time sitting by the front door knitting. They told us they had knitted "since they were three years old." They enjoyed their role in 'keeping an eye on everything going on' and called to staff when someone wanted to be let in. Staff repeatedly thanked the person for 'helping them out'.

People were supported by staff who took a positive approach towards their care, and staff took time to celebrate special events with people. One person had recently celebrated their 106 birthday. As the person had worked with the local fire service, the service had organised for a fire engine to come to the home to surprise them. The person had then celebrated with a lobster mayonnaise lunch of their choice. The service had developed a "Dignity tree" on the wall where people could post wishes for them to fulfil. The day before the inspection for example two people had celebrated their wedding anniversary. Staff had prepared them a special meal and put up banners to make the event feel 'special'. We heard how the cook had come in on their day off to prepare a buffet for one person's birthday and another person had been supported to attend a club to assist them develop their communication following a stroke.

People living at the service were involved in making decisions and the running of the home. For example two people told us how they had been involved in interviewing new staff. One told us how they had asked them to "tell us a joke" as they wanted to see if the person had a sense of humour, as that was important to them. The service also held meetings for people to share any views and welcomed comments in a suggestions box. The service had a regular newsletter.

People's privacy and dignity were respected in the interactions we saw taking place. People received care and support in private in their rooms where staff closed their doors. Where people needed support in an unplanned way we saw this was delivered without fuss and with respect for the person's dignity. Where people had expressed preferences about their care this was acknowledged and acted upon. One relative told us their relation had been a quiet person who didn't enjoy noisy or active environments. They told us the service's staff had assisted them to move their bedroom to a quieter area of the service where they were

much happier. They also told us the service assisted the person to maintain friendships and respected their views about notifying family members if for example they had a fall. Another relative commented on the lovely photographs the service had taken of their relation on their birthday which were on their bedroom wall. They told us "Staff take time to make sure people look nice, that they are well groomed."

We observed people were supported by staff with kindness and compassion. People were supported to maintain their independence, and we saw people being offered choices throughout the day, for example with meals, drinks, and where they spent time. When one person said they didn't want dessert staff asked if they would like a portion put aside for later which the person agreed to. People had time to eat their meals independently without being rushed by staff, and were offered any assistance to clean their hands afterwards. We saw care plans indicated activities of daily care people could do for themselves and any equipment that may support them to maintain or improve this.

At the time of the inspection no-one was receiving end of life care at the service, but staff had experience of supporting people at this time. Some people's care plans included clinical decisions indicating if the person wished to have significant medical intervention in the case of a sudden serious deterioration in their health. Some people had requested full support be given, others, or their families where appropriate had made the decision this would not be in their relations best interests. The service had copies of good practice guidance to enable them to support people well at the end of their life, for example NICE guidance on the Care of Dying Adults.

Good

Is the service responsive?

Our findings

People or their relatives told us they were very happy with the care and support they received. One person said "Couldn't be better" and a relative said "We are very happy with their care overall."

Each person living at the service had a plan of care, based on assessments of their need. Plans for people's care were contained on computerised tablets, and included information about all aspects of people's care. This included people's physical or emotional needs and any goals or aspirations they may have. We spoke with two relatives who had visited the service for a review. They told us this happened regularly and gave them an opportunity to raise any issues they had. They told us they felt they could be very open with the service about any changes they would like made to their relation's care.

People each had a key worker who was responsible for updating the person's care plans every month. Care and support plans included assessments of risk, and any actions to be followed following medical assessment. For example in relation to diet textures, following assessment by the speech and language therapy services. Plans were updated regularly and audited regularly to ensure there were no changes needed. Plans recorded people's wishes regarding their care. For example one person had requested they not be checked on during the night as it woke them up. However they had agreed that if they were unwell staff could do so.

As part of the care planning process people completed "This is me" documents. These gave information about the person's life history, important people and events to them and what they liked to do. A staff member told us "It's really useful – it tells you so much. People have had so much to say and it helps the carers have something to talk about with the person."

Assessments ensured staff were aware of anything that could be done to support the person. For example we saw one person had a visual impairment. Their room contained photographs of how the room should be kept and where everything needed to be in relation to other objects. This helped ensure when the person returned to their room they could find their way around independently.

We saw good examples of people being supported in accordance with their plans. For example, staff told us how one person with nonverbal communication was assisted to communicate their wishes. Communication tools had been provided by the speech and language therapy service and staff told us the person could communicate through facial expressions and a 'thumbs up' sign. We saw this happening.

People had opportunities to take part in activities each day. During the inspection visits we saw people joining together to carve pumpkins, play games, sing and listen to music. One person was supported to use a laptop to maintain contact with friends and 'look things up'. We spoke with the activities organiser who told us about how they worked to engage people at their own level, either individually or in groups. For example one person living with memory loss was engaging with an animated toy. The person was happy to show us how this toy worked but then came to take it back to have with them. We watched them interacting with the toy which responded to them stroking it. This clearly gave them pleasure.

The registered manager told us "We do not have a specific daily activity programme as the activities done each day are done based on what the residents want to do that day and what their hobbies and interests are. We have a list of the entertainers that are coming in each month and events we carry out and this is displayed on a PowerPoint presentation on the TV screen in the reception area. We display 2 months at a time and update this every 2 months." People were able to have trips out and in a recent provider report following discussions with people living at the service they had stated "they all were happy with what is being offered and the frequency of trips. They all told me, if they want to go out anywhere specific, they tell the staff and it get organised."

The service had a complaints procedure that was on display in the hallway. We looked at the services records of complaints and concerns that had been raised with the service since the last inspection. We saw there were clear records on how these had been managed including the involvement of other agencies where this had been needed. People we spoke with told us they would speak to the staff or a relation if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

In May 2015 we had rated this key question as good. On this inspection in October 2017 we identified many examples of good practice; but we also found some concerns that had not been picked up by the service's own quality assurance or quality management systems. This did not give us confidence the systems were operating as effectively as they could do. We have rated this key question as requires improvement.

Although we did not find that people had been harmed by what we had identified, we found people were at risk of not receiving consistent high quality or safe care because governance systems were not always robust or being operated effectively. For example, regular audits had been carried out of medicines administration. On the inspection we identified concerns over the governance regarding the accountability, oversight and training of staff to administer insulin. The home's medication policy needed updating.

We identified concerns the systems for maintaining people's safety were not always robust. We identified an audit had been undertaken of the safety of the environment in October 2017, in the week before the inspection. This had not identified risks within the environment such as from unsecured furniture or the laundry.

Where people were at risk of poor fluid or food intake the service had instigated food or fluid balance charts to monitor the level of fluids taken by the person each day. These did not contain a target figure for staff guidance in assessing the risks to people from poor fluid intake, which would be individually based on people's body mass and history. This had not been identified by the care planning audits and could leave people at risk of patterns of poor fluid intake not being recognised.

Many of these issues were addressed during the inspection; however the home's own systems had not identified or addressed all of these until they were identified during the inspection.

The failure to establish and operate effective systems to assess monitor and improve quality and safety; assess, monitor and mitigate risks and maintain accurate records was a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Ashtonleigh was part of a small group of care and nursing homes. The providers were a regular presence at the service, and operated oversight of the service, along with the group manager and registered manager. There were clear lines of accountability within the organisation. Staff knew the provider and management team well. They told us they were approachable, and there was a positive culture within the service. One staff member told us "The manager's great – you can go to her for anything- a really good manager and easy to talk to" and another said carers here really care…they are passionate about people's care."

The registered provider had commissioned a number of professional audits to monitor and maintain the quality and safety of the services at Ashtonleigh, as well as completing internal audits of their practice. For example the registered provider regularly carried out observations of interactions between staff and people living at the service to determine good practice. The service had a series of quality assurance and

management initiatives which included monthly provider reports, and there was a clear annual development plan for the service. Staff had been nominated to be individual champions, for example for medication. This helped to ensure staff were more aware of systems and how the home operated as well as take on extra skills and responsibilities in challenging their peers over any practice concerns.

Feedback from people using the service was used to drive improvements. Questionnaires were sent to people living at the service, staff, relatives and visiting professional every six months. The responses from these were used to make any improvement suggested to the service, for example a comment had been made that not all staff wore their badges. The provider had asked the registered manager to raise this with staff. On the inspection we saw staff were wearing badges. People had also requested a wet room for them to shower in and this had been provided. People living at the service were encouraged to nominate staff members for "Employee of the Month" to recognise support 'above and beyond' the normal.

The service had links with local and national organisations supporting quality care services for people, such as The Registered Nursing Homes Association, Investors in People, and local quality forums. The week following the inspection the service was hosting a talk from people from the local Alzheimer's society group, and staff had become Dementia Friends Champions. A Dementia Friends Champion is a volunteer who encourages others to make a positive difference to people living with dementia in their community. The registered manager also used the internet and support from other services in the group to update their practice.

A visiting healthcare professional told us one of the strengths of the service was the continuity and consistency of the staff team. People spoke positively about team working and supporting each other. There were regular staff meetings hld. We saw the minutes from two recent team meetings and saw staff were actively encouraged to share their views on improvements made. We saw staff members given opportunities to expand their skills and learn. For example a carer was delegated to support the GP with their rounds, rather than a more senior staff member. This helped show the service recognised skills people had, and encouraged staff to develop their potential. One staff member told us they had been supported to train to administer medicines, but had not enjoyed it so they had stopped.

Where changes had been made following the previous inspections we found improvements had been sustained. For example in the inspection of May 2015 we found that there had been a lack of clear guidance regarding the administration of 'as required' medicines, and there was no systematic approach to the assessment of staffing levels. We saw changes made at that time had been sustained.

Communication systems were effective and records were being well maintained. Effective communication between shifts ensured that important information about people and their needs was highlighted to staff coming on duty. We sat in on a handover which showed us that staff were made aware of activities going on that day, and allocated individual duties. This helped reduce risks to people by ensuring effective transfer of information. Other documents, policies and procedures and care plans were up to date.

Notifications had been sent to the CQC as required by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been operated effectively to assess, monitor and improve the quality and safety of the services provided, or mitigate the risks. Regulation 17 (1)(2) (a), (b)