Lotus Care (Ash Cottage) Limited

Ash Cottage

Inspection report

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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

We carried out an inspection of Ash Cottage on 4 and 5 July 2018. The first day was unannounced.

At our last inspection in June 2017 we found a breach of legal requirement in relation to medicines management. Following the inspection, we asked the provider to take action to make improvements and to send us an action plan. During this inspection, our findings demonstrated there had been an improvement in the management of people's medicines.

During this inspection, our findings demonstrated there was a breach of the regulations in respect of the provider's quality monitoring systems. Following the inspection, we asked the provider to take action to make improvements and to send us an action plan.

This is the second consecutive time the service has been rated as 'Requires Improvement'.

Ash Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Ash Cottage provides accommodation and care and support for up to 24 people, some of who were living with dementia. The service does not provide nursing care. There were 18 people living in the home at the time of the inspection.

Ash Cottage is located on a quiet lane in Edenfield, Rossendale. It is an extended converted farm cottage first built in 1886 and has a listed status and provides accommodation on four floors accessed by a passenger lift. The gardens are well maintained with a small car park for visitors at the front of the house.

The service was managed by a registered manager. 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.

Whilst the quality assurance and auditing processes had identified some shortfalls that had been actioned by the registered manager, they had not been fully effective. We noted that a new system was being introduced and would help the provider and the registered manager to identify and respond to matters needing attention. We will review this at our next inspection.

There were systems to obtain people's views of people. There was evidence that people were listened to.

People told us they felt safe in the home and they were happy with the service they received. People appeared comfortable in the company of staff. Safeguarding adults' procedures were in place however the

reporting processes needed to be updated. Staff understood how to protect people from abuse. Staff treated people respectfully and their privacy was respected.

The systems in place to manage people's medicines had improved. Staff administering medicines had been trained and supervised to do this safely.

Risks associated with the environment and with people's health and welfare had been assessed. There was a system in place to record accidents and incidents. However, the registered manager was aware further action was needed to analyse any incidents and accidents to identify any patterns and trends and to prevent a re-occurrence.

New robust recruitment policies and procedure had been introduced to ensure new staff were suitable. Arrangements were in place to make sure staff were trained and competent. People considered there were enough staff to support them when they needed any help.

Appropriate Deprivation of Liberty Safeguard (DoLS) applications had been made to the local authority and people's mental capacity to make their own decisions had been assessed. However, additional information was needed to ensure people's preferences were met.

People had access to activities inside the home and were supported to maintain relationships with friends and family. People told us they enjoyed the meals and their dietary preferences were met. People had access to a GP and other health care professionals when they needed them.

People told us they were happy and did not have any complaints about the service they received. They knew how to raise their concerns and complaints and were confident they would be listened to.

People's care and support needs and their preferences and routines were being recorded. However, the registered manager was aware further improvements were needed to ensure the records reflected the care given.

The home was clean and bright and appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort. Equipment was safe and serviced.

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 consistently safe.

People felt safe in the home and were protected against the risk of abuse. Reporting systems needed to be updated to ensure the appropriate action was taken to keep people safe.

Risks to the health, safety and wellbeing of people who used the service were being assessed. Accidents and incidents were recorded. Further analysis was needed to ensure appropriate action was taken to keep people safe.

People's medicines were administered by trained and competent staff.

The home was clean and equipment was safe and serviced.

Policies and procedures were in place to ensure the provider operated an effective recruitment procedure. There were sufficient staff to meet people's care and support needs.

Is the service effective?

Good

The service was effective.

The home was comfortable, warm and well maintained. Adaptations and aids had been provided to help maintain people's safety, independence and comfort. A development plan supported ongoing improvements.

Staff were provided with the training, supervision and support they needed.

People enjoyed the meals and were supported to maintain good health.

Staff had received training to improve their understanding of the MCA 2005 legislation. The records relating to people's capacity to make safe decisions and to consent to care were being improved further to ensure assessments were decision specific.

Is the service caring?

Good

The service was caring.

People told us the staff treated them with care and kindness. We observed good relationships between staff and people living in the home.

People were encouraged to maintain relationships with family and friends. There were no restrictions placed on visiting.

Staff respected people's rights to privacy, dignity and independence. Where possible, people could make their own choices and were involved in decisions about their day.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities which were arranged on an informal basis based on people's preferences.

The information in people's care plans reflected their preferences and needs; further improvements were underway to ensure the records reflected the care they received.

People had no complaints and felt confident raising their concerns and complaints with the management team or with staff.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems to assess and monitor the quality of the service in all aspects of the management had not been completely effective. However, new systems were being introduced.

People had confidence in the management team and staff enjoyed working in the home.

There were effective systems to obtain people's views and opinions. People felt they were listened to.

Ash Cottage

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 4 and 5 July 2018; the first day was unannounced. The inspection was carried out by one adult social care inspector.

The provider completed a Provider Information Return (PIR) before the inspection. This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make.

In preparation for our visit, we reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies. We requested feedback from the district nursing services, the community pharmacist and a podiatrist.

During our inspection visit, we spent time observing how staff provided support for people to help us better understand their experiences of the care they received. We spoke with five people living in the home, three care staff, the housekeeper, the cook, the deputy manager and the registered manager. We also spoke with an area manager and a director. Following the inspection, we received feedback from the local authority contracts monitoring team and we spoke with the local authority infection and prevention control lead nurse.

We had a tour of the premises and looked at a range of documents and written records including three people's care records, three staff recruitment files, training records, medication records, a sample of policies and procedures, meeting minutes and records relating to the auditing and monitoring of service provision.

Following the inspection, we asked the provider for additional information; this was promptly sent to us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of June 2017, we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found staff had not followed safe procedures and there were unclear directions for the administration of 'as needed' medicines. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made. We found the local commissioning medicines optimisation team and the local community pharmacist had recently undertaken monitoring visits; we noted there had been no concerns identified.

Staff had access to a full set of policies and procedures. There were safe processes in place for the receipt, ordering and disposal of medicines. Care staff who were responsible for the management of people's medicines had received training and checks on their practice had been undertaken. We observed staff provided patient and considerate administration of people's medicines.

We sampled eight people's medication administration records (MARs). We found a photograph identified people on their MAR and any allergies were recorded to inform staff and health care professionals of any potential hazards of prescribing certain medicines to the person. The directions on the MARs were clear and they had been completed properly. However, we found directions were lacking in clarity in relation to eye drops for one person; this was corrected at the time of the inspection. We were advised that new records were being introduced to support the safe application of external medicines such as creams.

Medicines that were prescribed 'as needed' were supported by clear guidelines. Handwritten entries had been witnessed, medicines were clearly labelled and dated on opening and carried forward amounts from the previous month were recorded. This helped to monitor whether medicines were being given properly. We counted two people's medicines and found the amounts corresponded with the MARs; this meant, people had received their medicines as prescribed.

Appropriate arrangements were in place for the management of controlled medicines, which are medicines which may be at risk of misuse. We checked one person's controlled medicines and found they corresponded accurately with the register. There was a system to ensure people's medicines were regularly reviewed; this would help ensure people were receiving the appropriate medicines.

We were told no one managing their own medicines. However, records did not clearly evidence that people had given consent for staff to manage their medicines or whether they wished to self-medicate. The registered manager assured us this would be addressed.

During the inspection, we observed people were comfortable in the company of staff. We observed staff interaction with people was kind and friendly. People told us they felt safe. They said, "The staff are lovely

and they make sure we are safe" and, "I have no concerns about my safety; I am safer here than on my own at home."

Staff had safeguarding adults' procedures and whistle blowing (reporting poor practice) procedures which were being reviewed. Safeguarding procedures are designed to provide staff with guidance to help them protect children and adults from abuse and the risk of abuse. Staff received regular safeguarding training. A designated safeguarding champion was available in the home. However, they had not received any additional safeguarding training and had not attended any local forums. The area manager assured us this would be actioned. Records showed the registered manager had contacted the local authority safeguarding team as needed; however, they were not yet using the updated local authority assessment and referral process.

Staff understood how to protect people from abuse and were clear about the action to take if they witnessed or suspected abusive practice. They were confident the registered manager would act on their concerns and were aware they could take concerns to organisations outside the service. The registered manager was aware of her responsibility to report issues relating to safeguarding to the local authority and the Care Quality Commission.

We looked at records kept in relation to accidents and incidents that had occurred at the service. We noted there had been a low number of accidents and the records were maintained in people's care plans. Referrals were made, as appropriate, to the GP and the district nursing team and we observed alarm mats in use for one person who had been identified at risk of falls. However, accident and incidents had not been analysed or shared with senior management in order to monitor any patterns or trends, to prevent further incidents occurring and to ensure lessons were learnt. We discussed this with the area manager and were told new documentation was being introduced to address this.

We looked at how the risks to people's health and safety were managed. We found potential risks to people's safety and wellbeing had been assessed and recorded. The assessment information was based on good practice guidance in areas such as falls, skin integrity, mobility and nutrition and had been kept under regular review. This helped to ensure good outcomes of care and support were achieved. Staff had been provided with guidance on how to manage risks in a consistent manner without restricting people's freedom, choice and independence.

Environmental risk assessments had been undertaken in areas such as the use of equipment and the management of hazardous substances. However, we found the risks relating to a lack of restrictors on the windows had been considered on admission, but had not been formally assessed. We discussed this with the management team; following the inspection we received confirmation that all window restrictors were in place. The service had emergency contingency plans to enable people to receive the care and treatment they required should an emergency occur that stopped the service from operating. The business contingency plans were under review.

Financial protection measures and regular checks were in place to protect people. We found minor discrepancies on two people's personal allowance records; appropriate action was taken at the time of our inspection. New systems were being introduced to ensure people's money was managed safely. Staff were made aware they were not allowed to accept gifts and assist in the making of, or benefiting from people's wills.

We found employment checks had been completed before new staff began working for the service. We noted policies and procedures were available and new recruitment and selection processes had been

introduced to reflect the requirements of the current regulations and to ensure a safe and robust process was followed.

People were happy with the availability and numbers of staff. Comments included, "There are enough staff; they can't do enough for me" and, "They are available at all times; when I ask for help, they come at once." Staff told us there were sufficient staff to meet people's needs and there were few changes to the staff team. During our visit, we observed people's calls for assistance were promptly responded to; staff were attentive to people's needs and available in the main lounge. A dependency tool was used to provide guidance about recommended numbers of staff.

We looked at the staffing rotas and found a designated senior carer was in charge with two care staff throughout the day and a senior carer and a care staff at night. There were sufficient ancillary staff such as cooks and cleaners. The registered manager and deputy manager worked in the home five days each week and provided out of hours support as needed. We were told any staff shortfalls due to leave or sickness were covered by existing staff or by the registered manager or deputy manager; agency staff were not used.

We looked at the arrangements for keeping the service clean and hygienic. We found all areas to be clean and people told us, "It is always lovely and clean", "It is a clean and tidy home" and, "They work really hard to keep it smelling nice and to keep it clean." We noted odours in two of the bedrooms and a number of extractor fans around the home were dusty; we were told the carpets were being replaced as part of the refurbishment plan and arrangements were made to attend to the fans. We discussed our concerns with the registered manager who assured us appropriate action would be taken.

There were infection control policies and procedures for staff to refer to and staff had been trained in this area. Staff were provided with protective wear such as disposable gloves and aprons; suitable hand washing facilities were available to help prevent the spread of infection. Additional paper towel dispensers were in place by the second day of our inspection. The service had a designated cleaner who was responsible for cleaning and laundry. There were no cleaning schedules in place; however, revised schedules were introduced following the inspection. The service did not have a designated champion in this area. The registered manager told us this was being reviewed and links with local forums would be developed. Following the inspection, we contacted the local authority infection control lead nurse who agreed to contact the registered manager to offer some support.

The laundry was well organised with sufficient equipment to maintain people's clothes. Improvements were planned to ensure all surfaces were easy to clean and were free from dust. Consideration was being given to providing a 'clean' hand wash basin as part of ongoing improvements; however, space was limited.

Equipment was stored safely and we saw records to indicate regular safety checks were carried out on all systems and equipment. People had access to a range of appropriate equipment to safely meet their needs and to promote their independence and comfort. The provider had arrangements in place for ongoing maintenance and repairs to the building and the service had access to a maintenance person who responded to promptly to any requests for maintenance or repair.

Training had been provided to support staff with the safe movement of people. We observed staff using safe practices when supporting people to move around the home. Records showed staff were trained to deal with healthcare emergencies.

Following our last inspection an advisor from Lancashire Fire and Rescue had served an Enforcement notice in relation to fire safety; we noted all areas requiring attention had been addressed. A fire risk assessment

had recently been completed and recommendations were being addressed. Records showed staff had received fire safety training. Regular fire alarm checks had been recorded and staff knew what action to take in the event of a fire. Each person had a personal evacuation plan in place in the event of a fire, that assisted staff to plan the actions to be taken in an emergency.

The environmental health officer had awarded the service a four-star rating for food safety and hygiene in January 2018. Work was underway to address the recommendations made. There was key pad entry to the home and visitors were asked to sign in and out which would help keep people secure and safe.

Good

Is the service effective?

Our findings

People told us they were happy with the service they received and felt staff had the skills they needed. They said, "They look after me. I couldn't be happier" and, "I am very satisfied; it is a lovely place."

Before a person started to use the service, an assessment of their physical, mental health and social needs were undertaken to ensure their needs could be met. Most people, or their relatives, were enabled to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff could determine whether the home was able to meet their needs.

We looked at how the service trained and supported their staff. Staff received a range of training that enabled them to support people in a safe and effective way. Each member of staff had an individual training record. However, there was no overall training plan; this meant it was difficult to determine when updates were needed. All staff had achieved or were working towards a recognised care qualification. Staff confirmed the training was useful and beneficial to their role and they felt well trained.

Staff were provided with regular one to one supervision and said they felt well supported by the registered manager. Supervision provided staff with the opportunity to discuss their responsibilities and to develop their role. Staff were also invited to attend regular meetings and received an annual appraisal of their work performance.

New members of staff participated in a structured induction programme, which included an initial orientation to the service, working with an experienced member of staff, training in the provider's policies and procedures, completion of the provider's mandatory training and, where appropriate, the Care Certificate. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care.

Staff told us communication about people's changing needs and the support they needed was good. Records showed key information was shared between staff and staff spoken with had a very good understanding of people's needs and the management of the home.

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 make 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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were policies and procedures to

support staff with the MCA and DoLS and records showed staff had received training in this subject; this would help improve staff understanding of the processes. We were told applications had been submitted to the local authority for consideration and three authorisations were in place.

People's overall capacity had been assessed and their capacity and consent to make specific decisions about care and support was referred to in the care plans. This ensured staff acted in people's best interests and considered their choices. We discussed how this information could be improved and reflected in the care plans. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff understood the importance of gaining consent from people and that, wherever possible, they supported people to make decisions about how they wished their care to be provided. This was confirmed by our discussions with people who told us staff always respected their rights and preferences. They said, "Staff know what I like and how I like things to be done" and, "We can do whatever we want here; I don't think there are any rules that say I have to do something in a certain way." Where people had some difficulty expressing their wishes they were supported by their relatives or an authorised person.

We noted people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions in place. Each person's doctor had signed the record and decisions had been taken in consultation with relatives and relevant health care professionals. A DNACPR decision form in itself is not legally binding. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. Where possible, we found people's care plans reflected their decisions and preferences in relation to this; we discussed ways of improving how this information could be included in the care plans.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals and that they had a choice. The menus were displayed and were available in picture format. We observed people enjoyed their meals. They said, "Everything is lovely; we get good choices" and, "The food is delicious." The meals looked appetising and the portions varied in amount for each person; people were provided with extra helpings. People were offered alternatives to the menu and their preferences were known to staff. One person said, "They asked me what I like and don't like and make sure there is always something else available for me. I enjoy the food."

We observed people being supported and encouraged to eat their meals at their own pace and we overheard friendly conversations during the lunchtime period. The dining tables were appropriately set and drinks were made available. Protective clothing was provided to maintain people's dignity and independence and napkins were provided. We observed drinks and snacks being offered throughout the day.

Information about people's dietary preferences and any risks associated with their nutritional needs was shared with kitchen staff and maintained on people's care plans. We were told records would be made of people's dietary and fluid intake where needed. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history and any needs related to their health. Records showed that the nurse practitioner and district nursing team regularly visited the service and monitored the care and treatment of people in their care; appropriate referrals were made to a variety of healthcare agencies. Staff could access remote clinical consultations which meant prompt professional advice could be accessed at any time, and in some cases hospital visits and admissions could be avoided.

Information was shared when people moved between services such as transfer to other service, admission to hospital or attendance at health appointments. People were accompanied by a record containing a summary of their essential details and information about their medicines; where possible, a member of staff or a family member would accompany the person. In this way, people's needs were known and taken into account and care was provided consistently when moving between services.

We looked at how people's needs were met by the design and decoration of the home. We found the home was comfortable, warm and well maintained. Aids and adaptations had been provided to help maintain people's safety, independence and comfort. There were well maintained, pleasant gardens with seating for people and their visitors to enjoy in the warmer months. There were plans to further improve the environment for people living with dementia.

There was a development plan for the home which was being monitored by the area manager and the directors. Improvements had been made and included redecoration around the home and new dining tables and chairs. Plans for further improvement included replacement of carpets, redecoration of corridors and redecoration and refurbishment of bedrooms; on the day of our inspection the lift was being replaced. Consideration had been given to ensuring the facilities were appropriate for people living with dementia.

People were happy with their bedrooms and some had brought in personal items to promote a sense of comfort and familiarity. Some people had been able to choose the décor of their bedrooms to meet their individual tastes. Six bedrooms had en-suite facilities and bathrooms and toilets were located within easy access; commodes were provided where necessary. Useful signage was in place to help people identify their bedrooms, bathrooms and toilets.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were kind and caring. Comments included, "Staff look after me properly; everyone knows everyone else – it's that sort of place" and "The staff are very caring and very kind; I'm grateful for that." Relatives had commented, "Heartfelt thanks for your wonderful care" and, "How grateful we are for the love and care you show."

Compliments received by the home highlighted the caring approach taken by staff. People's comments included, "Thank you for your kindness and help", "Thank you so much for your kindness and patience" and, "It was reassuring to know [family member] was happy here."

The atmosphere in the home appeared calm and peaceful. We observed staff interacting in a caring, friendly and respectful manner with people living in the home. There was a key worker system in place, which provided people with a familiar point of contact to support good communication. Staff were aware of people's communication needs and were knowledgeable about people's individual needs, backgrounds and personalities. Each person had a 'Remember I'm Me' notice board in their bedroom; this provided staff with up to date information about a person's preferences and routines and was also used as a reminder for people about their daily routines. Another person had a diary with important information about their routines and when friends and family would be visiting. We observed staff offering reassurance and referring to the diary during their discussions with the person.

We observed people were treated with dignity and respect and without discrimination. People told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter and doors were closed whenever personal care was being delivered. However, we found an inappropriate lock on a shower room door which could compromise people's privacy; this was changed immediately. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting.

From our discussions and observations, it was clear staff understood the importance of treating people equally and promoting people's right to be free from discrimination. Information about people's spiritual or religious needs had been recorded in their care plans. Ministers from various churches visited the home to support people's beliefs or people were supported to attend local places of worship. However, their wishes and choices with regards to receiving personal care from female or male carers and their ethnicity and sexual orientation was not always clearly recorded; this meant staff may not be clear about people's diversity. People were encouraged to maintain relationships with family and friends. People told us there were no restrictions on visiting.

People were dressed appropriately in suitable clothing of their choice. They confirmed there were no rigid routines imposed on them that they were expected to follow. We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills.

People told us they were involved in day to day decisions. They were encouraged to express their views by

means of daily conversations, completing satisfaction surveys and at residents' meetings. The residents' meetings gave people the opportunity to be consulted and make shared decisions and helped keep people informed of proposed events. There was good evidence people were listened to and changes had been made to accommodate people's requests. People were supported to be comfortable in their surroundings and could personalise their bedrooms with their own possessions.

Staff had access to a set of equality and diversity policies and procedures. We also noted people's individual needs were considered when care was being provided and some information was recorded as part of the care planning process. This helped to ensure all people had access to the same opportunities and the same fair treatment.

An information guide was issued to people when they came to live at the service; this was being reviewed to ensure it was in a user-friendly format. Information about local advocacy services was available. People can use advocacy services when they do not have friends or relatives to support them or want support and advice from someone other than staff, friends or family members.

Good

Is the service responsive?

Our findings

People were happy with the care and support they received and they made positive comments about the staff. They said, "I am very happy; I am looked after very well", "I can't fault the care and attention" and, "They do everything asked for, I get attention night and day." People told us they knew who to speak to if they had any concerns or complaints.

Each person had an individual care plan, which was underpinned by a series of risk assessments. The care plans were currently being reviewed to ensure they reflected the care that was being given and to ensure there were no gaps in the information in relation to people's care needs. We found information about people's likes, dislikes, preferences and routines was recorded; this helped ensure they received personalised care and support in a way they both wanted and needed.

Information about people's changing health needs and specialised care needs were recorded and the advice given by health care professionals was documented and followed. Daily records were maintained of how each person had spent their day and of any care and support given; these were written in a respectful way. We noted there were gaps in one person's personal care records; this meant the records were not always reflective of the care being given.

People's care and support had been kept under review and records updated on a regular basis or in line with any changes. People spoken with said they were kept up to date and involved in decisions about care and support. People or their relatives were involved in decisions about their care but had not always been formally involved in the review of the care plan. The area manager told us new records were to be introduced to address this.

There were systems in place to ensure staff could respond quickly to people's changing needs. This included a handover meeting at the start and end of each shift and the use of communication diaries and notice boards.

We looked at how the service managed complaints. People told us they would speak with a member of staff or to the registered manager if they had a complaint and they were able to discuss any concerns during resident meetings. One person said, "They regularly ask me if I am happy and if I have anything that is worrying me."

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. Information to support people with making a complaint was displayed in the entrance hall. We looked at the records of complaints. We found three minor complaints had been recorded and responded to.

A member of care staff was responsible for arranging and planning activities for people. People had mixed views about the provision of activities and entertainments. People told us, "There is something on each month; I look forward to that", "I enjoy playing bingo with staff; we can have a laugh", "There is not much to

do" and, "I prefer to stay in my room and read a book: I'm happy watching television or listening to music. There is always someone to talk to." Staff told us individual and group activities were arranged daily according to people's preferences and that entertainers visited the home. Activities were discussed regularly at regular resident meetings.

On the day of our visit we observed some people chatting to each other and to staff, people colouring, sitting outside in the gardens, reading books and newspapers and others watching TV in their bedrooms or in the lounges. We were told that people had enjoyed organising and participating in the Summer Fayre the previous weekend; some people had made items to sell.

We looked at how the service supported people at the end of their life. The registered manager and staff followed guidance from specialist professionals and the district nursing team. Where possible, people's choices and wishes for end of life care were recorded, kept under review and communicated to staff. Where people's advanced care preferences were known, they were shared with GP and ambulance services. There were systems in place to ensure staff had access to appropriate end of life equipment, training and advice.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information for people using the service, their visitors and staff. One person had their own laptop to enable them to chat with their relatives and friends. E-learning formed part of the staff training and development programme. Sensor or pressure mats were used to alert staff when people were at risk of falling and pressure relieving equipment was used to support people at risk of skin damage. Staff could access remote clinical consultations to access prompt professional advice.

We checked if the provider was following the Accessible Information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. During this inspection, we found there were no policies or procedures in relation to the AIS. However, we saw that people's communication needs were documented on their care records as well as the action staff should take to ensure people were supported to communicate their needs, wishes and preferences. The registered manager confirmed the menus and some of the customer satisfaction surveys were available in pictures and words and that the complaints procedure, and service user guide could be made available in different font sizes or different languages.

Requires Improvement

Is the service well-led?

Our findings

People living in the home and staff spoken with told us they were satisfied with the service provided at the home and the way it was managed. One person commented, "The home is well managed. They make sure everyone is looked after". Staff said, "The home is well managed", "I can approach the manager anytime" and, "It's a privilege to work with [registered manager]. [Registered manager] is very good and very supportive."

There was a manager in post who was registered with CQC. The registered manager had responsibility for the day to day operation of the service and was supported by an area manager and a learning and development manager. The area manager visited the home each week and we were told any issues relating to the day to day running of the home were discussed and appropriate action taken. The registered manager sent a weekly report to head office; this helped monitor the registered manager's practice and monitor the day to day running of the home. The registered manager had opportunities to attend meetings to share best practice with other managers within the organisation. People spoke positively about the registered manager.

We noted during the inspection, the registered manager was visible and active within the home and she interacted warmly and professionally with people. The registered manager could answer our questions about the care provided to people, showing that she had a good overview of people's needs and preferences. The registered manager also worked with staff which helped them to monitor staff practice. There was a relaxed, friendly atmosphere in the home.

There were systems in place to assess and monitor the quality of the service. We noted checks had been completed on areas including medicines management, the environment, care planning, and infection prevention and control. Information sent to us by the provider, prior to the inspection, indicated that a new system of quality monitoring was being introduced. The area manager confirmed the new system would be in place by 17 July 2018 but would need time to embed; training would be given to the registered manager and staff.

We looked at the available audits and noted that some shortfalls had been identified and acted on. However, we also found a number of shortfalls had not been recognised, which meant the current monitoring system was not fully effective. For example, audits had not highlighted the inappropriate bathroom door lock, the lack of window restrictors, the dusty extractor fans or stained bedroom carpets. Checks on records had not identified there were no systems to formally analyse accidents and incidents, no cleaning schedules and inaccurate personal allowance balances. Whilst care plans were being reviewed, the audits did not identify the ones that had been reviewed each month.

The provider had failed to operate effective quality assurance and auditing systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

We were advised that an improved system of auditing was being introduced this month. Following the

inspection, we were assured that the introduction of the new system and training for the management team had commenced.

Systems were in place to formally consult with people and to ask for their views on the service. This was achieved by daily conversations, meetings and annual satisfaction surveys. A satisfaction questionnaire had been distributed in May 2018. We looked at the results from the survey and noted people were satisfied with the service. We were told there were plans to improve the feedback to people. Resident's meetings had taken place and people had been given the opportunity to share their views, be kept up to date and to have input into the development of the home.

All staff had been provided with job descriptions, contracts of employment and policies and procedures which would make sure they were aware of their role and responsibilities. We noted there were systems in place to respond to concerns about staff's ability or conduct. Staff were aware of who to contact in the event of any emergency or concerns. If the registered manager was not present, there was always a senior member of staff on duty with designated responsibilities. We found the staff team was stable with few changes made; they told us they enjoyed their work. Staff said, "I love working here; we are a family", "I enjoy it so much that it's not like work" and, "Most of us have worked here for years; that says a lot about Ash Cottage."

Staff meetings had taken place and discussions had been recorded. Records showed they had been able to raise their views, kept up to date with any changes in the home and they were listened to. However, we noted that the areas for discussion had been quite limited and information was not shared with the staff team about accidents and incidents, audits, concerns and safeguarding alerts. We discussed this with the management team who agreed to address this.

We looked at how the service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including local authorities and commissioners of service; further links with other agencies were being developed. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams.

We noted the service's CQC rating and a copy of the previous inspection report was on display in the home. This was to inform people of the outcome of the last inspection and of any action taken to improve.

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 The provider had failed to operate effective quality assurance and auditing systems. Regulation 17 (2) (a) (b)