Care First (Smethwick) Ltd

Ash Lodge Care Home with Nursing

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection, which took place on 5 and 6 November 2014. We last inspected this service on 10 October 2013 there were no breaches of legal requirements at that inspection.

Ash Lodge Care home provides nursing and personal care to a maximum of 54 adults. The service consists of two separate units over two floors; the nursing unit on the ground floor and the dementia care unit on the first floor. At the time of our inspection 54 people lived at the home.

There was a registered manager in post at the time of our inspection. 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.

Summary of findings

People and their relatives consistently told us they were happy with the care delivered and they felt safe. Staff had been trained in adult protection and understood that they had responsibility to take action to protect people from harm. They demonstrated awareness and recognition of abuse and knew how to report concerns to outside agencies. The manager consistently reviewed accidents, incidents and safeguarding concerns to reduce the possibility of people being harmed.

The manager had undertaken training in the Deprivation of Liberty Safeguards DoLS). She understood her role and responsibilities and had followed the guidance where some people's liberty had been restricted. Applications had been submitted to the supervisory body so that the decision to restrict somebody's liberty is only made by people who had suitable authority to do so. The manager had ensured that where people lacked the capacity to make decisions about their care and treatment, appropriate capacity assessments were in place. We saw that staff obtained people's consent before providing them with support by asking for permission and then waiting for a response, before assisting them.

Risks to people's health and wellbeing were known by staff and well managed. The manager and staff team maintained close links with external health care professionals to promote people's health. People told us they were informed about their health needs and kept up to date so that they had choices about treatments.

People told us that they received their medication on time and in a way that they wanted. Supplies of anticipatory pain management medicines were in place for people on end of life care. People's medicines were managed by staff who had training to do this safely. People and their relatives said staff supported them with their health care needs. The manager had worked proactively to ensure people had access to services to maintain and promote their health and well-being.

People were cared for by staff who knew them well and who they described as kind, caring, respectful and patient. We saw that staff respected and responded to people's individual needs and saw positive interactions between staff and people that lived at the home as well as their families. People, relatives and staff said there were sufficient numbers of staff available to meet people's needs. Relevant checks had been undertaken on staff before they worked at the home.

The provider had sourced external trainers to provide a rolling programme of training that was tailored to develop the skills and knowledge of staff. Staff had access to regular support and supervision to ensure they could discuss their practice as well as their training needs.

People told us the quality and variety of meals was good and we saw that drinks and food was available throughout the day. People had direct support to help them eat, and links with health care professionals to support people's dietary in-take were evident.

People told us they enjoyed a variety of group and individual interests and activities. This included planned trips out with staff and parties and celebrations in the home's bar. Staff completed their own fundraising events to raise money for various events. All relatives we spoke with told us they were actively welcomed and encouraged to remain involved in the home and that they felt their relative had an enhanced quality of life since living at the home.

People told us that staff listened to them and they knew how to raise concerns. The manager responded to people's complaints and took action to improve the service as a result of complaints. The views of people and their relatives had been regularly sought via meetings and surveys to obtain their feedback.

There was a consistent and effective system of monitoring the service provided. People confirmed that a number of improvements had been made since the manager took up post and stated their admiration for her, the provider and the staff team. We saw the manager had worked in partnership with external organizations to support the provision of care. They participated in a 'Shaping Our Age' research project about involving older people in improving their well-being. The results of the discussion groups showed that people at Ash Lodge who participated were positive about their experiences at Ash Lodge. This demonstrated there was a commitment to defining the quality of the service from the perspective of the people using it.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe and arrangements were in place to minimise the risk of abuse. Staff understood their responsibility to recognise and report signs of abuse.

There were systems in place to make sure staffing levels were maintained at a safe level.

Arrangements were in place so that medicines were managed safely.

Good

Is the service effective?
The service was effective.

People were supported to make their own decisions. Where people lacked capacity decisions were made in their best interests and staff took the least restrictive approach to protect people's liberty.

People were supported to have enough food and drink and staff understood people's nutritional needs. Nutritional support from external professionals was evident to promote people's eating. People told us they were happy with the food.

People were referred to appropriate health care professionals to support their health and welfare.

Good

Is the service caring?
The service was caring.

People told us staff were very caring, kind and patient. We saw staff listened and talked with people and knew people well.

People told us that staff considered and acted on their views.

People told us staff respected their privacy, dignity and personal circumstances.

Good

Is the service responsive?
The service was responsive.

People received care and support when they needed it and in line with their care plan.

People told us that they knew how to raise a concern or complaint and that they felt they would be listened to.

Opportunities were provided for people to take part in a range of hobbies and interests in the home in line with their individual preferences.

Good

Is the service well-led?
The service was well led.

People and their relatives consistently stated their confidence in the manager, provider and staff team to maintain a well run home.

Good

Summary of findings

Monitoring of the service was consistent. People were happy with the home and stated the quality of their lives had been enhanced.

The manager had consistently reported accidents or incidents to the relevant external agencies and taken action to reduce risks to people.

Ash Lodge Care Home with Nursing

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 November 2014 and was unannounced. The inspection was undertaken by two inspectors. Prior to our inspection we received information alleging the abuse of people using the service. We referred the information immediately to the local authority who carried out a check on the safety and welfare of people. The local authority informed us following their investigation that the allegations that had been made were found to be unsubstantiated.

As part of our inspection process we ask providers to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not receive a completed PIR prior to the inspection and discussed this during the inspection. Our checks showed there had been an error and the provider had not received the PIR and was unable to inform us of this information. We considered therefore that there had not been a breach of this regulation. Before our inspection, we reviewed the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We requested information about the service from Sandwell Local Authority who have responsibility for funding people who used the service and monitoring its quality. Information we received prior to our inspection from the local authority told us that they had no concerns about the care people received or the way in which people were treated.

We spoke with 16 people who lived at the home, eight relatives, the manager, provider, 12 care staff plus the maintenance man and the cook. We also spoke with health care professionals and commissioners prior to our inspection. Some people were not able to tell us about their care so we spent time observing them being supported by staff. We looked at the care records related to nine people, and sampled accidents records, training records, menus, complaints, quality monitoring and audit information.

Is the service safe?

Our findings

People living at the service and their relatives told us that they had no concerns about the way people were treated. Comments from people included, "I feel safe here", and, "I love it here, people are jolly, they care for me and I feel safe". Relatives told us they were confident their family member's care was safely delivered. One told us, "I feel comfortable with my relative living here, I feel she is safe". Another relative told us, "Staff communicate everything to me; I am informed about any accidents or incidents and given a full explanation. I am confident the staff are professional and honest".

Staff we spoke with were well informed about the types of abuse people could be at risk of, and which external agencies they could escalate their concerns to. They also told us they had regular training in adult protection confirmed by the training records in place. Staff told us they were always encouraged to share any concerns they had with their managers for full consideration. One member of staff told us, "If I saw something in-appropriate I would report it to the unit manager, these people could be my family". Another staff member told us, "I would go through the manager, through the proper channels, Social Services or yourselves [CQC] if the manager wasn't available".

The risks of abuse to people were minimised because there were clear policies and procedures in place which were followed to protect people. We saw that information was on display to provide people, visitors and staff with guidance about reporting suspected abuse. The safety of people was regularly analysed by the manager and action taken to ensure people were safe. For example one staff member told us, "Any issue of poor practice is dealt with straight away; the whole shift is called together and concerns spoken about openly, they (management) do not tolerate poor or abusive practice". There was evidence that incidents and allegations had been reported to the relevant authorities so that people were protected from harm and abuse. Staff were fully aware of and had utilised the whistle blower procedures to report on staff performance issues. We saw alleged abuse had been investigated by the appropriate external safeguarding team who informed us the allegations were not substantiated.

We saw that detailed assessments were in place in people's care records to show how individual risks to their safety should be managed. These included the recommendations from external health professionals so that people's care was planned in a safe way. We observed staff managed risks that may cause harm to people. For example the risk of possible harm when providing care to a person who had unpredictable movement which prevented the use of equipment such as a hoist. We noted that safe strategies were written into people's care records and staff we spoke with were fully aware of the precautions needed to reduce the risk of harm.

We saw that staff practices were safe when supporting people to move from one place to another with the use of equipment such as a hoist. We spoke with the maintenance person and saw that safety checks on bed rails were regularly carried out to reduce the risk of entrapment. Staff checked and recorded pressure mattress settings to reduce the risk to people who had fragile skin.

A selection of records relating to people's nursing needs showed that appropriate wound plans were in place and an established pattern for changing dressings and reviewing progress. The clinical lead nurse described a clear outline of their responsibilities in the management of risks to people's health. This included liaising with the tissue viability nurses and the palliative care team. We saw records of clinical handovers which showed nurses shared information between shifts to ensure consistency when managing risks to people's health or safety. Records showed that accidents, incidents, safeguarding, falls and pressure sores were reviewed weekly by the manager and appropriate action taken to reduce the risk of reoccurrence.

People told us that there were always enough staff to help them. Staff we spoke with confirmed that there was sufficient staff to meet people's needs. Relatives stated that there had been some shortages of staff at weekends but that this had improved. We saw that strategies were in place to manage sudden absences. The manager had a system for reviewing and calculating staffing levels and demonstrated that disciplinary processes were followed where staff attendance had been an issue. People with nursing needs were cared for on the ground floor and people who had dementia on the first floor. We saw that the manager had a system for allocating staff with the right skill mix to either floor. Staff we spoke with confirmed that they were allocated to work in designated areas and that this was reviewed on a regular basis. Senior staff told us that they worked supernumery to support agency nurses whilst recruitment continued. An agency nurse told us,

Is the service safe?

“The senior role has been developed to support the agency nurses, this has been a real benefit in terms of allowing the agency nurse to focus on the clinical tasks whilst having the seniors take on some of the tasks, it provides great consistency and I’m very well supported”.

We spoke with two newly recruited members of staff and checked their records. We saw that pre-employment checks had been carried out to help reduce the risk of unsuitable staff being employed by the service. These included checking people with the Disclosure and Barring Service (DBS), and obtaining references.

We observed two medication rounds and saw people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. One person told us, “I have medication every day and pain killers when I need them; the nurse always asks me if I need them”. Medicines were administered safely; staff checked each medication and checked people had taken it prior to signing the records.

Some people required their medicines to be administered in a specific way, such as in a liquid or crushed. We saw a written protocol was in place to show the precautions needed to safely administer medicines. In relation to people who required their medication to be given covertly the care plan and medication records did not give specific details as to how to do this. We discussed this with the unit manager who advised specific instructions as to how to administer medication covertly would be added. The unit manager also rang the pharmacy and asked them to add a new code to medication administration records, (MAR) sheets identifying when medicines were given covertly. All staff spoken to advised that before administering covert medication they did attempt to obtain the person’s consent and that covert administration was seen as the last resort.

The medication records showed people were receiving their medication as prescribed. Medicines were available for people when they needed them as well as ensuring that supplies of anticipatory pain management medicines were in place for people on end of life care. A pathways plan was evident which showed that the medical needs of the person had been assessed and planned for so that their palliative care pathway was known. Nurses had the appropriate training to administer medicines safely and their competence to do this was monitored. We saw that medication was checked regularly to ensure any errors could be identified and reduced.

Is the service effective?

Our findings

People told us they were receiving care in the ways they wanted and were very happy and confident that staff understood their needs and how to meet them. One person said, "They are wonderful staff I am well looked after, they see to my health and they make me happy". All of the relatives spoken with told us about positive experiences regarding the way that staff recognised people's needs and ensured they had the support they needed. Comments included; "Wonderful staff the level of care is excellent", "There's an incredible plus factor here, staff are positive, welcoming and have a wonderful approach", and, "[my relative] has had falls and they have been dealt with quickly and made efforts to find out why she had been falling. They are very quick to deal with any medical matters". Information we received prior to our inspection from the local authority told us that people were supported with their healthcare needs. Referrals to health services were timely and people's nutrition was positively managed. They had no concerns about the care people received.

We spoke with three recently recruited staff. They confirmed they had an induction before starting work which included the opportunity to shadow staff so they were supported to learn about people and their needs promptly. They also confirmed they had access to advice and procedures they needed. They told us it was a good place to work with support from colleagues and specific training they needed was provided.

We saw staff training was tailored to meet people's care needs. This was supported by the provider who had employed an external trainer to deliver in house training. On the day of the inspection we observed that the trainer was conducting two separate training sessions for staff. Both the trainer and the manager confirmed they worked closely together to identify and design the individual training needs of the staff group. The care staff told us that they were supported and well trained. One staff member said, "Training is very good, dementia care, end of life, I am supported to do my job". Other staff confirmed that they had up to date knowledge about how to provide effective care to people from training they had attended. We saw training was frequent and varied; including safeguarding, equality and diversity, health and safety, nutrition and medicines awareness. Staff told us they had regular supervision and had time to discuss the needs of people and their own development. We saw a clinical lead nurse had been identified to oversee the assessment, planning and review of people who required nursing care.

Staff were well informed about people's health and personal needs and how they should meet these. We saw from nine people's care records that care plans provided detailed information about people's needs as well as being individual to the person with their likes, preferences and routines explained. Observations of staff supporting people living at the home showed that they knew people well and how to support them with conditions such as diabetes, Parkinson's disease, or dementia. Relatives we spoke with told us that they had been 'very involved' in contributing to people's care plans. One relative said, "The staff provide excellent care they are trained and they go out of their way to make sure people have a good quality of life". They also told us that the benefits of recent training for staff were visible, for example one relative said, "The manual handling is much better they move people properly", another relative said, "They have split the staff and the skills on the teams are much better matched to people's needs".

The manager had followed the requirements of the Mental Capacity Act [MCA] including Deprivation of Liberty Safeguards, [DoLS]. One person was subject to a DoLS and we saw appropriate authorisation was in place alongside an assessment of the person's capacity. The provider was complying with the conditions applied to be authorised because we saw the person whose liberty was restricted and how staff managed this. A plan was in place to provide detailed guidance to staff to support the person and staff we spoke with had the knowledge to ensure that the person was safe from having their rights restricted inappropriately.

The manager recognised the need to, and had made applications for, all the people living in the home who did not have capacity to consent to the use of bedrails. The dementia unit had a key pad entrance in place in order to keep people safe. We looked at how people who had capacity were protected from this restriction. We spoke with one person who confirmed to us that they had been given the key code as soon as they moved into the home and told us, "I have always had the code since I've been here". We saw that some people on the dementia unit had been supported to exercise their choice as to who visited

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them in their bedroom and that arrangements were in place to restrict other people entering their room. Staff spoken with had received training and we saw they knew the difference between lawful and unlawful restraint. We saw that staff obtained people's consent before providing them with support by asking for permission and waiting for a response, before assisting them.

We observed that people had been supported to have sufficient to eat and drink. People who use the service all spoke positively about the meals on offer. One person told us, "I was very ill when I came here and have put on two stone since being here". People told us that they enjoyed the meals; "The food is lovely" and, "I have never had a bad meal here". We observed during the day people being offered drinks on a regular basis and there were jugs of water and squash in communal areas and in people's rooms.

The cook was able to tell us which people had specific dietary requirements including their likes and dislikes and there was documented evidence to this effect available in the kitchen. Staff we spoke with were aware of individual dietary requirements and those people at risk of choking. We saw care plans were effective in identifying the support people needed to eat and drink enough and included recommendations from other health professionals such as dieticians. Daily food and drink intake was recorded and regularly reviewed to identify if people's nutritional requirements were being met. Weight records showed people's weight was monitored as part of their risk management plan for eating and drinking. Staff told us that the manager had encouraged them to ask people using the service what were their favourite meals when they were younger. This information was collected to introduce a new menu with more variety. One staff member said, "The manager has increased nutrition people are eating freshly made soup and really enjoy it". A relative told us, "I'm really pleased with the food, there's always a choice and I never worry because the staff provide a pureed diet and they are very good at making sure he doesn't choke; taking their time and encouraging him". We observed lunch in the two units and saw that people had a choice as to what and where they ate in a relaxed unhurried atmosphere with staff available to support people in the way they needed.

We heard from people that they received support with their health care needs. One person using the service told us about their medical condition and how staff managed this. They were confident that staff knew how to care for them and described how this was done. They told us, "I tell them when I'm not feeling well and they do half hour checks on me when I'm not well." We saw that this person had a detailed healthcare plan with guidance for staff.

Relatives told us that people received support with their health care. One relative told us, "I'm pleased with the health care, [person's name] see's the doctor when he needs, I have no worries there". Another relative told us, "They have nurses on site but the doctor and other health people come in whenever she needs them, never a delay". We saw that each person had a healthcare folder which included a health action plan. The manager had worked proactively to ensure people had access to services to maintain and promote their health and well-being.

Is the service caring?

Our findings

We heard consistently from people who lived at the home and their relatives that the caring approach was a particularly strong and valued characteristic of the staff, manager and provider. People told us that staff were caring, friendly and kind. One person said, "Wonderful staff, very kind and caring". Relatives told us they had positive and warm relations with the staff, the manager and the provider. Relatives told us they felt they were listened to, involved and that staff supported them as well as their relative who lived in the home. One relative told us, "I'm very happy with the care, they [staff] can't do anything more for [person's name] than they do". Another relative said, "They treat [person's name] like one of their own and they look after us [families] as well".

It was particularly pleasing to hear from staff themselves that they recognised in each other the skills necessary to provide a caring approach to people when carrying out care tasks. For example we saw staff carry out care and nursing tasks but ensured they spent time with people, talked to them and were warm and tactile in their approach. A relative told us, "[Person's name] is well looked after, staff are always coming into his room to say hello and have a chat. It's so important to have warm, friendly staff especially for people like dad who have nursing care because they really depend on staff being kind to them".

All of the staff we spoke with were able to give us a good account of how they promoted a caring approach to people they supported. They told us they had regular training in dignity, respect and privacy and we saw they had a good understanding of how important it was to promote this when delivering care. We saw that staff regularly checked that people were comfortable whether this was in their bed or in communal areas. Doors were closed when personal care was delivered to protect people's dignity and privacy. Staff knocked on people's bedroom doors and waited for a response before entering. We saw people had been supported with their appearance and dress so that when they were cared for in bed they had the option of wearing day clothes and not night clothes. This ensured people's preferences were respected. A relative told us, "Mom loves her jewellery and clothes and staff would always dress her even though she's in bed, its important". Staff had paid attention to people's appearance in line with their preferences. Staff told us they worked in a 'caring home'. They said the manager was a great role model and they had 'learned a lot' from her. A staff member told us, "The manager has really inspired me". Another staff member said, "She [manager] has made a lot of progress, a lot of difference to the quality of people's lives, she's very passionate about what she does".

We observed positive interactions between staff, people who lived at the home and their relatives, demonstrating good relationships were evident. We saw staff provide care and attention to people, not just when carrying out direct physical care tasks, but going out of their way to visit people in their bedrooms, thereby reducing the risk of social isolation for those being cared for in bed. We observed one person responded to the social contact from staff with smiles and visibly became more vocal in expressing their happiness.

People and or their relatives had been involved with developing care plans. One person told us, "I chose to move here I am looked after and they [Staff] always respect my decisions". We saw the person had actively made their own decisions regarding their living arrangements so that the person's choice and independence was promoted by staff. Relative's confirmed that they were actively involved in contributing to the review process. One relative told us, "I have every confidence because when I have spoken on my relative's behalf, they listened and acted on it". Another relative told us. "There's a real plus factor here; both the manager and provider are good people. Their door is open and they will involve us families and there are a lot of us but we are actively involved. It's good to feel valued by them".

We saw people had been supported to express their preferences and choices for their end of life care. Documentation to support this process was in place and relatives and health care professionals were involved in the decision making if people were deemed to have insufficient capacity to make their own decisions. A supportive care pathway was evident which showed that the medical needs of the person had been assessed and planned for so that their palliative care needs were known. Consideration of issues related to advanced directives of care and do not attempt resuscitation, (DNAR) was evident and known by the nurse we spoke with. We saw that the manager had ensured that nurses liaised with the GP and palliative care team to ensure that any orders such as a DNAR followed current guidance. Pain management plans were in place

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which included information about supplies of anticipatory pain management medicines to enable staff to support people with a comfortable and pain free death. Additionally we saw that the facilities available to families at this difficult time supported their needs. They had access to kitchenettes to make their own drinks and snacks, and we saw families were offered cooked meals and the opportunity to stay with their loved one at the home. We observed that nurses were aware of and sensitive to people's rapidly changing needs and were deployed to prioritise these.

Is the service responsive?

Our findings

People consistently told us that they were happy with the way in which staff responded to them. Relatives we spoke with told us staff responded well to people's needs. One relative said, "When people's needs change quickly, staff are very good at acting on this."

People said they were involved in planning and agreeing their care. They told us that the staff knew them well and cared for them in the ways they wanted. One person said, "They involve me in the care and support I receive." Another person said, "I am always consulted about my needs and the care I want". We saw regular meetings with people had taken place and confirmed that people's needs were assessed and planned for to ensure that support was personalised to them.

Staff had access to plans to cover people's changing needs. For example, people on end of life care had rapidly changing needs. We saw that preventative measures were known and recorded and that staff worked to these to ensure people had immediate support and treatment when they needed it. We saw the palliative care team worked closely with the nurses to ensure anticipatory medicines and care plans were in place should a person deteriorate so that they had the support they needed to keep them pain free and comfortable. We saw staff had been designated to support people on end of life care at the start of the shift so that delays were minimised in people getting the help they needed when there was a relapse.

Feedback from visiting professionals confirmed that the staff were responsive to the changing needs of people. For example people with reduced mobility, fragile skin or risks of not eating enough were provided with equipment they needed to reduce further health complications.

People told us about the things that were important to them in terms of maintaining their well-being. They told us that it was important to them to have varied things to do to occupy themselves and that they enjoyed a range of group and individual activities. We saw that organised events of interest had taken place such as fetes, visiting artists, and trips out to such places as the Safari Park. A fireworks display was taking place during our inspection and people told us they were really looking forward to this. One person said, "There's a bar here and we regularly have parties and get to-gethers which I really like". An activities worker was available to organise activities and we saw that table top decoration making was planned. Relatives told us they were also actively involved in activity events such as planting garden bulbs and looking to develop a 'window garden' with honey suckle and crocus. People told us quizzes, crosswords and regular visits out took place which showed that staff encouraged and supported people with their interests. We saw that some people attended a visiting church service to the home on a regular basis and the manager told us people's religious preferences would be catered for onsite.

We saw there was a very active and involved group of family members and friends who visited the home daily. All of the relatives told us they felt welcomed, had confidence in the manager and staff team and their views were valued. One relative told us regular family meetings took place in which they could raise any issues. This showed that people were supported to maintain contact with people who mattered to them.

People and their relatives told us they were able to speak with staff if they were unhappy and had opportunities to raise issues in meetings or surveys they had completed. Everyone was confident that any issues raised had been responded to. We saw that there was a formal complaints procedure where people could raise concerns and that concerns raised were addressed in a timely manner. There were examples of how complaints had been used to improve the standard of care, for example in communicating more with people, improving the skills of staff and improving the variety of food.

Is the service well-led?

Our findings

The registered manager had worked at the home for just over a year. The registered manager worked closely with the provider and both played an active part in the running of the home. Feedback from all of the people, relatives and staff we spoke with consistently highlighted their satisfaction at the improvements the manager had made and her inclusive style of leadership. One person living at the home told us, “I think she is a very good manager, always got time to talk to us and any concerns are dealt with". A relative told us, “She’s a strong manager, very effective and receptive and gets things done; she’s always there for support”. We also received lots of comments about the provider’s active involvement with people, their families and staff. One person living in the home said, “I see the owner quite a lot and he always pops in for a chat”. A relative said, “As an owner you couldn’t ask for better, he’s a good man always putting the people’s needs first”.

There was a positive and inclusive culture in which people felt able to express their views. People told us and we saw from minutes of meetings and questionnaires they had completed, that they were encouraged to share their views and these were acted upon. Some examples were shared with us which included reviewing staffing levels and the deployment of staff to the two units in the home so that people benefitted from the right skills mix of staff. There had been changes to the menus so that people were more involved in choosing meals and a number of environmental changes had been made to make it a more comfortable place to live. One person living at the home told us, “I have been on the interview panel three times and can ask the questions that I want to ask”. This demonstrated that people felt their opinions mattered and that they were listened to when important decisions that affected them were made. People told us that they were happy at the home. Some people told us they had actively chosen to live there because of its reputation within the community. Relatives we spoke with confirmed this view and told us that the standards of care within the home lived up to their expectations. A relative said, “There’s a great atmosphere, I’m very involved in discussing [person’s name] care and the attitude of staff is excellent”. Another relative said, “Communication and involvement is key, the staff and manager are excellent”.

Staff were all positive about the support they received from the manager and told us they were confident to question and report poor practice. Staff were aware of the whistle blower procedures and told us they would be encouraged to speak up about poor staff performance. We saw that these processes had been used to monitor and act on the performance of staff. Staff reported to us that they regularly received constructive feedback from their seniors/nurses and the manager to guide them in improving their care practice. We saw the manager had actively tailored training courses from an external trainer to support staff skills and awareness.

The manager did lead by example as confirmed by staff we spoke with. One staff member commented in particular, “If something wasn’t done right, [manager] would deal with it there and then”. Another staff member added, “The manager is everywhere, her eyes are everywhere”. We saw that lessons had been learned to improve the service provision to people from incidents in the home. On the dementia unit we saw steps had been taken to reduce avoidable harm to people from behaviours that could challenge. For example the manager had reviewed incidents and improved the environment by providing a calmer atmosphere with music playing instead of the T.V. Staff reported this had a calming effect on people and incident records showed a reduction in behaviour related incidents. We also saw the manager had relocated the office to the top floor thus providing a direct view of the communal areas to observe staff practice. One staff member told us, “The manager will often come out and guide us if she has observed we could do something differently”.

We saw that staff had opportunities to contribute to the running of the service through regular staff meetings and supervisions. Staff meetings and clinical meetings were established and had been used to continually review and improve the care provision. An example of this was the super-numery allocation of the senior carer to support agency nurses. This ensured there was a clear line of accountability and responsibility concerning the completion of clinical tasks. A nurse told us, “This system works very well, I can focus on clinical tasks and have 100% support from having an additional senior on shift”.

Is the service well-led?

The registered manager used a management tool which enabled her to seek feedback on all aspects of the service on a weekly basis. She was therefore able to review and identify if allocated care and clinical tasks had been carried out to the expected standards.

The home was consistently well led. Processes were in place to assess the quality of the service and these had been effective in identifying risks relating to the health, welfare and safety of people. The manager had informed us of notifiable events and understood the requirements for reporting any concerns to the appropriate external agencies. We saw she had used the learning from safeguarding incidents to improve practices and minimise the risk of reoccurrence.

Prior to our visit we spoke with commissioners about the home following their investigation into alleged poor care practices. This investigation had included direct contact with people and their families to obtain feedback on their experiences. The outcome of the investigation was there were no concerns at all and that the allegations had been found to be fully unsubstantiated.

People had access to a complaints procedure and we saw these were dealt with within the stated timescale, with correspondence to all affected parties. We [CQC] had not received any complaints about the service.

The provider has a good history of informing us of notifiable events. The manager's legal responsibilities were consistent when reporting accidents, incidents or suspicion of harm to the relevant authorities. There was evidence that the manager had proactively reviewed safeguarding concerns and made improvements to the safety of people in the home.

We had not received a completed PIR. We discussed this with the manager and provider. Post inspection our checks showed there had been an error and the provider had not received the PIR and was unable to inform us of this information.

We saw the manager and provider had worked in partnership with external organisations to support the provision of care. They participated in a 'Shaping Our Age' research project about involving older people in improving their well-being and the well-being of others. This involved conducting discussion groups with people at Ash Lodge for the 'Shaping Our Age' project. We saw the results of the participants feedback was positive regarding their experiences at Ash Lodge. This demonstrated there was a commitment to defining the quality of the service from the perspective of the people using it.

A relative told us, "The manager and provider walk the floor every day, their door is always open, we have an excellent home here that we are all proud of". Another relative told us, "Whenever I have raised issues they make improvements, since the new manager has been here they have stamped on poor practice, it's just not tolerated. We as families are kept in the picture we speak to the manager daily and have meetings, we are fully informed".