Bamford Care Limited

Ashbourne Nursing Home

Inspection report

Ashbourne Street
Norden
Rochdale
Lancashire
OL11 5XF

Tel: 01706639944

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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

Summary of findings

Overall summary

Ashbourne Nursing Home is a privately owned care home providing nursing and personal care for up to 42 older people. It is situated in the village of Norden, two miles from Rochdale town centre. At the time of the inspection 39 people were accommodated at the home.

The service had a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff were safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and homely in character. Staff were trained in the prevention and control of infection to help protect the health and welfare of people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business contingency plan for any unforeseen emergencies.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well fed.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of their responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home. Plans of care were individual, person centred and reviewed regularly to help meet their health and social care needs.

We saw that people could attend activities of their choice and families and friends were able to visit when they wanted.

Staff were trained in end of life care to offer support to people and their family members at the end of their lives.

Audits, surveys and meetings helped the service maintain and improve their standards of support.

People thought the registered manager was approachable and supportive. There were systems to audit the quality of service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and would recognise what a deprivation of liberty was or how they must protect people's rights.

People were given a nutritious diet and said the food provided at the service was good.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

Is the service caring?

Good

The service was caring.

We saw staff had a caring attitude and were careful to protect the privacy and dignity of people who used the service.

Records were stored confidentially and staff were trained and aware of protecting data.

Visiting was encouraged to enable people to remain in touch with their family and friends.

Is the service responsive?

Good

The service was responsive.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care and support.

There was a range of activities for people to attend if they wished which was suitable for their age, gender and religion.

There was a complaints procedure prominently displayed for people to raise any concerns they may have.

Is the service well-led?

Good

The service was well-led.

The audits we saw showed the registered manager looked at ways of maintaining and improving standards at the home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

All the people and staff we spoke with told us they felt supported and could approach managers when they wished.

Ashbourne Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was an unannounced inspection and was conducted by one adult social care inspector on 27 and 28 November 2018.

We requested and received 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 any improvements they plan to make. We used this information to help plan the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We also asked Rochdale Healthwatch and local authority for their views of the service and they did not have any concerns.

We spoke with three people who used the service, a relative, the registered manager, the administrator, the activity coordinator and three care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records of four people and medicines administration records for ten people who used the service. We also looked at the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

A relative said, "I have confidence in the staff. I can trust the staff to look after [name of person]. It is important to know you can leave your relative in their care."

From looking at the training records and talking to staff we saw that staff had been trained in protecting people from abuse. Staff had access to a safeguarding policy and procedure. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service also had a copy of the local social services safeguarding policies and procedures to follow a local initiative, which meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy, which is a commitment by the service to encourage staff to report genuine concerns with no recriminations. Staff we spoke with said, "I am aware of the whistle blowing policy. I would be prepared to raise any issues with the manager. There are also two safeguarding ambassadors to go to for support," and "I have not long since completed my safeguarding training. I would use the whistle blowing policy if I needed to report any abuse." Staff were aware of the need to protect people from abuse.

There was a recent safeguarding referral and we saw the registered manager was working with the local authority safeguarding team to determine what had occurred and how best the service could learn from the reported issues. The registered manager was relatively new but was aware to report any incidents to the CQC and local authority.

A relative said, "There used to be lots of agency use but it is rare now when you do not know the staff." Staff we spoke with told us, "We are getting new staff in. We are not short staffed but you could do with one more staff member now and again. We get time to sit and talk to people who use the service" and "We still get chance to have a sit and chat. As a rule, there are enough staff. We now have more permanent staff" and "I think there are enough staff which is made easier because we work as a good team. There is a good rapport and we have time to have a bit of banter with people." We looked at the off-duty rota and saw there was a consistent staff team of a manager or senior carer, four to six care staff dependent upon the work flow and a trained nurse at all times. Care staff were supported by an administrator, a person was working in the laundry, a cook and kitchen assistant, domestic staff, an activities coordinator and a person who completed any maintenance work. There were sufficient staff to meet people's needs.

We looked at four staff files and found recruitment was robust. The staff files contained a criminal records check called a Disclosure and Barring Service check (DBS). This check also examined if prospective staff had at any time been regarded as unsuitable to work with vulnerable adults. The files also contained two written references, an application form (where any gaps in employment could be investigated) and proof of address and identity. The checks ensured staff were safe to work with vulnerable people.

There was a business continuity plan to help ensure the service could function in an emergency such as a loss of utilities or staff shortage in bad weather and each person had a personal emergency evacuation plan (PEEP) to help people be safely evacuated in the event of a crisis such as a fire. There was a copy of the PEEP

in each care file. There was a grab bag which contained every person's evacuation plan, a detailed plan of the home to inform the fire service where people were located and equipment that may be used in an emergency such as a torch and high visibility jacket. There were arrangements to keep people safe in an emergency.

We saw in the plans of care that there were risk assessments for any specific need a person had. Personal risk assessments included moving and handling, the risk of falls, tissue viability (the risk and prevention of pressure sores) and nutrition. We saw where a risk was identified specialist advice, such as from a dietician was sought and specialist equipment provided for the prevention of pressure sores. There were also environmental risk assessments which highlighted possible hazards such as slips, trips and falls. We saw the risk assessments were used to keep people safe and did not restrict their lifestyles.

There was a system for the reporting and repair of equipment. Electrical and gas installation and equipment was maintained by qualified external contractors including the fire system, call bells, portable electrical appliances, the lift, hoists and slings.

The fire system was checked regularly and staff were trained how to respond to the fire alarm sounding including evacuation of the building. The maintenance person also undertook regular checks to ensure the hot water outlets were not a risk of scalds and windows had a device fitted to prevent accidental falls. Radiators and pipework were safe and there was a system to reduce the risk of Legionella.

Any cupboards or rooms that contained hazardous chemicals were kept locked to prevent possible accidents.

Staff had access to training in the prevention and control of infection. Staff also had access to personal protective equipment (PPE) to help reduce the risk of cross contamination of infection, for example gloves and aprons. The service used the National Institute of Health and Clinical Excellence (NICE) guidelines for the prevention and control of infection which meant they could advise staff around best practice issues to help keep people who used the service safe. A member of staff was an infection control ambassador (the staff member received more training) who conducted infection control audits and was available to other staff for guidance.

A person who used the service said, "The room is excellent. They keep it nice and clean." The laundry was sited away from food preparation areas and had sufficient equipment to keep clothes and linen clean. There was a sluicing facility in the industrial type washing machine. There were handwashing facilities in key areas, including the laundry and people's bedrooms. The service used different colour coded equipment such as red and yellow bags to control possible contaminated waste.

There was a medicines policy in place (the service also had the NICE guidelines for the safe administration of medicines) which guided staff to provide safe administration, storage, ordering and disposal of medicines. All staff who administered medicines had undertaken training. A person who used the service told us, "I only take pain killers but I get them when I need them."

Medicines were stored safely in a trolley attached to the wall in a locked room. All medicines were stored separately for each individual person in the trolley and away from external medicines, creams or dressings. There was a system for ordering and checking the numbers of medicines each month. Managers conducted audits and staff competence regularly to ensure the system remained safe.

We saw that any medicines that had a specific use by date such as creams were dated when opened by staff

and both the fridge and medicines room temperature was checked to ensure medicines were stored within manufacturers guidelines. We looked at ten medicines administration records (MAR) and found that all entries were accurate with no omissions. 'As required' medicines gave staff clear instructions what the medicine was for, the amount that could be given, when they were due and the total amount that could be given in a twenty-four hour period to avoid a possible overdose. Staff retained the information leaflets supplied with the medicines and had a copy of the British National Formulary to refer to for any contraindication or possible side effects.

There was a separate controlled medicines cupboard and register. Controlled medicines are stronger and more open to misuse. We saw controlled drugs were safely administered by two staff and audited daily. We checked the numbers of medicines against the register and found they tallied.

One person self-medicated. We saw there was a system in place to ensure the person continued to administer their own medicines correctly.

All accidents and incidents were recorded by staff and audited by management to see if any triggers could be spotted and reduce the incidents. Equipment was put in place for any known risks such as sensor mats for a person at risk of falling.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the service had informed the CQC of any DoLS authorisations as they are required to do. Staff had been trained in the MCA and DoLS and were aware what a deprivation of liberties was. Two staff had further training (ambassadors) for mental capacity and DoLS.

Each person had a mental capacity assessment and if required a best interest meeting was held. A best interest meeting may include the person, family members, staff from the home and any relevant professionals. If a decision was reached to apply for a DoLS by gaining the views of all concerned this ensured any actions would follow the least restrictive path and consider what the person may have wanted. The DoLS were reviewed to ensure they remained necessary. We saw the relevant paperwork in the plans of care and saw that the service had followed the appropriate guidance.

We saw that where possible people had signed their consent to care and treatment. We observed staff asking for people's consent before they performed any care or support.

All staff were enrolled onto the homes induction program. The homes own induction covered key policies and procedures, all mandatory training such as health and safety, moving and handling, safeguarding, the rules and regulations for working at the service. Staff members signed each area with a manager when completed. The staff member was shadowed and supported by a mentor until competent. Staff who had not worked in care before completed the care certificate. The care certificate is a nationally recognised induction program for people new to the care industry.

Staff we spoke with told us, "I think I have the training and support to do the job" and "I think the training is good here. I am a moving and handling train the trainer." We looked at the training records and saw that staff were up to date with their training or suitable refresher training was organised for topics such as food safety, moving and handling, health and safety, food hygiene or fire awareness. There was further training on offer which included the care of people with a dementia, medicines administration, the mental capacity act and DoLS, equality and diversity and end of life care. Most staff had completed or were encouraged to complete a recognised course in health and social care such as a degree or NVQ.

Nursing staff were supported to keep up to date with any training and had access to training by the local clinical commissioning group or representatives from companies who supplied specific equipment. Some staff received extra training to become ambassadors. A staff member said, "I am a dementia ambassador and link for daisy (this is a dignity in dementia scheme) so I train the other staff. I like training other staff. I am the oral care and infection control ambassador. I conduct audits for infection control."

Staff we spoke with told us, "I get regular supervision. It is a one to one and I can bring up my training needs" and "Supervision is a conversation where you can talk about anything. You can discuss your training needs" and "I have supervision. It is a one to one chat. You can discuss your own needs." We saw the records for supervision which was twice yearly, an appraisal yearly and spot checks to check staff competency around care delivery in between.

People who used the service told us, "The food is great. You get a choice of meals. You get what you want for breakfast" and "The food is smashing. I have to be careful what I eat. There is plenty of choice," and "The food is always nice. You get a choice. The tables are nicely set."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met and saw that there was good interaction between staff and people who used the service at mealtimes. The meal was held as a social occasion and people who used the service also talked with each other.

Tables were nicely set with tablecloths, a flower arrangement, napkins, place mats and condiments for people to flavour their food to taste. The food served on the day was warm, appetising and nutritionally balanced.

Breakfast was a choice of the usual breakfast foods such as cereal, toast or porridge and there was a cooked option. Lunch was the main meal of the day with two choices of meal or dessert. The evening meal was a lighter option but there were two choices. People could take a drink of their choice with their meal and water or fruit juice if they wished. Between meals there was a snack such as biscuits or fruit when drinks were served and a supper available later in the evening. The registered manager said if people did not want what was on the menu they would be offered something else.

We went into the kitchen which was clean and tidy. We saw there was a good supply of fresh, frozen, dried and canned foods. Fresh fruit was available from the kitchen and freely available when the drinks trolley was taken round. The kitchen had achieved the highest food standards agency rating which meant the systems for preparing, storing and service of food was safe and the cook followed good hygiene standards. The cook was notified of any diets and had allergy advice when required. Drinks thickeners were recorded and we saw that staff were notified of the amount to use to help prevent people from choking.

We toured the building on the first day of the inspection. People who used the service told us, "The room is all right – they keep it clean and tidy," and "It is always warm and there is a lovely environment." The décor was homely and we could see was well maintained. We saw communal areas contained sufficient comfortable furniture and people had personalised their bedrooms to their own tastes. Bedrooms and bathrooms were accessible for people who required assistance with their mobility and there was a choice of a shower or bath.

A person who used the service said, "They arranged the doctor's appointment for me. They are concerned about my health and are a nice set of people." We saw from the four plans of care we examined that people had access to their own GP and a range of specialists and professionals to ensure their health care needs

were met.

Good

Is the service caring?

Our findings

People who used the service told us, "The staff are brilliant. It is like a carry on film with all the laughing and joking. You can have a bit of banter with the staff" and "The staff are brilliant, extremely helpful. Nothing is too much trouble" and I like it here. They are my kind of people. The staff are all lovely people. They are all nice." A relative said, "It is all right here. I am very pleased. My family member is well looked after. The staff are kind and caring."

Staff we spoke with said, "If I had a family member that needed care I would be happy for them to come here. I am happy working here. I like to see service users happy" and "I like working here. I like interaction with residents and what I have done for them. I like making the residents laugh and working as a team. I would be happy for a relative to live here if I had to but would hope that we could look after them ourselves at home" and "The staff are good at looking after people with dignity but as a dignity ambassador I am there to support staff. I can nominate staff for good practice in the care of people and they receive an award. I can honestly say I have never woken up not wanting to go to work. When I leave here I go home with a clear conscience. I have recommended people to come in here."

One person told us they had chosen to stay at the home and came and went as they wished. Another person said they liked to do most of the care for themselves but staff did support them when they needed it. Plans of care showed the level of support people needed. People who used the service were supported to be independent where possible.

We observed staff when we were in communal areas. There was a good atmosphere between staff and service users although staff were polite and professional. We did not see any breaches to a person's privacy and people were assisted with their personal care discreetly. This helped to protect people's dignity.

Plans of care contained details of a person's past life, social history and their likes and dislikes. Although there were no people with any needs for their ethnicity we did see that people had access to the clergy to attend services of different denominations and could take communion if they wished to practice their faith in this way. All sections of the care plan looked at the known choices and preferences of people who used the service. This included if they preferred a bath or shower, how they wished to be dressed or what they liked to be called. This helped ensure people were treated as individuals.

All records were stored confidentially in an office and staff were taught about confidentiality and data protection. Staff were also informed about not putting confidential information on social media.

There was a section in the care plan which covered people's communication needs. For people who could not communicate verbally the service had a set of communication cards which people could point to if they were able to communicate this way. The menus were also provided in a photographic format to help people choose their meals.

Information around accessing the advocacy service was located in the hall way. An advocate is an

independent professional who acts on behalf of a person to ensure their rights are protected and where possible their wishes are considered with respect to any support people required. We were told three people currently used the advocacy service.

A relative said, "They (the staff) are welcoming and I can get a brew. They work very hard." Visiting was unrestricted to encourage people to remain in contact with their family and friends.

A relative said, "I attend the meetings. They have arranged games in the evening following the last meeting." The registered manager held meetings with people who used the service and answered any questions they had. We saw the records of the last meeting and a recent meeting with families. From the meetings with people who used the service meals had been changed to better suit people's tastes and from the relatives meeting the service was going to trial evening activities. The registered manager said the relatives meeting had been well attended and they were planning to hold joint meetings with people who used the service and their family members monthly from January 2019. This showed the service responded to people's views about the way the home was run.

Good

Is the service responsive?

Our findings

Each person was issued with a copy of the complaints procedure in the admission documents and a copy was retained in their bedrooms prominently displayed on the door. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of other organisations including the local authority and CQC. One recent complaint was being investigated by the local authority safeguarding team and we saw the registered manager had responded to the concerns raised.

We also saw compliments from the local authority for staff attending work in extreme weather conditions and from family members thanking the home for the care given.

People who used the service told us, "I don't join in the activities but went out to join in the war memorial services" and "The only negative is it is a bit limiting who I can talk to although I go to work during the day. I am bored stiff that is the only problem" and "I went out yesterday to bingo and we have other trips out. I like to enjoy myself. At my age you should. I like to get involved in the things they do. We do arts and crafts and things like that."

The activities coordinator said, "Initially I ask people who use the service and staff what people like to do. We come up with some ideas and see if they work. Most of the time I get a good turn out and for those that do not ever want to join in I have a one to one with them. We have a chat and see what they like and do it together or in a small group. I love doing the job. Knowing service users get a buzz out of it. It is good to see someone getting pleasure out of what I do."

The activities coordinator said people liked going out and on one day of the inspection some people went to the local bingo hall for lunch and a game of bingo. The service had arranged a game session in response to people saying they were bored in the evening. We were told there would be more sessions if that is what some people wanted.

People went out to places of interest, football matches, tea dances, museums and shopping. Activities in the home included pamper sessions, arts and crafts, armchair exercise, bingo, reminiscence therapy, movie nights, a gentlemen's club (men had a beer and played cards or dominoes), external musical entertainers and games. Local schools come in to the home to entertain people. The service also held larger events, for example we saw the service was preparing for a Christmas fair to raise money for the social fund. There had also been an Ashbourne's got talent competition with staff providing the entertainment and people who used the service and family members were the judges. The activities coordinator showed us photographs of many on the events.

Where people were not able to attend activities, the coordinator had a one to one session with them, either having a chat about the person's interests or an activity such as crosswords in people's rooms.

The plans of care we looked at showed that prior to moving into the care home a pre-admission assessment

was undertaken. Staff took a background history of a person's social and medical needs, a record of their medicines, any allergies, daily living abilities, what level of personal care was required and any religious, cultural or social needs. This provided the registered manager and staff with the information required to assess if the service could meet the needs of people being referred to the service prior to them moving in.

A person who used the service told us, "I get the care I want when I ask for it." A relative said, "They keep me up to date with any changes to our family members care." We looked at four plans of care. The plans of care contained detailed information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had been incorporated into their care plans. There were headings for each need such as moving and handling, eating and drinking and sleep patterns. There were details for staff to deliver care to meet people's needs. The plans were regularly reviewed to keep staff notified of any changes.

There was a handover at the start of every shift which was recorded by the registered manager daily. The handover informed staff if a person was unwell, doctor's visits or for items such as appointments people needed to attend. Staff also wrote daily notes to pass more detailed information on to their colleagues. There were systems to aid good communication between staff and management.

Other care records we looked at included a record of people's diet if this required monitoring, a record of two hourly checks to ensure people were safe, oral care records, any creams applied and pressure relief records. We also saw where a person took their diet via a tube (PEG feed) there was a chart on the wall to show the correct position a person should be cared for. The records we looked at showed staff completed the charts when they had delivered the care.

Four staff were completing the end of life passport at the local hospice. This is a locally recognised course for ensuring people are supported at the end of their life. The course also gives staff information about caring for people's spiritual or religious beliefs and providing bereavement support for families. The registered manager also said the hospice provided advice on any pain relief that may be required.

We saw that where people or family members were willing to provide information around their end of life wishes this was recorded. In the plans of care people had made advance decisions around what kind of funeral they wanted, burial or cremation, who they wanted to attend and if they had a preference for a particular funeral director. This ensured people's known wishes were followed at the end of their lives.

Good

Is the service well-led?

Our findings

At the last inspection the service did not have a registered manager. At this inspection a person had been registered as manager with the CQC in September 2018. A registered manager is a person who has registered with the CQC 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.

We asked people who used the service, a relative and staff if they thought the service was well run and if managers were available to talk to. People who used the service thought all staff and managers were approachable and we saw they knew the registered manager. A relative said, "Communication is vital and you can talk to any staff member or management. I am happy with the service provided." Staff told us, "The registered manager is brilliant. You can approach the manager with anything. The manager has given me a lot of confidence and I have learned a lot" and "There is a good staff team and we cover for each other. We get good support from the managers and the registered manager is approachable" and "I follow the organisational management system for support or passing on information. You can go to the manager with anything and they are very supportive. The registered manager is approachable and takes account of my family situation."

We found that two accidents which had occurred in the past had not been reported to the CQC. We spoke to the recently appointed registered manager who was employed and registered after the missed notifications who told us what they would report, which reflected the requirements of the CQC and we were satisfied that in future any accidents would be recorded. Other notifications such as DoLS had been sent to us in a timely manner.

There was a service user guide and statement of purpose available in the foyer for people who used the service, family members and professionals to read. These documents informed people of the facilities and services provided at Ashbourne Nursing Home.

We looked at some of the policies and procedures which included medicines administration, infection control, safeguarding, health and safety and whistle blowing. The policies were available to staff to follow good practice.

The service trained some care staff to be ambassadors. This is extra training to enable staff to provide better care for people who used the service and support staff in the topics they were trained in. There were ambassadors for the care of people with a dementia. The service was part of the DaisyMark scheme which promotes dignity and respect within an organisation. There were also ambassadors for infection control, oral health, moving and handling, mental capacity and DoLS, tissue viability (the prevention of pressure sores), continence and training. Staff were given opportunities to take a lead role in topics of their choice.

Staff meetings for all roles were held regularly. We saw the records of meetings and items on the agenda included care of people, the administration of medicines, staffing, use of agency staff and any other topics

staff wished to bring up at the meeting. The registered manager also made sure night staff had the opportunity to meet and had an evening put aside every two months for relatives and visitors.

The registered manager completed many audits to see how the service was performing. The audits included accidents, complaints, health and safety in the environment, infection control including cleanliness, the condition of equipment such as pressure relieving devices and mattresses, plans of care, training and DoLS. One audit was sent to the local authority for commissioners to view. We saw an action plan was produced and the timescale and person responsible for completion was recorded to follow up on any improvements that could be made.

The registered manager asked people and family members for their views of the service in a yearly quality assurance survey. We saw the results were positive and comments made included 'Our relative always says how well looked after they are and the home is relaxed and welcoming to visitors' and 'Sometimes there are too many agency staff'; 'It is homely, the menu looks great, the home is clean and staff give the best care' and 'Staff always keep in touch. Occasionally clothes go astray'. We saw the manager responded to any shortfalls, for example the service had held a recruitment drive and the numbers of agency staff had reduced.

The service displayed their CQC rating in the home and on their web site as required in the regulations.