Ashton Lodge Limited

Ashton Lodge Nursing Home

Inspection report

Spelthorne Grove,
Sunbury On Thames
Middlesex TW16 7DA
Tel: 01932 761761
Website: www.ashtoncare.org

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection that took place on 18 August 2015.

Ashton Lodge Nursing Home is owned by Ashton Lodge Limited and is registered to provide accommodation with nursing care for up to 100 people. At the time of our visit, there were 93 older people living at the home. The majority of the people who live at the home are living with dementia, some have complex needs and the service also provides end of life care. The accommodation is provided over two floors that were accessible by stairs and a lift.

At the time of the inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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 manager who was previously the home's dementia manager had been promoted to the home's manager two weeks prior to the inspection. The manager informed us they had begun the application process to become the registered manager.

Summary of findings

We found there were not always enough staff effectively deployed to meet people's needs. People and staff we spoke with told us they did not feel there were enough staff on duty to meet people's needs. This had an impact on the care and support people received.

People were at risk as their medicines were not administered or managed safely. We found some concerns around the storage of medicines that required refrigeration and the recording of medicines. Although risk assessments were in place we noted inconsistencies in the recording of information on risk assessments which could put people at risk of harm.

Staff had understanding of Deprivation of Liberty Safeguards (DoLS), the Mental Capacity Act (MCA) and their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation.

We noted that there were inconsistencies in the way people's care and support needs were met.

People were not always treated with dignity. However people's privacy was respected and promoted. We did see examples of caring practice from staff. People's preferences, likes and dislikes had not always been taken into consideration and support was not always provided in accordance with people's wishes.

Staff did not always respond to people's needs in the right way and information for people around their care was not always detailed with the correct information. Staff did not always have access to appropriate equipment to respond to people's needs. There were not sufficient activities to always meet people's needs. However some people did enjoy the activities and events that were on offer.

People's care and support needs could be affected due to records not being fully completed or kept up to date. The effectiveness of medicines were not appropriately monitored. There were not robust or effective systems in place to regularly assess and monitor the quality of the service provided.

People told us that they felt safe at Ashton Lodge. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from abuse.

Although the provider had systems to ensure appropriate standards of cleanliness were maintained, we still found some issues. We raised concerns about the carpets and chairs and some bedding in the home. We made a recommendation that the provider reviews their arrangements and implements current guidelines in regards to infection control.

The manager ensured staff had the skills and experience which were necessary to carry out their role. We found the staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. We found that some people had to wait quite a while for their lunch. We made a recommendation that the provider review their meal scheduling to ensure that people did not wait too long for their meals.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of people's health. The service worked effectively with health care professionals and referred people for treatment when necessary.

People's relatives and friends were able to visit at any time.

People told us if they had any issues they would speak to the nurse or the manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. Action taken had been recorded to make people aware of the concerns raised and how these were being addressed.

People told us the staff were friendly, supportive and management were visible and approachable.

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

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?

Requires improvement

The service was not always safe.

There was insufficient staff to meet the needs of the people living at the home. This had an impact on the care provided.

Medicines were not being managed appropriately and people were at risk of not receiving their medicines when they should. Medicines were not always stored.

Peoples' risk assessments were not always up to date and did not always have accurate information about their risks.

Staff understood and recognised what abuse was and knew how to report it if this was required. All staff underwent complete recruitment checks to make sure that they were suitable before they started work.

Is the service effective?

Requires improvement

The service was not always effective.

Mental Capacity Assessments had not always been completed for people where they lacked capacity. Applications had been submitted to the local authority where people who were unable to consent were being deprived of their liberty.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. However people did sometimes have to wait long periods of time for their meals.

Staff had the skills and experience which were necessary to carry out their role. We found the staff team were knowledgeable about people's care needs.

People were supported to have access to healthcare services.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with dignity. However people's privacy was respected and promoted. We did see examples of caring practice from staff.

People's preferences, likes and dislikes had not always been taken into consideration and support was not always provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wanted.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Staff did not always respond to people's needs in the right way and information for people around their care was not always detailed with the correct information.

There were not enough activities provided for people specific to their needs. However some people did enjoy the activities and events that were on offer.

People were encouraged to voice their concerns or complaints about the service and they were dealt with promptly.

People's needs were assessed when they entered the service and reviewed regularly.

Is the service well-led?

Requires improvement

The service was not always well- led.

Records were not always secure and well maintained.

There were not robust or effective systems in place to regularly assess and monitor the quality of the service provided.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. Action taken had been recorded to make people aware of the concerns raised and how these were being addressed.

People told us the staff were friendly, supportive and management were visible and approachable.

Ashton Lodge 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.

We visited the service on 18 August 2015 and it was an unannounced inspection.

The inspection was conducted by three inspectors, a specialist nursing advisor, two pharmacists and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We contacted the local authority and health authority, who had funding responsibility for people using the service. We also spoke to the health care professional who visited the service to obtain their views about the service.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. 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. This enabled us to ensure we were addressing potential areas of concern.

We spoke to 16 people who use the service, 12 visitors including relatives, 18 staff including nurses, care workers, housekeeping staff and management. We observed care and support in communal areas; we looked at some people's bedrooms with the agreement of the relevant person. We looked at 20 care records, risk assessments, 15 medicines administration records, accident and incident records, minutes of meetings, complaints records, policies and procedures and external and internal audits.

After the inspection, we received feedback from relatives providing their opinion of the home and the staff team.

We last carried out a full inspection in August 2014 and found no concerns.

Requires improvement

Is the service safe?

Our findings

There were not always enough staff effectively deployed to meet people's needs. People told us that they didn't feel there were enough staff. One person who used the service told us, "There is a shortage of staff, they can't cope, at weekends staff numbers are so low and nights are awful." Another person told us, "All the staff are kind and caring, very good, just not enough of them." One relative told us, "I think there could be more staff, staff are not around a lot, and this can be a risk to people as they walk around a lot." Relatives told us about the impact the shortage of staff had on people. One relative told us that their family member had a special wheelchair but they got little use from it because it required two members of staff to manoeuvre it. They said that this did not happen when there was a staff shortage.

On the day of the inspection, we observed there was a staff shortage. We found that people were not receiving care in a timely way. We spoke with staff who told us that due to the shortage, this had an impact on the care that they had to provide. One person told us at 1.00pm "'I haven't been washed yet." The person was not given personal care until 3.00pm that day. We spoke with staff at 3pm; one told us that they were "Three washes behind" as a result of the staff shortage. Some people had to wait until the afternoon for their personal care needs to be attended to. One person told us staff had only been in their room once in the morning to turn them despite them needing to be turned every two hours to reduce the risk of them developing pressure sores. We saw from their turning charts that over a period of 10 days they had not been turned for extended periods of time which would increase the risk of them developing pressure sores.

Staff told us, "We make sure that we give breakfast to people first as (giving) personal care (to everyone first) takes too long." Another told us "We do not have enough staff, I feel so sorry for the residents, I only have a chance to say hello when I walk through and nothing else. The residents are left for long periods of time alone; I would love to do more for them. There are too many areas on this floor and so many people to get up."

We reviewed the staffing allocation on one unit. The manager told us that there were nine care staff on duty on the upstairs unit during the day and five staff at night. We reviewed the rotas covering a two week period for this unit. We found that on seven separate days staffing allocation for early shifts were between six and eight members per shift which was below the minimum amount of staff required. There was also three additional occasions were staffing allocation for the night shift were four. This meant the service on these days was operating below the minimum staffing levels required to support people safely.

As there were not enough staff deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not stored securely and the temperature records for the medicines refrigerators did not provide assurance that medicines were kept within their recommended temperature ranges which could impact on the medicine's effectiveness. Medicines were not administered safely on the day of our inspection. The morning medicines round had been delayed and therefore were not completed until after midday. Whilst the midday medicines round was deferred the gap between the two rounds may not have been sufficient and may not have been safe for some people.

The administration of medicines was recorded using the Medicine Administration Records (MAR) charts. The MAR charts for two people had been reprinted and the duplicate of one page was also being completed for these two people resulting in two sets of the same record. There was a risk that people may have received the same medicine twice. Staff applied creams to people as part of their personal care however there was no record kept of when creams had been administered.

Information available to support the administration of medicines was variable. Whilst information on allergies, PRN (medicines to be taken as required) and 'Variable dose' were available, the PRN information was not personalised and lacked information for staff. Three people were administered medicines covertly. (The administration of covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it.) We were unable to identify from their care plans that an assessment of mental capacity with respect to medicines had been undertaken, a best interest meeting had been held or specialist pharmaceutical advice had been obtained to ensure the medicines remained active whilst administered covertly. One medicine was being administered crushed and in food when it should be swallowed whole and on an empty

Requires improvement

Is the service safe?

stomach. The records also indicated that a relative of each person had consented to the covert administration of medicines when they did not have the legal authority to do so.

Homely remedies were available within the home. The home had agreed a list of homely remedies with the lead GP. However, this list had not been individualised for each person as required by the home's policy for homely remedies. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

We noted inconsistencies in the recording of information on risk assessments which put people at risk. For example one person had a contagious condition; more specific assessments were needed to be in place to protect other people from harm as a result of this condition. Another person had been identified as losing weight; a referral to the Speech and Language team (SaLT) was made and they were identified as being at risk of choking. The person was placed on a fork mashable diet; however we did not find any choking risk assessments on the file.

Where people were at risk of developing pressure sores there was a plan in place to reduce this risk which was followed. For example by using pressure mattresses or pressure cushions. However when we checked some of the mattress settings we noted that they were sometimes too high for the person's weight. This meant that the person was not always provided with the appropriate comfort and relief on susceptible areas. We raised these issues with the clinical lead nurse who reviewed the setting and adjusted them.

Risk assessments were discussed with the involvement of relatives and social or health care professionals. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm.

People were provided with the necessary equipment to assist with their care and support needs and to help keep them safe such as wheelchairs, walking frames and hoists.

Failure to ensure the proper and safe management of medicines and Failure to assess and act upon risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had systems to ensure appropriate standards of cleanliness were maintained, we still found some concerns on the day of the inspection. For example there was a smell of urine on the top floor which lasted throughout the day. One relative told us that the lounge upstairs "Doesn't smell very nice." We noted that some chairs were dirty and stained on the top floor. One person's chair was wet with urine and staff did not clean it. They placed the person back on the chair after they had given them personal care. We raised these concerns with the manager who told us that they would address this.

We recommend the provider reviews and implements current guidelines in regards to infection control.

People told us the staff were very good and they felt safe with them. One person told us, "Staff are great, I feel very safe here." Staff understood what to look for when they suspected abuse. There was a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults which provided staff with guidance about what to do in the event of suspected abuse. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme. Staff told us, "You need to make sure people are safe. Protect them from abuse like physical, mental, financial and sexual." Another member of staff told us, "We are trained in safeguarding, if I witnessed safeguarding issues, I would discuss it with colleagues first and then go to the management." All staff stated that they would report the incident to the manager.

There was a staff recruitment and selection policy in place and followed. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provide proof of identification and contact details for references. The provider ensured that the relevant checks were carried out to ensure staff were suitable to work at the home. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff confirmed that they attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

Requires improvement

Is the service safe?

We observed information displayed regarding the Fire Evacuation plan. We saw in people's care plan a 'Personal Emergency Evacuation Plan' had been completed. This meant that staff had information on how to support people in the event of an evacuation.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used and would help minimise the impact to people if emergencies took place.

Requires improvement

Is the service effective?

Our findings

People we spoke with told they felt the staff knew how to take care of them. People felt that staff were competent. One relative told us "I do think they know what they are doing. I've shown them ways to handle my relative and they've taken that on board." Another told us, "I think the staff know what they are doing."

People were at risk of having decisions made for them without their consent, as appropriate assessments of their mental capacity were not completed. Where important decisions needed to be made there were not always detailed Mental Capacity Act 2005 (MCA) assessments that related to the specific decision. Where staff had recorded that relatives had given their consent for treatment there was no evidence to say that they were entitled to do this. This meant that where people lacked capacity they were not fully protected and best practices were not being followed in accordance with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We spoke with the manager who advised us they were aware they were behind with submitting their paperwork to the local authority. They told us they had spoken with the local DoLS team who had advised them to make applications for all the people in the service. We saw that one person had a gate placed on the door of their room. Staff told us that this was placed with the consent of their relatives as a means of stopping people wandering into their room. However we found no MCA assessment around the person consenting to this or any record of a best interest meeting.

As the requirements of the MCA were not being followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe their understanding of MCA and the meaning of Deprivation of Liberty Safeguards (DoLS). The manager understood their role and responsibilities with regards to the MCA and DoLS. We saw staff obtained consent before carrying out any tasks for the person.

On the floor where there were people who lived with dementia the walls and doors were decorated in different colours to help orientate people. We also saw that some walls were wallpapered with brick to give a sense of a street feeling with lanterns and hanging baskets. Doors to people's rooms had been painted to look like front doors and there were memory boxes specific to each person outside their bedroom doors. We saw people were able to find their rooms easily. There were specific areas in the home where reminiscing objects or pictures could be found to help people. There were also areas of interest for people to be involved in.

Staff had the appropriate and up to date guidance in relation to their role. Comments from staff included, "We received training to support people and understand their needs", "The training was delivered in DVD format; sometimes it is difficult to take it all in when training was delivered in this way." Staff we spoke with told us they were undertaking their NVQ 3 and felt they were trained to provide support to people. The manager ensured staff had the skills and experience which were necessary to carry out their responsibilities. New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The manager confirmed that they used agency staff to cover staff absences where necessary and additional duties were covered by bank staff that were familiar to the home and were knowledgeable about people and their needs.

Staff had received training in areas relevant to their roles. For example training was provided in safeguarding, moving and handling, fire awareness, health and safety, infection control, dementia awareness. During our observations, we saw staff assisted people moving from wheelchair to a lounge chair using a hoist. Conversations with staff and further observation of transfer techniques confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out this task safely and effectively.

People told us they felt supported and staff knew what they were doing, a relative told us, "I do think they know what they are doing. I've shown them ways to handle my family member and they've taken that on board." Staff told us they felt supported in their job and the manager confirmed that supervision and appraisals took place with staff to

discuss issues and development needs. We reviewed the provider's records which reflected what staff had told us. This meant that staff had received appropriate support that promoted their development.

When asked about the food at the service one relative told us, "The food is great; I've ordered sausage and egg for her today." People told us, the meals were good and the staff would bring alternative food to their room if required.

People at risk of dehydration or malnutrition did not always have systems in place to support them. People's meal time experiences varied depending on what floor they were living on. On the top floor where people lived with dementia we saw that some people waited a long period of time before there were provided with their meal. For example one person had not eaten since 9am and was not provided with their lunch until 1.40pm. Where people had their lunch in the lounges some had to wait for the 'Second serving' of the meal which for some was at 1.50pm. People were not always offered visual choices of meals and when the meal was placed in front of them were not told what it was. The chef did not have accurate records for people on the top floor, their individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. However they did have this information for people on the ground floor.

On the ground floor people were offered plates with different meals to allow people to see them to make choices. People appeared to be enjoying the food that they were given. There were snacks and drinks available to everyone on both floors throughout the day. Soft or pureed food was presented in an appetising form and staff assisted people during mealtimes to ensure that they were supported appropriately to eat.

Where people needed to have their food and fluid monitored and recorded this was being done appropriately by staff. Staff confirmed that a dietician was involved with people who had special dietary requirements.

We recommend that the provider reviews the meal time arrangements for people.

People had access to healthcare professionals such as GP, district nurse, dietician, and SaLT team. One person told us, "The doctor is next door. They will make appointments if you are unwell." Another person told us, "They take us to hospital for tests by ambulance and a carer goes with you." We saw from care records that any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records and staff were told what actions they should take to keep people well. This meant staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

Requires improvement

Is the service caring?

Our findings

There were times when people were not treated with dignity and respect. On the top floor one person had been sleeping in their chair all morning. The person was woken by a member of staff and told that it was time for lunch however the person was still quite unresponsive. The person was supported into a wheelchair whilst still very sleepy and taken to sit at the dining table. The person rested their head face down on the dining room table to sleep. Rather than supporting the person back to their chair or to their room a member of staff just placed a cushion under their head at the table. It wasn't until we alerted staff that the person was having difficulty breathing due to the positioning of the cushion that staff moved the person to their room

When asked about what activities were on offer for people who were being cared for in their rooms one member of staff said, "To be honest with you, I'm less likely to spend time with people in their room". The member of staff then indicated to a person in bed and said "It would be pretty pointless going in there as I would be talking to myself and (the person) wouldn't reply." However although it appeared the person was sleeping we were able to engage with them in a small conversation.

Although people were asked what time they wanted to get up and go to bed staff were unable to accommodate this due to the lack of staff. Some people were still having their morning care at 13.30 hours when they told us that they wanted to get up sooner.

As people were not always treated with dignity and respect and people's choices were not always respected this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received kind and caring support. People said that staff were kind and treated with them with respect. The atmosphere was relaxed with laughter heard between staff and people. Staff showed kindness to people and interacted with them in a positive and proactive way. One person told us, "Staff are smashing'. Another person told us, "The staff care for me they are genuinely caring." One relative told us, I don't have any issues with staff, I can't fault it here, staff are good carers. I think it's great they have male carers. I've asked that my relative only have female carers and this happens. I think it's the little touches with staff, seeing them give people a cuddle, they listen to them. Additional feedback from relatives received after the inspection included 'The caring is excellent' and (The family member) 'has received nothing but the best of care and attention.'

People confirmed they were actively involved in making decisions about their care and treatment. People were involved in making decisions about their daily care for example in relation to what drinks they wanted. Staff did not rush people for a response, nor did they make the choice for the person. Staff told us, "We always ask if (The person) if they want to go to the lounge, but they prefer to stay here (talking about their room)." People were able to personalise their room with their own furniture, personal items and décor so that they were surrounded by things that were familiar to them.

People were cared for by staff who knew their individual care and communication needs. Staff patiently informed people of the support they offered and waited for their response before carrying out any care. Staff knew what people could do for themselves and areas where support was needed. They were able to talk about these without referring to people's care records. Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them.

People told us that staff treated them with respect and dignity and promoted privacy when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. People were able to choose if they wanted their door open or closed. We observed that care was given with respect and kindness. We also observed staff guiding people as they walked along the corridor and talking to them in a calm, kind and reassuring way. People were supported to wear clothing protectors where appropriate. We saw staff assisted people when eating which was done at a slow and steady pace. We saw the staff were respectful and chatted with people as they walked. Staff explained to people what was happening and asked the people where they would like to sit during meal times.

Relatives and friends were encouraged to visit and maintain relationships. People confirmed that they were

Requires improvement

Is the service caring?

able to practice their religious beliefs and attended the local religious centres. We also saw that religious services were held at the home and these were open to those who wished to attend. This showed us that care and support was provided with due regard for people's religious persuasion. During the inspection we saw relatives and friends visiting without restriction. One visitor told us they come regularly and that there are no issues with visiting.

Requires improvement

Is the service responsive?

Our findings

Staff that were not always given the appropriate information or equipment to enable them to respond to people's needs effectively. We saw in a person's nutrition plan it is documented that one person was seen by a SaLT team in hospital, the advice and guidance given did not correlate with the information recorded on the file. For example the SaLT recommended a normal diet and at the home they were on a soft diet. There was no information about the change in diet texture and we found no choking risk assessments in the file.

Another example was that we saw that where people had pressure sores, photographs of the wounds where on the file, however these are not dated and there are no scales or rulers in the pictures to highlight the size. We also noted that this person regularly 'Refuses' to have the dressing changed. We were unable to find any follow up information from staff around this issue. This meant that there was not always up to date information about people's wound care management. We also noted that there was not sufficient information in people's care plans about how and what support is provided in regards to managing diabetes.

One person told us their catheter bag had not been changed for three weeks. They told us the bag should be changed on a Monday when they have a shower. The person told us staff had advised them that the correct sized bag was not in stock. We saw in this person's care plan that there had been a three week gap in between changing the catheter bag. We were told by staff that the appropriate bags had been out of stock and that these should have been available.

However people said that staff were attentive and responsive to their needs. One person told us, "If you ask for something, they (staff) get it as soon as they can." People told us they were happy and comfortable with their rooms and one that we were invited to view was attractively decorated with some personal touches including photographs. One person told us, "Yes my family is all round me."

As care and treatment was not always provided appropriate to the needs of people this is a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the activities provided were not always what people wanted or were appropriate. One relative told us, "My family member doesn't really like the activities and would much prefer having a sit and a chat with a cup of tea but this didn't happen much."

There were not sufficient activities to always meet people's needs. We noted that one of the activity co-ordinators was off on the day of the inspection. This meant that some of the activities scheduled such as sewing and afternoon tea did not take place. An activity programme was in place, but was not person centred. We saw documentation about the activities people attended and their interaction but this did not include people who were cared for in their rooms. One member of staff told us that the activities they provided did not include people in their rooms but said that they would always ensure they had said hello to them.

There were some physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening. However people were not always encouraged to take part. On the top floor staff told us that activities for people were arranged for those people who were more able. They said that for those were not as able they didn't have time to undertake any meaningful activities.

As care was not designed around the persons individual preferences this is a breach of regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were carried out before people moved into the home and then reviewed once the person had settled into the home. The information recorded included people's personal details, medical history, mental health and current care and support needs. Details of health and social care professionals involved in supporting the person such as their doctor or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had up to date information.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare

Requires improvement

Is the service responsive?

appointments and messages to staff. Daily records were also completed to record support provided to each person; however they were task orientated. This showed us that although there was up to date information about the support provided, the information was not always person centred. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Information was also recorded if any changes had happened such as: wound care, falls, medicines, incidents, accidents and dietary needs.

People told us they knew what to do if they needed to make a complaint. People we spoke with felt able to express concerns or would complain without hesitation if they were worried about anything. One person said that if they were unhappy, "I would speak to management but I've no complaints." We saw that information about complaints was provided in written form and pictorial formats. Staff we spoke with knew what to do if someone approached them with a concern or complaint. There have been six complaints received in the last 12 months. All were dealt with in a timely and satisfactory manner.

Requires improvement

Is the service well-led?

Our findings

People's care and support needs could be affected due to records not being fully completed or kept up to date. The effectiveness of medicines were not appropriately monitored. Test results and subsequent tests were scheduled for these people along with records of the exact dose administer. However, we were unable to follow consistently by whom and when dose changes recorded in the MAR had been authorised. We reviewed the MAR and care plans for people's whose health could rapidly deteriorate. Their care plans lacked information on how to identify and manage these situations including the use of appropriate medicine.

There were inconsistencies in the recording of people's care. For example lack of information about the frequency of 'turning positions' for people who required relieve or prevention of pressure sores. We also found that records and items were not secured appropriately. We noted that the nurse's station was not locked which provided people with access to medicine stored in the refrigerator, other people's prescriptions, people's personal belongings and other documents which were left on the desk.

Appropriate systems were not always in place to monitor the quality of the service that people received. Quality assurance checks were carried out by staff as well as the provider to monitor the level and quality of the care provided to people living at the home. We reviewed the audit undertaken regarding infection control. We noted issues identified for example odour on the first floor, some chairs require steam cleaning, had not been addressed. The service had been audited by their community pharmacy. We were shown eight medicine audits; however, these lacked cross-referencing and only the most recent had an action plan. This meant that whilst there were some arrangements in place to monitor systems and standards, people were not fully protected against the risks as there was no systematic approach to managing them.

Failure to have robust and effective systems in place to protect people from harm was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed documentation of a relative's meeting held in July 2015 where issues in regards to food, menus, equipment were discussed. There was a record of actions taken. We also saw an action plan from the previous 'resident and relatives' meeting held in March 2015. Information was recorded about relatives and resident's opinion about the activities, equipment provided and the use of agency staff, comments included "Lovely positive comments about members of staff, they are passionate about the quality of care they deliver."

We saw records of accidents and incidents that occurred every month. We reviewed an analysis of the falls were carried out. The analysis identified a number of issues and as a result recommendations and learning outcomes were made. There were maintenance records which identified repairs and maintenance checks to be carried out. There were monthly audits which covered areas in environment, nurse call systems, health and safety, communication needs and care plans. We noted that action taken was recorded.

People and staff said that the manager and staff were approachable and open to suggestions. One person told us, "The manager was approachable, always had an open door and was seen around the home." Whilst another person said "I feel supported by the manager." They went on to say, "She's really good with the residents." One relative told us, "All staff are always welcoming, friendly, caring professional and do an amazing job." People were supported by a consistent staff team. Staff said that they worked well as a team. Another member of staff told us, "We all get on well and residents benefit."

People were involved in how the service was run in a number of ways. The manager told us that questionnaires had been given to relatives and residents and an analysis was carried. We noted that comments such as 'All residents feel their privacy is respected', 'All residents expressed their decisions and choices were respected by all staff.' Relative's comments were 'happy with the way the residents were addressed.' And relatives 'Felt that the events organised for Ashton were super however they wished that there were more activities in the home for their relatives to do.' We noted that an action plan been developed and actions were ongoing. We reviewed documentation of a relative's meeting held in July 2015 where issues in regards to food, menus, equipment were discussed. There was a record of actions taken. We also saw an action plan from the

Requires improvement

Is the service well-led?

previous 'Resident and relatives' meeting held in March 2015. Information was recorded about relatives and resident's opinion about the activities, equipment provided and the use of agency staff.

Staff were involved in the improvement of the delivery of the service provided. We reviewed information from a staff survey conducted. We noted the analysis made was 30% of staff commented that they feel they always have enough support to carry out their job, 70% felt they most had enough support to do their job. Actions from the analysis were identified and undertaken were recorded.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. Events had been informed to the CQC in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing** **The registered provider had not ensured there were sufficient staff deployed to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1)(2)(a)(b)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment** **The registered provider had not ensured the proper and safe management of medicines and there were not always sufficient risk assessment to ensure that people were kept safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.** **The registered provider had not ensured that people's consent had been gained and their capacity had been assessed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect. The registered provider had not ensured that people were always treated with dignity and respect and had their choices respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 1 (a)(b)(c) and 3 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered provider had not ensured that people received care and treatment that was appropriate to their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good Governance The registered provider had failed to assess, monitor and improve the quality and safety of the services provided, did not manage the risks relating to health, safety and welfare of service users and others who may be at risk and maintain securely an accurate, complete and contemporaneous record.