Ideal Carehomes (Number One) Limited

Ashworth Grange

Inspection report

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27 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 21, 26 and 27 September 2017.

At our last inspection we identified two regulatory breaches which related to consent to care and safe care and treatment. At this inspection we found the registered provider had not made sufficient improvements in these areas and we also found further breaches of the regulations. Following our inspection the registered provider sent us an action plan which showed how some of our immediate concerns would be addressed.

Ashworth Grange is registered to accommodate up to 64 people. The service provides care for people with residential needs as well as those living with dementia.

At the time of our inspection the service had a registered manager, although this individual had not been in day to day control for 12 months. A manager had been appointed in May 2017 and told us they expected to submit an application to become registered following our inspection. 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.

People and their relatives told us they were safe living at this service. However, we found the registered provider had identified safeguarding concerns in February and August 2017 which they had not reported to the Care Quality Commission (CQC). During our inspection, we found there were still concerns regarding people's safety.

We found medicines were not managed safely as not all staff responsible for the administration of medicines had an up to date assessment of their competency. The management of creams, covert medicines and storage arrangements were not robust.

Staff were uncertain how many people lived in the home and we found there were gaps in staff knowledge regarding how to respond in the event of a fire. Fire drills had not been carried out in line with the registered provider's policy. Personal emergency evacuation plans were in place, although staff were not aware they existed or where they could find them.

Staffing levels were insufficient to provide timely responses to people's needs. Staff support through a programme of training, supervision and appraisal was not up to date. Most recruitment checks had been carried out safely to ensure staff were suitable to work with vulnerable adults.

Care plans contained information regarding people's life histories, although we found there was insufficient detail recorded to ensure person-centred care was provided. Risks assessments did not always contain sufficient information and conflicted with what staff told us. The roles and responsibilities for people's pressure care were not clear and we found concerns regarding the use of equipment.

Staff knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards had improved since our last inspection. The recording of people's mental capacity required improvement and evidence of power of attorney was not sufficiently recorded.

We looked at the governance arrangements and found issues identified during this inspection had previously been highlighted through the registered provider's quality audit in July 2017.

We saw the quality of support people received from staff at lunchtime was variable. People's special dietary requirements were not always met. People told us they enjoyed the meals provided.

People and their relatives were complimentary about the care provided by staff and there were examples of their involvement in care planning. However, we found concerns regarding people's privacy and dignity which was not always respected. People received timely access to healthcare, although the recording required improvement.

Healthcare professionals provided positive feedback about this service. A programme of activities was in place. A social committee met on a monthly basis to discuss upcoming events they wanted to see. Relatives knew how to make a complaint if they were dissatisfied. Complaints were found to be responded to appropriately and within identified timescales. Most staff, people and relatives told us they thought the manager was approachable and effective in their role.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient numbers of staff to provide timely responses to people. Concerns regarding people's safety had not been appropriately managed.

Medicines were not safely managed. Risks to people had not been appropriately recorded and acted on.

Not all staff were aware of their responsibilities in the event of a fire.

Is the service effective?

Requires Improvement

The service was not always effective.

The recording of people's mental capacity required improvement, and evidence of power of attorney was not sufficiently recorded.

There was limited evidence of formal staff support. Training was not up to date.

People's special dietary requirements were not always met. People liked the food served. Staff supported people to receive access to healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives were complimentary about the care provided.

Some privacy and dignity concerns were found during the inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information in care plans was not always recorded consistently and with sufficient detail.

A programme of activities was in place.

Complaints were appropriately responded to within identified timescales.

Is the service well-led?

Inadequate

The service was not well led.

Breaches of the regulation found at our last inspection had not been appropriately acted on.

Notifications to the Care Quality Commission had not been submitted as legally required.

Audits did not always indicate timescales and confirmation of completion. Not all actions previously identified by the registered provider had been completed.

Ashworth Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 21, 26 and 27 September 2017 and was unannounced. On day one, the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On days two and three, two adult social care inspectors completed the inspection. On each day of our inspection there were 51 people living in the home.

We spoke with a total of 10 people who lived at this service as well as 10 relatives who were visiting at the time of our inspection. We also spoke with the manager, regional director, head of compliance, the care manager, two deputy managers and seven members of staff. We observed care interactions in the communal lounges. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at four people's care plans in detail and a further 16 care plans for specific information.

Before our inspections we usually ask the provider to send us 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 ask the provider to complete a PIR prior to this inspection.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Inadequate

Is the service safe?

Our findings

Before our inspection, we received information of concern relating to night shifts not always being covered by senior staff, which meant there may not have been appropriately qualified staff to administer medicines. On each of the three days of our inspection, we started early enough to meet with night staff and found there was always a senior on shift who was trained and assessed as competent in administering medicines. The registered manager told us night shifts were always covered by a senior staff member who was able to administer medicines. They added that a system of cover had been agreed if a senior care worker did not arrive for the night shift. The care manager told us either they or the manager would attend the home in such an event and noted this had happened twice since May 2017 due to staff sickness.

We looked at staffing levels and the deployment of staff throughout the home and found this was not appropriately managed.

Staff we spoke with told us there were insufficient numbers of staff to meet people's care needs. Staff comments included; "I don't know the residents are getting the care they want and need", "You haven't time to give 'sit down care'. Some people want you to sit with them. We're always saying we're understaffed. They [senior management] want to come and work a shift" and "It saddens me that things are rushed." It had been identified by staff who completed the staff survey in July 2017 that staffing levels were a concern.

The manager told us they had looked at staff response times to call buzzers sounding and told us it usually took staff between one minute and one minute and 40 seconds to respond. Staff we spoke with told us that where they were working with people who needed two care staff and a call buzzer sounded, one of them had to leave to go and switch the call buzzer off and tell the person who had requested assistance they would be with them as soon as they were available. This meant the registered provider could not evidence that people received timely assistance. Staff comments included: "It's what everybody does in each unit; knocking call bells off and saying they will return" and "Sometimes you might have to say 'I'll come back to you in 10 to 15 [minutes]." Although people told us staff responded promptly when they needed assistance, we could not be sure this was to provide the care they needed or when staff acknowledged the request for support and returned later.

The care manager told us staffing levels were expected to be two senior care staff and eight care staff during the day. The regional director told us people's dependency levels were reviewed monthly. We looked at staff rotas which covered a three week period and found on 10 occasions between 28 August and 17 September 2017 the home operated with a maximum of 9 staff members including senior and care staff. On 8 and 17 September 2017 there was eight staff on duty during the day. On 9 September no staff were allocated to the 7:30am to 2:00 pm shift. The staff rotas also confirmed that two senior carers were not on duty on five occasions during this three week period namely on 10, 14, 15 and 16 September. On 17 September 2017 no senior carers were recorded as being on duty. On 4 and 14 September 2017 the night shift was recorded as being staffed by one senior and three care staff.

The regional manager said staffing levels at the time of our inspection were set at a level based on the

service being fully occupied. The care manager told us that in future, deputy managers would be expected to work on the floors throughout their shifts.

At the time of our inspection the registered provider consistently used agency staff on night shifts. We saw deployment of staff was a concern as on day one of our inspection, two agency night workers had been allocated to work together in the same area which was for people living with dementia. One of the agency staff had not received an induction to the home. We found agency staff had not received dementia training and had a poor understanding in this area. This meant not all staff had sufficient knowledge to people living at this service. Following our inspection, the manager advised us that an additional night care manager had started working at this service, which meant the use of agency staff on night shifts would reduce.

We concluded this was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us they felt safe at this service. However, records we looked at and our discussions with staff demonstrated there were concerns about people's safety.

We saw records of a staff memo dated February 2017 sent by the manager who was responsible for the service at that time. This concerned night staff not carrying out regular checks on people, people being left in a soiled state and staff sleeping whilst on duty. We checked our records and found the registered provider had not notified us of these concerns.

We looked at staff meeting minutes dated 1 August 2017 and found concerns were again raised regarding staff practice on night shifts. The minutes referred to sensors in people's rooms being switched off, beds being found wet and profiling beds being set to an unsafe height with no brakes on. This meant the manager was not taking sufficiently robust action to ensure these issues were addressed.

During our inspection, staff told us that on occasions when they arrived for the day shift, people were found wet due to incontinence, people were wearing clothes they wore the previous day and sensors used to monitor people's movements had been switched off. We found the manager had not notified us regarding these safeguarding concerns. The inspection team asked the manager to report this to both the local safeguarding authority and the Care Quality Commission. The manager completed this action following our inspection.

We concluded this was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to our findings, the manager made us aware of spot checks they had completed on two night shifts. They told us a weekly night shift spot check would continue.

Staff we spoke with were able to identify types of abuse and were aware of their responsibility to report any concerns. Staff told us they would report abuse to the manager and also said they could contact the registered provider's whistleblowing service. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. One staff member told us, "I'm here to keep them safe."

On the first day of our inspection, we asked three members of staff how many people were living in the home and found they were unaware of this number. One staff member told us, "I don't count them, I just come in and do my job." On day two of our inspection, we asked a further member of staff how many people were in the home and found they were unable to provide this information. This meant staff were unclear

about the number of affected people in the event of an emergency.

During our inspection we spoke with staff about the procedures they were expected to follow in the event of a fire. We found staff had a variable understanding of the registered provider's fire evacuation procedures. In addition, some staff were unaware of the personal emergency evacuation plans (PEEPS) used to identify people's moving and handling needs in the event of an emergency. These were kept in the manager's office. We saw the list of PEEPS had last been updated in June 2017 and saw this was out of date. One person had a PEEP which stated they needed a stand aid to mobilise, but also stated on the same form they were able to exit the building without assistance from staff.

The registered provider's fire procedure dated April 2015 stated: 'Fire drills must be carried out monthly and all staff must attend at least two fire drills per year'. In July 2017 we saw records of a fire drill and a note which asked 'What further actions are required?' The response recorded was 'More drills to be carried out'. We saw no evidence of further fire drills having been carried out after this date. We discussed this with the manager who told us they were aware of this gap. Subsequently, the manager carried out a fire drill with night staff on day two of our inspection. Following our inspection we contacted the manager to ask them what further action they had taken to ensure staff had a clear understanding of their responsibilities in the event of a fire. The manager told us they had initially carried out a further fire drill and met with senior staff to discuss fire safety arrangements. Additional training had been arranged for the full staff team which was to commence in October 2017.

We concluded this was a breach of regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of weekly fire alarm testing from different points in the home as well as a weekly visual inspection of the means of escape.

At our last inspection, we took enforcement action as the registered provider breached the regulation concerning safe care and treatment in respect of assessing risks to people. At this inspection we still had concerns regarding a lack of detail and conflicting information in these records.

We looked at the pressure mattress settings for two people and found these were not set correctly. We found there was confusion amongst the staff team regarding who was responsible for ensuring pressure mattresses were set correctly. The care manager told us the deputy manager was responsible for completing these monthly checks. The manager told us staff were able to use their hand held device to check these settings. However, one member of the care staff said they only checked to ensure the mattress was inflated, rather than the setting. This meant staff responsibility for pressure mattress settings was not clear and these checks had not been completed.

We found the information in moving and handling risk assessments was not always completed in full and information recorded contradicted what staff told us. For example, one person's moving and handling risk assessment did not mention the use of a stand aid, although a staff member told us they used this equipment. The safe environment care plan for this person stated staff should use a full hoist and sling.

We concluded this was a breach of regulation 12 (2) (a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were found to be appropriately managed. We looked at records for June, July and August 2017 and saw these were reported and people's moving and handling needs were reviewed after

each occasion. We saw evidence of close observations which were completed following accidents and incidents as well as body maps which recorded any injuries.

Falls risks were documented and managed appropriately. For example, where people had experienced a fall, there was evidence to show relevant action had been taken in response to these events. For example, we saw a motion sensor had been put in place for a person who was at risk of falls in their own room.

We looked at the management of medicines and found this was not always safe.

Medicines kept in the fridge were not always stored safely. We saw two bottles of eye drops were open, but did not have a date of opening written on them. The pharmacy label recorded 'discard 28 days after opening'. We also saw a nutritional supplement for a person was open, but did not have a date of opening written on it. Once opened, nutritional supplements have a limited shelf life.

We observed one member of staff administer people's medicines. We saw they locked the medicines trolley every time they left it to support a person to take their medicines and they signed the medication administration record (MAR) after they had administered each person's medicine.

Protocols for the use of medicines prescribed for use 'as and when required' (PRN) were in place, although we noted one person's PRN protocol did not contain sufficient guidance for staff to know when their medicine should be given.

The system to manage the applications of creams was not robust. We found the body maps which guided care staff where to apply creams were kept on the medicines trolley, which meant they did not readily have access to these records. We spoke with a member of staff and they showed us how they recorded the administration of creams in the person's electronic care records using a handheld device. They clicked on a body map to show where the cream had been applied, but the staff member was unable to show us any instructions which told them where to apply the cream. A staff member told us they applied a topical cream to one person's legs. We looked at the MAR for this person and saw there were no creams recorded and their care plan made no reference to using this cream. The manager told us they thought the district nurse was applying creams and therefore, this was not recorded in the electronic care records.

Two people who lived at the home received their medicines covertly. Covert medication is the administration of any medicine in a disguised form. We did not see evidence to demonstrate the involvement of a pharmacist in the decision making process and there was no evidence a mental capacity assessment had been completed for one person. When we spoke with staff, they gave us conflicting information regarding the administration of these medicines. For one person, a senior carer told us, "It is no problem; [person] will take them. If [person] doesn't, then go back in ten minutes and it's not a problem." Another staff member said, "I put them in jam sandwiches, crush the tablets, but the capsule we leave whole. We just have to watch [person] eats them and no-one else takes them." When we asked the deputy manager, they told us, "[Person's] character changes when they have a urine infection. Yes, we would have given the medicines covertly when [person] had a urine infection. That is when [person] is reluctant to take them." We saw from recent MARs the person had been prescribed antibiotics three times between April and July 2017. We were unable to establish from the records if these medicines or any other prescribed medicines administered during these dates had been given covertly.

We checked the training records for staff who were responsible for administering people's medicines. We saw evidence they had completed training, although two members of staff did not have a documented assessment of their competency. This meant people did not always receive their medicines from staff who

had the appropriate knowledge and skills. Current NICE (National Institute for clinical Excellence) guidelines for managing medicines for adults receiving social care in the community, advises staff 'are assessed as competent to give the medicines support being asked of them, including assessment through direct observation' and 'have an annual review of their knowledge, skills and competencies'. The registered provider had identified this concern in the July 2017 quality audit tool. The manager told us they planned to complete competency checks every three months on staff responsible for administering people's medicines.

We concluded this was a breach of regulation 12 (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff files and saw safe recruitment practices were not always followed. In one case, a staff member had commenced their employment prior to checks having been carried out with the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safe recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. We saw references had been taken and identity checks had been carried out.

We looked at maintenance records and buildings certificates and saw these were all in date. At the time of our inspection, the registered provider was in the process of appointing a person who would be responsible for routine maintenance. Maintenance was either being carried out by a member of staff from another home operated by the registered provider or through external contractors. Records showed repairs were usually completed in a timely way.

Requires Improvement

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

At our last inspection, we took enforcement action as the registered provider breached the regulation concerning consent to care. At this inspection we found staff knowledge regarding the MCA and DoLS had improved. However, we still had concerns regarding the recording of people's capacity, Power of Attorney (POA) and best interest decisions.

We looked at care records for two people who were assessed as not having capacity and found they did not have mental capacity assessments in place for the administration of their medicines. One of these people was receiving one of their medicines covertly, although there was no evidence in their care records of pharmacy involvement in this decision.

Where people had relatives or other representatives who held a POA for them, we found records did not indicate whether this was for management of finances and/or health and welfare. This is important to evidence in order to ensure decisions are lawfully made on a person's behalf.

We looked at mental capacity assessments and saw these were not decision specific, as multiple decisions were assessed on the same form. For example, one person had a mental capacity assessment which contained four separate areas; 'maintaining safety', 'DoLS', 'care delivery' and 'bed rails' which had been assessed as one decision. The assessment of mental capacity for this person showed they had capacity which had been identified in the registered provider's quality audit tool in July 2017. In addition, a DoLS application remained outstanding which had been submitted to the local authority for this person on 9 December 2016. This meant the use of mental capacity assessments and DoLS applications was not always appropriate.

At this inspection we saw the care manager had contacted the local authority in August 2017 to ask for an update regarding DoLS applications. The care manager told us when they started in post in early 2017, all of the people living at Ashworth Grange had a DoLS application. They told us one person who had an outstanding DoLS application had capacity. During our inspection, we found a second person who had capacity had a DoLS application. The care manager said they were reviewing the status of DoLS applications as people's care plans were transferred to new system.

The above evidence demonstrated that the MCA and DoLS was still not correctly followed. We concluded this was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff giving people choices as part of their daily routines. Where people refused care and assistance, staff were seen to respect people's decisions. We asked one staff member how they ensured people supported people to make day to day decisions. They said, "Show them things. You might know [what they prefer] by their facial expression." Staff also provided appropriate responses around responding to people refusing care.

We looked at the induction staff received and saw this was provided over a 10 day period. This covered, for example: challenging behaviour, end of life, equality and diversity, fire safety, food hygiene, nutrition and hydration, health and safety, infection control, medication awareness, MCA & DoLS, person-centred planning and safeguarding.

The registered provider's safeguarding policy dated July 2017 stated 'Agency/temporary worker: Use and Induction' 'All agency staff or temporary workers that attend the home must be taken through an induction of the home'. We spoke with one agency worker who told us, "I didn't get an induction. I didn't get shown around." We looked at the records for this person and saw they had not received an induction. However, evidence we saw showed other agency staff had received an induction to the home. The manager told us they would ensure this was addressed.

Records looked at during our inspection showed staff did not always receive the training they needed to be effective in their roles. Following our inspection, the manager submitted an updated training matrix which showed levels of completion, although there were gaps we identified in training. For example, 51% of all staff had not received first aid training. Records showed night staff, bank staff and ancillary staff did not always receive the training they needed to be effective in their roles. Following our inspection, the manager advised us staff would receive moving and handling training in October 2017.

The head of compliance told us the registered provider's supervision policy stated staff should receive these sessions every six weeks. We discussed this with the manager who told us, "I'm behind with them." Annual appraisals were also part of the programme of support for staff. The manager said, "My appraisals are out" adding they would start to carry out staff appraisals in October 2017, which they felt would allow them a chance to become familiar with the staff team and provide more meaningful feedback.

The regional director told us, "Supervision needs to be improved and appraisals need to be improved." We saw the deputy manager had carried out some staff supervisions before our inspection, although this was not sufficient to demonstrate staff were effectively supported in their personal development. Following our inspection, the manager contacted us to say they had commenced supervisions with staff.

We concluded this was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of our inspection, we found one person who had been assessed as needing a soft diet due to a risk of choking had been served gammon at lunchtime. We spoke with the cook who told us the gammon had been boiled. They said, "That [the gammon] literally broke up." We asked the manager to report this incident to the local safeguarding authority which they did.

We spoke with a visiting health professional who told us one person had been assisted as needing their

meals served on a small spoon to assist with their swallowing. They told us they had previously approached a deputy manager as they had seen this person not being served their meal as advised. On days one and three of our inspection, this person was assisted with a small spoon. However, on day two we observed a staff member providing one to one assistance for this person at lunchtime using a fork. We spoke with a staff member about this assessed need who told us they were not aware of this requirement.

One person was supposed to receive a supplement drink which had been recommended by the dietician in July. However, we found the prescription for this had been missed and staff had not followed this up.

We looked at the records for one person who was at risk of weight loss and needed their food and fluid intake to be monitored and saw the information was limited. Staff used hand held electronic devices to record how much people had to eat. They were able to select from 'nothing', weak', 'poor', 'and 'good'. One staff member told us the system was capable of recording actual meals eaten in addition to portion size, although at the time of our inspection this was not being done.

We observed the lunchtime experience on both floors on each day of our inspection and saw the support people received varied. One person's care records dated March 2017 showed their relatives had requested the person was to be assisted to eat at the dining table during mealtimes. At lunchtime on day two of our inspection, we saw this person had been left in a side lounge. A staff member told us this person couldn't be moved because they had a pressure cushion which needed a power supply. We saw there were available electrical sockets in the dining area.

We concluded this was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked one person whether they had enjoyed the meal they had just eaten. They told us the food was "Smashing." Another person who commented regarding food at Ashworth Grange said, "It's great. I've not been fed like it in my life." A third person commented, "The food's cooked alright." The manager told us, "I've never had any complaints about food."

At breakfast time people were offered hot and cold options. One member of staff was heard asking a person, "What would you like for breakfast? Cornflakes, full English, Rice Crispies"? However, we found there was a lack of visual choice for people who may be living with dementia to be able to select their meal option.

We observed some positive interactions between people and staff at lunchtime including singing and staff talking with people. Staff who provided 'one to one' assistance for people during mealtimes were seen to be interacting with people they were supporting. We observed a staff member as they responded to a person who declined to eat. The staff member accompanied the person on a short walk around the dining room and gently encouraged the person to have some dessert which they agreed to. Snacks and fresh juice were available and we saw people were given milkshakes which staff actively encouraged them to drink.

In March 2017, the home had been awarded a 'Healthy Choice Award,' by Kirklees Council for being committed to good standards of food hygiene and healthy food options.

We looked at people's access to healthcare and found staff were responsive when this was needed. One person told us, "The doctors and chiropodist come here to see us." One relative said, "They've got the district nurse coming every day." A second relative commented, "They're on to it if there's something medical. It's been like getting my aunt back. She's thrived all the way. She's just got better and better." We spoke with two visiting healthcare professionals who said referrals received from staff had been appropriate.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were happy living at Ashworth Grange and were complimentary about staff. One person said, "It's a home from home. They're a grand lot." Another person commented, "I like the nurses. I like the food. It's a good place. It's one of the best." A third person said, "We couldn't have better staff. They make sure things are just right. They're more like your family." A fourth person commented, "They're alright with me." A fifth person said, "Staff always listen to you."

Relatives also spoke positively about the care their family member received. Comments included; "She's very happy here", "They actually talk to her. All of them seem to speak to her affectionately" and "They do seem caring." Relatives we spoke with felt staff were mostly aware of their family member's preferences. One relative said, "Sometimes, I'm surprised by how much they know."

Staff we spoke with were confident people received good care. One staff member said, "They're well cared for and loved." Another staff member told us, "You've either got the passion for the job, or not."

We saw examples of staff engaging with people and providing warm interactions. Staff were able to start conversations with people as they were familiar with their life history.

We looked at whether staff respected people's privacy and dignity regarding access to their bedrooms. One member of staff told us, "I knock on the door before entering." With the exception of one instance, we saw staff consistently knocked on people's doors before entering their rooms. People who lived at Ashworth Grange had differently coloured symbols on their bedroom doors which were to indicate their personal preferences around when their door should be open or closed, locked and unlocked and whether they had a 'Do not Attempt Cardio Pulmonary Resuscitation' instruction in place. We spoke with staff about their understanding of the differently coloured symbols and found they were unclear about what these meant. For example, one staff member said a blue symbol meant the person's door could be open. Another member of staff said this meant the person had their own key. Staff were unable to identify what a yellow symbol meant. This meant staff were unaware of people's privacy preferences.

One person told us they did not feel their privacy and dignity was respected as their preferences regarding the gender of staff who assisted them had not been followed. They said, "It's not right sending a young man to help an elderly lady to dress and get washed." We spoke with a member of staff regarding a person who was female who lived in the home who they referred to several times as male.

One member of staff told us, "If someone's had an accident I try to make them feel as comfortable as possible." On day one of our inspection we observed a member of staff speaking to a person discreetly as they asked the person whether they wanted to use the toilet.

We looked at a compliment received from the relative of one person which stated 'It has been a great comfort over the years for me and my family to see [person] treated well and with dignity by committed, caring staff. We were always confident that [person] was in a safe environment and looked after proficiently

by professional staff who would always go out of their way to make us feel welcome and give advice and support when required'.

Requires Improvement

Is the service responsive?

Our findings

At the time of our inspection the registered provider was overseeing a change from paper to electronic care records. The care manager and deputy manager made us aware that 14 care plans had transferred from the old to the new system. One staff member told us, "[Name of manager] has helped us through it."

The care plans we looked at did not always contain sufficient details to provide person-centred care. A number of people living at Ashworth Grange presented with behaviours which may challenge others. The care plans for these people were found to have insufficient guidance for staff to recognise and respond appropriately in these situations. A staff member we spoke was able to describe specific behaviours for one person which we found were not recorded in their care plan.

We saw one person had two different dependency scores in their care plan. The same person's care plan did not contain reference to their diabetes which meant it was not clear how this person's health condition was controlled.

The manager and staff were able to describe arrangements in place regarding people's health appointments, although the care records we looked at did not reflect this information. For example, one person was scheduled to attend a health appointment in August 2017. We saw there were no records regarding the outcome of this visit.

Another care plan we looked at stated the person could not eat and drink independently. However, we observed a staff member leaving a meal in this person's room. The staff member told us, "When she is alert, she eats her meal herself." This meant care records did not always reflect people's needs and preferences.

We concluded this was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we did not see records for people's bath and showers. Following our inspection, the registered provider submitted evidence which showed people's personal hygiene records for baths and showers were recorded.

Care plans we looked at showed relatives had been involved in providing information about people's life history. One relative we asked about care planning told us, "I am involved in that."

The registered provider employed an activities coordinator who worked 20 hours per week. The activities coordinator recognised the importance of being flexible with the activities programme and focusing on what people wanted to take part in. They told us, "I have to adapt things as I go."

On the second day of our inspection we saw a bun making and cake decorating activity which involved people from different floors. People were given protective clothing to wear. We saw good humour and singing.

We saw some examples of photographic evidence of activities and themed events. The activities coordinator said, "Some see me every week. Some see me every day." One staff member said, "I do think it's good on activities here. They normally share it out on to the floors." One staff member told us when the weather allowed, three people had been planting flowers and growing vegetables in the garden. Following our inspection the registered provider submitted evidence which showed people's participation in social activities had been recorded.

We saw a monthly social committee meeting place a social committee meeting took place which was largely focused on the programme of activities. In September 2017, it was agreed at the meeting that people could make costumes for a Halloween party in October. The activities coordinator told us, "They [people] do love their crafts." A 'knit and natter' group was scheduled to commence in September 2017. The group discussed inviting families in for afternoon tea. One person asked for a choir to be started with and suggested visiting and singing at other homes.

Other events were being arranged for the next three months which included; a boat trip, , entertainment and restaurant dining with a 'posh do' theme, a bonfire party, an American thanksgiving themed evening and a trip to the theatre.

People and relatives we spoke with knew how to complain if they were unhappy with the service they received. Relatives comments included; "I think I'd ask to see the manager", "If I had a problem, I'd come in for a meeting" and "If I was concerned about something, I would speak to the staff."

We looked at the systems in place to manage complaints received by the registered provider and found this was effective. We saw evidence of acknowledgements which were sent as an initial response to complaints. Subsequently, investigations concerning the nature of the complaint were carried out and a letter of response was sent. We saw evidence of action taken in response to individual concerns which meant people were listened to and their feedback was acted on.

Inadequate

Is the service well-led?

Our findings

At our last inspection we identified breaches of the regulations concerning the safe management of medicines, how risks to people were managed and consent to care. At this inspection we saw evidence which demonstrated there were still concerns in these areas as well as further breaches of the regulations. This meant there had been a failure to take sufficient action to become compliant with the regulations.

Our inspection was partly prompted by a recent incident which had a serious impact on a person using the service which indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. Plans had been put in place to reduce the risk of a repeat of the incident.

At the time of our inspection the registered provider had a manager registered with the Care Quality Commission who had not been in day to day control of the service in the last 12 months. The current manager had commenced employment at this service in May 2017 and told us they expected to submit their application to become registered shortly after our inspection.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents and changes to the service. During our inspection, we found allegations of abuse in February and August 2017 which the registered provider had failed to make us aware of at the time of these events.

On the third day of the inspection we reviewed the medicine audits. We saw no evidence any medicine audits had been completed in January, April and May 2017, however, six audits had been completed during June, July and August 2017. The audits evidenced a reduction in the recording errors related to boxed medicines, but the audits had not identified the poor recording of creams applied by care staff or the issues around covert medicines which we found at this inspection. We spoke with the care manager about this and they told us the audit did not include these two topics. We also noted each audit had a score for stage 1 and stage 2, this indicated if the audit was a 'pass' or 'fail'. The audit also had a section for the auditor to work out the overall score and subsequent 'pass' or 'fail'. We noted none of the audits had an overall score recorded and we could not identify any information on the audit to instruct staff how this score was to be calculated. We asked the care manager about this and they told us they did not know. This demonstrates the system for auditing people's medicines was not robust or effective.

We looked at the mattress audit for June 2017 which showed one person's mattress cover had soiling which could not be removed and the mattress was soiled or stained. The mattress and cover were recorded as having failed. In July 2017, the mattress and cover had failed again, but the mattress was recorded as 'passed'. A note recorded 'new cover ordered'. In August 2017, the mattress was passed, although the mattress cover for the third consecutive month was recorded as soiled. The care manager told us there had been problems with the supplier, although there was no evidence this had been chased up. The manager told us, "That's my fault."

We looked at a range of other audits which included, for example, finances, bed rails, care plans and catering. We found that whilst action plans were created, these were not always given a timescale for completion and there was no evidence the actions had been completed. For example, in June and July 2017 the health and safety audits showed actions had not been completed and signed off. In June 2017 the monthly bed rail audit listed eight actions which were not signed off.

The regional director showed us evidence of their involvement and oversight. We looked at the review of compliance reports for July and August 2017. We saw these looked at, for example, number of people who used bed rails and saw this had reduced. The regional director had also reviewed medicines and found the temperature in the clinic room was not always recorded and there were concerns regarding five people's medication administration records. The compliance report noted 'Medications are being better managed and this is clear'. However, this was contrary to our findings during this inspection.

In July 2017, the registered provider's quality audit tool identified a number of concerns regarding the recording of mental capacity, staff supervisions and appraisals, medicines management and gaps in the content of care plans. We looked at three of the same care plans reviewed during the July 2017 visit from the quality team and found actions needed had not been followed up since this date as we identified the same concerns during our inspection. We saw the action plan following the quality audit which indicated a number of the actions should have been completed prior to our inspection. The head of compliance told us the action plan was the responsibility of the manager and regional director.

On day two of our inspection we found the supply of incontinence pads used for people who were awaiting a formal continence assessment had run out. This meant the oversight of the supply of pads was not well managed. A staff member was asked by the manager to purchase a quantity of pads locally.

On the first day of our inspection, we asked the manager to provide us with details of how many people living at this service required the assistance of two members of staff for their care needs. During our inspection we requested other records such as the staff training matrix and supervision matrix and found these records were not current and needed to be reviewed by the manager before they could be shared with us. This meant important information regarding the service was not up to date and readily available.

We saw evidence of some staff meetings for senior team members and heads of department, although full staff meetings were infrequent and had been held in response to specific concerns. This meant staff did not always have the opportunity to provide feedback and share ideas. The manager told us, "It's [staff meetings] not been happening as often as I like it."

The manager told us there had been no meetings for people and relatives in 2017. The last survey people and relatives had been asked to complete took place in May 2016 when four people responded. We saw feedback from the registered provider was on display in the home. This meant there were limited opportunities for people and relatives to provide feedback about the service they received.

We concluded this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw where two medication errors had occurred earlier in 2017, there was evidence to show the registered provider had provided refresher training and rechecked the staff member's competency to administer medicines.

In July 2017 a staff survey was carried out by the registered provider. Issues raised concerned staff morale,

feeling valued and staffing levels. Nine staff said morale was good, seven staff said morale was not good and three did not answer this question. In response to staff feedback, the manager indicated they would hold team talks and handovers; management would work on floors, boost morale and teamwork and start a staff member of the month. The manager told us they wanted to use a staff memo to communicate key messages.

Relatives we spoke with were complimentary about the way the service was managed. One relative said, "There's been times when I've been frustrated with the management changes, but there's always been someone to talk to." The same relative commented regarding the manager, "She's been lovely. She's really warm." Another relative said, "This year, I think it's been better." A third relative told us, "I feel the management are managing the home. Now everything is followed through. I just feel the whole atmosphere is changing. [Manager] is so hands on."

We spoke with staff about leadership at Ashworth Grange and observed how the team worked together. The manager told us, "Morale was at an all-time low when I walked through the door." The care manager said, "Staff morale is better. It's a really good team ethos that does go above and beyond for residents."

Staff gave mostly positive feedback about the manager. Comments included; "I do believe she's taken over really good. She is approachable," "She is the best one we've ever had and so are her deputies. She always listens and tries to help", She's approachable. She says anytime you've a problem, come and see me", "I don't like the management. She's arrogant. I don't think she is approachable. I think this is the worst it's been" and "Now it seems to be settling down. More relaxed and more trust." Following our inspection, the manager told us they were meeting with staff to give them an opportunity to discuss any concerns they had regarding leadership in the home.