Pages Homes Limited

Ash Grove Care Home

Inspection report

8-10 Woodville Road
Bexhill On Sea
East Sussex
TN39 3EU

Tel: 01424730497
Website: www.woodvilleresthome.org

Date of inspection visit:
23 May 2017
30 May 2017

Date of publication:
27 July 2017

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 23 and 30 May 2017. It was unannounced. The home is registered to provide care and accommodation for 30 people. There were 13 people living there when we inspected. People cared for were all older people who were living with dementia, some of whom could show behaviours which may challenge others. People were living with a range of care needs, including arthritis, diabetes and heart conditions. Most people needed some support with their personal care, eating, drinking and mobility

Ash Grove Care Home had changed its name since the last inspection; it was called Woodville Rest Home. The home is a large domestic-style house which has been extended. People's bedrooms are provided over three floors, with a passenger lift in-between. Single story accommodation is provided in an extension to the rear. There is a sitting/dining room on the ground floor.

There was a registered manager in post. They worked part-time at Ash Grove Care Home and were also the registered manager of another care home which is owned by the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider for Ash Grove Care Home is Pages Homes Limited. They own one other care home, also in Bexhill on Sea.

The home has been inspected three times since 2014. At the inspections of 30 December 2014 and 2 January 2015, and 21 and 24 July 2015, it was rated as inadequate and a range of breaches in regulations of the HSCA 2008 (Regulated Activities) Regulations 2010 and 2014 were identified. Following these inspections the CQC took enforcement action in accordance with its procedures. The last inspection took place on 5 and 6 April 2016. At that inspection the home was rated as requires improvement, and the provider had made considerable progress to address the breaches identified at previous inspections. However despite these improvements, we continued to find three breaches in Regulations. Following the last inspection, the provider and registered manager have been in regular contact with the CQC to advise us of progress towards meeting the requirements of Regulations.

At this inspection, we found the provider and registered manager had not been successful in making all relevant improvements.

At the last inspection, people's safety was not always ensured. By this inspection, some areas relating to people's safety and risk, including risk of infection, had not been ensured for all people. Other areas had been addressed, including appropriately supporting people who were at risk of falling.

Audits continued to be developed at this inspection, however some areas relating to people's health and well-being had not been identified and some records continued not to be completed. Although the provider aimed to ensure adequate staffing levels to meet people's needs, they had not identified they were regularly not achieving these staffing levels. This could have put some people at risk to their safety and welfare.

Training and supervision systems were being developed at the last inspection, but not all areas had been fully actioned by this inspection, including training staff in certain key areas to meet individual people's healthcare needs. Training and supervision had been further developed in other areas.

At the last inspection, management of medicines had much improved and only one area needed to be addressed. By this inspection, this one area relating to 'as required' (PRN) medicines still had not been addressed.

Improvements had been made to support people with nutrition from the last inspection but people still did not consistently have the support they needed at mealtimes because there were not enough staff deployed at some meals.

As at the last inspection, some staff were not consistently caring and respectful towards people in certain areas particularly in relation to engaging with them. However staff were caring and respectful at other times and responded to people in a friendly, understanding way.

Activities provision to meet people's individual needs had been developed and improved. At this inspection, people were still not consistently provided with appropriate diversional activities, particularly when the activities worker was not on duty.

Assessments and care plans were much improved from the last inspection and only admission assessments needed to be addressed.

Staff were aware of their responsibilities for protecting people from risk of abuse. The registered manager had ensured recruitment processes protected people from risk. People's capacity was assessed in accordance with the Mental Capacity Act 2005 (MCA) and appropriate action taken to support people when necessary.

The provider continued to make improvements to the home environment to make it more dementia-friendly. There were effective working relationships with external healthcare providers.

We found a three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over recent comprehensive inspections, as had happened for this service on 30 December 2014 and 2 January 2015, and 21 and 24 July 2015. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures

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?

Requires Improvement

The service was not always safe.

Some people's safety was not ensured. Other safety systems were in place.

People were not consistently protected because appropriate staffing levels were not always maintained.

One area relating to management of medicines had not been addressed. All other areas for medicines were safe.

People who could be at risk of abuse were protected by staff who were aware of their responsibilities.

There were safe systems for recruitment of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Training and supervision systems had been developed, but not all areas had been fully actioned, particularly in relation to supporting people with their healthcare needs.

Improvements had been made in supporting people with their meals, but certain areas still needed to be addressed.

The requirements of the Mental Capacity Act and Deprivation of Liberties Safeguards were followed.

People were referred to relevant external healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff did not always support and respect people's individuality.

People were involved in decisions about their care and were

supported in making choices.

People were supported by staff who knew them well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's admission assessments were not always clear. People had other ongoing assessments and care plans about their needs.

Activities were not consistently provided to support people in engagement. When activities were provided people enjoyed them and became involved in the life of the home.

People said when they raised issues, they were generally responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

Audits were in the process of being developed. Some areas had not been identified and acted on. Some areas, including record-keeping, still needed to be fully addressed.

The provider had made some improvements to the service to make it more dementia-friendly.

Staff appreciated the inclusive management style of the registered manager.

Ash Grove Care 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.

The inspection took place on 23 and 30 May 2017 and was unannounced. The inspection was undertaken by an inspector 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.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We received two 'Share your Experience' forms from people since the last inspection and used information from them when planning the inspection. The provider had sent us an information return (PIR) in which they outlined how they ensured they were meeting people's needs and their plans for the next 12 months. As part of the inspection, we reviewed the PIR. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. After the inspection, the provider wrote to us to clarify certain issues and provide us with further information.

We met with all 13 people who lived at the home and observed their care, including lunchtime meals, medicines administration and activities. We spoke with four people's relatives and one visiting healthcare professional. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We inspected the home, including the laundry, bathrooms and some people's bedrooms. We spoke with four of the care workers, the activities worker, the cook, a domestic worker, the care leader, the registered manager and the provider.

We 'pathway tracked' five of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed

us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included four staff training and supervision records, staff recruitment records, all of the medicines records, risk assessments, accident and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At the last inspection this area required improvement and the service was not meeting Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. This was because the provider was not always ensuring care was provided in a safe way for people. They were not always assessing risks to people and doing all that was reasonably practicable to mitigate such risks. The provider and registered manager have been in regular contact with the CQC since the last inspection to advise us of progress towards meeting the requirements of the Regulation.

At this inspection, while the provider had addressed some areas, they had not taken action in others. We met with a person who used a prescribed appliance to manage their continence. The National Institute for Health and Care Excellence (NICE) set out guidelines in 2014 on the use of such appliances. These guidelines identify a risk of infection to the person who uses these appliances unless safe procedures are followed. The person's records showed they had sustained infections in the recent past. The person had a range of different information in their records about management of this appliance, only some of which conformed to NICE guidelines. We spoke with three care workers about how they supported the person with the appliance, they gave us differing responses. The lack of a consistent approach to supporting the person with their appliance could put them at risk of infection.

Risk had not been reduced for people in other areas. One person had been assessed as being at high risk of pressure damage. Their care plan did not outline how the risk for this person was to be reduced, for example by the use of equipment or regular changes of their position. When we asked staff they gave us differing replies about how they supported the person to reduce their risk. This could have put them at risk of pressure damage. One of the people was living with diabetes. They had a foot care risk assessment. Information from Diabetes UK outlines risks to people's feet from diabetes and the additional supports people need in the light of this. The person's risk assessment and care plan did not outline any issues in relation to the person's diabetes and actions to be taken to reduce their risk.

At the last inspection, management of medicines had been improved and the only issues requiring improvement related to 'as required' PRN medicines. This continued at this inspection. We looked at records for six people who were prescribed PRN medicines. Three people had clear instructions about their PRN medicines, however three people did not have any instructions at all. This included a person who was prescribed a mood altering medicine. Records showed the person had been given the mood altering medicine on several occasions during the previous week. Without a clear instructions about their PRN medicines the provider could not ensure all staff were supporting the person in a consistent way or review the effectiveness of the medicine for the person when they showed challenging behaviours. The person was also prescribed a PRN medicine to be used to support their diabetes in an emergency. Although the person's records showed they had experienced a recent episode in relation to their diabetes, which had required medical attention, they did not have any instructions for staff about when to use this medicine or how to support the person in taking it, to reduce the person's risk.

This was a continued breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured there were sufficient numbers of staff deployed. People gave us mixed responses about whether the home was adequately staffed. One person told us, "More staff are needed, but nothing has been done about it" and another, "At times when someone is off sick they struggle." However other people were more positive. One person told us, "They come very quickly when I push the button." The provider did not have a written staffing plan. The duty rota for the two weeks before the inspection showed variable staffing levels. For two days there were two care workers on duty, for eight days, three care workers and for four days, four care workers. Staff told us people's needs could vary on a day-to-day basis, so between two and six people needed support from two care workers for their personal care, depending on how they were on that day; one person did not need any support. Staff said when there were only two or three care workers on duty, staff might not be readily available to support people who were in the sitting/dining area, many of whom were at risk of falling. Staff told us when this happened, they relied on the activities worker to ensure the safety and comfort of people. There was no activities worker rostered on weekend days or in the afternoons. Staff confirmed agency staff were not used.

On the first day of the inspection a care worker was off sick, so there were only two care workers and a senior care worker on duty to support people. We looked at records, including the duty rota and shift handover sheets, these showed this was not an isolated occurrence. On the second day, the activities worker was on annual leave and there were periods of time when no care workers were available to support people in the sitting room and ensure their safety. The lack of sufficient staff had the potential to put people who were living with dementia at risk. During the first inspection day, a person found another person walking about in their room, they brought them back to the sitting room because they did not want them to be there. This had not been noted by care workers because they were busy providing care to other people in their rooms. On the second day of inspection, we met with a person who needed urgent personal care in their own room. We were unable to find a care worker to support the person and ensure their dignity because they were busy supporting other people. When we informed the registered manager, they provided the person with the care they needed.

This is a breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014 in relation to the deployment of sufficient numbers of staff.

The provider ensured the safety of people in other areas. A person told us, "Yes I feel very safe living here, it's very quiet and the back of the building is secure." Where people were at high risk of falling, they had clear assessments and care plans about how their risk was to be reduced. This included the use of aids which would alert staff if the person unexpectedly got up from their chair. People all had risk assessments and care plans about moving safely. We saw staff supporting people to move in a safe way, following people's individual care plans. A domestic worker came through their sitting/dining room with their trolley, they careful checked people's feet were safe from the trolley wheels. A person chose to smoke. They had a clear risk assessment and care plan about this, which the person knew about and followed. All people had personal evacuation plans (PEEPs) which outlined how they were to be supported in the event of fire. A person who had been assessed as being at high risk of pressure damage was provided with an air mattress. There were records to show the mattress was regularly checked and maintained at the right level to reduce their risk.

People were supported with taking their medicines. One person told us, "I'm happy not to have to remember when to take my medicines, they bring them round and mark it off on their sheet," another, "They give me my medication on time, which is essential." We observed a care worker supporting people taking their medicines. They carefully checked each person's medicines administration record (MAR) before giving people their medicine. They sat down with person and discussed their tablets with them. They reassured one person who was concerned about a tablet. The care worker signed for medicines only after they had

ensured the person had taken all of their medicines. Where people were prescribed skin creams, each person had clear instructions about this, including a body map to show where each cream was to be applied. Records showed staff applied these creams in accordance with these instructions. Medicines were securely stored.

People said they felt safe at the home. One person told us, "I feel safer than being at home" and another, "The staff are very good, I feel very safe." We asked staff about safeguarding people. A newly employed domestic worker was very clear on their responsibilities, they told us firmly, "If it's not right, I'd report it." Care workers were all aware of the ways people could be at risk of abuse. They all confirmed they would always report any concerns to the senior member of staff on duty. The care leader knew how to alert the local authority safeguarding team. They told us they would, "Not hesitate" to do this when they had concerns. Two people showed verbal aggression towards each other. This was very quickly observed by staff who took prompt action to ensure both people's safety. One person had a clear safeguarding plan from the local authority about external people who might affect them.

The registered manager told us they were currently trying to recruit further staff. We looked at records of four staff who had recently been employed. These showed prospective staff were assessed for their suitability. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the home.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, this area required improvement and the service was not meeting Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014. This was because while training and supervision systems were being developed, not all areas had been actioned. The provider and registered manager have been in regular contact with the CQC since the last inspection to advise us of progress towards meeting the requirements of the Regulation. At this inspection the provider had made progress in some areas but certain areas relating to people's specific health care needs continued to require improvement.

One person's relative told us they felt staff needed training to ensure they effectively supported their relative's diabetes. We met with two people who were living with diabetes. These people's records were written in general terms, for example that if the person was 'experiencing a hypo/hyper staff to be aware of symptoms.' The care plans did not include information relating to the people's diabetic management such as what blood sugar levels were considered to be low or high for the person or actions to take to ensure the person's health if their blood sugar levels were low or high. We asked staff what would be high or low blood sugar levels and what actions they should take for these people. They gave us differing answers. Neither person had records to show their blood sugar levels were being regularly monitored, although one person had needed to be admitted to hospital because of their blood sugars just before the inspection. Neither person had a clear care plan about support for their nutrition in the light of their diabetic needs. One of these people had a care plan which stated only, 'Staff to encourage a diet suitable for medical condition,' with no further information. The person's food intake records indicated they were eating a diet which was high in carbohydrate. The registered manager told us training in diabetes had been booked and was to take place shortly. However one of these people had been admitted to the home over nine months before the inspection, but training had not taken place before or after their admission to ensure staff were aware of how to effectively support the person with their diabetes.

Some people had other healthcare needs. There were not effective strategies for ensuring such people's health needs were managed effectively, and staff had not been trained in how to support them. One person had needs relating to their blood pressure. We asked staff about this, they all confirmed they took the person's blood pressure if they were concerned about them. They gave us differing responses about blood pressure levels they would be concerned about. The person had no care plan to outline what blood pressure readings staff should be concerned about or actions to take if the person showed high or low blood pressure readings. Training records did not show staff had been trained in supporting people who experienced difficulties with their blood pressure. One person was supported by staff with an appliance for their continence needs. There was no evidence staff had been trained in caring for people who used such appliances. Discussions with two care workers indicated they were not aware of certain key areas of safe care provision in relation to supporting a person who used this type of appliance.

This was a continued breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured staff had the skills and competence to meet all people's needs safely.

While improvements had been made to support people with nutrition and dehydration since the last

inspection, a few areas still needed to be addressed. On the first day of inspection, there were no staff made available to support people at lunchtime, so meals were given to people by the activities worker. Some people chose to eat their meals in their own rooms but as only the activities worker was available to support people, people who wanted to eat in their own rooms had to wait for their meal until a member of staff was available to support them. There was no a clear system for staff to ensure all people who chose to eat in their rooms received their meal. We asked the cook if everyone had received their meal, they said they had, but we found one person who had chosen to eat in their room had not received their meal. The provider wrote to us after the inspection to explain the meal had not been well managed due to the regular food delivery to the home happening at that time. They said they had now changed the timings for the food delivery. On the second day of the inspection, the mealtime was very different, with plenty of staff in the sitting/dining room to support people and ensure people who chose to eat in their rooms received their meals in a timely way.

People were effectively supported in other areas relating to their food and drink. One person told us, "The food is nice if I want something else they'll always knock it up," another, "The good thing about living here is I can have seconds when I want it" and another, "There are choices for lunch and always jacket potatoes. You can have tea or coffee any time of the day." A person told us they were a vegetarian. They said they received the diet they wanted. All of the staff knew about this person and their dietary wishes. Regular hot drinks with biscuits were served and cold drinks were available in the lounge/dining room. The cook plated up each person's meal individually so they received the portion size they wanted. One person's care plan outlined their specific dietary needs. Their care plan was followed at both lunchtimes. Another person had been seen by the Speech and Language Therapist due to a swallowing difficulty. Staff followed instructions about the consistency of their drinks and used correct equipment to ensure their drinks were correctly mixed.

The provider had ensured staff were supported by training in other areas. New members of staff all confirmed they had received an induction into their role. A new domestic worker told us about the range of their induction training, which had included hygiene and infection control as well as areas like safeguarding and fire safety. They said the training had equipped them for their role. The registered manager had developed a training plan to ensure all staff received regular training in key areas such safely supporting people in moving, dementia care and supporting people who could show challenging behaviours. A care worker commented particularly on the, "Good training" in moving and handling. The activities worker told us they had attended a course about activities, which they said, "Helped quite a lot." Care workers confirmed they received regular supervision from their line manager. One care worker told us, "I'm 100% comfortable talking to seniors" and another, "I always do bring things up at supervision and they usually take action."

People were effectively supported with their other healthcare needs. A person told us, "I had a blocked ear and I mentioned it to the girls and they organised a doctor's appointment and it was fixed." We met with an external healthcare professional who told us care workers made, "Timely referrals" and said staff followed what they asked them to do. A person had needs relating to a past substance abuse. They had a care plan about how they were to be supported if issues happened again and who staff were to liaise with if they had concerns.

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. 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.

Due to living with dementia, several people had difficulty with certain aspects of consenting to care. These people had written assessments of their capacity, which were individually competed. All of the staff we spoke with had a clear understanding of their responsibilities under the MCA and how they supported people in relation to consent in their daily lives, for example by supporting them in choosing which clothes to wear. Staff also knew which people were able to recall and retain information. They also knew which people needed support with consenting to care, for example if they needed attention from emergency services. The registered manager knew who had given another person valid and active lasting powers of attorney (LPA). An LPA is a legal process that allows people to appoint someone to make financial or health and social care decisions on their behalf. The registered manager understood advocacy issues and ensured they had seen and recorded appropriate LPA authorisations so as they could be assured decisions were being made appropriately. The registered manager had applied for Deprivation of Liberty Safeguards (DoLS) where this was relevant for people. All people who needed a DoLS had clear documentation on their files.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, this area required improvement. This was because some staff did not always support and respect people's individuality or acknowledge them. By this inspection, the provider had taken some action, but some areas continued to require improvement.

On both days of the inspection, a person who had a catheter had their catheter bag showing, hanging down from under their clothes. Action was not taken to ensure the person's privacy and dignity on either day. On both days, some staff continued not to acknowledge people by taking the opportunity to engage with them in any way as they walked back and forth through the sitting/dining room. These are areas which continue to require improvement.

People said staff were caring. One person told us, "The girls are very good they treat you like they'd treat their own family" and another, "I couldn't ask for a better bunch they are fantastic." One person's relative told us, "Girls are brilliant, my [relative] is clean, warm and well fed." People commented on the humanity of staff. One person told us, "We have young staff here and sometimes they tell us about their exploits at the weekend, which keeps me entertained." We saw a care worker with a person, there was lots of laughing and jokes between them.

Staff respected people's privacy. One person told us, "Staff always knock before entering my room" and another, "Staff always knock first." One person told us they appreciated the way, "Staff check on you at night but don't wake you up." A care worker discreetly listened to a person who told them they had "Trouble in the toilet," and was worried they might have made "A mess." The care worker quietly answered, "I'll go and check, it's alright don't worry." One person told a care worker they wanted to discuss something confidential with them, the care worker took them to a quiet corner of room, so they could talk without being overheard by others.

Staff treated people with respect and supported them in making choices. One person asked a care worker about what they should do next, the care worker responded by saying, "It's your home you choose." Care workers supported people in standing up and sitting down in a respectful way. When supporting one person they said, "If you stand up when you are ready" and with another, "If you put your hands on the chair then you can lower yourself down, well done." Two care workers supported a person to stand up from the dining table, using a standing frame. They spoke very gently to the person, giving them step by step instructions as to what was going to happen and asking their permission at every stage. A person was asleep before lunch, a care worker gently woke them and checked they understood what was happening, before they supported them further. The activities worker offered people napkins for their faces and hands during and after the meal when they needed them.

People said staff supported them in remaining independent. One person told us, "They help me but allow me to be independent, my balance is not always good at times so they are always there to support," another, "I dress myself but the carers help with my shower," and another "I can have a bath or shower every day if I want, they are very dignified and explain everything they are doing." A person whose first language

was not English had signs on their en-suite in their first language, to support them with their continence management. Before lunch one person wanted to be involved in folding up napkins for everyone to use, they were supported in doing this. The activities worker asked people if they wanted condiments with their meals and listened to their replies before helping people. One care worker checked with a person if they wanted to come to the table for lunch or not and followed what they said they wanted to do.

Staff knew people as individuals. Some people's rooms were highly individual, reflecting their likes and preferences. One care worker was chatting to a person, asking them to show them dance moves, saying they knew the person had been a dancer in the past. An external healthcare professional told us staff knew people as individuals, so they asked them which interventions would work for a person when providing healthcare. All of the care plans we reviewed showed people had been asked if they would prefer to have a care worker of the same gender to provide them with personal care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, this area required improvement. This was because all people did not have full and consistent assessments and care plans. At this inspection, while most areas had been addressed, some still required improvement.

We met with a person who had been newly admitted and looked at their records. The person had an admissions assessment completed. There was sparse information documented on their admissions assessment to show the home could meet the person's needs, this was partly because the information provided by the previous provider and funding agency was limited. The person was visited regularly by close family members who were aware of their range of needs, but information from them had not been included in their admissions assessment to assess if the home could meet the person's needs. The person had a specific care need. When we inspected, the district nurses were still meeting one part of the person's specific care need and staff were meeting the rest of it. The person's care plan about this specific need was not drawn up until six days after their admission. The care plan about this specific care need was limited and did not outline how staff were to meet all of this person's specific need. Three care workers we spoke with were unsure of how they were to appropriately support the person in relation to meeting this person's specific care need.

The home employed an activities worker every morning. During the afternoon, weekends and when the activities worker was on annual leave, care workers provided activities. On the first day, after the activities worker went off duty, no activities took place in the dining/sitting room until just before 4pm. During this period people sat in their chairs either asleep of disengaged, with the only activity provided by the television. The activities board in the entrance hall stated the activity for that afternoon was 'colouring.' On the second day of the inspection, when the activities worker was on annual leave, no activities took place in the lounge/sitting room until after 11am. Before then, people sat in the lounge either asleep or disengaged from their surroundings.

When activities were provided, there was a noticeable change in people's demeanour. On the first day when the activities worker was on duty, people were playing with a ball and bean bags, using a parachute. People were clearly enjoying keeping the ball on the parachute. One resident jokingly said, "Before you start you need to swing the bean bags over your head three times for good luck," all the residents laughed. Two people had rummage boxes which included items familiar to them, which they enjoyed handling. On the second day, after 11am, people were supported with being involved in a game of bingo; they were clearly enjoying themselves. At this time, there was lots of chat and laughter between people and staff.

The activities worker told us they were fairly new in their role. They said they could see the importance of their role in supporting people who were living with dementia in engagement with their surroundings. They said they had learnt a key area was to provide a variety of shorter activities to people. They said they had plans to further develop activities in the future, for example they had made arrangements for weekly visits by an ice cream van. The provider had recently purchased a minivan and this would be used in future for trips out of the home.

The provider was responding to people's other needs. One person told us, "They discuss my care plan with me and review it every now and again." One person's relative told us staff had phoned them, "Straight away," about a change in their relative's condition.

One person had specific mouth care needs. They had a clear care plan about how these needs were to be met. Staff followed the person's care plan. Another person had a clear care plan about their continence needs. This was updated when their needs changed. The person's daily records showed staff were following this person's care plan. A person's care plan documented they experienced auditory hallucinations, which could trouble them and cause them anxiety. All of the staff we spoke with knew about how these occurrences affected the person, and how they supported the person when they happened.

The home's complaints procedure was displayed in the front hall for all to access. People said they could raise issues of concern and complaints. One person told us they had raised issues, but the matter they had told us about was not documented on the complaints file. We discussed this with the registered manager who said they would impress upon all staff the importance of documenting all matters so they could ensure issues raised had been appropriately assessed and reviewed. One person told us if they were not happy about something, they would tell the staff and, "They take it to whoever's necessary." Another person told us, "I have complained twice and both times it was dealt with quickly." We looked at complaints records and saw the issues the person had raised had been documented, together with an action plan for improvement. The complaints folder showed a concern had been raised about the cleanliness of a person's room. The file also documented actions taken to address this matter.

Inadequate

Is the service well-led?

Our findings

At the last inspection, this area required improvement and we identified the service was not meeting Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014. This was because the provider did not always ensure they had systems which operated effectively to assess, monitor and improve the quality and safety of the services provided. They also did not always maintain an accurate record for each person. The provider and registered manager have been in regular contact with CQC since the last inspection to advise us of progress towards meeting the requirements of the Regulation.

This home had a history of failing to meet the HSCA Regulations 2014. It was rated as Inadequate at the inspection of 30 December 2014 and 2 January 2015 and the CQC took enforcement action. It was again rated as Inadequate at the inspection of 21 and 24 July 2015 and the CQC took further enforcement action. A new manager was appointed to the home four weeks before the inspection of 5 and 6 April 2016. The new manager had made substantial improvements by that inspection and although three breaches in the Regulations remained, risk to people had been much reduced because of improvements made. By this inspection, the provider had not addressed these breaches in full and some new areas relating to the breaches were identified, although some other areas had been addressed.

Since the last inspection, the new manager had been registered as the manager of Ash Grove Care Home. They did not work full-time in this post because they were also the registered manager for another home run by the provider. The registered manager told us they usually worked in Ash Grove Care Home three days a week and at the other home two days a week. There was no deputy manager. The registered manager was supported by a care leader who managed Ash Grove Care Home when the registered manager was in the other home. This situation had continued for about a year. At the time of this inspection, the provider had attempted to recruit a registered manager and deputy but had not yet succeeded. The registered manager was supported by senior care workers who were on duty every shift, but only the care leader drew up and reviewed people's assessments and care plans. There was no action plan about ensuring adequate management arrangements for the home until further appointments were made. After the inspection, the provider wrote to us to inform us about the appointment of a deputy manager and recruitment process for a new registered manager for Ash Grove Care Home.

The provider had not identified some areas for action to ensure the safety and well-being of people. People and staff told us they had concerns about staffing levels. Duty rotas and safety handover records for the weeks commencing 8 and 15 May 2017 showed variable staffing levels. There was no management action plan about how people's welfare and safety needs were to be met by reduced staffing levels including at weekends. This was despite the home caring for three people who had more complex dementia and health care needs who needed more frequent support and monitoring to ensure their safety and welfare.

The provider had set up a sensory room for people to enjoy as a quiet, relaxing area, which provided a pleasant environment for people. Unfortunately the door to the room was locked on both inspection days. We were told that people needed to be supported one to one in the room for their safety, so it was only used when there were sufficient staff on duty.

Where the provider was auditing the quality of the service they did not always identify relevant matters and ensure necessary actions were taken. The health and safety audit of May 2017 had not identified risks to people from the unlocked gate in the smaller patio area. This patio had an area where a range of items had been left, some of which could present risk to people. It had a gate in front of it, but for both inspection days, this gate was not secured in any way. On both of the inspection days, we observed different people walking about in this patio area. They were not supervised by staff. We asked the provider how they prevented risk to people in this second patio area, and he put a padlock on the gate. However he had not identified and taken relevant action about this risk to people before the inspection. This was despite a similar risk being identified during the inspection of July 2015 in relation to the larger patio area.

The provider had not ensured people's records were kept up to date, so all staff were aware of how to meet people's individual needs. One of the people we met with had fallen the day before the inspection. Their fall had resulted in an injury and attendance at hospital. On the second day of the inspection, eight days after the person's fall and injury, their assessment and care plan had not been updated. One person's records showed that their weight had increased by 4.2Kg in the last nine months. They had other healthcare needs which could be affected if they increased their weight. Their care plan did not document any strategy for supporting them in weight management. We discussed these and other examples with the care leader. They told us they were allocated two days a week to review and up-date all of the people's records. Due to staffing levels and the complexity of some people's care needs, two days a week was not enough time to ensure they could keep all people's care records up to date. The provider had not identified this issue and taken relevant action to ensure people's records were up to date and reflected their current care and welfare needs.

This was a continued breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The provider had successfully developed other audits. The registered manager reviewed all accidents and incidents and wrote a report every month. The audit identified which people experienced more accidents, whether accidents were more frequent at different times of day and where they occurred in the home. Where issues were identified, action was taken. For example a person who tended to experience falls frequently had assessments and care plans which were regularly reviewed to reduce their risk, including with external professionals. The provider had identified the previous contract cleaners were not performing their role to the necessary standard. They had changed their procedures and now employed their own domestic workers. The quality of cleaning was regularly audited by the provider. All areas we inspected were clean, including areas such as bathrooms and toilets.

People told us they thought Ash Grove Care Home was well-led. One person told us about the provider, "He is a very hands on owner, he keeps the place in order." One person told us how much they liked the home, saying "I moved here from another home which I did not like." One person's relative described the registered manager as, "Very thorough." Staff reported on the support they received from the registered manager. One member of staff described the "Huge improvements," since the registered manager had come in post. Another member of staff told us, "I feel quite comfortable bringing thing up, I can discuss things with the manager."

People commented on the improvements to the home environment since the last inspection which had made it more supportive of people who were living with dementia. There were signs in the communal areas and corridors with pictures directing people around the home, for example 'Dining Room' and 'Lounge'. Some of the people's rooms had their names on them, although some did not. One quiet area had been redecorated with wallpaper so it looked like a library.

People were consulted about the service. One person told us, "We have residents meetings once every couple of months." Records of these meetings, showed a range of issues were discussed, particularly relating to activities, meals and the home environment. Staff were also regularly consulted, including regular staff meetings. One member of staff told us, "You can bring up different ideas, say how you're feeling etc." Minutes of a recent staff meeting showed staff had raised issues relating to training, which the registered manager was looking into. One senior member of staff's one to one meeting showed active discussions were taking place about training they wanted to pursue.