Runwood Homes Limited

Ashwood - Ware

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashwood is a purpose built care home and is registered to provide accommodation and personal care for up 64 older people some of whom are living with dementia. At the time of our inspection 60 people were living at Ashwood.

The home had a registered manager in post who left the service one week prior the 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. At the time of the inspection the home was managed by an interim manager who told us they will be registering with CQC shortly.

The inspection took place on 13 July 2017 and was unannounced. When we carried out an unannounced comprehensive inspection in Ashwood on 27 July 2016 we found that the service required improvement in some areas which included incidents not being sufficiently identified and reviewed to ensure people were kept safe. Systems and processes for monitoring and reviewing the service were not consistently effective. We undertook a focused inspection on 13 April 2017 in response to concerns raised to us about lack of staffing in Ashwood. During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to keeping people safe, medicines management, staffing and governance.

At this inspection we found that some improvements were made around medicine management and staffing however the change in management had slowed the process and further improvements were needed to ensure people living in Ashwood received safe and quality care.

Risks to people`s well-being were identified and assessed, however actions were not always in place or followed by staff to help ensure risks were sufficiently mitigated to keep people safe.

Where people sustained unexplained bruises, these were documented, however were not investigated or reported to local safeguarding authorities.

Although the environment in Ashwood was newly decorated and looked fresh there were persistent odours around the home throughout the day and by the afternoon some people had unpleasant odours around them.

Governance systems and people`s care records continued to be an area in need of improvement. The interim manager and the provider told us they identified and were working on improving the quality of the governance systems used, updating care plans and building a permanent staff group.

People and staff told us that staffing had improved and their needs were met in a more timely way, however

at times we saw that staff were under pressure especially during busy times in the morning to meet people`s needs.

People`s medicines were managed safely by trained staff who had their competencies checked regularly.

Staff felt supported by the interim manager who enabled them to carry out their role effectively. Staff had received training relevant to their role and were offered the opportunity to develop their skills and progress in their career.

People's consent was sought prior to care being carried out and staff took time to explain the task they wished to carry out. People's nutritional needs were met and their food and fluid intake and weight were monitored, although not always documented. People were able to choose what they ate from a varied menu and the provider was working to further improve this area so people had more choices at breakfast time. People`s health needs were met and they had access to a range of health professionals when needed.

Staff spoke with people in a kind, patient and friendly way and respected people`s privacy. People felt listened to and told us they felt the home has improved since our last inspection. Staff were aware of people's needs, choices and we saw that a friendly rapport had developed between people and staff who cared for them.

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 consistently safe.

Where people sustained unexplained bruising these were not always investigated or reported to local safeguarding authorities.

Risks to people's health and well-being were identified and managed in most cases, however staff did not always recognised or followed existing risk management plans to keep people safe.

There were sufficient numbers of staff however further improvements were needed to ensure they were effectively deployed to meet peoples` needs safely.

People's medicines were managed safely by staff who were trained and had their competencies checked.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training in areas considered mandatory by the provider, however they had no training to understand special conditions some people in the home had.

Staff told us they felt supported by the interim manager and provider to enable them to carry out their role sufficiently.

Staff were observed to gain peoples consent prior to assisting them with tasks.

Where people lacked capacity to make certain decisions assessments were carried out in line with the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink sufficient amounts.

People had access to a range of healthcare professionals to support their needs when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always protected and promoted.

Staff spoke with people in a kind and sensitive manner, and knew people's needs well.

Confidential information was kept secure.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People`s care plans were not always personalised and had not accurately reflected people`s current needs.

People had mixed views about the activities provided in the home.

People's wellbeing was supported by staff who were aware of their preferences and choices and responded to these effectively.

People were aware of how to make a complaint or raise concerns and meetings were held for them to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People's care records continued to lack in sufficient information for staff to deliver safe and effective care.

The provider`s policy and procedure to raise and report safeguarding concerns was not always followed.

Staff felt supported by the interim manager and valued members of the team. The interim manager was supported to improve the home by the provider`s quality team.

Staff and people told us the interim manager was approachable and they felt they were able to contribute to ideas about the running of the home.

Ashwood - Ware

Detailed findings

Background to this inspection

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

This inspection took place on 13 July 2016 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed a copy of the action plan that was submitted to us after the previous inspection, and also sought feedback from social care professionals visiting the home regularly.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with ten people who lived at the home, two relatives, one visitor, five permanent staff, two agency staff, the manager and representatives of the provider. We looked at care records relating to six people together with other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person told us, "I feel safe as I'm with other people so I don't feel lonely." Another person told us that they felt safe as the home improved and that they felt safe enough to leave their bedroom door open in the evening so staff could check on them if they needed to. Relatives told us that they did not always feel that people were safe. One relative told us, "[Person] keeps forgetting their frame and I have to remind them [staff] that they need it." Another relative told us"I don't think [person] is that safe as I had to call for an ambulance when I saw [person] was having a heart attack when I went to visit [person]." We discussed this with the acting manager although this happened before they started at the home and they told us the person had been admitted to hospital with dehydration an not a heart attack.

Staff were knowledgeable about what constituted abuse and they were confident in how and when they should report their concerns. They told us they had regular safeguarding training and information about local safeguarding authorities with relevant contact details was available to them. However we found that some of the incidents which should have triggered a report under the safeguarding process were not recognised and reported by staff. For example where people sustained unexplained bruising staff were quick in recording on the accident, incident form they completed that the bruises were likely caused by the medicines people were taking. However people who take certain medicines are more prone to bruising not just developing bruising without a reason.

We found that staff had not reported any unexplained bruises to the local safeguarding authorities and no investigations were carried out to try and establish the reasons for these. As a result there were no reviews done for people who sustained these bruises and no preventative measures were put in place to help protect people from the risk of harm. For example we found that staff recorded that they found a person in the morning with a large bruise to the right side of their face, eye and temple. There was no investigation done to establish how this occurred and staff assumed this had happened because they were taking a medicine which could have caused the bruise, however they did not request a visit from the GP to discuss this and review the person`s medicines.

Information and guidance about how to report safeguarding concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike. This showed us that the provider had taken steps to help ensure that people were protected from abuse and avoidable harm; however their processes were not robust enough to identify potential safeguarding concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for such areas as the risk of choking, the risk of absconding, use of wheelchairs and the risk of falls. These assessments identified potential risks to people's safety however, lacked detail for the provider to be able to be confident that staff had the information they needed to be able to mitigate the risks. For example,

one person had been assessed as being at risk of becoming angry and abusive whilst being supported with their personal hygiene needs. The instructions for staff were, "To offer verbal assurances to help restore [person's] mood." There was no detail about alternative approaches to be considered, any distraction techniques for staff to use or how to best manage the person's hygiene needs.

We also found that when staff completed an assessment tool to ascertain if a person was at risk of chocking the tool indicated that staff should contact the speech and language therapist (SALT) team immediately because the person had displayed the signs of aspiration when they were eating and drinking. However we found that although the tool was completed accurately and staff confirmed that the person had frequent chest infections and they were coughing when eating and drinking the SALT team had not been contacted and the care plan detailed that the person was low risk of chocking. We discussed this with the provider and they referred the person to the SALT team on the day of the inspection.

This was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks involved in people`s daily living were not sufficiently mitigated to keep people safe.

At the previous inspection people told us that there were not enough staff around to meet their needs in a timely way. At this inspection people were happy that staff answered their call bells in a timely fashion and their needs were met. One person said, "Call bells are answered quickly." Staff told us that there were enough staff available to meet people's needs. One staff member said, "We are not working short anymore. The rota is covered with agency staff if needed. It means a lot to have the floats around." Another staff member said, "It is a lot better now. The [interim] manager always covers the rota to make sure we are not short."

The staffing levels at the home were assessed by the provider using a dependency tool. The interim manager told us that they did not have autonomy at a local level to increase staffing numbers if needed. For example, the service had five 'step down' beds where people stayed for a short term after a hospital stay before returning to their own home. In some instances people accommodated in these beds had high needs and required additional support from staff to settle into their new environment.

The provider had an expectation from the Care Team Managers (CTM) to help with personal care after they administered medicines to people, however as we reported in the previous inspection there was little evidence that the CTM`s were able to actively help as they were administering medicines, dealing with emergencies, visiting professionals and other duties relevant to their job roles. For example we observed on one unit in the home there was an air of chaos for a short time early in the day and the CTM was not able to help the staff member on the unit. One person was calling for assistance with using the toilet, another person had accessed someone else's room, some people were asking for assistance to get dressed and others required support and supervision with their breakfast. Once the staff member had restored calm to the unit in a measured and reassuring way we found that people received their care and support when they needed it and wanted it. Call bells were answered in a timely manner and staff went about their duties in a calm and organised way, however staff`s deployment around the home at busy times was an area in need of improvement.

We observed a staff member administering medicines to people. Medicines which were suitable were pre-packed by the pharmacy in individual pots for each person for the times of the day they were prescribed for. Medication Administration Records (MAR) were completed once staff observed the person taking their medicine. Those staff who administered medicines to people were appropriately trained to do so, and a signature list at the front of the MAR confirmed those staff authorised to manage people medicines. We

checked a random sample of boxed medicines and found only in one unit stocks did not always agree with the records maintained. We had a discussion with the staff responsible for administering medicines on this unit and found that the issues identified related to shortfalls in record keeping and that people had received their medicines as needed.

We found that although the environment was recently decorated the home was not clean and fresh throughout. For example, there was a background aroma throughout the home all through the day, bathroom sinks were stained with lime scale and a shower chair was rusty with paint flaking off the legs which created a non-wipe clean surface. One relative told us, "When I come to visit I often smell urine, other friends have commented on it too." The interim manager and the provider told us they have identified this issues and there were in the process of replacing sinks and baths and also carpets to ensure there were no infection control risks present for people.

Requires Improvement

Is the service effective?

Our findings

People told us staff were knowledgeable when they needed support. One person told us, "They [staff] sorted out my swollen leg problem which they didn't do at my previous home." We saw a record of a compliment had been received in June 2017 about care and support that had been provided to a person who used the service. The person had been admitted from a stay in hospital where they had been confined to bed and was unable to walk. The relative had stated, "After a week at Ashwood [person] was up and walking and eating. The transformation was miraculous, we can only put this down to the care and encouragement [person] has been given."

Staff told us they had regular training and they were happy with the support they received from the interim manager. One staff member said, "I was ready to hand in my resignation before this manager started. I decided to stay because things are better and we feel supported." Another staff member said, "It is a lot better now. The support from the [interim] manager is very good. They are on the floor and help us out." Staff and the management team confirmed that there was a programme of staff supervision in place, all staff we spoke with said they received support as and when needed and were fully confident to approach the management team for additional support at any time.

However we found that staff were trained only in subjects considered mandatory by the provider. These included infection control, health and safety, safeguarding, dementia and others. Staff had not received training in all the areas of care they provided to people such as continence care, behaviours that challenged, diabetes, Parkinson, pressure care and supporting people with swallowing difficulties. We found that some people who lived with dementia in Ashwood had behaviours which challenged and staff had little guidance in how to effectively manage this. On the day of the inspection some people had an unpleasant aroma around them by the afternoon clearly suggesting that their continence needs were not met al all times. We also observed some people coughing when eating and staff confirmed that one of them also had frequent chest infections which could have been a sign of aspiration and swallowing difficulties. Staff had not referred people to the speech and language therapists team for assessment. This was an area in need of improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, we found that all the people who were considered to require a DoLS, had one submitted and were awaiting a decision by the local authority.

People where needed had their mental capacity assessed and if they lacked capacity certain decisions were made in their best interest following a best interest process. For example the manager told us about a

person who had frequent falls. The person lived with dementia and was not aware of their own safety. The interim manager invited the person`s relatives to discuss measures to put in place to ensure that the support the person received was in their best interest. Staff asked for people`s consent for the care and support they received.

People spoke positively about the food saying it was good and there was a good choice. One person said, "The hot food is hot and we get a choice." Another person told us, "You have a choice from two options and if you don't like either they [kitchen staff] will do you a jacket potato and cheese." One relative told us, "[Person] likes the food and they [staff] always offer me a cup of tea when I come and visit." There was a copy of the menu displayed on each table in the dining areas. We observed that drinks were available and were being offered to people throughout the day of the inspection. However at breakfast there was a limited choice of hot food on offer daily. The provider and the interim manager told us they scheduled meetings with people to gather their feedback about the food and to help ensure the menu was based on peoples` preferences.

We observed the lunchtime meal served in the communal dining rooms and noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were laid with placemats and menus were on the tables to remind people of the choices available. Staff showed people the two main meal options so that they could make an effective choice based on the look and the smell of the food. Staff then asked people if they wanted sauce or gravy and provided these in quantities according to people's wishes.

Staff were monitoring people`s nutritional intake. People were weighed regularly and where a weight loss was identified staff involved the person`s GP and a dietician to ensure they had specialist advise in meeting people`s nutritional needs. Staff also monitored people`s fluid intake. Charts were completed when people had drinks. However some relatives told us that they were not sure that staff encouraged people to drink enough. One relative said, "It's on [person`s] care plan that they must be given drinks, but twice they had been in hospital for dehydration so I don't think they [staff] cater for [person`s] needs."

People had regular GP visiting and reviewing their health. We noted form people's care plans that appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dieticians, opticians and chiropodists.

Requires Improvement

Is the service caring?

Our findings

Staff respected people's dignity and tried to support people in the way they wished whilst encouraging them to remain as independent as possible. However, we saw some examples where people had accessed toilet facilities independently and had chosen not to close the doors. Whilst the people had made the choice to leave the door open this meant that the dignity of other people who used the service and visitors who may be passing by was not protected. Support with people's personal care needs varied throughout the home. For example, we saw some people who had clearly received good support and were well presented and well groomed. Whereas others had not had their hair brushed, were wearing creased clothing and had an odour around them which clearly indicated that they had not received appropriate support with their toileting needs. This was an area in need of improvement.

People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures. On most of the bedroom doors there were laminated posters giving a little bit of information about the person living there like their name where they came from and their likes along with a picture of them. The communal areas of the home had some items and pictures on the wall designed to engage people who lived with dementia and we saw items in the individual bungalows for people to pick up and engage with at will. However, in one bungalow there was music playing in the kitchen/diner and the TV was on quite loudly in the lounge area. This created a confusion of noise which may be unsettling for people who live with dementia.

People's care records were stored in a lockable office in order to maintain the dignity and confidentiality of people who used the service. However, this office was located away from the individual bungalows which meant that staff did not have information and guidance about people's care needs close at hand.
People told us they were looked after in a kind way by staff. One person said, "They [staff] are more caring here than my last place, they sorted out a doctor to see me and my leg problem has gone." A second person said, "The staff are very nice here."

People were offered choices and these were respected which contributed towards people feeling that they had control in their lives. For example, we heard a staff member say, "Would you like a top up [Person's name]?" The staff member then offered a visual choice of drinks for the person to select their preference. Staff were calm and gentle in their approach towards people and clearly knew people well. We heard staff chatting with people about the colour of the T shirt they wore and events in their past lives.

We observed staff interact with people in a warm and caring manner listening to what they had to say and taking action where appropriate. For example we observed a staff member take time to reassure a person who had become anxious. The staff member suggested to the person that they took a little walk together and we heard them chatting about pets the person had in their earlier life. When the person returned to the bungalow we noted that their demeanour had brightened and they were no longer anxious.

Care plans had details about people`s support needs. Many of the people in the home were living with dementia and we saw little input from them in their own words in the care plans. However we found that

staff had completed an assessment form, 'This is me` where they captured important events from people`s life, their likes and dislikes. This helped staff to understand people better and offer personalised care to people. Care plans were reviewed and relatives were invited to participate and share their views on the care and support people received.

Requires Improvement

Is the service responsive?

Our findings

People gave us mixed views about opportunities available for them to pursue their hobbies and interests. Some people were more able and participated in daily chores around the home and also they were growing their own vegetables in the garden. Other people who were less mobile told us there was not much going on. One person said, "I like to get involved with helping with the chores as it gets boring otherwise. I have my own patch of garden where I grow tomatoes." Another person said, "I don't like to speak out of turn but there's not much to do here. I don't think they have any activities like Bingo."

A staff member told us, "The activities have improved; the new activity co-ordinator has been here three weeks. Activities have been taking place in the front lounge every day." A member of the provider's senior management team reported that the newly recruited activity co-ordinator was in the process of developing individual activity plans for each person who used the service. We were told that once this had been completed a review of the activity planner for the home would be undertaken to create a more tailored approach in response to the feedback received from individuals.

One the day of the inspection there was a morning activity session of arts and crafts and musical instruments in the afternoon. We also saw a person who was enjoying a dolls therapy. They were comforting and talking with a doll which obviously made them happy.

People's care plans were not always sufficiently detailed to be able to guide staff to provide their individual care needs. For example, there was a lack of information and guidance for staff about how to meet people's dementia needs and alternative approaches to try should people resist personal care. However, some care plans we viewed contain good information such as which brand and fragrance of bath foam and talcum powder a person liked and how deep they preferred their bath to be.

Staff were knowledgeable about people's preferred routines, likes and dislikes, backgrounds and personal circumstances and used this to good effect in providing them with personalised care and support that met their individual needs. Throughout the inspection we observed several examples of staff being proactive in assisting people and responding to their needs in a way that confirmed they knew people very well.

Records showed that concerns and complaints raised by people who used the service or their relatives were appropriately investigated and resolved in accordance with the provider's policy and procedure. However people and relatives told us they were not aware of a complaint policy although we have seen this displayed in the home. One person told us, "If I wanted to make a complaint then I would find the person in charge." Another person said, "I have been to a residents meeting and if I had a concern I would raise it there."

There were monthly residents meetings and we saw the dates displayed on the notice board. People told us they were aware of these meetings and they could raise any issues they had there.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found that there were insufficient robust or effective systems in place to assess, monitor and review the quality of service provided. Governance audits were not effective in identifying issues or concerns and staff did not feel supported by the management team or provider. At this inspection we found that some improvements were made, however the change in management has slowed the process down and further improvements were needed in some areas.

The interim manager and the provider told us they had identified that people`s care plans were not accurate in reflecting current needs and also that some of the assessments were not completed accurately. They told us they were working on updating care plans and re-assessing people`s needs to ensure the information in these plans were accurate. The interim manager was supported by the provider's quality team which consisted in a dementia services manager and a peripatetic manager.

We found that staff were not always knowledgeable about some signs and symptoms people had which may have suggested that their health was deteriorating. For example staff told us about a person who showed signs of aspiration whilst eating. Although the care plan instructed staff to refer the person to specialist health professionals staff had not recognised the signs and the request for a specialist assessment was only made when we talked to the provider. We also observed another person who was coughing a lot when eating and asked the manager to carry out their observations and establish if they needed the advice from a health care professional. Relatives also told us they had to prompt staff on occasions to call for a person`s GP as they noticed people were not feeling well. We found that staff had no training to understand some of the specialist needs some people had in the home. For example there was no training for Diabetes, Parkinson or Dysphasia. This meant that there was a possibility that staff were not skilled enough to recognise and action in a timely way when people`s health declined.

At the previous inspection we found that there were no Personal Emergency Evacuation Plans (PEEP) for people. At this inspection we found that the interim manager was reviewing all fire procedures in the home. They were planning to do fire drills during the day as well as night time. They told us that the previous deputy manager completed the PEEPs, however when we looked these were care plans and not emergency evacuation plans. We found that the provider had no awareness about the current legislation and requirement regarding PEEPs and this was left for the interim manager to action.

Not all incidents or accidents were thoroughly investigated and reported to local safeguarding authorities to ensure that people were protected from the risk of harm or abuse. For example we found that staff recorded unexplained bruising for a person on four separate occasions from May 2017 to June 2017. For another person they noted unexplained bruising on two separate occasions in June 2017. A third person was found to have bruising on their back, arm, thighs and leg, however there was no link to any falls the person may have had. None of these incidents were investigated or reported to local safeguarding authorities. The interim manager and the provider told us they will be looking into this as a matter of urgency. They told us they had a policy and procedure in place which instructs staff and manager to investigate and report all unexplained injuries.

This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a different atmosphere in the home at this inspection than previously. Staff were more relaxed and smiling when talking to people. They told us they felt more supported and listened by the interim manager. Staff told us that the management team was approachable and that they could talk to them at any time. One staff member said, "There have been some changes with management lately, it has been a shock. The changes have definitely been for the better so far." Another staff member said, "I feel I am well supported by [manager`s name] and that I can talk to her about any issues. There are notices up in the staff room with contact numbers if I wasn't able to talk to anyone here." Staff told us and we saw that there were staff meetings held to enable them to discuss any issues arising in the home.

Following the focused inspection we carried out on 13 May 2017 the provider carried out several audits and observations in the home. We found that their audits have found similar issues as we reported in this inspection as well as previously. For example care plans not completed accurately and odours around the home. The manager told us they were prioritising the actions to take to improve the quality of the care people received. They told us they were actively recruiting to ensure they could build a permanent staffing team and provide continuity of quality care for people. They held meetings with relatives, people and staff to discuss issues and give people the opportunity to influence the running of the home. We found that the interim manager was open and transparent in sharing the last CQC report and the actions they were planning to take with relatives and staff. They told us it was very important for staff to understand what needed improving and why. This helped staff to feel important and valued and encouraged them to take responsibility for their actions.

The regional manager told us they would continue to support the interim manager and the staff team to improve and sustain the improvements made in the home. They told us they were committed to improve the quality of the care people received in Ashwood.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people`s well-being were identified and assessed, however actions were not always in place or followed by staff to help ensure risks were sufficiently mitigated to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that where people sustained unexplained bruises these investigated and reported to local safeguarding authorities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems or processes that were established were effectively used to monitor and improve the quality of services people received, and to keep people safe. An accurate contemporaneous record had not been maintained in respect of each person relating to the care and treatment provided to them.