Bondcare (London) Limited

Ashwood Care Centre

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

The inspection took place on 11 October 2017 and was unannounced.

This was the first inspection of the service since it was registered with the provider Bondcare (London) Limited on 4 October 2017. Previous to this the service was registered with and managed by another organisation.

Ashwood Care Centre is a care home providing nursing and personal care to up to 70 older people. At the time of our inspection 50 people were living at the service, some were living with the experience of dementia and some had general nursing needs. Nurses were employed to work on two of the three floors.

Bondcare (London) Limited manage nine care homes within London and are part of Bondcare, a national provider of care homes in the United Kingdom.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

There was not always the equipment needed to care for people safely and meet their needs.

People received their medicines as prescribed but the way in which medicines were managed meant that there was a risk they would not always receive medicines in a safe way.

The staff who cared for people did not always get the support they needed. People were not always cared for by suitably qualified and experienced staff.

The provider was not always meeting people's hydration needs.

The staff were not always kind and did not consider people's feelings.

The staff tended to focus on the tasks they were performing rather than the person they were caring for.

People were not always cared for in a way which met their needs and reflected their preferences.

The provider's systems for identifying and monitoring risk were not always effective.

We found breaches of six Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Some aspects of the environment were not suitable to meet the needs of people living with the experience of dementia. We made a recommendation in respect of this.

There were enough staff to keep people safe, but people's needs were not always being met and the staff felt this was because there were not enough of them.

People were happy living at the service. They felt their needs were being met and they told us that the staff were kind and caring.

The staff were generally happy working at the service and felt supported by the new manager and provider. The staff had opportunities to meet with their manager and were provided with training to help them understand their roles and responsibilities.

The risks to people's wellbeing had been assessed and planned for. The provider had procedures designed to safeguard people from abuse. The provider's procedures for recruiting staff were suitable.

The provider was acting within the principles of the Mental Capacity Act 2005.

People knew how to make a complaint and felt confident they would be listened to.

People were encouraged to be independent where they could be.

The provider had a good understanding about the areas of the service which needed improving and had an action plan so that they could make these improvements. They worked closely with the local authority who was monitoring the improvements they made.

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

Some aspects of the service were not safe.

People were placed at risk of harm because there was not enough equipment to meet their needs.

There was a risk that people would not receive their medicines as prescribed.

There were enough staff to keep people safe, but not all of their needs were being met.

The staff had assessed risks to people's safety and wellbeing.

People lived in a safe and clean environment.

There were appropriate systems for recruiting staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not responsive.

The staff who cared for people did not always get the support they needed. People were not always cared for by suitably qualified and experienced staff.

The provider was not always meeting people's hydration needs.

Some aspects of the environment were not suitable to meet the needs of people living with the experience of dementia.

The provider was acting within the principles of the Mental Capacity Act 2005.

People's healthcare needs were being met by the staff working closely with other professionals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The staff were not always kind and did not consider people's feelings.

The staff tended to focus on the tasks they were performing rather than the person they were caring for.

People were encouraged to be as independent as they could be.

People felt that the staff were kind and caring.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's needs were not always recorded and planned for.

People were not always supported in a way which met their needs and reflected their preferences.

There were organised activities which some people enjoyed.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider's systems for monitoring and identifying risks were not always effective.

Records were not always accurately maintained.

The provider had identified areas of concerns and had an action plan which they were implementing in order to improve the quality of the service.

People were happy living at the service and felt well cared for.

Ashwood Care Centre

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 comprehensive inspection took place on 11 October 2017 and was unannounced.

The inspection team consisted of two inspectors, a nurse specialist advisor, a pharmacy 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 the inspection visit we looked at all the information we held about the service. This included information about the service when it operated under the previous provider, notifications of significant events and the provider's own action plan for making improvements at the service. We spoke with a member of the local authority quality monitoring team who visited the home each week and looked at the report of their latest findings.

During the inspection we spoke with nine people who used the service and five visiting friends and relatives. We met with the service manager. The registered manager works as a regional support manager and the day to day management was provided by the service manager. We also met and spoke with staff on duty who included the deputy manager, nurses, care assistants, senior care assistants, the activities coordinator, domestic staff and catering staff. At the end of the inspection we gave feedback to the service manager and two senior managers who worked for Bondcare (London) Limited.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI) during the morning. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care records for 12 people who used the service. We also looked at the staff recruitment records for six members of staff, records of staff training and support and other records used by the provider

for managing the service, which included records of complaints, accidents and incidents, quality monitoring checks and action plans. We viewed the environment and records relating to checks on this and equipment used. We looked at how medicines were stored, administered and recorded.

Requires Improvement

Is the service safe?

Our findings

People who used the service and visiting relatives told us they thought the service was safe. Some of their comments included, ''There is a good atmosphere here and it feels safe'', ''You get the best care here'', ''The care is good for me and safe'' and ''I feel safe here.''

The staff told us that there was not enough equipment to meet the needs of people who lived at the service. Not everyone who required transfer using a hoist had been provided with their own sling and some people had to share slings. For example, the staff told us that five people living on the ground floor needed the support of a hoist to move and there were only two slings available. This meant that there was a risk that the sling was not appropriate to meet their needs. There is a risk of cross contamination with people using the same slings.

People did not always receive their medicines in a safe way because there was a risk that this was not always the case because medicines were not being managed safely all of the time. When we checked the balance of medicine stocks we found two people's medicines where the number of tablets had been inaccurately recorded. The reason for this was not clear, although it was possible that these two people had not received all their doses of these medicines. In both cases, the record of administration indicated that more doses had been administered than the amount we found had actually been administered. We discussed this with the manager who agreed to investigate what had happened and make sure action was taken if there had been a medicines error.

The staff had created pain protocols for some, but not all, people who had been prescribed PRN (as required) pain relief medicines. These protocols helped the staff to make judgements about whether these medicines were needed when people were unable to describe whether they were in pain. However, there were no protocols for the administration of PRN medicines for people who may become anxious or agitated. PRN protocols for these types of medicines would describe people's individual needs and when the administration of these medicines would be needed. Without proper guidance the staff may make judgements which were not appropriate or centred around the individual person's needs and they could be at risk of being sedated when they should not be.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and appropriately. The staff undertook checks on the temperature of medicines storage areas. We observed people being given their medicines. The staff responsible for this were appropriately trained and their competency had been regularly checked. They administered medicines in a safe and suitable way, making sure the person understood what was happening and was able to express their choices. We looked at the records of medicines administration and saw these were accurately completed, with the exception of the two examples described above.

There had been a number of incidents where people had sustained minor skin injuries whilst being

supported to move. These incidents had been investigated by the provider, and where appropriate, the local safeguarding authority. We discussed this with the local authority quality monitoring team. They were carrying out weekly monitoring visits at the service and as part of that they looked at the number of incidents and accidents and how the provider had responded to these. We also saw that the provider analysed all accidents and injuries and recorded the action they had taken in response to these. There was evidence that staff had received updated training and support to help move people safely. Also the nurse in charge of one part of the home explained that they had started to obtain some new equipment to support people to move, such as sliding sheets, and that this had reduced the number of injuries.

The staff told us they did not always think there were enough of them to safely care for people. We observed that the staff were busy throughout our visit with various tasks and they did not spend time talking with people or providing emotional and social support. We also observed that almost two thirds of people on the ground and first floors required assistance to eat their meals. This meant that not everyone ate at the same time and people who were independent were sometimes left without any support and supervision. The activities coordinator offered additional support during lunch times, but staffing levels at this time meant that the mealtime experience of some people was not as pleasant as it could have been.

We did not observe people waiting for support when they required assistance with personal care and people who were able to tell us explained that they had assistance when needed. However, we noted that the staff tended to encourage people who were able to walk around independently to sit in one of the communal areas with others. This meant that less staff needed to be available in different parts of the building but at the expense of people's freedom to spend time where they wanted. We also observed that the staff rushed tasks with people and did not spend time checking on people's wellbeing or comfort.

The manager and senior managers representing the provider told us that they felt there were enough staff. We discussed our concerns that the staff did not have sustained interactions with people and tended to rush tasks when they were providing support. The manager and senior staff acknowledged this was a concern but told us they did not feel this was a result of insufficient staffing levels. They told us they felt this was a training need for the staff.

There had been a number of vacancies at the service for some time, and the provider had employed temporary staff from an employment agency to cover these. The manager acknowledged this situation was not ideal and told us that they were in the process of recruiting staff with the hope that all the staff vacancies would be filled.

The risks to people's safety and wellbeing had been assessed. There were individual assessments for risks associated with people's mental and physical wellbeing. These had been reviewed monthly and updated as needed. We saw that information from risk assessments had been included within care plans.

The provider had appropriate procedures regarding safeguarding adults. The staff had received training in these. They were able to tell us where they could find information about safeguarding and whistle blowing and what they would do if they were concerned someone was being abused. There had been no safeguarding concerns since Bondcare (London) Limited took over as the registered provider. However the provider had been involved in responding to safeguarding concerns before their registration for this service. They had responded appropriately and there were clear records of action taken and work with the local safeguarding authority to investigate concerns.

People lived in an environment which was safe and clean. However, we noted that some of the call alarm bells in bathrooms were tied in a way which meant someone who had fallen would not be able to reach

these. We discussed this with the manager who agreed that they would ensure that all call bells were made accessible and that this was regularly checked.

Throughout the day we saw domestic staff undertaking cleaning of the building. The staff providing care and domestic staff wore suitable protective equipment, which we saw they disposed of appropriately. There were schedules for maintaining health and safety and for cleaning and the staff followed these.

We saw evidence of checks on the environment and equipment used which ensured that any faults were identified and acted upon. There were appropriate procedures for fire safety. There was an up to date fire risk assessment, and personal emergency evacuation plans in place for each person which described the support they would need in event of an emergency.

The provider had systems to ensure that only suitable staff were employed at the service. These included inviting the staff for interviews with the manager. The provider carried out checks on staff members' identity, eligibility to work in the UK, references from previous employers, employment history and checks by the Disclosure and Barring Service on any criminal records. The staff recruitment files we viewed were all appropriately completed but these staff had been recruited by the previous provider. Staff working for the previous organisation had been transferred to the new provider under the legislation governing this which preserved their rights and contractual arrangements.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with told us, ''The staff do know what they are doing and provide me with good services.''

The staff who cared for people had not always got the support they needed in the past, although some told us the situation was improving. Nurses are required by law to revalidate their registration with the Nursing and Midwifery Council (NMC). In order to do this they need to demonstrate that they can practice safely and effectively. The nurses working at Ashwood Care Centre told us that they did not feel they had been given enough time and support with their revalidation. They also said that they had not been provided with some of the essential training in specific interventions, for example venepuncture and catheterization training

The care staff did not demonstrate a good knowledge of how to support people with dementia. We saw examples throughout the inspection which showed the staff lacked understanding about people's needs in this area. For example, we saw a member of staff supporting a group of people to complete colouring sheets. One person stood up and started to walk away. The member of staff told them to sit down and finish their colouring. We saw repeated examples of the staff not taking time to explain to people what was happening and what they were doing. As a result people were disorientated and sometimes expressed their frustration. This meant that people were placed at risk of poor and inappropriate care and treatment.

Some staff commented that training was not always effective as too much was delivered on line and there were no competency checks to ensure that knowledge levels were adequate following training. One senior member of staff said that questions and issues raised with care staff following training indicated that it had not been delivered effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff told us that they had regular individual supervision meetings with their line manager. Although some staff told us they would like more frequent opportunities than they had previously had to meet as individuals and groups with the manager to discuss their work in the future.

The provider had arranged for all the staff to undertake basic training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. At the time of our inspection they were experiencing some technical issues with the on line training provider but were hoping that these would be resolved in the near future. There was evidence the staff had previously undertaken training with the previous provider, which this provider had considered mandatory.

The provider was not always meeting people's hydration needs. We examined the care plan for one person where a healthcare professional had given specific guidance about their fluid intake. We looked at records of their fluid intake for the month. We saw that the person was not receiving the daily required level of fluid and

this placed their health and wellbeing at risk. We noted that no action had been taken by the staff despite the person's intake consistently falling short of the required levels. We discussed this with the nurse in charge of their care who agreed to review the situation and take appropriate action.

We noted that whilst some people were left with drinks they could not always reach these. People in communal lounges were offered hot drinks at one point in the morning but were not given any cold drinks until lunch time. The staff did not routinely observe how much people drank and therefore could not accurately record fluid intake. At one point during the morning we overheard a person asking a member of staff for a drink. The staff member responded by saying, ''I will check if you have had your cup of tea.'' The staff member left the room and did not return. The person was not offered a drink until lunch time.

The staff were not always monitoring people's weight. People's nutritional risk level determined how frequently they should be weighed. This was recorded in their care plans. However, the staff were not always doing this. We looked at two people's weight records which showed they had not been weighed according to their care plans, despite being assessed as at risk of malnutrition.

The staff told us, and the menu and information at the home explained, that snacks were available at other times. However, we did not see evidence of this. During the morning hot drink round people were not offered anything to eat. There was not any fruit or finger food available for people. People living with the experience of dementia sometimes find traditional mealtimes and large meals challenging. There was no evidence that this need was recognised or understood by the staff. We saw that some people did not eat a lot of their lunch time meal, although records of food and fluid intake did not describe how much people ate. Therefore people were placed at nutritional risk. Furthermore, we noted that in two people's care records the staff had not reassessed their nutritional risk for several months.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed the food provided at the service. Some of their comments included, ''I do have a choice'', ''My dietary needs are met'' and ''The food is fine.'' One person told us their relatives bought in home cooked food for them and that the staff supported this and understood the importance of this.

There was a menu offering different choices of freshly prepared food at each mealtime. Menus were displayed on dining room tables, so that the people using these rooms were able to see what was on offer. The people who remained in bed did not have the information presented to them and we noted that, with the exception of one member of staff, staff at lunch time did not explain what the food was or offer people choices when they brought them their meals.

People's nutritional needs were recorded in their care plans. The majority of these were reviewed each month, with the exception of the two people described above. Kitchen staff had information about different nutritional needs and catered for specialist diets, including providing high calorie food and drink for people who were at nutritional risk. The chef regularly met with people to discuss the menu and obtain feedback on the meals they provided. There was evidence that the staff had made referrals to healthcare specialists when they had identified that people had specific nutritional needs.

Some aspects of the environment were not suitable to meet the needs of people living with the experience of dementia. Bedroom doors were labelled with signs of the person's name, a current photograph and a sentence describing something about them. However, there were not many other features to help orientate people around the home and the type of room label used on the bedroom doors was a useful guide for the

staff rather than the occupant of each room. Notice boards around the home were not designed to give clear information to the people who lived there and were often used to provide the staff or visitors with information. The design of the building was not in line with current best practice guidance for care homes accommodating people with dementia. There were a few features designed to provide interaction for people on the second floor, but none in other parts of the building where people with dementia were living. There were some videos, books and magazines available in communal rooms but very little else for people to take, hold, use or play with. We discussed this with the manager and provider's representatives who acknowledged this was an area they had already identified for improvement. They discussed some of their plans for redesigning the environment and demonstrated an understanding of good practice in this area.

We recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked that the provider was acting in accordance with the principles of the Act and found that they were.

The staff had undertaken assessments of people's capacity in respect of different decisions. Each aspect of the care plan was accompanied by an assessment detailing whether the person was able to make a decision about how this need was met. The assessments had been appropriately detailed. However, there was not always clear evidence that people's representatives had been involved in the best interest decision process for people who lacked capacity. Some of the records designed to record their involvement had not been completed. From our discussions with the staff and manager it appeared that this was a recording issue and that families and other representatives had been involved in decision making and were consulted.

The provider had made applications for DoLS authorisations when needed. There was evidence they had included conditions from any DoLS authorisations into people's care plans. The provider also monitored when the authorisations were due to expire and had made applications for renewal when needed.

The staff had received training about the MCA. When we spoke with them about this their responses varied and indicated that some staff had more understanding about this than others. We fed this back to the manager so that they could address this with individual staff.

People's healthcare needs were being met by the staff working closing with external healthcare professionals. There was evidence that the staff made referrals for additional care when people needed these. The staff recorded medical consultations and recommendations from healthcare professionals were included in people's care plans.

Requires Improvement

Is the service caring?

Our findings

People using the service and visiting relatives told us they were happy with the care provided and told us they had good relationships with the staff. Some of their comments included, ''The staff provide me with the best care needed'', ''I was living at the home when [my relative] passed away and this is the best place because they cared for me'', ''I am very happy with the staff and care given'', ''The staff are nice'', ''The staff are compassionate and respectful'', ''I can't say that they all do, but some of the staff work hard to deliver care'', ''The staff try to meet my needs'', "[My relative] is fine, she's happy here and I would complain if she wasn't. It looks fine here but I don't think they ever take any of them out" and ''They seem to be providing good care – I would recommend the home.''

During our inspection we witnessed a number of incidents where the staff did not treat people with dignity or respect. We overheard one person calling out that they wanted to go home and that they were cold. Several members of staff were within hearing distance when this person spoke but none of them responded at any time. In one instance the person spoke directly to a member of staff saying, ''I can't wait to go home.'' The member of staff said, ''Hmm'' and then walked away from the person without further interaction. At no point did any member of staff comfort or reassure this person.

We overheard the staff speaking about people in front of them and others. Some of this could be interpreted as inappropriate and offensive. For example, a member of staff walked into a person's bedroom with one of the inspection team and said, ''She is end of life'' referring to the person who was in bed in this room at the time. In another incident a person started vomiting whilst they were eating their food. A member of staff stood on one side of the room pointing and calling out, ''Look she is throwing up.'' We heard the staff giving each other instructions about caring for people when they could be overheard by the people. For example, one member of staff pointed at a person and told another member of staff, ''You take [person] to the lounge.'' In one dining room at lunch time where a number of people were seated we heard one member of staff tell another across the room where others could hear, ''[Person] looks tired, she always looks tired.'' One member of staff walked into a lounge where four people were seated. They did not interact with anyone but pointed at each of them in turn saying their names to themselves and then walked out of the room. At another time we overheard two staff members having a small disagreement with each other while standing in a room where people who lived at the home were seated.

The staff did not always consider bout people's feelings when providing care. For example, we saw a member of staff walk up to someone who was eating their lunch. They did not speak to the person but started to cut up and mix up their food whilst standing next to them. They then put a spoonful of food in the person's mouth and walked away again.

The staff did not always consider how people were feeling or offer them choices. For example, we saw that one person was in bed in their room. A member of staff walked into their bedroom switched the television on and walked out again without any interaction with the person. A large number of people remained in bed for the duration of the inspection. Most people had their doors open. We noted that none of the staff knocked on people's doors when they entered or announced their presence. They also placed protective

aprons on people at mealtimes without asking the person's permission.

Throughout the visit we saw the staff giving people instructions without explaining what they were doing or what was happening. For example, we heard the staff telling people, ''follow me'', ''come this way'' and ''come and sit down.'' In other examples the staff told people they would help them in some way but then did not. For example, we heard one member of staff tell a person, ''I will get you a drink in a minute.'' However, over an hour later they still had not brought the person a drink.

At one point during the morning three people were seated in a lounge with the television on. A visiting minister arrived to see one of the people. They walked into the room, turned the television to a low volume and started to say their blessings and prayers without any consideration for other people in the room. A member of staff witnessed this but did not challenge it or suggest they supported the person to move to their room.

We saw one instance where a member of staff told a person, ''Don't hit me.'' The person had started to walk into the room where the member of staff was but had not shown any signs that they were going to hit the person so it was not clear why the member of staff said this.

The above examples were ones where the staff behaved in an unkind way towards people. This was not always the case, however the majority of interactions we witnessed were task based and did not take account of people's feelings. The staff appeared rushed and distracted when supporting people. For example, staff members offering people food and drinks often did so without speaking with the person. We saw the staff giving people food and drinks and turning away from them immediately not acknowledging when people thanked them or made other comments. We also saw one member of staff who had returned to the lounge to collect empty cups after people had hot drinks. One person had not finished so the staff member stood next to them and said, ''Drink up.''

We observed the staff in people's bedrooms supporting them at mealtimes. None of the staff we saw were talking with people and as soon as meals were finished they walked away. The staff supporting people with meals in bedrooms took both the main course and dessert at the same time, presumably because this was easier for them, but as a result desserts such as ice cream melted and hot desserts became cold. We saw two people who were able to eat independently had been left with trays of food in their rooms. These remained untouched over half an hour after they had been given them and there was no indication that the staff had returned to check on the person or encourage them to eat. Also at lunch time one member of staff noted that people had not been offered gravy after people had been eating for about 20 minutes. The staff member poured gravy onto people's plates, and in some cases mixed this with the remaining food, without checking that this is what they wanted or that the food and gravy were warm.

The above evidence is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some examples where the staff were kind, caring and thoughtful. For example, some people did not speak English as a first language. Many of the staff were able to communicate in people's first languages and spoke with them using these. We heard one person tell a member of staff that they were very kind. The staff offered people choices about where they wanted to sit in the lounge and dining rooms. We also saw, that most of the time, people were supported to be independent if they were able. For example, people who were able to eat independently were encouraged to do so and equipment was provided to assist them with this, such as plate guards. For the majority of time people who were independently eating and drinking were able to take their time to do this and were not rushed by the staff. One person arrived almost an hour later

than others to the dining room at lunch time. The staff did not rush the person or make them feel as if they were late, they welcomed them and the person was able to eat at their preferred time.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were not always being planned for or monitored. For example, people who have diabetes need to have their blood glucose levels monitored regularly. If these fall outside of expected ranges the person may require additional interventions so they do not become ill. The records for one person stated they had a very high blood glucose level on 4 September 2017. However, there was no indication that the person's levels had been checked since. We spoke with the staff supporting this person about why they had not monitored the person's levels regularly. They told us that they were not allowed to carry out these tests. They did not show an understanding that high blood glucose levels could endanger the person. We discussed this with the manager who agreed to speak with the staff involved, investigate what had happened and make sure the person's blood was checked immediately and then again regularly afterwards.

We looked at the care records for one person who had been prescribed anticipatory medicines which could be administered to provide pain relief and comfort at the end of their life. However, there was no care plan in respect of this so the staff may not know at what stage to administer these medicines. The person was receiving palliative care but there was no record of a care plan explaining their and their family's wishes for how they would be cared for during the last few days and hours of their life.

One person's care included information about how the person could become physically challenging. However, there was no plan to describe how the staff should support the person should this occur. Therefore there was a risk that the person may receive support which was inappropriate.

Another person had developed a wound which had worsened over time. The care plan for this person had not been updated to describe the status of the wound or the regime which the staff were using to treat this. The care plan continued to refer to the treatment of the wound in a previous state. This meant there was a risk that the person would not receive the right care and support with this need.

It was not clear whether people's personal care needs were being met in a way which reflected their preferences. We looked at a sample of records for the delivery of personal care on each floor. On one floor we saw that some care plans referred to people's preference for a weekly bath or shower, although this was not reflected in records of personal care provided. A separate record of baths provided to all people on this floor did not match the information recorded in their individual records of care delivered which were kept in their rooms. On a different floor the records of personal care indicated that people had not always received care as planned. For example, one person's records stated that they had been helped to clean their teeth on only three occasions during the month of October 2017. Another record stated that the person had received support to clean teeth/dentures on only six of the 11 days in October up until the inspection. Some people's records showed inconsistent support with brushing their hair, shaving and receiving bed baths.

We saw that one person's care plan stated that they preferred to wear robes (traditional for their culture) rather than trousers. On the day of the inspection the person was wearing trousers. We spoke with the staff about this. They told us that the person had changed their mind and now liked to wear trousers. However this had not been documented in their care plan or in the monthly evaluations of this plan. The person was

not able to confirm what their wish was to us.

People's social, emotional and leisure needs were not always met. During our inspection we observed that the majority of people were left without much stimulation or support to meet these needs for the day. For example, in one part of the building most people were in bed. Some people had television or radios on but the staff did not spend time with them and they were not offered any other form of stimulation. A small number of people in this area of the home spent time in communal areas. The television was left on and some laminated photographs were left on one table. One person spent time holding and looking at the photographs. No other activities or things to do were offered to people. People did not have a choice about the television channel. When staff entered the room it was for a task such as to bring drinks or they sat and completed paper work. There were limited sustained interactions between the staff and people who lived at the home.

In another part of the home two people took part in a colouring activity for some of the time. Two others were escorted to take part in an organised group activity on another floor. The others did not take part in any form of activity.

People's care plans included basic information about their interests and social needs. Some people's families had provided life stories with information about events which were important to people. However, there was limited evidence that the staff took account of these or that people were provided with meaningful support.

Records of care provided confirmed that people had not engaged in meaningful or stimulating activities during October 2017. We looked at records of activities for a sample of people for this month. These indicated people had little variety. For example, one person's recorded activities for the month were four days listening to music, three days listening to the radio and one day resting. Another person's recorded activities had been four days listening to music, four days watching the television and one day listening to music and talking. A third person had a record stating they had listened to music for four of the days, watched television for three days and rested in their chair one day. Other people's records were the same with the only activities recorded as listening to music, watching television, some form of resting (either in their chair or bed) and some family visits.

The staff also recorded hourly observations to summarise how each person had spent that hour. These records also showed little variety or stimulation with one person's records for 12 waking hours the previous day showing their activities as ''breakfast'', ''sleeping on bed'', ''personal care'', ''had tea'', ''had lunch'', ''resting on chair'', ''had tea'', ''sitting on chair'', ''had dinner'', and two entries of ''sleeping in bed.'' Other people's records showed a similar pattern with the only varieties to these activities being, ''watching television'', ''listening to music'' or visits from family members.

The above evidence shows a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of care plans we viewed had information about people's needs. These had been reviewed monthly. We saw that information from healthcare professionals had been added into care plans.

There was a short guide to each person's care plan which gave a quick overview of how to meet their basic needs. This was available in each person's bedroom.

People were wearing clean clothing, had clean hair and fingernails and looked comfortable in the clothes

they were wearing During our visit a hairdresser was visiting and we saw that people had an opportunity to visit the hair dressing salon at the home.

The provider employed an activities coordinator. They organised and facilitated group activities. In the morning on the day of our inspection four people took part in a singing activity and enjoyed this. During the afternoon there was a tea party. The activities were advertised on notice boards. The activities coordinator had a programme of different events and had organised these to meet varying needs of people. Some people enjoyed regular participation in these. However, for most of the time the majority of people were not involved in these activities. The activities coordinator spent some time with individual people talking or playing a game.

The complaints procedure was displayed. People using the service and their representatives told us they knew how to make a complaint and felt confident concerns would be addressed. One person told us, ''My church representative visits me and I talk to them about issues that are bothering me.'' Another person told us, ''I can always voice any concerns at the office.''

he provider had a record designed to log any complaints which were received and also to show how they were investigated and acted upon. They had not received any complaints since they started managing the service.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the home and their relatives felt it was a good home and enjoyed living there. One person said, ''It's all very good here.'' Other people told us they would recommend the home and that they liked it. One person said, ''It is very quiet here and I can do whatever I like.''

The staff told us they enjoyed working at the service, although some staff told us they did not have enough time to do the work and said they were tired. The staff generally felt positive about the new manager and new provider. Some of them commented that they had felt unsupported in the past but felt happier now. For example one member of staff told us, ''The previous managers did not listen – the new manager is willing to listen to us.'' Another member of staff said, ''The manager comes to help out at the weekends when we are short of staff, this is very positive.'' The staff told us they were optimistic that things would improve.

Some of the systems for assessing and monitoring the service did not adequately identify and mitigate risks. For example, the staff undertook audits which included audits of care plans and medicines management. We saw that these had identified some areas of concern, however there was no evidence that action had been taken to address these. We also identified concerns during our inspection which the provider had not previously recognised. For example, insufficient information in some of the care plans and monitoring of people's nutritional and hydration needs.

Records were not always accurately maintained. For example, we saw that staff had completed one person's care notes to show that care had been provided on the 12 October 2017, a day after our inspection. The staff had also completed a record indicating daily care of prosthesis for a person who did not have prosthesis. One man's care records used the term ''she'' when describing what they had done. We found the care records for four different people had been left in the room of a fifth person. Care records contained some out of date information so it was not always clear what people's current care needs were.

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

Bondcare (London) Limited were registered as the provider of Ashwood Care Centre in October 2017. They had been overseeing the management of the service since July 2017. There was a registered manager in post. However, their role was as a regional support manager. They visited the home twice a week. The provider had employed a manager for the service who had started work shortly before our inspection. They told us they were in the process of applying to register with CQC.

We spoke with the provider's representatives and the new manager and fed back our findings. They told us that they had also observed these failings and had started to plan action to address these. The provider had shared their audit of the service with us and their action plan for making improvements. We saw that they had identified areas of concern. We recognised that some of the breaches we identified were a result of the staff culture at the home and that it would take time to embed changes and make improvements. In

addition the local authority quality monitoring team were visiting the service weekly and working with the provider to identify areas which needed to be improved.

The provider had introduced a number of audits and checks which included the analysis of accidents and incidents, checks on infections, wounds, equipment and records. The senior staff had meetings each morning where they shared essential information and they appeared to have a good understanding about people's individual needs.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not make sure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure that the nutritional and hydration needs of service users were always met. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure that sufficient numbers of suitably qualified,

competent and experienced persons were deployed to meet the regulated activity.

Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always provide care and treatment in a safe way to service users because: There were not sufficient quantities of equipment to ensure the safety of service users and to meet their needs. Regulation 12(1) and (2)(f) There was not always the safe and proper management of medicines. Regulation 12(1) and (2)(g)

The enforcement action we took:

We have told the provider that they must make the required improvements by 31 December 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not effectively operate systems and processes to: Assess, monitor and improve the quality of the service or assess, monitor and mitigate risks to the health and safety of service users. Regulation 17(1) and (2)(a) and (b) To maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1) and (2)(c)

The enforcement action we took:

We have told the provider that they must make the required improvements by 31 December 2017.