Ashleigh Manor Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Ashleigh Manor Residential Care Home ("Ashleigh Manor") is a residential care home that was providing personal and nursing care to 43 older people and younger adults and over at the time of the inspection. They are registered to accommodate 65 people.

People's experience of using this service:
•The quality of people's care continued to raise serious concerns.
•People dependent on staff to pre-empt and meet their needs were being failed by the service.
•People were not receiving care that was fully safe, effective, caring, responsive to their needs and well-led.
•The service is now judged to be inadequate in keeping people safe, providing effective care as well as continuing to be inadequately well-led.

Rating at last inspection: The rating at the last inspection was Requires improvement overall. The report was published on the 8 August 2018. This service had been rated repeat Requires improvement at the previous two inspections. They were last rated as Good in 2015.

Why we inspected: We inspected in line with our inspection methodology. This was within six months of publication as the service had been judged to be Inadequate in well-led at the last inspection. Prior to this inspection, the service was also placed into whole home safeguarding by the local authority due to a number of concerns in respect of people's care. CQC have been liaising closely with the local safeguarding adults team. The areas of concern were used to inform our planning for this inspection.

Enforcement: Following our last inspection we added positive conditions to the provider's registration. This required them to report to us each month to ensure we could monitor their progress. On this inspection, we found some conditions were met and others were not. Whilst some elements of the conditions had been met this had not led to sustained improvements and in many areas, we identified deterioration in people's care.

In respect of this inspection, full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Ashleigh Manor Residential Care Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by three inspectors from adult social care, one 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.

Service and service type:
Ashleigh Manor is a residential care home. Nursing is provided by the community nursing team. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashleigh Manor has two separate units; The Lodge and the Manor. The Lodge historically has been where people who are more able have resided. However, currently people with more complex needs live there. The Manor is where people reside that are living with dementia. The level of need varies in the Manor from medium to high.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager deregistered with us on 23 August 2018. A new manager has been employed and we met them on the last date of the inspection.

Notice of inspection:
The inspection was unannounced.

What we did:
Before the inspection, we reviewed:

•The Provider information return
•Notifications we had received
•The provider's monthly responses to us

During the inspection we visited everyone currently living at the service, we:

•Reviewed 14 people's care records
•Reviewed records of accidents, incidents and complaints
•Audits and quality assurance reports
•Completed three SOFI (Short observational framework for inspection)
•Observed people's care and staff interaction
•Four staff personal files
•How the provider demonstrated staff were trained, competent, supervised and appraised

We spoke with:
•Sixteen people using the service and five relatives
•Ten members of staff
•Two family and friends completed a questionnaire for us.
•One district nurse and one podiatrist during and after the inspection

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
•People's records did not always reflect their current risks and were not then being updated when something changed for them which left staff with inaccurate information.
•Of the 14 people we reviewed, all were referred to the local authority safeguarding team due to concerns about their care and their safety. The local authority is actively reviewing 11 of the referrals as safeguarding.
•People who were identified at risk of falling and/or had experienced multiple falls were not having their needs identified, assessed and acted on to keep them safe. We reviewed the accidents and incident reports from July 2018 to January 2019 (by the date of the inspection and identified people who had fallen a lot; also in October 2018 there were 26 incidents of falls by 20 people. Six of the people we reviewed were identified by the accident reports and/or by the provider as a high risk of falls. We were concerned about all six as their records were not up to date and/or support had not always been sought.
•The management of injuries caused by falls, such as a head injury, were not management well and placed people at risk. Appropriate support and or advice were not consistent and ranged from immediately dialling 999 (the provider's only policy) or staff testing for "bumps" on people's skin without a medical background.
•People at risk of choking were not having their needs identified, assessed and acted on to keep them safe and were given food which could put them at risk of choking. Of the people we reviewed, we were concerned about the management of five people in respect of choking.
•People were not protected from the risks associated with malnutrition because staff were not ensuring that people had enough to eat and recognising when this was taking place. We were concerned about three people we tracked however, we observed incidents for other people during lunch on all three days where people living with dementia were not having their needs identified by staff.
•People at risk of their skin breaking down or skin injury were referred to the district nurse service quickly however, records did not show that people were then monitored consistently to keep them safe. Staff knowledge around the risks people faced was not consistent. This affected anyone needing staff to identify when they needed support to turn in bed, for example.
•Staff were not identifying when people faced a new risk and communicating this with team leaders or management to ensure this evolving need could be monitored and/or assessed by external professionals in a timely way. For example, in relation to an incident of constipation, falls, changes in eating.

Learning lessons when things go wrong
•The provider had systems in place to record incidents and accidents; falls were entered on to a spreadsheet. However, not all falls for example, were being reported by staff to ensure these could be reviewed and have appropriate action taken.
•Staff recording of people's daily care and handovers between shifts were not robust enough to ensure messages about changes in people's care, mood and risks were passed on, then reviewed and monitored.
•We found the provider had made lots of changes since the last inspection. However, these had not ensured

people were safe.
•Staff did not work in a way which ensured people were safe. For example, passing on concerns or identifying concerns raised by other staff in previous shifts and making sure that person's presentation or health had improved. If not, then acting to call in external support.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
•All staff were not trained in safeguarding vulnerable people. However, staff demonstrated a good understanding of what constituted abuse and knew what action to take.
•Staff told us they felt comfortable raising concerns with management, and knew how they could raise concerns outside of the service
•Management demonstrated that they had acted in response to whistleblowing and concerns raised.
•Environmental risk assessments had been undertaken to keep people safe, however some of these had not been reviewed within the last 12 months.
•At the last inspection, practices around fire safety needed some improvement. On this inspection we found this had improved. Personal emergency evacuation plans remained in place and equipment was kept maintained
•People said, "I feel relaxed here" and another, "I definitely feel safe here. I can leave my door open all the time; it's quite safe".
•A family member said, "I feel happy he's safe here" adding, "I can go home and sleep at night."

Staffing and recruitment
•The provider did not ensure that all staff employed had the required background checks in place. In that, the seeking of references did not always meet the provider's requirement of two successful references and details of gaps in employment were not being explored.
•There also was not always a record of an interview having taken place and how the provider then judged that new staff member had the right skills and attributes to deliver safe care to vulnerable people. We discussed the recruitment concerns with the provider who could demonstrate that an audit of recruitment had taken place to identify gaps. For example, seeking second references where these were missing. They stated they would add the other issues to improve their processes.
•At the last inspection we identified that the service was not staffed safely with the right number of staff to meet people's needs. We added to the provider's registration, "The Registered Provider must carry out monthly reviews of staffing levels to ensure these are adequate at all times to meet the needs of service users, taking into account any changes in service user's need". We found this had been resolved on this inspection. A dependency tool was now being used to calculate how many staff were needed to meet people's needs. Rotas indicated, and staff told us, that there were enough staff. We saw that agency staff were utilised where necessary.
•People commented, "In the last year there's more staff on duty; there's plenty now. There's no excuse for not answering the bells on time" and another said, "They usually come pretty quickly."
•Following the last inspection, to be assured that staffing level improved, we added the following to the provider's registration. "The Registered Manager must carry out a monthly audit of the call bells relied upon within the service to establish whether or not the length of time service users are waiting for care is appropriate". We found this had been resolved on this inspection.

Using medicines safely
•At the last inspection, we found people's oral medicines were safely administered; their prescribed creams however were not always safely managed. We added to the provider's registration, "The Registered Provider

must carry out a monthly audit of service users' prescribed creams and ensure the creams have been made available to service users, their use recorded and clear instructions given about their application to each service user requiring those creams." On this inspection we found this had been resolved.
•Since the last inspection, the management of topical creams had been reviewed and was being monitored closely
•People's medicines were managed safely by trained staff who were checked to ensure they remained competent
•People could administer some or all of their medicines which was risk assessed and kept under review
•If people received their medicines covertly (disguised in food or drink without their knowledge) this was only done in their best interests after a mental capacity assessment.
•There were systems for checking, auditing and reporting any medicines issues. We saw that any errors or incidents were identified, reported and investigated to try to improve medicines management in the service
•The medicines policy was recently updated but was not easily available to staff. The provider told us they would raise awareness and ask staff to sign when the new policy and procedures had been read.
•People said, "Staff bring my medication on time, if not I suffer from anxiety. They always ask if I am ready" and another said, "They come on time; they're always regular."

Preventing and controlling infection
•The provider did not highlight infection control as mandatory training for staff and not all staff had undertaken training. However, is there something missing here?
•Staff followed policy and used personal protection equipment when required
•The home was clean and free from offensive odour.
•There was a system in place between the housekeeping team and the maintenance person to communicate any health and safety concerns.
•Daily checks were made to ensure cleaning was carried out to the required standard and a system was in place so people's bedding was changed regularly.
•There was an infection control policy in place which included a protocol for collecting specimens and the full Department of Health guide to preventing infection which had been read by key staff.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to live healthier lives, access healthcare services and support
•Staff were not always identifying when people were ill and in need of further assessment
•On the first day of the inspection, we identified a person choking on their food which they spat out. They were wincing in pain, making noise on each exhale of breath. They were not eating their food. We raised this as an immediate concern with staff and the provider.
•This person was diagnosed with pneumonia and admitted to hospital on the third day of our inspection. Staff told us, "We wouldn't have known" if inspectors had not raised the issue.
•Records of people's needs and ensuring they were up to date and current was not always evident.
•Events, such as the person above, were not communicated effectively. Staff were told by the GP to closely monitor this person's health and to call them immediately if they became more unwell. The handover notes did not carry this message through; records did not detail how they were being monitored.
•Continued concerns recorded by staff in their daily records were not linked to the current concerns and acted on, nor did that staff member advise the team leader
•Records of people's health detailed when some professionals had visited or been contacted, but could be on separate sheets of paper in different files meaning people's needs could be missed
•Gaps between records meant the records did not flow; not all staff detailed their care/interventions/ communications with other agencies to the same level.
•There was evidence in the SOFI and other observations, that people living with dementia were not fully stimulated to help support their wellbeing, or physical health

Supporting people to eat and drink enough to maintain a balanced diet
•On this inspection we were very concerned that staff could not guarantee that people were having enough to eat
•We identified people during the inspection who were not eating their food and were not being offered alternatives.
•One person was seen to spill their juice on their food; staff saw this, cleaned up the juice on the table but left the person with the spoiled food
•One person was offered a packet of crisps for their tea when they voiced they did not want the sandwich on offer
•People living with dementia or with other health needs were at risk of not having enough food if they disengaged with their meal because staff were not identifying when this was happening and encouraging and supporting them to enjoy their meal.
•People who had been risk assessed as requiring support and monitoring with their nutritional intake, were

at risk of not eating enough as these records were not accurate or complete and communication about their changing needs was not taking place
•Two staff were allocated as 'dietary assistants' and responsible for recording what people ate and drink throughout the day. We asked staff who undertook this role if records were consistent and accurate. They told us, "I don't think so now, it's a manic job"; "It depends on the staff member, it's a difficult role" and a third, "I think it's impossible to know".
•People were not being offered the full range of choices available to them at meal times. This included drinks and desserts
•People living with dementia were being asked on the morning before what they wanted to eat for lunch the day after. Picture cards were shown to them of what the meal would be however, people struggled to understand and had not yet eaten that day's lunch
•People being supported to eat were not experiencing this in a caring, supportive manner
•When we spoke with staff about people's specific needs and risks in respect of their eating, we received inconsistent messages from staff that could put people at risk of choking or receiving an incorrect diet due to staff not knowing how their food should be prepared and what support they were required to give
•At the last inspection we were concerned that people were not having enough to drink to remain hydrated. On this inspection we found this had improved and people's records showed good fluid intake. There was some inconsistency in ensuring these records were reviewed and totals recorded but people were offered regular drinks throughout the day.

The above concerns demonstrated a failure to prevent harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

•People gave positive feedback about the food. People told us, "It's all about the food. The food is very good here"; "I'm a vegetarian. They give me food I can eat and enjoy. It's good" and, "The food's good. It's red hot. There's almost too much." A relative said, "He loves the food and he can have as many snacks and drinks as he likes."
•The kitchen staff put on food for events such as the rugby, royal events and special dates.
•People had birthday cakes made especially for them. The chef told us for people with a specialist diet, how a 'soft' cake was made and decorated to look nice, with whipped cream.
•In respect of their health, people said staff would contact their GP when needed. One person said, "They get the doctor if I need one" and another, "they get the podiatrist each week".

Ensuring consent to care and treatment in line with law and guidance
We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

•People had a document called 'Mental Capacity Act' in their files that looked at their ability to consent to certain functions or areas of care offered. This document had not been reviewed as people's needs changed.

•People had decisions made about their care which had not been evidenced as having been done so in their best interests for example, being supported to eat by staff and being moved in the service to other rooms
•Some people had alarm mats in place to alert staff if they were moving independently and were at risk of falling however, this was not evidenced as being part of a best interests decision and/or in a DoLS application

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Relatives said they had been involved in discussing their family member's care. One said, "We are in regular discussions with the owners about mother's care" and another, confirmed they had discussed their relative's care in detail with the providers.

Staff support: induction, training, skills and experience
•Following the last inspection, we added to the provider's registration, "The Registered Provider must complete a monthly review of training and ensure all staff are trained to carry out their role effectively". We monitored these monthly action plans. Despite them saying training had improved, we found this condition was not met on this inspection.
•New staff were not undertaking a robust induction to ensure they developed the right standard of care
•The Care Certificate was not being used to induct staff who had not worked in care before, we were told there were plans to introduce this. However, at the last inspection we were told this was in place.
•Staff were not being trained to meet the current needs of people in their care
•The provider did not identify training staff in dementia as part of their core training despite them offering a specific home to people living with dementia
•The provider told us that training and ensuring staff were up to date was not currently assured; this was despite the condition and their monthly reporting being positive about this. In 1 February 2019 they wrote, "All outstanding training identified and is reviewed monthly by the provider" and, a number of courses had been booked. Since the last inspection, there remained significant gaps in staff training according to the provider's records.
•Staff in important decision-making roles did not always have qualifications or training that reflected their level of responsibility

Not ensuring staff are suitably trained is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Staff told us and records showed that staff were undertaking a level of supervision and competency checks.

Staff working with other agencies to provide consistent, effective, timely care
•There had been lots of multi-agency involvement with the service since the last inspection; this was largely due to the safeguarding concerns found in 2018
•We found the recording and pro-active monitoring of people's needs, and when to obtain advice still needed improvement to ensure staff knew what to do.
•The district nurses told us there had been improvements in communicating with them since November, following the safeguarding concerns being raised.
•The podiatrist told us they were happy with how the staff communicated with them.

Adapting service, design, decoration to meet people's needs
•Following the last inspection, we set a condition on the provider's registration that, "The Registered Provider must complete a monthly audit of the necessary equipment they needed to meet service users'

needs". We found this had been largely met. There were some practical steps to ensure the required equipment was available to care staff. This was resolved during this inspection.
•Some areas of the service had been designed to create space for recreational activity and people had a choice of where to spend their time.
•Spaces included a well-stocked activities room, a cinema room, a hairdressing salon, a chapel for quiet reflection and, a lounge and dining room in each area of the home.
•The provider had taken action to ensure there were sufficient bathing facilities since the last inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•People had initial assessments completed before they moved into the service and needs such as particular diets were communicated to the kitchen. It took time to develop a full care plan and there was no evidence of an initial care plan meaning it was unclear how staff knew what people's needs were when they first moved to the service.
•We found risks associated with people's care that demonstrated the service was not ensuring people's needs and choices were met (Examples are above and throughout the report)
•We found concerns throughout the inspection that reflected care was not always being given in line with standards, guidance and the regulations (Examples are above and throughout the report)

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity
•Whilst we saw some lovely, kind interactions, we also saw some extremely poor interactions between people and staff, which did not respect people.
•The SOFI and our other observations identified people not being treated well and supported
•We observed that staff continuously ignored people and their emotional needs
•We saw staff respond to one person, living with dementia, being told her parents "are dead". This is not in line with dementia principles.
•We saw staff did not promote a warm dining experience for people. People were not always told what was on their plate when put in front of them and people were sometimes rushed when supported with eating and drinking.
•People, especially those living with dementia with varied levels of ability to recall information in the short term, were asked too far in advance what they wanted to eat the day after; this was people. We asked one person if they had chosen the soup they had eaten for their tea. they told us, "No, it's just what I was given".
•One person, who had been assisted with their lunch, had been left with a dirty face (dry and crusted food round her mouth) which staff did not notice.

Supporting people to express their views and be involved in making decisions about their care
•Care was observed to be task orientated and institutionalised
•People's care plans did not indicate how they/and or their loved ones were involved in their care.
•We saw few examples of staff involving people in their care.

Respecting and promoting people's privacy, dignity and independence
•People were not always treated with respect by staff
•People were referred to as needing to be "fed", "done" and "toileted" in respect of their care needs used above
•One staff member was assisting a person into lunch and said, "Dinner time; come on, din dins" as if the person was a child.
•One person had to signal to staff by putting their hand up to got to the toilet and have a cigarette; they did not have a call bell or discreet way to ask for support. The inspection team were often asked during the inspection to help people and use the call bell on the wall to ask a staff member to attend to their needs because they had no call bell within reach. On one occasion, a person saw what another person wanted and banged on the office window with their walking stick to get staff attention
•One person fell asleep and spilt their coffee down their trousers. The inspector intervened and asked a member of staff to help the person because staff had not responded. The person returned from their room

with clean trousers. The member of staff was going to sit the person back in the same wet chair, until the inspector intervened. The member of staff did not remove or dry the wet cushion, which meant other people could have sat on it, nor was the person offered another hot cup of coffee. The person continued to drink the lukewarm coffee they had left.
•A person was brought into the conservatory area who had just had a bath. The staff member sat the person in a chair in a communal area in front of other people including of the opposite sex and proceeded to dry the persons hair.
•There was little evidence that people were supported to play a full and active part in their local community

Not treating people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People told us they felt staff respected their privacy. Comments included, "They always knock before entering my room and then ask if they can help me" and, "Their respect for my privacy is superb". A relative told us, "They do respect him. When they change him, they cover him up. They always close the door when he uses the toilet."
•A relative told us, "[The atmosphere] is very homely and friendly. I am always welcomed and treated with dignity and respect and so is my wife".
•Comments we received from people and relatives were positive about the service they received and the staff. One person said, "They're nice to me and kind" with several other people echoing that comment. Other people said, "The staff are wonderful here" and, "They take time with me. And they took time to sort out new headphones for my CD player and TV".
•We observed some caring interaction. One staff member had a conversation with a person about their hometowns and both showed genuine interest in the other.
•A staff member told us they, "Make each person feel that they are the only person I care about at that time".
•One male member of staff told us they always checked if a female was happy to be assisted by them, and if not, they understood this and worked with colleagues to ensure people's preferences were respected.
•The podiatrist told us, "Staff have always treated everyone with kindness from what I see".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Following the last inspection, we added a requirement "The Registered Provider must complete a monthly audit of service users' care records to ensure all their needs have been identified, risk assessed and mitigated". We monitored these monthly action plans. Despite indicating records were improved, we found this condition had not been met
•People had care plans in place, but these were not always reflective of their actual needs, and what was happening in practice.
•Staff had mixed views of people's essential needs.
•People's care plans had not been kept up to date with people's changing needs.
•For people cared for in bed, it was not clear in people's care plans, why they were in bed.
•People in the communal areas were observed not receiving care that supported them to remain involved in their day and care. Throughout the SOFIs there was limited engagement from staff, and people stared passively. For example, during one session of 30 minutes, one person spent the time playing with their jumper; a second person spent the time staring/passively at the television and a third person was asleep.

This is an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Activity coordinators were employed by the service to interact with people. They supported people in groups and on their own. However, social engagement for people outside of this, was very limited.
•We saw a scrapbook with photographs of people enjoying group activities and entertainment. We were told about and saw photographs of pre-school children visiting once a month to join people in craft and music activities.
•The service was aware of the requirements of the Accessible Information Standards and acted to support people to communicate important information. For example, one person who was deaf had a BSL interpreter to support them to speak to their GP about their needs. The service had provided pictures of food to help people make a choice. A folder with a variety of picture was available to help people communicate, for example one set of pictures explained how a hoist works.

End of life care and support
•No one was identified as being currently at their end of life
•People did not always have end of life care plans in place. When these were in place, they were not personalised.

Improving care quality in response to complaints or concerns
•People's complaints and concerns were recorded and responded to.

•Complaints information was available in different formats, including leaflets with pictures to help people understand more easily.
•One comment by a person was echoed by others, "If I had a complaint and anything was wrong I would talk to the owners" and another, "I have no complaints, only occasional minor issues which they deal with".
•A relative said, "I had minor concerns and these have been dealt with swiftly" and another told us they had not had any concerns and knew they could raise their concerns informally.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
•Following the last inspection, work had been undertaken by the provider however, this had not meant that the quality, effectiveness and safety of people's care had improved. In fact, in these areas, the service had deteriorated.
•The provider did not demonstrate during this inspection that all the requirements that were added to their registration following the last inspection were met. This was despite them sending a monthly action plan saying improvement were being made. This is especially in respect of people's care plans, meeting people's needs and, the training of staff to complete their role effectively.
•Issues that had not been a concern on the last inspection, were now being considered an issue and/or a breach of regulation.
•The provider had failed to ensure robust quality assurance systems were in place. The service has had multiple managers employed to manage the service; each time, systems, paperwork and styles of running the service had changed dramatically. This had caused chaos and confusion for staff which had directly impacted on people's care.
•We found the work by the provider to address the concerns had started in November 2018 following the safeguarding concerns being made known to them and the then manager leaving. The previous inspection took place in July 2018.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•Leadership of the service was weak. Communication did not keep people safe. This led to unsafe practice for example, the provider and those needing to make decisions on people's care, were not aware of many concerns we raised during our inspection.
•There was again no registered manager in place at the service. Since the last inspection, a manager was registered and left. Another manager came for a short time and left. A third manager had been employed.
•Different levels of staff did not ensure people's changing needs were passed on or adequately recorded meaning people were at risk of not having their needs met.
•Staff required to make complex decisions about people's care did not have the training and expertise to understand the limits of their responsibility.
•Some staff who were responsible for leading on people's care were on occasions making decisions about people's welfare without seeking expert advice and guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
•In the office was a poster stating, "Ashleigh Manor is - a colourful safe place to live. Full of people living, life to the full, with lots of humour, love and sometimes excitement. A place where people are in charge of their own lives, living it how they want". Our observations of people, would question this statement being followed through for people.

This is an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•There were ongoing opportunities for people and their family members to give feedback on the service. A meeting was held on the 31 January 2019. One person said, "There are regular residents' meetings. They definitely listen to me and if I want something they do it".
•We found the provider had been open with people and family that there had been concerns to address following the last inspection.
•People, family and staff felt improvements had been made. A person who had lived at the service in the longer term, said they had noticed good changes adding, "The owners are always chasing up staff" and, "they're always having meetings day and night with the staff".
•A staff member said, "There has been a big improvement; [the providers] listen to what we need and our concerns" and, "Since the change in management, they [providers] have really uplifted not only the home but staff and it's a pleasure to come to work without being looked down on".

Continuous learning and improving care
•The focus of the provider has been on the results of the last inspection and, the safeguarding concerns. We have found them to be responsive to concerns but struggle to maintain positive changes in the long term.
•The service has not been able to sustain areas that were not previously a concern/breach of regulations.

Working in partnership with others
•There has been a lot of involvement by external agencies due to the concerns from the last inspection and the safeguarding issues. Despite this, the service has continued to deteriorate.
•The providers have responded to requests for information and have worked openly and honestly with other professionals.