Loxley Health Care Limited

Ashbourne Lodge

Inspection report

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Date of inspection visit:
16 February 2016

Date of publication:
31 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on the 16 February 2016. The inspection was unannounced which meant the staff and registered provider did not know we would be visiting

Ashbourne Lodge is a purpose build care home built across two floors. The lower floor Ash unit accommodates up to 23 people with residential care needs. At the time of our inspection there were 14 people living on the Ash unit. The upper floor is split into two units, the Cedar and the Oak. The Cedar unit offers accommodation for up to 15 people with residential care needs, at the time of inspection there were ten people living on the Cedar unit. The Oak unit is a dedicated dementia care unit designed for older people living with a dementia and can accommodate up to 17 people, at the time of our inspection there were eight people living on the Oak unit. Each unit has its own kitchenette area, where people who use the service, their visitors and relatives can make use of the tea and coffee making facilities. Each bedroom offers en-suite facilities and each unit also provides additional bathing and showering facilities. There is also an onsite laundry facility with dedicated laundry staff. The home itself is positioned in a residential area and offers designated parking to visitors and people who use the service. The total amount of people living at Ashbourne Lodge at the time of inspection was 32 people.

The service had a manager in place that was not registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people arising from their health and support needs or the premises were not always assessed, and plans were not always in place to minimise them. A number of checks were carried out to monitor the safety of the premises. Personal Emergency Evacuation Plans (PEEPs) did not contain the required detail of information.

Neither the manager nor staff fully understood the requirements of the MCA and had a limited understanding of when they would need to consider if someone had the capacity to make decisions.

Due to sickness there were not sufficient numbers of staff to provide the support needed, call bells were ring constantly throughout the day. People in their own rooms were left for long periods of time. Staff did not receive regular supervisions and appraisals to monitor their performance.

Training for staff was not up to date and the training matrix was difficult to follow.

The registered provider did not always follow safe processes to help ensure staff were suitable to work with people living in the service.

People's care records were person centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. The care plans were found to be very confusing, difficult to work through with a lot of duplicated information.

The registered provider had developed a quality assurance system and gathered information about the quality of their service from a variety of sources. However action plans were not always robust

Medicines were not always managed in a safe way. There were some concerns around the application of topical medicines.

We were told by people who used the service and staff that meetings had previously not occurred on a regular basis but since the new provider had taken over they were taking action to ensure regular meetings occurred.

The activity coordinator was on annual leave, we saw no evidence of activities taking place.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

We observed staff to be caring to people. People's privacy was respected and people said they felt safe and cared for.

People were supported to access healthcare professionals and services.

Accidents and incidents were monitored each month to see if any trends were identified. At the time of our inspection the accidents and incidents were too few to identify any trends.

We saw that the service was clean and tidy however there were some issues. For example, wheelchairs needed cleaning and there was malodour in some bedrooms. There was plenty of personal protection equipment [PPE] available.

We observed a lunchtime meal. People were provided with choice and enjoyed the food on offer. Some work was needed to improve the dining experience for people living with a dementia and people choosing to eat in their own rooms.

Staff felt positive about the change of ownership of the home.

The service had a system in place for the management of complaints.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and electrical safety.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe
People felt safe and staff knew what to do if they had concerns about abuse.

Risks to people's health, safety and wellbeing were not always assessed and action was not always taken to reduce the risk.

Medicines were stored securely and administered safely. However there were some concerns around the application of topical medicines.

There were not always sufficient numbers of staff to care for people's needs. Safe recruitment practice was not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not provided with up to date training. Staff did not receive regular supervision and appraisals.

Neither the manager nor staff fully understood the requirements of the MCA and had a limited understanding of when they would need to consider if someone had the capacity to make decisions.

Staff signed on behalf of people for consent however we could not see best interest meetings to enable staff to do this.

People had access to a choice of nutritious food and drink; however we could not evidence this for people in their own rooms.

People were supported to access health care when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.
Although staff supported people with respect for their privacy and dignity, there were concerns for people's personal hygiene.

We observed staff and people who used the service's interactions and found these were calm and appropriate, and included some elements of humour.

Staff interacted with people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Although care plans were person centred they were very confusing and care requirements were buried in the midst of multiple assessments and records.

Activities were not taking place.

People knew how to complain and complaints were dealt with satisfactorily

Is the service well-led?

Inadequate

The service was not always well-led.
The manager was not registered with the Care Quality Commission

Audits were taking place however action plans were not robust.

We were told that people who used the service and staff meetings had previously not occurred on a regular basis but since the new provider had taken over they were taking action to ensure regular meetings occurred.

Ashbourne Lodge

Detailed findings

Background to this inspection

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

This inspection took place on the 16 February 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and three specialist professional advisors. (SPA). A SPA is a person who has a specialism in a certain area such as nursing or working with people living with a dementia.

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the provider is required to send us by law. This information was reviewed and used to assist us with our inspection.

The provider was not asked to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with six people who used the service, two visitors, five staff members, the manager, the area manager, the deputy manager, the administrator, the head cook, the assistant cook and the handyman. We also carried out observations and looked at records, these included eight people's care records, four staff files, audits and other relevant information such as policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We found that risk assessments of the building were not completed in a manner that identified all of the risks. We found a baffle lock (a mechanism that has two handles on a door each pushing a different way) had been removed as this could prevent a hazard if there was a fire. However after these were removed the manager had not risk assessed the matter and left the door unlockable. The door was located near to a lounge on an upstairs unit where people who lived with dementia and people subject to Deprivation of Liberty Safeguard (DoLS) authorisations. The door led to an open stairwell and the door at the bottom of this stairwell was not lockable. We found that the door was not alarmed and no one we spoke with had taken into consideration the risk of accidental injury that could occur if someone fell down the stairwell. We spoke with the manager and area manager about this issue and the area manager undertook to install an electronic keypad of a similar style to the one at the entrance to the unit.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment, gas boiler and the lift. We also saw weekly water temperature checks. The service had a system for daily checks such as environment walk about, we found these were not completed every day due to the handyman only working three days a week. The manager had nothing in place to cover the other four days. The area manager said they would arrange for this to happen straight away.

We saw that the service was clean, tidy and free from clutter. However there were some issues for example upstairs on the Cedar Unit, the floor in the kitchenette was dirty and had no hand towels available. Tables and chairs in the dining room needed a clean and some bins did not contain a bin liner. Downstairs did appear clean and tidy, however, one person's en suite had an overflowing bin and the panelling behind the toilet was falling off. Care Assistants and Ancillary staff were observed to wash their hands at appropriate times. Gloves were also used by both care staff and ancillary staff when required. There appeared to be adequate supplies of aprons and gloves. However two wheelchairs found in people's rooms were in need of cleaning, although there was a rota pinned up in the kitchenette area it had not been completed for some time. Infection control or cleaning audits had not picked this up. Bedrooms were carpeted and some were noted to have a lingering odour of urine, the domestic assistant agreed that it was difficult to clear the residual odour in some bedrooms, despite regular scrubbing of the rooms. One of the standing hoists had a lot of debris on the frame and spare equipment such as walking frames, wheelchairs etc. stored in an unused bedroom appeared disorganised and unkempt with no inventory or cleaning schedule. The manager said they were waiting for these items to be collected.

We also found that store cupboards with cleaning fluids in were unlocked. These cupboards were on the thoroughfare of the units for where people who lived with dementia resided. The staff were spoke with were unaware of the risk this practice may pose to people living with dementia who could accidentally drink these toxic liquids.

We looked at risk assessments incorporated into people's care plan. Risk assessments provided limited detail and were not reviewed regularly. For example, for one person they were at high risk of falls, a falls

analysis was carried out 19 January 2013 to 14 October 2014, nothing since, a room risk assessment was carried out in 2014 and a fire risk assessment was carried out in January 2015. We saw a moving and handling risk assessment carried out in 2011; this was reviewed in February 2015 and only stated no change. A person with epilepsy had their risk assessment reviewed in December 2015 with a note saying must be reviewed in one month. This had not happened. This meant that people were at risk of unsafe care due to risk assessments not being current or up to date.

Personal Emergency Evacuation Plans (PEEPs) needed further information and detail. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The service had a personal needs assistance form which was a tick sheet and stated, 'does the person require assistance with mobility', it was ticked yes but had no information of what the mobility needs were. A fire risk assessment for one person showed a score of 18 which made this 'red.' We asked a member of staff what the colour red meant in the event of an emergency evacuation, the staff member said they did not know. However a senior carer said that a person's profile on their bedroom door would be printed in red ink to indicate high dependency. However there was no information on what the high dependency was.

There were plans in place if an emergency, such as a fire, happened. We saw evidence of weekly alarm testing and a fire drill had been carried out five times since November 2015. This included a one am drill to cover night staff of the 17 December 2015. However one member of staff said, "I have not done this for so long I don't feel competent." We did see nearly half the staff 49% were overdue fire training.

We saw people's weights were recorded, however we did find gaps. One person's care file said they were to be weighed weekly but the last weight recorded was 6 January 2015. One person had not been weighed since 2014. In the care plan we saw recorded each month that they were waiting for special scales from the district nurse. We found no evidence of weights being recorded in other ways such as measurements. The area manager said they would resolve this issue straight away.

This was breach of Regulations 12 (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with said they felt safe within the home and with the staff who supported and cared for them. One person said, "I feel safe, especially at night, I am secure 24 hours a day."

From observation staff knew the people who used the service well. The staff members we spoke with were knowledgeable about abuse and the signs they would look for if they suspected someone was being abused. Not all staff had received up to date safeguarding training.

Staff did tell us that they felt confident in whistleblowing [telling someone] if they had any worries and knew how to take this further if need be.

Accidents and incidents were monitored each month to see if any trends were identified. We could see no trends or patters had been identified.

The manager told us that for the 32 people who used the service the staffing levels were two seniors and five care staff during the day and one senior and four care staff during the night. In addition to this two domestic staff and a laundry staff member worked each day, also an administrator and an activities coordinator worked five days a week and the handyman worked at the home three days a week.

On the day of inspection we were told that an ancillary worker had called in sick and they were arranging for someone to come and work in the laundry and the laundry person to take over cleaning duties. However we learnt a couple of hours later that a member of care staff had also phoned in sick. The manager did not seem to be aware of this. Arrangements were made for a member of bank staff to cover the shift. This member of staff normally worked nights and we observed that they did not know people well. We saw there was one senior covering both units upstairs and they were having to work between both units. They stated that they did not know people well on the Cedar unit. We discussed this with the manager who said the staff member does know people well.

We found that call bells were ringing repeatedly throughout the day. One call bell rang for about ten minutes and the laundry assistant had to respond and find a carer. The manager explained that the staffing levels were the same as had been set in 2013 and did not believe these were insufficient as there were less people at the home now. However she could not explain the process they used to determine the dependency level for the people and how this was then translated into staffing levels. Throughout the visit there appeared to be a lack of direction in relation to 'who was doing what'. One member of staff said, "We don't always have enough staff." This staff member cited a person who had needed three members of staff to support them. The staff member said, "We could really use a 'floater.'"

The registered provider did not always follow safe recruitment processes to help ensure staff were suitable to work with people living in the service. We saw they had obtained references from previous employers and we saw evidence that a Disclosure and Barring Service (DBS) check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

However, for one member of staff who had recently transferred from another service now operated by the registered provider. The position the person was now appointed to was a promotion. We were unable to see an interview for their current position and the manager could not provide evidence to show this had occurred. We saw in the person's folders that there had been some problems whilst they were working at their previous home but found that no follow up information had been sought by the manager prior to this person commencing work. We also saw some gaps in employment with no suitable explanation. When we spoke with the home manager they told us that they had received the person's staff file on 12 February 2016 and had not had the chance to review this and they reassured us that they would undertake a the follow up information needed on the same day of the inspection.

This was breach of Regulations 17 (Good governance); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were notified in January 2016 that all three baths were out of commission and apart from using the shower people could go to a sister home for a bath. When we discussed this with the manager and staff we found that one bath had been out of commission since July 2015 another since December 2015 and the last one had been condemned in January 2016. The registered provider was taking action to install replacement baths and we saw that one adapted bath had been installed that week and heard that plans were in place to replace the other two baths by March 2016. The area manager explained that on purchasing the home in November 2015 they had not been fully apprised of the situation but since the final bath had been condemned they had been taking action to install new baths. To do this they told us that the bathrooms had needed to be altered in order to increase the size of the pipe work.

We checked the management of medicines and saw people received their medicines at the time they needed them. We saw photographs were attached to people's medicines administration records (MAR), so staff were able to identify the person before they administered their medicines.
Staff who administered medicines had completed training to do so. We could not see any evidence of received regular competency assessments.

We checked the stocks of three people's medicines and found these to be correct. MAR charts showed that on the day of the inspection staff had recorded when people received their medicines and that entries had been initialled by staff to show that they had been administered. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. However we did notice quite a few gaps in past weeks where staff had not signed and the medicine had been removed from the blister pack. It was therefore unclear of whether this had been given or discarded. We also saw handwritten MARs did not have two signatures in place. The handwritten record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. We recommend that the registered provider consults national guidance on completing the MAR charts.

We saw all medicines were appropriately stored and secured within the medicines trolley. We saw that temperatures of the room and of the fridge for medicines were documented daily. Records to show that each person had provided signed consent for staff to administer their medicines, were signed by a staff member, therefore we could not be certain people had consented to this. We saw evidence of a protocol for when required medicines with each person's MAR and staff had to sign a form when a PRN was administered. However when staff reached the bottom of this form, rather than obtaining a new form they just stopped completing it. We observed a morning time medicines administration. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people's medicines on the MAR and medicine label, prior to supporting them, to ensure they were getting the correct medicines. People were offered a drink of water and the staff member checked that all medicines were taken. We saw in one person's care file that the doctor had written to say they could have their medicines administered covertly [disguised] in September 2015. The staff member administering the medicines was not aware of this and said the person consents to taking their medicine and therefore does not always need medicines to be administered in a covert manner. The registered provider should ensure that the process for covert administration of medicines includes assessing mental capacity, holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the person knowing (covertly) is in their best interests, recording the reasons for presuming mental incapacity and the proposed management plan. We could not see any evidence of this. Topical medicines were not routinely signed for. Therefore we could not evidence that topical medication had been applied. For example one person's topical chart said apply Piroxicam [an anti-inflammatory] twice a day to both knees; this was last applied once on the 13 February 2016 and had only been applied twice since January 2016. Medicine audits had not picked this up. The deputy manager who had started at the service four days before the inspection had planned in a full medicine audit.

Requires Improvement

Is the service effective?

Our findings

We asked to see the training chart and matching certificates. We were provided with two training charts, one from the previous registered provider and one from the new registered provider. The manager said they were currently updating the information from one to the other. We saw that there were a number of gaps in training. For example infection control 49% of staff were overdue, food hygiene 62% of staff were overdue, first aid, 70% of staff were overdue and health and safety 66% staff were overdue. However, there were difficulties experienced in interpreting the training matrix as staff that were not eligible for the training were also included in the percentages. This meant staff may not have been supported to develop their skills and understanding in supporting people, in addition to enabling them to consider their own career progression. New staff completed a 12 week induction, the policy was very basic and did not provide much information on what the induction involved, for example there was no information on new staff shadowing existing staff. We were provided with an updated training matrix a week after the inspection date. This provided a clearer account of what training was needed. The area manager said, "We are in the process of booking training to fill the gaps."

Staff had not received regular supervisions and appraisals to monitor their performance. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. In the staff files we looked at we saw supervisions had not taken place. Files we looked at did not include notes on staff member's appraisal meetings. The home manager told us "No appraisals were done last year, they were due in August 2015, however we then had the CQC inspection and then the deputy left". This meant that staff may not have been offered support in their role as well as identifying their individual training needs.

This was breach of Regulations 18 (2) (a) (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We checked whether the staff were working within the principles of the MCA and the existence of the MCA code of practice. Neither the manager or staff fully understood the requirements of the MCA and had a limited understanding of when they would need to consider if some one had the capacity to make decisions. The staff told us that three people had capacity to make choices however when we reviewed their care records we found that they had conditions that compromised their ability to make choices. We asked if these people were able to go out and about by themselves and staff did not feel this was an option for people but did say people could go out with their relatives if they wished.

We saw that relatives were asked to consent to treatment such as flu vaccinations, which included giving permission for people the staff deemed to have capacity. No information was available in the care records to show whether relatives had obtained the authority to make decisions on behalf of people via the enactment of Lasting Power of Attorney care and welfare or been appointed by the Court of Protection as a deputy. Therefore it was unclear as to on what basis relatives were making decisions for people who used the service.

The service had an assessment record in place to check whether people had capacity to make decisions. These were decision specific and stated that the assessment covered, "ability to go out alone, open personal mail, making decisions regarding voting, manage finances". However, the assessment was signed by the manager or a senior carer and did not appear to have involved the person or the person's family as part of a best interest decision. This meant that the person's rights to make particular decisions may not have been upheld and their freedom to make decisions maximised, as unnecessary restrictions may have been placed on them.

We saw that the majority of consent had been signed by the home manager or a member of staff. There was no information to state whether people had been involved in this consent or any best interest decisions being made. All consent to photographs were signed by the manager.

Care records did not describe the efforts that had been made to establish the least restrictive option for people was followed and the ways in which the staff sought to communicate choices to people, for instance via people going with the staff or pointing to what they wanted.

This was breach of Regulations 11 (3) (Need for consent); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of the inspection six of the people using the service had been subject to a Deprivation of Liberty Safeguards (DoLS) order. In addition to this nine DoLS authorisations had been applied for. From our discussion with the manager we found that despite making telephone calls asking when the authorisations applied for would be completed they had not proactively dealt with the matter so had not used urgent authorisation in respect of the continued deprivation these people were experiencing. We also found that one of the authorisations had expired and required renewing. No record had previously been kept of when the DoLS expired and it was difficult to find the documentation as this was not stored in the care records.

We checked whether the staff understanding of who was subject to a DoLS authorisation and whether any conditions on these authorisations were being met. The staff we spoke with were unsure as to who had a DoLS authorisation in place and believed that an application meant the authorisation was agreed, which is not the case.

The area manager told us that they recognised the manager and staff needed more support to ensure they fully understood and applied the requirements of the MCA.

This was a breach of Regulation 13(5) (Safeguarding people from abuse and improper treatment); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were concerns for people eating in their own rooms. Food taken to them was not always covered and we did not see accompanying condiments and napkins. Lunch was served around one pm. We noticed one person who was in bed all day did not receive their lunch until two pm. They then received both the main meal and the pudding and custard at the same time. This would mean the pudding and custard would be cold by the time the person got round to eating it. The person was semi lying down in bed and was struggling to eat their food. No napkins were provided. We checked this person's daily food and fluid chart, as they had a cup of tea and a biscuit on their bed table all morning, untouched. Their dietary intake on the previous day had been a total of 150mls liquid recorded, 2 biscuits and sandwiches. On the day of inspection, although staff took some drinks and food into the room, no entries were made on her fluid / diet record. Also we noted that from 9.30 am until 2 pm they did not receive a drink. We passed these concerns onto the manager and area manager and we also raised a safeguarding alert with the local authority.

This was breach of Regulations 12 (1) (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a lunchtime meal both upstairs and downstairs. People had a choice of where they wanted to sit in the dining room or eat in their own room. People had a choice of chicken casserole or sausage and onions with pineapple sponge and custard for pudding. In the dining room downstairs the environment was calm and unhurried. The meal was well presented, warm and the portion size varied to suit the individual. A pictorial menu was displayed outside the dining room entrance. Two people needed support with either feeding or cutting up their food. This was done in an unhurried manner.

Upstairs people were asked for their choices and staff respected these. For example, people were asked where they wanted to sit, where to eat their meals and what to eat or drink. In addition we saw staff sought consent to help people with their needs. The atmosphere was pleasant and there was background music playing which people were enjoying. Staff interacted well with people and were available to support people with tasks such as cutting their food up. Staff were attentive and we heard comments such as 'do you want your tea topping up' and 'do you want some more.' The food was well presented and hot and cold drinks were available. However the pictorial menu board was displayed in a foyer which was not accessible to people who used the service. We asked the manager why this was not outside the dining room. The manager said they only had one board and needed two therefore they had put it there. We also did not see staff show people both meal choices. This meant that they would not be able to see and smell the food which was particularly beneficial to people who were living with dementia.

The majority of people were complementary about the food. However one person said, "The food is not so good, they don't do anything for people with insulin controlled diabetes."

Discussion with the Head Cook, and Assistant Cook indicated a good knowledge of the people living there and their likes and dislikes. Catering staff had clear notices of who was on special diets in the home as a whole including; insulin dependent diabetic diet maintained, soft and pureed and low fat. Whilst there was no demand they could accommodate cultural / religious diets. The registered provider had introduced a new recipe book which catered for a variety of needs.

People were supported to access external services to maintain and promote their health and wellbeing. People's care records showed details of appointments with and visits by healthcare and social professionals and we saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), district nurses, diabetes nurse specialists, nutrition nurse specialists, dietician, chiropodists and the speech and language team (SALT). The visiting healthcare professional we spoke with said, "I have had a

number of referrals from the home and have come to see several of the residents." One comment made in a care plan from a dietician said, "I am pleased to report that the person's weight has increased since their referral."

Requires Improvement

Is the service caring?

Our findings

We were concerned about the support for people's personal hygiene. The service had informed CQC that all baths were broken; with the last bath breaking in January 2016. The options open to people who used the service were showers, full body washes or to go to another service for a bath. We were told that the first bath would be fixed by 29 January 2016. On the day of inspection we found that two baths were still not fixed and the third bath had been fixed the day before (15 February 2016). However this bath still had an out of order sign on the door. We asked people how they had coped with not having a bath. One person we spoke with said, "I have been washing myself down, I know one of the baths is fixed so it will be Thursday before I go in." We asked what they meant by 'Thursday' the person said, "That is my day for a bath, I go in once a week, I would like more." We discussed this with the manager who stated that people don't have set days and can go in when they want. The area manager said, "We need to speak to people if this is their perception."

We looked at personal hygiene in people's care plans. One person's care plan detailed each day whether they had received a full body wash, a wash or a shower. This person had only received six showers since 2 November 2015.

This was breach of Regulations 10 (1) Dignity and Respect; of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were very complimentary about the staff. One person we spoke with said, "You can not fault the staff." Another person said, "I have been here years, I really enjoy being here." A relative we spoke with said, "The staff are lovely." And the visiting healthcare professional said, "The staff are lovely and very caring towards the people who live here." One member of staff we spoke with said, "I left Ashbourne for a career move but I returned because I missed the residents."

Staff we spoke with, knew people well and spoke fondly of people living in the home. We observed staff and people who used the service's interactions and found these were calm and appropriate, and included some elements of humour. This included ancillary/ maintenance staff interactions with people.

When personal care was taking place explanations were given, and interventions were unhurried. Frequent supportive and caring interventions by the staff were noticed throughout the inspection day.

We observed staff treating people with dignity and respect. Staff knocked on people's doors before entering.

At the time of Inspection there was no one receiving end of life care, although there was evidence in care records reviewed that plans were in place, and had been discussed with family. We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans for eight people who used the service. We found the care plans to be confusing, difficult to work through and duplicated. Within the care files there was a mixture of a previous owner's care plans and Ashbourne Lodges care plans. For example the previous owner's care plan stated how a person communicates, risk assessments, continence files, then we found these were repeated for Ashbourne Lodges care plans but with sometimes conflicting information. Due to the volume of information, information such as weight records were hard to find as the folders were not consistent in their content layout. Whilst personal data and emergency information was easy to locate at the front of the file information regarding physical conditions and immediate care requirements were buried in the midst of multiple assessments and records. We found that vital information about people's needs could be missed because of these difficulties.

One care plan we looked at had a number of assessments included. These were for continence, moving and handling etc. These assessments were reviewed but continually stated no change. There was no information as to how they had come to the conclusion of 'no change.' There were no records to show that people were involved in the planning of their care. Care plans had a signature list of people who had read them. The signatures included staff that had left the service. The manager stated that these needed updating.

Another person's care plan was not up-to-date to inform staff about the persons care and support needs. We saw that the skin assessment dated 26 May 2015 stated a grade 3 pressure sore on the left ankle and we saw a note stating that no dressing was required after 9 September 2015 and if there was any concerns staff were to ring the specialist team, this had last been reviewed on 21 December 2015 We noted that a moving and turning chart was in use to monitor the persons care in this area and these had been completed on only 14 days since the 21 December. Although this person was prone to pressure sores and presumably needed a moving and handling chart, the moving and handling care plan stated that this person can move and re position themselves in a chair and can turn independently in bed.

There were also gaps in this person's daily skin assessment chart which stated that all areas must be checked on delivering personal care each day. This had been completed only 22 times since 20 November 2015. On the 9 December it was recorded 'noted red marks on back.' On the 10 December 2015 it was blank, no checks and on the 11 December it was recorded noted broken skin under left side under stomach. They were checked again on the 12 December 2015, then only six more times in December and were never checked in January 2016.

Daily records were also kept in the care files. We found the daily records to be concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. We found daily charts for food and fluid intake, continence, moving and handling etc. were not always completed. The office where these charts were kept was locked so carers would have to locate the senior with a key to enter the office and complete the charts. We discussed this with the manager and area manager who agreed that these charts needed to be more easily accessed for staff to complete. The area manager said they would rectify this immediately.

Handover notes were quite basic with bullet points. Not all staff attended handover, only the seniors. The seniors were then to pass on the handover to the rest of the staff. We had received comments that the seniors do not have time to do a full handover. We asked the manager why all staff were not included in the handover, so everyone was receiving the same information at the same time. The manager said, "I have asked staff if they want to come in but they often don't." Area manager said they would look into this.

We discussed the care plans with the manager and area manager. The area manager was aware that the care plans needed work. We were shown new care plans which had arrived the day before inspection. The area manager said that all care plans were to be transferred to the care file as soon as possible.

This was breach of Regulations 12 (1) (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care files we looked at were person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. The care files included a 'my life history' and a 'my family and friends' and 'my hobbies and interest.' Some information was repeated and could be condensed to make for easier reading.

We saw a large activity board on display. The activity timetable was rather limited in nature, in that there was only one type of activity on a morning or afternoon for example on a Sunday morning the activity was 'Radio' and in the evening was 'Film & TV', and on a Monday afternoon it was 'tasting'. The manager said they were advertising for an activity coordinator to work 25 hours alongside the existing activity coordinator. At the time of our inspection the activity coordinator was on annual leave. Therefore we did not see any activities taking place. The manager said staff would provide activities in this person's absence. However the manager also said that staff were not provided with extra hours to do this and were expecting to do activities as well as care, therefore they did not have time to complete this.

We asked people if they were happy with the activities on offer. One person said, "We have exercise on a Thursday, a singer comes in and we play games like bingo, I love bingo." We did have concerns about social isolation. On the day of inspection several people were noted to spend lengthy periods of time on their own, either in their own room, or in a lounge, with very little interaction. One person we spoke with who was sitting alone in the lounge enjoyed the interaction and spoke about the budgie and how they enjoyed colouring and Disney movies. However apart from this interaction with an inspector and having lunch, most of their day was spent alone. One person spent the day in bed, we could not gain an understanding why, one staff member said it was unusual as they are usually up in the lounge watching television. The manager said this person often decides to stay in bed. We observed this person throughout the day and did not see one member of staff speak to them.

We saw the complaints policy. We looked at complaints the service had received. They had received two complaints so far this year. Although the complaints had been acted upon the outcome was not documented. We discussed this with the manager who was going to add this information.

Inadequate

Is the service well-led?

Our findings

We saw that systems were in place to monitor the quality of the care provided. Frequent quality audits were completed. These included checks of; premises, medication, risk assessments, food hygiene, health and safety and care files. Where remedial action was needed an action plan was not produced and issues were not addressed. For example, we saw that an audit of medications, each month the manager had highlighted that they needed a new signature list, a BNF and a clear out, due to not making someone accountable for this, with a date for the action to be completed, this same issue came up every month.

We found that the systems in place were not effective, as there was no information to show any actions needing addressing had been completed. We found that the information the manager kept in respect of the application and renewal of DoLS authorisations was incorrect. We found that people were no longer at the home but the DoLS authorisation information suggested that they still lived at Ashbourne. Also the system for monitoring DoLS authorisation application had not prompted the manager to be more proactive in chasing up applications or ensuring DoLS authorisations had not expired. We found the folder very chaotic and misleading as did the manager. The manager was unable to use this folder to give us the correct number of people at the home who were subject to DoLS authorisations.

We found that the manager had not recognised the need to maintain detailed information about their response to complaints or to use this and other information from a review of incidents to produce lessons learnt documents. We found no evidence that this any other such information was used to learn lessons and to take steps to improve the service.

We did not observe the manager to be actively involved in the day to day running of the service or to have a managerial presence. We asked the manager if they do a daily walkabout. The manager provided the records for the last few days' walkabouts after the inspection. These were a tick sheet with the odd comment such as floor needs sweeping. However there was no evidence that someone had been made accountable to sweep the floor. On the day of inspection we found cupboards with signs on 'keep locked' open, this cupboard was an activity cupboard and contained bottles of sherry. A bathroom that was fixed still had signs on saying out of order, and bathrooms that were broken had no signs on and were not locked. The manager may have also been aware that two staff members had phoned in sick rather than one, creating a shortage of staff. This meant that the daily walkabouts were not always effective.

This was breach of Regulations 17 (1) (Good governance); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Understanding that on inspection day the manager was busy providing the inspectors with information, we left a few questions that they could if they want; provide answers to up to 48 hours after inspection. This provides the manager opportunity to send evidence of good practice, what has worked well etc. Unfortunately we did not receive any further information.

At the time of our inspection the service had a registered manager but they did not work at the home and

the area manager was taking steps to ensure their registration was cancelled. There was a manager in charge of the day-today who was not registered with the Care Quality Commission.

Staff were very positive about the new registered providers. One staff member said, "The new management have been noticed by their presence, they've been listening to staff and purchasing quality items." Another staff member said, "There is a good working atmosphere."

One relative we spoke with said, "[Person's name] is really settled here, they have been here since June."

We asked a member of staff about what it was like to work at the service, they said, "There has been changes, things are still up in the air, and it has been unsettling for staff and has caused conflict."

We were told that resident and staff meetings had previously not occurred on a regular basis but since the new provider had taken place they were taking action to ensure regular meetings occurred. Staff described how the operational director had visited and held a meeting with them and one with relatives. Also that the area manager visited every week and always ensured they spoke with staff and the people who used the service. The staff told us this was significantly different from their previous experience and a very positive development.

The new registered provider had very recently sent out surveys but it was too soon for any replies.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There were concerns about the support for people's personal hygiene

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Neither the manager or staff fully understood the requirements of the MCA. No information was available in the care records to show whether relatives had obtained the authority to make decisions on behalf of people via the enactment of Lasting Power of Attorney care and welfare or been appointed by the Court of Protection as a deputy. Peoples rights to make particular decisions as unnecessary restrictions may have been place. Staff or the manager signed consent forms for people

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments of the building were not completed in a manner that identified all of the risks. Daily checks such as environment walk about, were not completed every day. Store cupboards with cleaning fluids were unlocked. Risk assessments for people using the service provided limited detail and not reviewed regularly. Personal Emergency Evacuation Plans (PEEPs) needed further detail. There were

gaps in weight recording. There were concerns about the dietary and fluid intake for one person

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The manager had not proactively dealt with DoLS applications so had not used urgent authorisation in respect of the continued deprivation nine people were experiencing. We also found that one of the authorisations had expired and required renewing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The manager could not explain the process they used to determine dependency levels for people and the registered provider did not follow safe recruitment procedures. There was not registered manager in place. We did not observe the manager to be actively involved in the day to day running of the service or to have a managerial presence. Audits showed areas which needed addressing, however action plans were not evident and issues were not addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not always follow safe recruitment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive up to date training. Staff did not receive supervisions and appraisals.