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Ashmeadows

Inspection report

Moorbottom
Cleckheaton
West Yorkshire
BD19 6AD

Date of inspection visit:
14 March 2017
21 March 2017

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 and 21 March 2017. We previously inspected the service in September 2016 at that time we found the registered provider was not meeting six of the regulations and we decided to take enforcement action. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made. We found some noticeable improvements had been made, although there were still areas that the provider needed to address.

Ashmeadows Care Home provides personal care for up to a maximum of 17 older people. On the days of our inspection 13 people were living at the home.

The service had a registered manager in place. 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.

Staffing levels were sufficient to meet people's needs and this had improved since the last inspection, which meant people did not have to wait for staff to support them in their care. However, procedures for the recruitment of new staff did not demonstrate staff had been thoroughly vetted before they were allowed to work with vulnerable people.

There were improvements to the management of risks in the service, such as with the premises and equipment, although some risks to individuals were not sufficiently assessed or managed.

The management of medicines was not always carried out safely to ensure medicines were stored securely or given with clear direction.

Support for staff was more consistent than at the previous inspection, with regular supervision and opportunities for training. Staff were more confident regarding people's mental capacity, although there were some minor errors in recording mental capacity assessments.

People were enabled to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's dietary needs were known by staff and staff encouraged and supported people to eat and drink. However, monitoring of people's food and fluid intake was not done thoroughly and recording was not accurate.

Staff were kind, caring and compassionate and they had secure professional relationships with people living at Ashmeadows. The environment was welcoming and homely and people were happy living there.

People were involved in meaningful activities and staff engaged well with them in conversation. Staff understood people's individual needs although it was not clear how people's preferences for personal care were reviewed day to day.

The complaints process was known by people and their relatives and they were confident any matters they raised would be dealt with by staff and the registered manager.

Improvements to the way the home was run and managed were evident with staff having more clear direction and support in their role. The provider had made noticeable improvements in response to the last inspection in relation to the premises, environment, staffing levels, staff working hours and audits of the quality of the service. However, some audits still lacked rigour around key areas of safety and there were still three breaches in the regulations identified at this inspection.

You can see what action we told the provider to take at the back 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.

Staffing levels had improved, although recruitment procedures were still not thorough enough to ensure all checks were carried out for new staff.

Safety in the premises had improved, although some risks to individuals had not been fully assessed.

Systems for the management of medicines were not always safely or effectively in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training and support had improved since the last inspection.

Staff were more confident regarding the legislation for people's mental capacity.

Food and drink was of good quality overall, although monitoring of people's diet and nutritional risks was not robust.

Is the service caring?

Good

The service was caring.

People enjoyed kind and caring relationships with staff, who knew them very well.

Staff promoted people's dignity and privacy and respected their rights.

People's independence was supported and staff encouraged people to do as much for themselves as they were able.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities had improved since the last inspection and staff took time to spend socially, engaging in conversation with individuals about what mattered to them.

Care records were maintained up to date, although not all information was recorded accurately and it was not clear how people's preferences had been checked with them on a daily basis.

People felt confident to approach staff or the registered manager If they had any concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had made noticeable improvements to the service since the last inspection and had taken many steps to address the issues raised, although there were some continuing breaches identified at this inspection.

Staff had clear direction and leadership was more consistent because the registered manager was able to focus on their role in running the home.

Systems and processes for monitoring the quality of the provision had improved, although there were still some areas that required more rigorous monitoring.

Ashmeadows

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 21 March 2017 and was unannounced. The inspection team consisted of an adult social care 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.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group (CCG), and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

We spoke with the registered manager, the operations manager, three staff, the cook and a visiting professional. We spoke with five people who used the service and four relatives. We looked at four care records and reviewed documentation to show how the service was run.

Requires Improvement

Is the service safe?

Our findings

All people we spoke with told us they felt safe. Nobody expressed any concerns about safety. Comments included, "I feel safe, if not I would just tell the staff", "Yes I do feel safe I have no trouble that way", "No problem that way (safe)
Oh yes I could talk (to staff) if not", "My possessions are safe, the money is kept by the chief" and one person said, "I have no concerns about safety". Three out of four people expressed concerns about the level of staffing. One said, "There are times when there are not enough (staff)". From our observations there were sufficient staff available for the people and one of those who had expressed concerns did not need any help with moving around or eating. People were happy that medication was given in a timely manner. One person said, "I get the right meds at the right times". Everybody we spoke with was happy with the level of hygiene. One person said, "It's fine they do a good job (cleanliness)".

Staff understood the safeguarding procedures to follow and they were confident to identify the signs of abuse. They told us any concerns would be referred to the registered manager or the local safeguarding authority without delay. Staff understood the whistleblowing policy and said they would report any poor practice. One member of staff told us: "People come first, we are here to protect them".

Staff were quick to intervene in order to prevent situations from becoming safety concerns. For example, when two people began to disagree and raise their voices with each other, staff quickly diverted their attention to calm the situation. Where one disagreement continued, staff invited one of the people to sit in a different place, which they were happy to do.

We found staffing levels had improved since the last inspection. At the last inspection there were only two staff on day duty to care for people and the registered manager was acting in a range of different roles, such as the cook and care assistant in order to meet people's needs and supplement the staffing levels. At this inspection we saw there were three care staff on day duty in addition to the cook and the cleaner. This meant the registered manager was able to carry out their management role.

With three care staff on duty we saw people's needs were met in a timely manner. People did not have to wait for their physical needs to be met and staff had time to spend with people in activities and conversation. Staff we spoke with all said they were able to meet people's needs much better now that staffing levels had increased.

Where there had been shortfalls in staff availability, the provider had used agency staff to ensure staffing levels were maintained. The registered manager obtained a profile of each agency worker, although there was no induction checklist to show how agency staff had been made familiar with the home. The staff rota stated 'agency' so it was not possible to verify which staff had been on shift.

At the last inspection we identified concerns in the way staff were recruited as there was no evidence to show they had been interviewed thoroughly or their skills and abilities checked. There had been improvements to the way staff were interviewed and selected, although we still found recruitment

procedures were not robustly followed. The registered manager told us interviews were more detailed and two references and a DBS check were obtained before a member of staff could work unsupervised. However, we looked at three staff files for staff appointed since the last inspection and we found two of the staff had appeared on the staff rota before their Disclosure and Barring Service (DBS) checks had been returned. The registered manager told us the new staff had been shadowing other staff, but was unable to confirm the new staff had been supervised at all times; the staff rota showed one of the members of new staff was down to cover for other staff absence, which meant they were used as fully operational staff.

This meant there was a continued breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people were recorded in more detail than at the last inspection, but still not always identified or managed effectively. For example, staff told us all people in the home used equipment, such as the shower chair, but there was no assessment of people's safety for the use of this. We discussed this with the registered manager who responded by producing a generic risk assessment template for each person's use of this equipment, although acknowledged it would take time for staff to assess each person's risks individually.

Staff were observed to support people safely with mobilising and they gave reminders for people to use their walking frames. Staff encouraged people to move safely and take their time going from one place to another around the home.

Some people's moving and handling care plans were vague and lacked direction for staff. For example, one person's records stated they may need the sling / hoist 'at times' but did not state at which times or how the staff were to assess this. Another person's daily notes referred to a moving and handling belt, but this equipment was not in their care plan. The care plan stated 'can transfer with two carers and a zimmer' but did not state how this was to be done safely.

Some risk assessments were in place, including standardised risk assessments such a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and a Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. However, risk reduction plans were not always clear. For example, some people were identified as being at high risk of pressure ulcers, but it was not clear from care records if they needed any pressure relieving equipment.

Where people were at high risk of malnutrition, their weight was not monitored closely. We spoke with staff who said all people were weighed monthly and there was a lack of understanding about the use of the MUST tool. Records showed some people had significantly lost weight, yet there was no evidence they had been re-weighed to monitor this in a timely manner. For example, three people were weighed on 19 February 2017 and records showed they had lost several kilograms, yet they had not been weighed since. The MUST assessment showed these people to be at high risk and guided staff to ensure weekly weighing, yet this had not been done. The registered manager told us they knew who had lost weight, their food and fluid intake was recorded and other professionals, such as the GP or dietician had been consulted. We looked at food and fluid records for people and saw staff recorded what people had been offered and how much they had had. We sampled three people's records, two of whom were at high risk of malnutrition. These showed they had eaten 'all' of their tea time meal, yet when we saw these records, the meal had not occurred and therefore the recording was false. We brought this to the attention of the registered manager who agreed to take action.

These examples demonstrate a continued breach of Regulation 12 (1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw each person had a personal emergency evacuation plan (PEEP) which was risk rated in traffic light colours and staff knew how to support people safely in the event of an emergency.

Accidents and incidents were recorded and there was evidence of the registered manager's oversight of these on a monthly basis, to identify where there may be trends or patterns. Where there were concerns about a person's high number of falls,, they were referred to the falls team.

At the last inspection there were concerns about the safety of the premises. At this inspection we found the provider had addressed these issues. For example, there were regular checks of the water temperatures to ensure these were within safe limits and there was appropriate legionella testing carried out. Gas and electricity safety concerns had been addressed and the provider had documentation to ensure the utility supply and equipment was safe. The provider had taken steps to improve the environment. Some rooms had been redecorated and there had been new floor covering installed in some areas. The premises was still in need of further refurbishment due to wear and tear and the registered manager told us there was an ongoing programme of improvements to maintain the home in an acceptable condition.

We looked at how medicines were managed. We saw staff supported people patiently and appropriately with their medicines and explained what each medicine was for. Staff asked people if they had any pain and checked whether they wanted any pain relief. People told us they had their medicines on time.

We saw medicines were stored securely in the trolley which staff kept locked. However medicines no longer in use to be returned to the pharmacy were not stored securely and were kept in a room outside the manager's office. This meant they were inappropriately accessible to others. We asked the manager to remove these to a secure location.

Staff signed a form for the keys to the medicines storage, to show who they had received them from and who they were handing them to. This was supposed to take place at the beginning and end of each shift but we saw there were gaps in the recording which meant security of the keys could not be assured.

Some medicines in the medicines trolley were labelled 'as directed' and there was no clear direction for staff to know how these should be given for the person, how many, how frequently or the correct dose. There were also some medicines that were labelled 'give one or two as required' but again there was no direction for staff as to when to give one or two.

We looked at the medicines administration records (MARs) for the people living at the home. We found records were kept up to date and there were no gaps in the recording for medicines. However we saw some dates had been overwritten on the printed MAR sheet which read that the medicines had been given on the wrong day. Staff explained this was an error in the recording but said they understood how the system worked. We found gaps in recordings of topical creams which meant it was not possible to demonstrate if these had been applied as prescribed.

These examples demonstrate a breach of Regulation 12 (1) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who needed certain medicines, such as painkillers, only when necessary (PRN) had individual protocols in place showing when these should be given, although it was not always clear how staff would

know if a person was experiencing pain, particularly if they were unable to communicate this verbally.

Staff we spoke with were knowledgeable about how to ensure medicines were given to each person and when to seek a review of these. We saw one person had repeatedly refused their medicines and we saw in their care record there were recorded reasons why, with consultation from the person's GP and appropriate risk assessments in place. There was evidence staff had discussed with the person the consequences of not taking their medicines and the person understood the decision they made. Another person had been referred to their GP for a medicines review and their health had improved since an adjustment to their dosage.

The home was visibly clean and there were no offensive odours. Bathroom bins had secure lids and there was an adequate supply of personal protective equipment (PPE) for staff to use, such as disposable gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

People and relatives spoke positively about the level of training of the staff. One person said, "Yes I do and I think they do (think they are trained and give good life quality)" and reported that the staff were good at asking consent and explaining what was happening. One person said, "They tell me what they are going to do and explain why". One person said "The training is not good enough but the girls are clever" and another said, "I am sure they are (well trained).The training is reasonable".

Many people were positive about the standard and quantity of the meals. One person said, "Food is excellent, I enjoy it" although one person, whilst still generally positive had some reservations and said, "Some meals good, some poor, depends on the chef". One person said, "You get a choice and if you don't like them they will make sandwiches" and another said, "There are plenty of snacks and drinks". All reported that in between meals there was good access to snacks and drinks. One relative said, "I presume [my relative] has snacks all day, [they have] put half a stone on". Everyone we spoke with felt that there was good access to other health care professionals if required.

Staff we spoke with told us they felt they had improved support through supervision and training. We spoke with a new member of staff who said they had completed an induction and shadowed more experienced staff until they felt confident in their role. Staff told us the registered manager carried out spot checks of their work and they understood the importance of this.

The training matrix showed staff had completed training and the registered manager said they carried out competency checks to ensure staff were effective in their work. Where the training matrix showed staff were due for training the registered manager told us this was scheduled to be completed, such as moving and handling for new staff. The registered manager showed us competency workbooks for staff who administered medicines and we saw from the training matrix medicines training had been undertaken for senior staff. However, the recent pharmacy audit identified the staff training in medicines was not accredited and the registered manager was taking action to address this.

The registered manager told us there was a programme of supervision in place. We saw supervision meetings were documented with the next supervision date scheduled and clear agenda for staff training and development discussed. Some staff's last recorded supervision was November 2016 and the registered manager told us this was a rolling programme. We saw there was a core agenda for supervision which included discussion around the mental capacity act, deprivation of liberty safeguards, safeguarding and whistleblowing, key worker responsibilities, equality and diversity and teamwork.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw a record kept at the home regarding DoLS applications. We saw three people's DoLS were approved although there was no overview to show expiry dates to ensure, where appropriate, a further application was submitted.

Staff told us they received training in MCA and we saw this was recorded on the training matrix. Staff we spoke with were more confident in their knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and they understood how to promote people's rights. Staff told us they assumed all people had capacity to make decisions, unless there was a reason to doubt this. Staff we spoke with were clear about people's right to make their own choices and decisions about matters that affected them.

We saw staff asked people their consent before assisting them with care tasks. Care plans we looked at showed best interest meetings had been held in relation to care and consent. Staff were clear people's mental capacity assessments were specific to each decision being made.

We spoke with the registered manager about the use of bed rails. They told us no one in the home currently required the use of these but they were aware to seek consent should anyone need these to stay safe in bed.

People enjoyed mealtimes and the dining experience for people was relaxed and sociable. People were invited to the dining tables to eat together, although some people chose to eat in their own room and staff facilitated this. The layout of the furniture in the home had been altered since the last inspection to enable one dining area to be created. Two of the three tables had tablecloths, all had place settings, condiments and a small menu on the tables. There were four members of staff in the room most of the time and they were occasionally joined by the cook who also helped to serve the meals and give drinks. The four care workers wore plastic aprons when serving food or assisting people and were all involved in interacting with everyone.

As people were seated they were offered a choice of meal and different juices, with visual choices of drinks available and they were given new drinks as the meal progressed. Staff told us and we saw, people were given choices of what they might like from the menu. On the first day of the inspection we heard the cook tell staff they were going to adapt the meal because people did not want the choice on offer.

There was variable conversation between most of the people. The staff were continually speaking with people who needed support and listening to and interpreting their responses. Nobody was rushed and people were encouraged to eat more. The portion sizes were suitable for people and we overheard one person telling a carer "I don't think I can finish there's so much". There was a choice of two main meals and two desserts. The food appealled to people as there was little food left on the plates.

Staff were on hand to offer assistance if people needed this and we saw there were appropriate plate guards and clothes protectors if people wanted to use these. Staff encouraged people to eat and drink at mealtimes and at regular intervals throughout the day.

We spoke with the cook who told us they communicated with staff to support people's dietary needs. They said where people needed extra calories they fortified the food and if a person did not want what was on the

menu, alternatives were offered. One person who was new to the home and had a poor appetite was offered a range of different foods to encourage them to eat.

We saw menus were varied and there was a variety of food in stock, including fresh fruit and vegetables. Staff told us people enjoyed baking and items they baked were available as snacks.

The care staff worked closely with other professionals, to ensure people's health care needs were supported. We saw a visiting community nurse carrying out frailty assessments with people and reviewing their care needs. One person told us they were having new glasses after having their eyes tested and we saw evidence of opticians, GP, dentist and chiropodist input in people's care plans.

Good

Is the service caring?

Our findings

All people we spoke with indicated that they were generally happy living at Ashmeadows. One person said they were 'relatively happy'. Other comments included, "Yes, I think they are kind and caring", "They are kind and caring and do their best for the difficult ones", "They do actually care for you, kind", "As well as can be expected", "They treat you with respect", "They treat me well", "They talk and listen to me", "They should know me well", "On the whole they know my likes and dislikes" and "They let me do things my way".

Relatives' comments included, "They are great, I think they are really friendly", "I think they are friendly and approachable" and "I know they had a poor inspection report last time, but the good care has always been there".

Staff interaction with people was friendly, kind and compassionate. It was evident staff knew people well by the way in which they spoke with them; staff knew which family members would be along to visit and they engaged in conversation with people about their individual interests.

Staff told us they enjoyed working at Ashmeadows. One member of staff said, "I just love everyone, the atmosphere here, it's like home from home. I treat people as though they were my own family".

Staff noticed when people needed support and offered this. For example, staff noticed one person was falling asleep in their chair and offered to make them more comfortable by bringing a blanket. Another member of staff noticed a person had sore lips and reminded them to use their lip balm.

People's independence was encouraged and staff enabled them to do as much as possible for themselves without intervening. Staff were patient and allowed people to do things at their own pace without feeling rushed. One person said, "I'm taking my time" to which staff replied, "You can take all the time you need". Staff involved people as much as possible when supporting them with care tasks, giving explanations about what was happening. One person told staff they did not feel they could walk to the dining table from their chair and staff said, "Well, we'll go together, you can do it and I'm right here".

We saw people spontaneously showed affection to staff and staff responded warmly and professionally. For example, one person told staff, "I love you" and offered their hand to hold, which staff took responsively. Staff used plenty of eye contact, smiley facial expressions and appropriate touch, such as stroking a person's shoulder when they felt anxious. Staff encouraged people's friendships and supported people to sit together where they expressed an interest in doing so. For example one person said, "I like [person's name] they are a good friend" and staff said, "Well would you like a chair next to [person's name] then?"

Staff told us they had time to look at people's care plans and many of the staff said they knew people very well because they had worked at the home for a number of years. Care plans recorded people's individual needs in relation to lifestyle, beliefs, sexuality and end of life wishes, although in the care plans we reviewed we saw it was recorded people did not want to discuss their end of life. Staff we spoke with said one person had been assessed as approaching the end of their life, but there had been improvements in their condition

and this was no longer applicable. One person said their religious beliefs were important and they were visited by the local vicar. Another person told us they had visited the church next door to the home.

Staff promoted people's dignity and respected their privacy within the daily routine. Staff knocked on people's doors before being invited in and they were discreet when supporting people with personal care. People were smart in their appearance and staff supported them with this where necessary. People's rooms were personalised with family photographs and personal belongings. Staff we spoke with said they tried to ensure a homely, cosy environment for people as this was their home. Feedback received from relatives was consistently about the homely atmosphere for their family members.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said staff were responsive to their needs on the whole. Comments included, "I am not bothered who looks after me, I prefer females", "The staff are mostly female so you don't get a choice", "There is plenty to do and you can opt in or out. I don't take part", "There aren't many activities, you can choose to join in", "They help me to do my painting" and "They would arrange transport to see family and friends".

Relatives' comments included, "[My family member] hasn't got any health problems but they would get [them] the support [they] need", "Yes I have seen [my family member's] bible", "I have not wanted to complain but I know how", "There are enough activities" and "There are no restrictions on visiting". One relative said there were more activities than previously and they thought this was because staffing levels had increased.

The last inspection had highlighted concerns that people did not have sufficient meaningful activities for them to be purposefully engaged. The provider's action plan stated they would employ a designated activity co-ordinator for this role. At this inspection, we saw there was no activity co-ordinator in post, but staffing levels had increased and so care staff had time to spend with people socially. The registered manager said when the home increased in occupancy, an activity co-ordinator would be employed. We saw staff played a game with a group of people and encouraged people to join in. Later, a craft activity was arranged and people told us they were supporting 'Comic Relief' with the crafts they were making.

We saw people had spent time decorating their walking frames and personalising them. Staff said this helped them and helped people to recognise their own and encourage them to be used.

One person who enjoyed writing had an office area within the conservatory and they told us they enjoyed doing their work in there. Areas of interest had been created in the home, such as a Post Office and a sweet shop, which was a trigger for some conversation. We saw staff sat with people on a one to one basis and played a board game, or engaged in a chat. There were magazines, books, films and CDs for people to look at, listen to or watch.

We spoke with one person who was new to the home. They told us they had chosen the home themselves after visiting a friend there and they liked the way staff supported their independence. The person told us they were going out for the day and staff assisted them to be ready on time.

We saw when people wanted staff's attention, staff were responsive. One person asked for a 'nice cup of coffee, with plenty of milk and sugar' which the member of staff brought promptly. As they drank it they told us, "That's lovely, just how I like it".

People said they were aware of their care plans, although we saw limited evidence people had been involved in discussion around their individual care needs or involved in the care planning process. One person said, "I have seen my care plan, I'm not involved in it" another said, "I know about my care plan, my

[relative] would review it" and another said, "I have seen my care plan and have talked through it".

Care records we saw were up to date with information about each person, although it was not always clear whether people's preferences, such as for bathing/showering had been checked with them. For example in one care record it stated 'would prefer a shower' but it was not clear if this had been discussed with the person, or whether it was reviewed each day as people's preferences varied. One person we spoke with said they were not asked each day whether they would like a bath or a shower and they did not get one as frequently as they would have liked. They told us, "I have complained about not getting a shower every day, they say there are not enough staff and nothing has changed". We looked at the person's care record which stated 'Staff are to offer bath or shower daily' and records showed this was offered daily, but the person declined. Another person said, "I don't get the chance every day, but I know they're busy so I don't mind."

Daily notes within people's care records contained up to date information, although this was not always used in the care plan evaluation. For example, one person's daily records showed they had low mood for three months, yet the evaluation showed 'no risks identified at this time' in spite of staff describing concerns about the person being socially isolated and making attempts to involve them in what was happening in the home.

We looked at a care plan for one person who was new to the home and we found it contained a range of risk assessments and relevant information to enable staff to provide appropriate care.

Some people and relatives said that they did not know the formal complaints procedure but this was not an issue as they did not want to make a complaint but would feel comfortable in raising issues with staff. One person said "I have not made one (complaint), I would just talk to the boss". Another person said, "I have not wanted to complain but I would feel comfortable to make one" and another person said, "I have not made one (complaint), I would just talk to the boss, quite happy to do it". Relatives we spoke with said they would feel equally comfortable to raise concerns with any member of staff or management. We saw the complaints and compliments record included the details of the matter or concern along with the action taken.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with and their relatives all felt the home was well led and managed. One person said, "Yes I would say it is really organised". Everybody reported that there was a good atmosphere created by the staff. One person said, "It's kind, friendly, comfortable" and that they felt they could raise issues and influence the daily running of the home. They said "You could say things and they would try to do it".

People's comments included, "It's fine living here, it's comfortable", "It's kind, friendly, comfortable, the days are long and a bit boring". "Yes I know the manager, very approachable, hands on", "The staff are approachable and very kind", It's well managed and run, other than the staff levels". Relatives said, "Yes I do feel involved but I think they do really well. I talk to the manager if [they are] in here, very friendly".

The majority of the people we spoke with recalled taking part in surveys but were less sure about residents' meetings. One person told us, "I have done some surveys but no meetings". One relative did not know about the meetings although there was a poster about the next one in the entrance hall. We saw minutes of residents' meetings and the last one was in November 2016, with evidence of discussions and actions taken. Quality assurance questionnaires produced results which reported on improvements in the service.

There was a registered manager in the service who had managed the home for a number of years. Everybody knew who the registered manager was and felt that they were approachable. One person said, "Yes I know the manager, very approachable, hands on". We observed the registered manager was out of their office and talking to people, staff and visitors on several occasions during both days of the inspection.

The registered manager said they had received continuous support from the operations manager and the provider since the last inspection and they had worked very hard to make improvements and respond to the findings of the last inspection report. The operations manager told us they had taken the inspection findings seriously and given priority to ensuring better standards for people living at Ashmeadows.

People, staff and relatives all reported improvements since the last inspection. One member of staff said, "There's been a massive improvement in this home since the last inspection. It's not just one thing, it's lots of little things". Another member of staff said there had been 'immense improvement'. One staff member said staffing levels had increased which made a positive difference to the way they had time to support everyone and offer better quality activities.

Staff had clear direction and they told us they felt supported 'by all the management'. We saw there were timelines for each shift in the staff room, with guidance for staff on each shift about what was expected of them. Staff said they could approach the registered manager at any time to raise any issues and felt their views would be taken seriously. Staff told us morale was good in the staff team and we saw staff worked well, communicating with one another to meet people's needs.

The registered manager said they had spent time with the operations manager and the provider working on the action plan from the last inspection and they had been able to focus more on the day to day running of

the home because staffing levels had improved.

We saw systems were more organised in relation to quality monitoring and audits of care and practice. Meetings were more consistent between groups, such as managers' meetings, where managers from the provider's other homes came together to discuss practice issues, staff meetings and residents' meetings. Monthly checks were in place for premises and equipment and compliance checks were carried out by the provider or operations manager, both of whom had visited the home regularly. We saw managers' quality monitoring audits produced action plans with dates and signed when actions were completed.

We found that although the consistency of audits had improved there were still some areas that lacked rigour and needed to be more thoroughly carried out to ensure the quality of the service and identify breaches in regulations. For example, there was no robust oversight of recruitment procedures to make sure staff were thoroughly vetted, the monthly medicines audit was only done in relation to two people's medicines each month, so discrepancies in people's medicines may not be identified for several months. Care plans were audited, although not in sufficient detail to identify where individual risks needed more thorough assessment. Some documentation, such as staff rotas, was disorganised and lacked detail and accuracy.

This meant there was a continued breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always fully considered in relation to people's individual care. Systems for managing medicines were not always safely or effectively in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were some weaknesses in the systems for monitoring and assuring the quality of the service. There were some gaps in recorded information about people's care, and some records were not completed accurately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not robust enough to demonstrate staff had been thoroughly vetted before working with vulnerable people.