Bupa Care Homes (CFChomes) Limited

Ashley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Ashley Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. There had been six managers since the previous registered manager left in May 2017 and this had resulted in a period of instability and low staff morale. Not all staff had not felt supported during this time. The new manager had started at the home in April 2018 and is referred to throughout the report as the 'new manager'.

There were insufficient staff deployed to meet people's needs and keep them safe. There was a task focussed culture within the home. Risks associated with people's health, safety and welfare had not always been identified and assessed, and guidance was not always in place to help staff to reduce those risks.

People's plans of care did not always provide appropriate guidance for staff and people were not always supported in line with their assessed needs. Most staff were kind and caring although people were not

always treated with dignity and respect and were not always encouraged to maintain their independence and choice.

People's medicines were not managed safely. Staff administering medicines were constantly interrupted which increased the length of the rounds and increased the risk of medicines errors occurring.

Infection prevention and control procedures and standards of cleanliness were poor. Some areas of the home were dirty and unkempt, including people's bedrooms.

People were not always protected from abuse. Staff understood how to identify abuse and who to report to if they suspected abuse was taking place. However, concerns were not always reported to external agencies for investigation as required.

People's rights were not always protected because staff did not always understand the principles of the Mental Capacity Act 2005 or work within them. Deprivation of liberty safeguards had been submitted to the local authority for authorisation when required.

Systems were in place to monitor and assess the quality and safety of the service although these had not always been effective. People and relatives were offered opportunities to feedback their views about their care although this was not always acted upon and did not always drive improvements.

People were not always supported appropriately or provided with the correct equipment to enable them to eat and drink according to their needs.

Complaints procedures were available and displayed throughout the home, although not all people and relatives knew about the complaints procedure. Where complaints had been raised, they had not always been dealt with appropriately.

Staff had not received training and supervision to support them in their roles. The new manager had started to address this and it was an improving picture, although appraisals had not yet taken place.

Activities were limited and adequate cover had not been put in place to ensure activities could be offered during the activity co-ordinator's holiday. People told us there was not much to do. The new manager had started to address this with additional recruitment to the activities staff team.

Recruitment procedures were safe and ensured only suitable staff were employed to work at the home.

People had access to health care services when required and were supported by staff to maintain their health and wellbeing. People and their relatives were involved in developing their plans of care most of the time.

People were encouraged to maintain important relationships with family and friends.

The provider was working toward meeting the Accessible Information Standards. Staff used some pictorial signs and memory boxes to enable people to become more orientated around the home.

We last inspected the service in June 2016 when we found no concerns and rated the service as good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Individual risks and environmental risks had not always been identified or mitigated to ensure people's safety and wellbeing. Incidents were not always analysed appropriately to identify trends, inform learning and reduce the likelihood of re-occurrence.

There were insufficient staff deployed to meet people's needs and keep them safe.

People did not always receive their medicines as prescribed. Staff who administered medicines were interrupted and distracted increasing the risk of medicines errors.

Infection prevention and control was poorly managed within the home which resulted in areas of the home being dirty and neglected. The provider could not be assured that people were always protected from abuse because safeguarding procedures were not always followed.

Recruitment procedures were in place which ensured only staff suitable to work in adult social care were employed. Maintenance of the environment and equipment was well managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always have their rights protected as staff had not always followed the principles of the MCA. People did not always receive appropriate support to ensure their nutritional and hydration needs were met.

Appraisals had not been held with staff to support them in their roles. Staff had not received regular training and supervision, although this was an improving picture.

People were supported to access to a range of healthcare professionals to support them with their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff had not always respected people's dignity and privacy or promoted their independence. Staff were mainly task focussed as rotas had not been arranged to ensure they always had time during the day to sit with people and listen to what they had to say.

People were able to have visitors at any time. Visitors felt welcomed by staff. People were made to feel special on their birthdays with a cake, singing, balloons and banners.

Staff respected people's day to day decisions and wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have plans of care in place which reflected their assessed needs. Staff did not always have time to review care plans and ensure they were up to date.

Complaints were not always responded to appropriately and relatives were not always confident in the process. Action was not consistently taken, at all or in a timely way, where failings were identified.

There were limited opportunities for people to engage in meaningful activities which met their interests, preferences and wishes. Improvements were planned but this was a work in progress with the recruitment of additional activities staff underway.

Is the service well-led?

Inadequate

The service had not been well-led.

Management instability had led to low staff morale and concern amongst staff, relatives and people about the deterioration of the home. There was a task focussed culture in the home due to insufficient staffing and some staff felt guilty they could not do more for people.

Systems to identify, assess and monitor the quality of the service were ineffective and had not identified, or addressed in a timely way, the concerns we found.

Feedback from relatives and staff had not always been acted on to keep people safe and help drive improvement.

Staff felt that improvements were being made since the new manager had come into post. They were more visible and listened more to staff. A system of recognition for staff had been implemented.

Ashley Lodge Care Home

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. We brought forward a scheduled inspection in response to several concerns and complaints that had been raised with us about staffing levels, the standard of people's care, cleanliness of the environment and medicines errors. This inspection checked whether the provider was 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.

The inspection was carried out on 17 May 2018 by a lead inspector, a second inspector and two experts by experience. Experts by experience are people who have experience of using, or caring for someone who uses this type of service. The lead inspector and second inspector returned to continue the inspection on 22 May 2018. The lead inspector completed the inspection on 25 May 2018. The inspection was unannounced.

Before the inspection we reviewed all the information we held about the service including previous inspection reports and notifications. Notifications are sent when events happen in the home which the provider is required to tell us about law. We used this information to help us decide what areas to focus on during our inspection.

We spoke with thirteen people who lived at the home and nine relatives, a regular visitor, eight care staff members four registered nurses, a maintenance operative, the new manager, the regional director and the quality manager. We observed people being supported on all three days of the inspection to help us understand their experiences of daily life in the home. We spoke with three healthcare professionals to gain their views of the service. We also spoke with the acting managing director for BUPA to discuss our concerns.

We looked at ten people's care records and pathway tracked six people's care. Pathway tracking enables us to follow people's care and to check they had received all the care and support they required. We looked at records related to the running of the home, including medicines management, incidents and accidents, complaints, staff recruitment and training records and systems for assessing and improving the quality of the service provided.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people and their relatives about how safe they felt. Positive comments included, "Yes, I do feel safe here," and "Yes, it's fine here. I've been here nearly a year." Others were not so positive. One relative told us, "If I could take [my family member] out I would. I sit at home and worry about her."

Although some people told us they felt safe, we identified a number of concerns which meant the provider could not always ensure people's safety.

Ashley Lodge is a large nursing home comprising of three separate units, Willow, Maple and Oakview. Willow and Maple were in the large, main building. Willow (ground floor) provided care to people with more complex nursing needs. Maple (first floor) provided secure accommodation for people living with more advanced dementias. Oakview was in a smaller, secure residential building to the rear of the main building and provided care to people living with dementia.

There were insufficient staff deployed within the home to keep people safe and meet their assessed needs. Whilst the new manager used a dependency tool to assess how many registered nurses and care staff were required to adequately care for people on each unit, we noted that this did not take into account the size and layout of the home and therefore the impact of this had not been adequately taken into account when assessing the staffing levels. We reviewed the daily staff allocation sheets for each unit and noted that there were numerous days when the provider's planned staffing levels had not been met within some of the units. For example, between 14 May 2018 and 23 May 2018 there were four days on Maple, three days on Willow and two days on Oakview when planned staffing levels had not been met. The new manager gave us copies of agency bookings to provide evidence that staffing had been covered. However, the names and dates did not always match the allocation sheets we had been given and did not confirm that the assessed minimum staffing levels had always been met. We discussed this with the new manager and regional director and gave them the opportunity to review the information. The regional director sent through additional allocation sheets. However, these still showed that planned staffing levels had not always been met.

During the inspection we heard about, and observed, a number of concerns with the assessed staffing levels which were in place. Most of the staff we spoke with thought there were not enough staff on duty in each of the three units. A staff member in Oakview told us, "No, people are not always safe. There are not enough staff here. People are at high risk of falls and there are not enough of us to watch." Other staff reported similar concerns to us saying it was not always possible to watch people in the communal areas as sometimes both available staff were needed to manage people's care. On one occasion our inspector had to intervene and find a staff member as two people were helping another person to get up from their chair in the lounge, which was unsafe practice and put people at risk of falls. The staff member acknowledged this and responded appropriately.

There were vacancies within the housekeeping and catering teams which staff told us impacted upon their ability to provide people's care as they often had to do cleaning, serve meals and wash up as well. We noted

that staff from other homes were sometimes deployed to help cover vacancies, as well as agency staff. However, staff often worked twelve hour shifts and some staff told us they didn't always have time to take their breaks. A senior staff member who worked a twelve hour shift said, "I often work late to finish things off. I always make sure my staff have a break even if I don't get mine." Another staff member told us that during a twelve hour shift they often took a fifteen minute break around eleven thirty. Their lunch break could then be anytime between four pm and six thirty pm. They told us this was because it was difficult to get away due to the shortage of staff. The lack of appropriate breaks increased the risk of staff making mistakes, such as medicines errors, due to tiredness. One nurse told us, "I have started doing a night shift each week so I can catch up on paperwork. It's so busy in the day, it's not possible to do everything. I look in the diary and think how will I get all that done?"

Three people, who each had a very high level of care needs were moved from Oakview to the nursing unit after the first day of our inspection. Staff told us this had improved the situation in Oakview. However, we noted that staffing levels in the nursing unit had not been increased to take account of the three additional people with complex needs now living there. The new manager had informed us they had increased the staffing in this unit by one on the 13 May 2018 as a result of a review of staffing, although this was before the three people had moved over from Oakview during the weekend of 19 & 20 May 2018. A healthcare professional had concerns about the availability and consistency of nursing staff within the home which they said was, "Highlighted by a lack of senior nurses and a lack of ability to keep hold of those nurses they do manage to employ."

Three staff members told us they could not always get everyone up each day as they did not have enough staff. One staff member told us, "We get people up on opposite days. We can't get everyone up." Another staff member told us, "We prioritise. A few residents [people] like to be up. We concentrate on them. If someone was up the day before, they may not need to be up [the next day]. We assess on the day and see what we can do. You do your best, you can't do more than that. If they don't get up one day we prioritise them the next day." A third staff member said, "There are not enough staff. We can't always get people up. We have to choose between personal care and feeding [or getting people up]. It makes me feel bad." A relative told us they had arrived at 13.10 to visit their family member. They said, "He was only just getting his morning wash!" We also heard from a regular visitor that some people often missed their hair appointments because staff could not get people up in time. They told us, "Staff have said they haven't got enough staff to get people up. They've no time to sit and chat. They all seem worn out. It's a hard job anyway."

Comments from people and relatives included, "Staffing levels have always been a problem," and "They are very short staffed with carers." We observed, and heard about several examples where people could not find staff to ask when they wanted a drink and we have written more about this in the effective section of the report.

We discussed our concerns with the new manager and regional director to try to understand the rationale behind the staffing levels given the feedback we had received and our own observations. They explained that there had been a high turnover of managers within the past year and this had had a knock-on effect with a high number of care staff also leaving. The new manager was in the process of recruiting new staff to fill vacancies within the care, catering, housekeeping and nursing teams. We asked the new manger if they intended to increase care staff levels once they had recruited more staff. This did not seem to be the case and they told us, "The staffing calculator [dependency tool] is slightly over. I would need to increase on Maple if we had another resident [person]." The provider sent us a written response and stated, "Staffing levels on each unit are reviewed regularly to ensure there are sufficient numbers of staff to meet the needs of the residents." This did not acknowledge or reflect on the concerns with current staffing and people's unmet needs, identified by our inspection team, staff and relatives.

Failure to deploy sufficient staff to ensure people's safety and meet their assessed needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Risks associated with people's care needs had not always been identified and actions taken to mitigate these risks. Due to the reliance on agency staff who may not be familiar with people's needs we were concerned this increased the risk of people receiving unsafe or inappropriate care.

For example, where people had been identified as being at risk of choking there was no risk assessment or information in their care records as to the actions staff should take to mitigate this risk and ensure their safety and welfare. Three people were at risk of seizures due to a medical condition. There was no risk assessment or information to show how these risks should be mitigated, what actions staff should take in the event of these seizures or the risks associated with these. We asked the new manager to complete these assessments as a matter of urgency and saw they had been completed when we returned on the second day of inspection.

One person had a catheter in place the risks associated with this clinical intervention and treatment, such as infection or blockage of the equipment, had not been assessed and actions identified to mitigate these. We raised this with the new manager on the third day of our visit and they arranged for this to be completed.

The risks associated with one person's care had been identified but the actions taken to mitigate this risk had not been followed by staff. They had been assessed as at risk of aspiration, (inhalation of fluid) when drinking, by a speech and language therapist. Their care records clearly identified that they should be supervised when taking fluids and should not be offered drinks from a beaker or cup with a straw. On the first day of our inspection we observed this person in bed with a drink placed in front of them which had both a beaker lid and straw in it. The person was not being supervised by a member of staff and was able to reach this drink unaided. The risks associated with this person's care had been identified but the actions taken to mitigate the risk had not been followed. This meant the person was at risk of drinking and aspirating and there would not have been any staff around to respond to the emergency.

Risk associated with clinical equipment had not always been assessed. One person required the administration of oxygen to aid a breathing condition. Care records demonstrated this need, however no assessment of the risks associated with the use and storage of this combustible gas had been completed to ensure the safety and welfare of people in the home. The risks associated with the administration of oxygen for a person, had also not been assessed. This person used a machine called an air condenser to administer oxygen. There was no information for staff on the steps to take should this machine fail or how this treatment could be continued in the event of a power failure. A registered nurse acknowledged that care plans and risk assessments were not up to date for oxygen. This same person had a cardiac pacemaker, however, there was no information in place to identify any risks associated with this treatment. We were not assured the risks associated with the care needs of this person had been fully assessed to ensure their safety and welfare.

Some people cared for bed were not able to use their call bell to summon assistance. There was no robust system of checks in place to manage this, instead staff were reliant upon hearing people calling out for assistance.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Environmental risks had not always been assessed to ensure people's safety. During the inspection we identified concerns relating to the security and safety of people living in Willow and Maple. We noted the electronic doors into the main building opened automatically when approached by people and visitors entering and leaving the building. When the reception area was unsupervised, anyone wishing to gain access to both Willow and/or Maple (via the lift) could do so, and would not be seen. We spoke with the new manager who told us Willow was not a secure unit, so people could come and go when they wanted to. Visitors could access Maple as the lift could be activated from the ground floor without a code. However, a code was required to activate the lift to come back down from the unit. The new manager told us there was always someone at reception, and if there wasn't, the doors would be set not to open automatically. We observed the reception area during the first two days of inspection and saw that on a number of occasions, there was no one at reception and the doors still opened automatically with people entering and leaving the home unnoticed and on one occasion left without signing out in the visitor's book. On the second day, we recorded spot checks of the reception area and noted it was unsupervised and the doors were left open at the following times; 09.37 to 09.46; 09.48 to 09.50; 10.35 to 10.44; 11.10 to 11.14 and 13.30 to 13.48.

The provider stated in a written response, "There are two offices located directly next to the main entrance which are occupied by the home manager and home administrator, who both have an open door policy and are therefore able to monitor the entrance in addition to the receptionist. It is also practice for the doors to be locked when the receptionist goes for her break in the afternoon. This evidences that the home had considered the security of the main building." We found this was not always the case. For example, on the second day of inspection, both the office doors were closed at 09.37, 10.35, 13.30 and 13.45, there was no-one at reception and the main entrance door was not locked, enabling people to come and go unnoticed.

A regular visitor to the home told us, "I have walked in, all the way through and out of the other door [at the rear of the building]. I've not seen anyone at all." An incident form noted that on one occasion it was thought a member of staff had left their shift at night and not secured the front door. We spoke again to the new manager as we were concerned that, not only did the lack of monitoring of the doors increase the risk of someone leaving the building who might be at risk, but potential strangers could also walk in off the street without being identified or challenged. This posed a risk to people's (and staff members') personal safety and to the security of people's personal belongings. Following this second discussion the new manager took action and instructed reception staff to always lock the doors when they left the reception area. We observed this was in place for the remainder of our inspection.

We observed a member of the management team brought their small dog to the home when they were working. The dog ran freely around the home when people were walking around the communal areas and up and down corridors. On one occasion we observed the dog ran at speed around the corner from the corridor and into the reception area. This surprised our inspector and could have surprised a frail, older person who may have become off balance or tripped over the dog. We spoke to the management team member to ask if they had completed a risk assessment for their dog in relation to trip hazards and infection prevention and control. They told us they had not and took steps to confine their dog in an area away from people.

The risks associated with the environment had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Infection prevention and control procedures were ineffective. Whilst most people and relatives told us they thought the home was clean, we found this was not always the case. Records showed that cleaning was not taking place on a regular basis. Several areas of the home were dirty and neglected. Communal areas in

Oakview, such as the dining room and corridors, were dirty. Corridor floors were ingrained with dirt and dust. A handrail in one of the corridors had a small smear of brown matter. The downstairs toilet had a mal-odour. There was brown matter on the back of the toilet door, and grime around the feet of the toilet seat frame. The dining room had dried stains from spillages on one wall. A staff member told us, "We don't get a regular cleaner, not every day. Maybe once or twice a week. The toilet's a mess." Another staff member told us, "We're forgotten over here. We've raised it…not having the staff. They only have one or two cleaners over there [Willow and Maple]". They described behaviour that some people displayed which may have been an infection control risk and said, "Let's be on top of it." Another member of staff told us the care had to be the priority and they tried to do cleaning if there was any time left but they were short of staff. We showed our concerns to the new manager who told us, "I have to agree with you." They arranged for staff to come over from the main building to do some basic cleaning. The regional director and quality manager also came to have a look. The regional director did not acknowledge, or make any comment to our inspector about the lack of cleanliness. They responded by telling us they were upgrading Oakview and replacing the windows. Whilst this planned improvement was welcome, this response did not address our concerns about the unacceptable state of cleanliness in Oakview. In Willow and Maple units, the dining room floors were dirty and dusty and had food debris around the edges of skirting boards. Walls and serving areas were spattered with liquid stains which had not been wiped. We showed this to the new manager to address.

Failure to follow effective infection prevention and control procedures is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

People were not always supported to receive their medicines safely and as prescribed. Whilst some people and relatives told us they were happy with the way they received their medicines, we found a number of concerns. We looked at incident records for April 2018 and up to 17 May 2018 and noted there had been a high number of medicines errors recorded. For example, in April, one person had continued to be given a medicine when it had been stopped four days earlier by their GP. Another person had not received a medicine for three days as it had run out and had not been ordered in time. A third person had not been given their correct medicine. Other errors related, for example, to missed signatures on medicine administration records (MARs) and one person's blood sugar level had not been checked before being given their insulin.

Staff who administered medicines did not have this time protected so that they could do so safely and in a timely way. We observed medicines rounds and saw that staff administering medicines were constantly interrupted to attend to other tasks. We observed the distractions included the medicine administration staff meeting a visiting GP, helping a care staff member to get a person ready to go out and getting a cigarette for another person. One staff member told us, "I dread doing meds as I am too stressed. I made a mistake last week." We noted that one medicine round took one hour and fifty-five minutes to complete with only eleven people requiring their medicines. Another took one hour and fifty minutes. We noted, however, that where medicines were time critical, these were prioritised and administered appropriately.

The registered provider had a policy in place for the safe administration of homely remedies. Homely remedies are medicines which can be bought over the counter for common ailments such as colds and pain. Whilst staff understood when these medicines could be administered, medicine administration records did not always reflect when these medicines had been given. Information had not been sought from the GP about the use of these medicines in the home and to confirm they were compatible with other medicines being taken by people, which is recommended in national best practice guidance. We raised this with the new manager and quality manager. They felt the provider's policy was in line with national guidance, but have agreed to further review this.

Failure to ensure the safe and proper management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Medicines were stored securely and within their recommended temperature ranges. All medicines that required stricter controls by law were stored securely and a stock check was completed weekly. Liquid medicines and eye drops had the date of opening recorded on the label. Medicine administration records (MARs) held information about medicines to be taken and these were administered by registered nurses and senior care staff who had received training on the safe administration of medicines. Medicines were disposed of safely although not always in a timely way. For medicines which were prescribed as required (PRN) a protocol was in place to support staff in the safe administration of these medicines.

Some people received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. Records showed staff had taken steps to ensure families and health care professionals had been fully involved in a best interest decision making process, in line with the Mental Capacity Act 2005, to ensure the safety and welfare of these people. People had a six monthly review of their medicines with their GP which ensured they remained current and relevant.

Equipment used in people's care, such as a nebuliser, suction machine and syringe driver were checked daily along with fridge temperatures to ensure these remained fully functioning.

Incidents and accidents were recorded but learning had not always taken place to reduce the risk of the similar incidents re-occurring. For example, insufficient action had been taken to identify and address the clear link between pressures and distractions on staff when administering medicines and the high number of recorded medicines errors. The new manager told us they had arranged for staff to complete additional training in administering medicines and to wear a red 'do not disturb' tabard when completing the medicines rounds. The provided sent us a written response which stated, "The staff had been instructed to wear red tabards and not to answer the phones during medication [medicines] rounds, this was evidenced in the 'Take 10' [meeting]. However, we observed that this instruction did not work in practice and we have written more about this in the medicines section of this domain. There had been two incidents where a person had been able to get out of Oakview by following relatives out of the door which was unnoticed by staff. This had been investigated and reviewed and new security arrangements had been put in place for Oakview. However, arrangements for the security of people and their belongings living in Maple and Willow had not been adequately reviewed, implemented and monitored following these incidents. Other incidents were analysed, such as falls, with trends identified and remedial action taken.

Failure to take adequate action to learn from incidents is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

The provider had not always followed safeguarding procedures to ensure people were protected from abuse. Staff had received training in safeguarding adults and knew how to identify and report any concerns to senior staff or the new manager. However, concerns had not always been reported to external agencies as required. The provider had not notified us of an incident between two service users which had resulted in assault, as they are required to do. We noted a number of medicines errors had been recorded in April 2018. We checked with the local authority who told us they had not been notified about four of these errors so they had not been able to investigate them to reassure themselves that people were safe. A healthcare professional told us they thought the home was not consistently safe mainly due to "Safeguarding procedures not always being clearly followed through."

Failure to safeguard people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding.

Recruitment procedures were in place which ensured only staff who were suitable to work in adult social care were employed. We looked at eight staff recruitment records and saw that relevant checks had been completed, such as; proof of identity, previous employment references and a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions. We noted that one staff member had not provided details of a short gap in their employment history which the new manager said they would address.

The maintenance of the environment and equipment was well managed. A small maintenance team was employed to carry out regular checks; such as fire alarm systems, legionella, bedside rails, and electrical appliance testing. There were robust systems in place to identify when checks were required, that issues identified were addressed and any remedial actions taken.

Requires Improvement

Is the service effective?

Our findings

Two people who were able to express their wishes told us they were provided choices in their daily lives including what they wanted to eat and how they were supported with their care. Where people had the mental capacity to make decisions about their care we saw staff respected their wishes and supported them to remain independent.

Whilst we observed people were offered choices, we were concerned that information about people's ability to make decisions about their care were not always recorded or recognised by staff.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

For people who did not have the capacity to make decisions, or their capacity fluctuated, people did not always receive care for which they had consented and which was in line with their wishes. Care records held extensive information about people's ability to make decisions for themselves. Many of these records stated the person did or did not have capacity to make decisions; however, there was no clear information about people who had fluctuating capacity to make decisions. Best interest decisions had been made for people without a clear rational for when they may be required. For example, one person who had been assessed as having the capacity to make decisions about how they received their personal care. However, staff told us this person's ability to make decisions fluctuated and they were not so able to consent if they became anxious. Staff did not have clear guidance and information on what to do if this person declined to have personal care. Staff told us a relative had given instruction on when a best interest decision should be made for this person and personal care should be given even if they did not consent to this. This relative did not have the legal authority to make this decision on behalf of their loved one. Whilst staff told us they were always respectful of this person's wishes this was not what was reflected in their care records. We were not assured this person received care and support to which they had consented to, when they had the capacity to do so, and which was in line with their wishes or in their best interests.

For people who lacked the mental capacity to make specific decisions, their care records did not always hold information to show when and who should be involved in best interests' decisions on their behalf. Where relatives had the legal authority to make decisions for their family member, documentation did not clearly reflect this. One relative told us they were not involved in making best interests decisions on behalf of their family member who did not have capacity to do so themselves.

Failure to ensure care and treatment was provided with the consent of relevant people is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Need for consent.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). Some people living on the Oakview Unit were subject to a DoLS as certain restrictions had been put in place in order to maintain their safety. This included being unable to leave the home unescorted for example. We spoke with a member of staff who did not demonstrate an understanding of the DoLS that were in place and the implications of these for how they might deliver people's care. This is an area for improvement.

People did not always receive appropriate help and support to enjoy their meals or drinks according to their needs.

The new manager told us they had identified that staff often covered other tasks such as the kitchen duties. They told us the current kitchen arrangement "Doesn't suit the needs of the home," and one of their tasks was to review the deployment of staff and restructure the kitchen staff hours. We observed the breakfast and lunchtime meals in all three units during the inspection. On the first day of the inspection in Oakview, we observed staff were not able to prioritise giving support to people to eat their meals. This was because they were often busy in the kitchen areas, serving meals and clearing up. A staff member told us, "We sometimes have a kitchen assistant but not always. We need to serve dinners and clean up. It takes us away from prompting and assisting. We will have meals with people [when we can]. We notice it makes a difference, it's not rushed. We can check they're enjoying it." On the first day of our inspection, one person had been served a large cooked breakfast which took them over an hour to finish and had got cold. During this time, no member of staff approached them to check they were okay or to ask if they needed help. On other occasions we noted that staff provided support to people to eat with patience, banter and good humour.

People were not always provided with appropriate equipment to help them eat and drink. People who had difficulty keeping their food on their plates had not been offered the use of a plate guard, which would have enabled them to eat more easily and remain more independent when eating. A relative told us that their family member had been given their drink in a cup and saucer that morning, which they could not use as they required a beaker with a lid. They continued, "[My family member] has their breakfast in bed. The table is always too high and they have difficulty eating. It goes all down them." They had raised this with staff but the problem continued. Another relative told us," [My family member] can't eat by himself but he's left to his own devices." Minutes from the residents' and relatives' meeting in April 2018 showed several relatives had raised concerns about meal choices and support. For example, comments included, 'Pureed food presentation not good' and '[Name] doesn't have meals until 2pm sometimes and it's not covered up.' We also noted one incident report on Willow, dated 20 April 2018 which noted, "Carers forgot to feed [Name]. Found their lunch in the hot trolley an hour and a half later." The person was given their lunch as soon as this was realised. However, we found this to be unacceptable.

On the first day of inspection in Willow lounge, a person told us they wanted a hot drink but couldn't find a member of staff to ask. Our expert by experience went with them to try to find a staff member but could not find one. Our inspector also tried to locate a staff member to ask on their behalf but could not do so. The person said it didn't matter and sat back down in the lounge. Another person was calling out from their room for a cup of tea. We waited to see if a staff member would arrive to assist, however, after several minutes our inspector went to find a member of staff and informed them the person wanted a cup of tea. We waited and still the tea hadn't arrived. When the new manager walked past we informed them of the situation. They gave the person some squash from a jug which was in their room, but the person did not receive the hot drink they had requested. Another person told us, "I once asked a night carer for a cup of tea but it never came. The staff are very busy, they're rushed off their feet." Another person told us, "They could organise things a bit better. One morning I had breakfast at 10.20 am and I didn't get a drink before that."

We noted that on the first day of our inspection there were no jugs of water or juice available in the lounge in Oakview so that people could help themselves or be prompted by staff. On day two in Willow lounge there were no jugs of juice or water. For people who were on fluid charts to monitor their fluid intake, there was not always a target intake amount recorded for people to aim for.

The provider had not ensured that people received person centred support that met their eating and drinking needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

We received mixed feedback from people and relatives about the quality, choice and availability of food and drinks. Positive comments included, "I really enjoyed that [meal] today," and "The meals are fine," and "I like most things but I'm not keen on curry. I get enough [food]." Another person told us, "The meals are indescribable. There's been several changes of chefs. The menus are never right." There was a vacancy in the home for a permanent a chef manager. We spoke with the chef manager who was covering the vacancy. They told us the butcher had got the meat order wrong that day so they were cooking an alternative dish to the one advertised. One person had complained they did not want the alternative meal and staff offered them other choices instead. The chef told us they would always prepare an alternative if someone did not like the main meal choice and gave an example of one person who had requested salmon and cream cheese, so they went to the local shop to buy it.

One person required registered nurses to support them with their nutritional needs through a feeding tube, we saw policies and procedures were clear for staff to follow to ensure this support was carried out safely and effectively. Registered nurses had a very good understanding of how to support this person, monitor them for signs of good nutrition and hydration and ensure they were positioned correctly to have this feed. A dietician had been involved in the management of this person's nutrition and contact details and information on support staff may require was available. People who required fluids to be thickened to help them to swallow these safely had clear records of how these fluids should be prepared and how they should be supported to manage these.

Staff had not always received appropriate training, supervision or an appraisal to support them in their role. Supervisions and appraisals are formal opportunities for staff to meet with their line manager and talk about any work issues and discuss areas for development as well as any concerns. Most staff told us they had not felt supported, although this was now improving. They had not received regular supervision and records confirmed this. However, this was also an improving picture. The new manager showed us that they were in the process of completing supervisions, including group supervisions when there were themes and generic information to share. They had also reviewed the training plan to identify where training had lapsed. They were in the process of updating staff training. They told us, "You can't manage staff if you don't give them training." They had booked a training day for moving and handling and had ordered workbooks for staff to complete on topics including food hygiene and medicines competency. People and relatives were mostly positive about the staff and their abilities. One person told us, "Staff are very good at what they do, they are well trained." The new manager was yet to organise a schedule for staff appraisals.

The provider had not ensured staff received regular appraisal of their performance. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Care records showed people were able to access a wide variety of core and specialist external health care professionals. For example, referrals had been made to professionals such as tissue viability nurses, dieticians, mental health specialists and speech and language therapists. GP visits were clearly recorded in care records and community nurses supported people who lived in the residential unit of the home. One

healthcare professional told us the staff sent details of who needed to be seen during twice weekly 'ward rounds' which gave them time to check notes before they left the surgery and help to develop plans of care. However, they also told us that some of the referrals they received should have been able to be dealt with by the trained nursing staff, rather than calling the doctor. We saw records on Oakview which clearly identified how staff needed to support people who the community nursing team were caring for in between their visits. Staff sought guidance from them appropriately when it was needed. One person told us, "I believe my healthcare needs are met."

Requires Improvement

Is the service caring?

Our findings

People told us that although the staff were busy, they were kind and helpful. One person said, "They are kind to me. It must be difficult for them, they are under a lot of pressure." Another person told us, "I've nothing bad to say about the staff but there are not enough of them." A relative told us, "They [staff] are very good and treat [my family member] well." A second relative said, "It's not like your own home but staff are kind and friendly." A third relative said, "They are very good and treat [my family member] with dignity." People and relatives confirmed that staff knocked on their door before entering and respected their privacy. A healthcare professional confirmed, "I think the home is caring," and a second one said, "All staff I have seen at work have been caring throughout the organisation."

Whilst most people thought the staff were kind, caring and helpful, we observed on occasions that people were not treated with dignity and respect. We observed one person was using a mattress on the floor for their safety whilst waiting for a special bed, which had been ordered. On the first day of our inspection we observed they had not been assisted to get dressed and were rolling around their bedroom floor in their vest and continence pants. Their door was wide open for anyone passing to see them, and this lack of privacy and dignity had not been identified by staff. We discussed this with the new manager and regional director as part of our final feedback session as this had not afforded the person any privacy or dignity. The new manager said the door could have been closed. We also queried why the person had not been assisted to get dressed and the regional director concurred with this query.

A relative told us on one occasion that a staff member had pulled back their mother's bedclothes in front of her son-in-law who was very embarrassed and left the room. This did not respect the person's dignity. Another relative told us, "[My family member] doesn't get his hair washed very often. I'm not sure he gets showered. They [staff] mostly dress him in just a vest. He has clothes but he's not dressed." Another relative raised a concern with us about their family member who they came to visit one morning to find them in bed in their day dress. They told us their family member had been put to bed the night before in their day dress, and had not been assisted to get ready for bed appropriately. This had been raised as a complaint with the new manager. We also heard that on one occasion, their family member had asked a staff member to help them go to the toilet. The staff member told the person that they had a pad on and "to go in that". This did not respect the person's dignity and did not promote their independence and choice to use the toilet. This had also already been raised with the new manager during a relatives' meeting on 27 April 2018 which identified a number of other concerns. These included; lost clothing, a person's hearing aids not always being put in and another person's radio being unplugged and being put out of reach along with their book. The omission to ensure people had appropriate hearing aids and recreational items available to them did not respect their wishes, their dignity or promote their independence.

People's rooms were not always kept clean and well decorated. In Oakview, one person's room was very dirty and there was a malodour. The carpet was stained and debris was left on the floor by and under the bed. The windowsill was dusty and dirty with dried up spillages which hadn't been wiped up. There were cobwebs in the corners of the window recess. In Willow, one person's room had liquid spillages which had run down the wall and not been wiped up. In Maple, a person's room also had spillages which had run down

the wall and dried. There were large scuff and knock marks on the walls which were in need of redecoration. It was unacceptable that people's rooms were so poorly maintained and little thought given to the impact on their dignity.

The provider had failed to ensure people were treated with dignity and respect at all times and their privacy and independence had not always been promoted. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Dignity and respect.

Rotas had not been arranged so that staff always had time to listen to people, answer their questions and provide information in a way that enabled them to be involved in decision making. We observed care staff were mostly task focussed and did not often have time to engage with people. Comments from staff included, "We don't have time to sit with people," and "We could offer a little extra" [if we had another staff member]." A person said, "The staff are fine but they haven't got time to stand and talk with you."

We observed a lot of good practice during the inspection and saw that staff did respond with compassion and kindness when people became anxious or upset. For example, one staff member gently encouraged a person to use their oxygen which they said was noisy. The staff member talked about the importance of the oxygen, found a solution to the noise and offered to turn up the music for the person. The staff member was very calm, kind and re-assuring to both the person and their relative, who was concerned, and offered them both a cup of tea. Another staff member provided comfort to a person who was worried. They knelt down to their level and gently stroked their arm whilst listening to them and re-assuring them in a gentle voice. They asked if the person was cold and said they would find a blanket. The staff member could not leave the activities room as other people required support and supervision, so our inspector went to find another member of staff to help.

Staff understood their responsibilities in managing people's sensitive information and maintaining confidentiality most of the time. People's paper records were locked away and not left out. However, we did note one occasion at one of the nurse's stations, a clip board, which contained some people's personal notes, had been left out and unattended.

Staff respected people's choices and wishes in their day to day decisions. For example, what to wear and what to have to eat. People were able to have visitors when they wanted to and we saw that relatives and friends were made welcome by staff. One relative told us, "I can come in whenever I want to." Another relative said, "I come in every day so I know how [my family member] is dressed and if the drawers are tidy." A third relative told us how they were involved in choosing things for a memory box to go outside their family member's room. The said, "There's a mini [Jar of spread] because she loves it and a sparkly bracelet and photos because she loved going out."

People were helped to celebrate their birthdays and were made to feel special. A relative told us, "There's always a cake and they put balloons and a banner on the door of her room. Cake is taken around so everyone has a slice. They always bring a birthday cake and sing. They even sang 'happy birthday' to me."

The provider was working towards the Accessible Information Standard, which aims to ensure that people with sensory loss are communicated with in a way they understand, can receive information and make informed decisions. We noted that staff tried hard to ensure this was the case most of the time. For example, some pictorial signs and memory boxes enabled people to become more orientated around the home.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback about whether people were involved with planning their care and support. People told us they did not know about their care plans. Most relatives and people were happy that staff knew what care they needed although they did not remember being involved in the care plans and reviews. However, one relative showed us their family member's care folder and said they remembered helping with care planning. Another relative told us, "They [care plans] are reviewed yearly."

Whilst people were assessed before they were admitted to Ashley Lodge, we were not assured people always received personalised care that was responsive to their needs.

A member of staff told us three people had been admitted to the residential unit of the home in the previous four weeks. They told us each of the assessments had been poor and had not given accurate information about the needs of these people. For example, one person had been admitted to the residential unit of the home two weeks before our inspection. Their preadmission assessment showed they lived with a complex neurological condition and had recently sustained a serious injury resulting in a reduction in their mobility. There was no information in their care records about these conditions, their high level of need, or how they needed to be supported or how the conditions affected their daily lives.

On the first day of our inspection, three members of staff told us they were no longer able to meet this person's needs in Oakview as they were too complex and required close monitoring. The new manager told us they had identified this person required close one to one support which could not be delivered in Oakview and that they were addressing this matter. This person had been moved to the nursing unit on the second day of our inspection. However, we remained concerned that staff did not understand how to support the person. We asked a member of staff how they should respond to the person if their behaviour became challenging and they told us, "We have just been told to reassure [the person]." We asked if there were any risks associated with the person and the staff member told us, "I wouldn't know about that."

Staff did not always have up to date information on how to support people with their preferences and current needs. Two staff in Oakview told us, "We don't access the care plans, they are for the seniors." A senior carer told us there were no records held in people's rooms because people were able to wander everywhere in the unit and may destroy them or access them inappropriately. We saw rooms in this unit did not have any daily records stored for staff to access. We asked staff how they knew what people's needs were. They told us they had a hand over every day and knew people very well. We asked a senior carer how an agency member of staff would know how to meet people's needs and they told us they would get a good handover. Although there was no handover sheet available with people's care needs identified. The new manager took action before we left the home on the first day of our inspection to address this. We also discussed with the new manager that staff in Oakview did not have access to care plans. They told us they had reminded care staff of where the key was so they could access the office when they needed to look at people's plans of care.

A senior carer, who led each shift they worked, acknowledged care plans were not always up to date as they

did not have enough time to do everything. They said, "There is lots of paperwork to do and I get stuck in the office but there are only three of us here and so I am needed on the floor." They told us, "There is a lack of support for the seniors who work here." Two registered nurses told us they did not have time to review and keep care plans up to date due to the workloads and distractions on shift. One registered nurse told us, "I should read the care plans before updating them but to be honest there isn't time. I do the evaluations but wouldn't necessarily update the whole care plan." Another registered nurse acknowledged care plans and risk assessments were not up to date for oxygen and would complete these as soon as possible. They told us they had not had time to do this. This person's care plans and risk assessments had been updated on the second day of our inspection.

The provider had not ensured that people's plans of care were regularly reviewed and always reflected their current needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

Where people required support with nursing and clinical interventions, care records held clear and personalised information on these matters. Registered nurses followed clear policies and procedures to ensure the safety and welfare of a person who required their nutrition via a feeding system. Another person required the administration of oxygen and we saw staff sought the support of registered nurses to ensure this was administered correctly. For people who had wounds which required dressing and treatment registered nurses had clearly documented these needs and how they should be met.

Care records in Willow and Maple held clear information on people's preferences, likes and dislikes, (although this was not so clear in the records of people who lived in Oakview). For example, a document called, "My Day, My Life, My Story" gave information about people's life history, favourite places and activities. One person's care records gave information on how they enjoyed Pet therapy and that their favourite place was Guernsey. Another person liked information to be presented verbally and through the use of pictures and we saw this happened. Care plans identifying the support people needed with skin care, moving and handling, communication, personal care and nutrition were mainly person centred and most held information which had been discussed with the person and their relatives.

The provider had a complaints policy and procedure which was on display in the home. However, we heard from several people and relatives that they were not all aware of the complaints procedure and when they had complained, they were not all confident in the process. One relative told us they would try and find a member of staff if they wanted to raise a concern but said it was not always possible to do so. A second relative had spoken to a member of reception staff as they wanted to raise a concern but had been unable to find a registered nurse to speak to. The reception staff said they were unable to help and suggested the relative spoke with a nurse. The relative re-iterated they could not find one. We spoke with the relative who told us the response they had received was not helpful. Another relative told us the home had deteriorated and that they had complained on several occasions about cleanliness, medicines errors and general care of their family member. They told us, "I have no confidence at all. It's like bashing your head against a brick wall." We were concerned therefore, that in light of our findings, complaints and concerns were not being used effectively as a way of driving improvements within the service.

We reviewed the complaints that had been recorded and saw that in most cases, these had been investigated and the outcome sent to the complainant. However, one complaint had not been appropriately investigated. It had been made by a person who lived at Ashley Lodge. They had complained about delays in answering call bells and staffing. The complaint record did not refer to an investigation into these concerns but referred to the person's history of calling staff and their behaviour, which could be challenging. We found this response had not taken the person's concerns seriously, was dismissive and had discriminated

against them because of their previous history of behaviour that staff found to be challenging. The provider had not followed their complaints policy in this regard. The response did not afford the person the right of knowing their complaint had been handled appropriately. We raised our concerns about this with the new manager who told us this had happened before they had been employed. We asked them to look into the complaint and ensure it was appropriately investigated. We were awaiting the outcome at the time of writing this report.

The provider had not always ensured that people's concerns had been appropriately investigated and that people were not discriminated against in the making of a complaint. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Receiving and acting on complaints.

Following our discussion, the new manager acted to ensure information about the complaints procedure was clearly visible to people and relatives. They had completed a 'You said, we did' exercise which informed people about how they had responded to feedback that not all people and relatives knew how to make a complaint.

There was a low level of satisfaction with activities amongst people and relatives as they told us these were very limited. The provider employed a full time activities co-ordinator who arranged a variety of activities for people, such as arts and crafts, chess, gardening and a knitting club. They maintained a diary of activities and kept a record of people who attended. We noted from records that it was mostly the same small group of people who engaged with planned activities. We could not be assured that people who remained in their rooms had equal access to social interaction and stimulation. The full-time activities co-ordinator was on holiday at the time of the inspection and there had not been adequate planned cover to ensure meaningful activities took place during this time. One person felt strongly that there were not enough activities. They told us, "There's nothing to do all day long. Times change and new activities are found but a place like this can't keep up. I like politics and sport. There are not many men living here and most can't talk to me for long." A relative said, "[My family member] needs more interaction." A regular visitor said, "They don't do much in the way of activities. It's a very long day with nothing to do. The activity co-ordinator is quite good with what she's got."

Activities were minimal in Oakview unit. A staff member told us," There aren't a lot of activities. We had someone playing the piano but it's not regular. A couple from a local church come and play guitar and sing religious songs once a month. We definitely need more activities. We'll sometimes go a week or two weeks and you'll get nothing. We tend to get forgotten over here." A senior carer told us the activities coordinator never visited the unit but one had been available in the unit on the first day of our inspection and was seen to play dominoes with people. The senior carer told us, "I don't know why." This activities co-ordinator stated she was a volunteer and only worked two mornings. We noted that activities had been raised at the residents' and relatives' meeting in April 2018 One relative had said there never seemed to be any activities in Oakview. People were always just sitting around. A request was made for more bus trips out using the community bus, with the last trip being about two years previously.

We spoke with the new manager about our concerns. They told us they were in the process of reviewing staffing for activities. By the end of our inspection the new manager told us they had put additional hours in place. One staff member had been contracted to work between 15.00 and 17.00 pm seven days a week to provide activities and help to monitor for falls. Another staff member had been contracted to provide ten hours across four days a week. The full-time activities co-ordinator had been allocated to work part of each of their shifts, from 14.30 to 16.30in Oakview. The new manager told us that left 28 hours still to recruit to. They told us, "It needs a bit of livening up". They said that they wanted more community organisations to

come in. On the second day of our inspection they showed us a video of a Zumba class that had taken place the day before which people seemed to enjoy.

We recommend the provider reviews activities in line with people's interests, hobbies, likes and preferences and ensures all people living in the home have equal opportunities to engage at a level appropriate to them.

People who were nearing the end of their lives were supported appropriately. Registered nurses managed people's pain and this was confirmed by a healthcare professional who told us, "We work closely with the senior nurses to assess pain…. They are excellent at identifying patients in pain and delivering as needed medications."

Inadequate

Is the service well-led?

Our findings

The home had gone through a period of significant changes in management since the previous registered manager left in May 2017. Between then and December 2017 there had been four managers. One had been recruited to the permanent post of manager but left soon afterwards. Following this, two temporary managers were appointed and left, followed by another permanent appointment in December 2017. However, this person also left soon afterwards. In January 2018 a BUPA interim manager was seconded to work at Ashley Lodge to oversee the management of the home and provide some stability whilst a permanent manager was recruited. During this time, the regional director and the quality manager had supported the interim manager. The interim manager had in turn remained at the home for a period of time to provide continuity and to support the new manager to settle in. The new manager told us a 'clinical lead' [staff member] from another home had been brought in to provide support and a dementia specialist was also supporting to review the home's dementia care. However, we found that oversight of the quality and safety of the care provided had not always been effective in driving improvements.

A substantial range of systems and processes were in place to identify, assess and monitor the quality of the service. During the inspection we reviewed, for example, 'First impressions', quarterly health and safety, nutrition and catering, infection prevention and control and care plan audits. However, we found that these systems had not always been effective. Whilst some audit findings had been actioned, other findings from audits had not always been translated into improving standards across all areas of care delivery and had either not picked up, or had not addressed (at all or in a timely way), the numerous concerns we identified during the inspection. For example, first impressions audits carried out on 23 March 2018 had identified that 'floors, walls and carpets needed hoovering and washing, especially the corridors'. A further audit on 18 April 2018 stated some windows in Oak View were 'very dirty and floors need cleaning, sticky'. Cleanliness of the home remained a significant concern at the time of our inspection in May 2018. Care plan audits had also not been effective as they had not identified that risk assessments had not been completed for people at risk of choking, seizures or for people who had a catheter in place or who used oxygen.

We reviewed a copy of the new manager's latest home improvement plan (HIP) during the inspection. This included numerous handwritten actions that had been added by the new manager. They told us they had collated all outstanding actions from the home's audits and were in the process of transferring them onto the home's quality improvement plan (QIP). This was a new electronic system. The regional director sent us a copy of the updated version of the QIP following the inspection. This was an on-going action plan and working document which captured areas for improvement and development identified from issues raised during meetings, complaints and audits. However, we noted from this document that where issues had been identified they had not always been acted upon, at all or in a timely way. For example, findings of an internal inspection in December 2017 stated, 'All areas of the home to be clean'. The timescale for this had been one month. This had not been effectively addressed. Another action from the improvement plan was, 'All staff to have supervisions'. The timescale this time was two months. It was apparent from the HIPs dated February 2018 and March 2018 that this action, which had been identified in December 2017, had remained as outstanding and had not been progressed until the new manager came into post. This was reflected in the actions recorded in the April 2018 HIP. The regional director had been providing oversight during this

time so we were concerned that these issues had not been progressed sooner.

This inspection has identified a number of breaches of the legal requirements. There were consistently insufficient staff deployed to ensure people's needs were being met. People did not always receive person centred care. The systems in place to assess and manage risks to people's safety and welfare were not robust. Medicines were not consistently managed safely. Infection prevention and control procedures were ineffective. Staff had not always sought appropriate consent for care. Staff had not been supported through appropriate appraisal. Complaints had not always been managed effectively. Records relating to people's care were not always accurate or complete. Safeguarding procedures had not always been followed.

This demonstrated that the provider had failed to always ensure that the systems they had in place to identify, assess and mitigate the risks to people's health, safety and welfare were consistently effective in driving improvement. Whilst we were able to see that the new manager was taking action to drive some improvements, the provider had failed to always maintain effective oversight of, and ensure the quality and safety of the delivery of care in these areas. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

Staff told us they felt unsupported and that morale was low. One staff member said, "A lot of [staff] left at once. We've had four managers in seven months." Another staff member told us, "We need a manager to want to stay or they'll lose the relationship with staff on the floor. A lot of [staff] handed in their notice, no management, no continuity." Two staff told us they thought the provider operated a blame culture. One staff member went on to say they felt that staff were being set up to fail as they didn't have enough staff to carry out their roles properly. There was a task focussed culture which had developed as a result of staff workloads and pressures. Staff told us they felt guilty about not being able to do more for people. During this time, care staff had not received supervision or appraisal to discuss their role or feel supported and valued. A staff member told us, "We haven't been heard. It's been tricky. We feed things back but we're forgotten." Some staff had an opportunity to attend staff meetings. For example, registered nurses attended clinical risk meetings and senior care staff attended '10 at 10' meetings (to discuss daily issues, concerns and updates). Following the inspection, the provider sent us minutes of one care staff meeting which had taken place in March 2018 where they had received updates about, for example, staffing, vocational training, clocking in and out and the use of mobile phones.

There was a high level of concern amongst staff and relatives about the deterioration within the home. A staff member told us, "It never used to be like this. It wasn't always a struggle. I'm still proud of what I do otherwise I wouldn't be here." One relative told us, "They need a big boot up the backside. I have no confidence at all. What the hell are they doing?" Another relative said, "It's gone downhill since Christmas." A healthcare professional told us, "I would suggest the home has been poorly led and the senior clinical staff have had no managerial support. Every time a new manager starts the senior staff are told to call the Dr for everything which undermines their professional status. This includes medicine errors, most of which cause no harm and the nurses are well able to assess that risk."

Improvements were needed to ensure that the service continuously learnt, improved and managed the challenges to quality and safety. Investigations into information of concern had not always been rigorous enabling learning to be noted and implemented in a timely way. For example, safety concerns raised by a staff member had not been investigated or addressed. We noted in one staff file that they had raised a concern dated January 2018 which related to a thickener that was being left out. This is a powder that is mixed with a drink to thicken it up to prevent a person from choking. If the powder is not safely stored and is accidentally swallowed it can cause asphyxiation. We spoke with the new manager to ask what action had been taken following the concern. They told us it had not been investigated at the time and the thickener

had not been securely stored until they had dealt with the issue when they come into post, which was several months later. They told us, "It is now being locked away in the dining room meds cupboard."

It was not always clear what action had been taken as a result of feedback from surveys, complaints and meetings. Where issues had been raised by relatives in the last survey in December 2017, such as cleanliness, staff availability and standards of care, these had not always been addressed, at all, or in a timely way, to help drive improvement. This was evidenced when we found on-going concerns in these areas during our inspection. Relatives had commented in a residents' and relatives' meeting in April 2018 about difficulties in contacting the home. This feedback had not been acted on and concerns were still being raised about this. For example, a healthcare professional who told us, "It can be incredibly difficult to get through to the home on the telephone." Our inspector had also been unable to get through to the home at 16.43 one evening and received an answerphone message telling them the office was closed. The phone was not diverted to a member of staff and meant that relatives would be unable to contact their loved ones outside of 'office hours' if they wanted to. Following the inspection, the provider told us that some relatives had a code to get through to the individual units. However, this meant other callers, who did not have a code, would not be able to get through after the reception was closed.

The provider had failed to always act on feedback. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

The new manager had started to address some of the issues in the home, such as recruitment, training and supervision. They told us they had gone through all of the individual audits and quality assurance documents and showed us that they had started to pull it all together in the home improvement plan which they were using to update their QIP. However, we were concerned this had not been done before. We saw the new manager had a list of action points on a board in their office and were prioritising these.

The new manager was starting to address the issue of staff morale. They spent long hours at the home, including evenings, nights and weekends. They said that staff had commented on this as they had not seen previous manager's working outside of office hours. One staff member told us, "I have seen a whole lot more of her than the others. She comes over and gets things done." Another staff member told us, "[The manager] is very new. I would like to think she knows what she wants; to have the best home. She needs support from above and below. It's better than it was. I'm optimistic." Another staff member said, "[The new manager] is picking up issues quickly. She's coming out. I see her more, asking people how things are, following up on things. We can tell her if things are too much. Morale is getting better, more stabilised." Another staff member said, "Since [the new manager arrived] things are pulling together. She's more organised and listens to us. We've had four managers in seven months."

The new manager told us staff recognition had been missing. They had started to send out 'thank you' cards to staff and a points system was now in place for staff. This enabled staff to accumulate points awarded for recognition and a monthly reward of £40 was given to the staff member with the most points. They told us, "You can't sit on your throne. I'm confident it will get done but not in one day. This is a home that needs some care and support." They had also bought ice creams for staff and told them to help themselves. They told us, "Staff need electrolytes as well as everyone else. I expect hard work in return, everyone needs to be happy.

The new manager had started to make plans to develop links with the wider community. For example, they had been in contact with Dementia Friends to setup a café and help to identify a dementia champion for the home.

Following the inspection, the acting managing director of BUPA contacted us to discuss our findings. They told us that Ashley Lodge had always been on their list of homes they wanted put right. They said they had not seen the movement they had wanted to at Ashley Lodge and they would be very focussed on addressing the issues raised in our report.

Following receipt of our draft report, the provider took the decision to close Oak View unit and with consultation with relatives, had transferred people to the main nursing or dementia units. The new manager told us they had a new regional director and said, "We are being moved to the support/recovery team so I will be having the support needed to get the home right."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people always received person centred care that was appropriate and met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that consent to care was always sought from relevant persons.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure their systems and processes were effectively operated to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to always respond appropriately to and learn from failings identified through the complaints process.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure sufficient staff were deployed to meet people's needs and keep them safe. The provider had failed to ensure that staff had been supported through appropriate appraisal.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure the dignity, privacy and respect, of service users and their independence was promoted at all times.

The enforcement action we took:

We have issued warning notices to the provider and told them to make improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems to identify, assess and mitigate risks associated with people care and the environment were ineffective. Systems to manage infection prevention and control were ineffective. The management and administration of medicines was not safe.

The enforcement action we took:

We have issued warning notices to the provider and told them to take action to improve.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure systems and processes to assess, monitor and improve the quality of delivery of the service and to identify and mitigate risks were ineffective. Records were not always accurate, complete and up to date. The provider had not always acted on feedback from people and relatives and staff.

The enforcement action we took:

We have issued warning notices and told the provider to make improvements.