Askham Village Community Limited

Askham Grove

Inspection report

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31 July 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Askham Grove is a care home with nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Askham Grove accommodates up to 29 people in one two-storey building. The home provides care to adults with complex physical disabilities.

Askham Grove is one building with two separate units (upper and lower floors) each offering single, ensuite bedrooms and shared facilities such as lounge/dining and kitchen areas. At the time of this inspection there were 12 people living on the upper floor. There are also four one-bedroom flats on the upper floor, separated by a code-locked door from the main unit and with their own lift/staircase access to a separate front door. At the time of this inspection, the flats accommodated one person using the service, a relative of a person living in one of the other care homes on the site and two members of staff. Rooms on the lower floor accommodated staff members.

Askham Grove is the newest of five care homes on one site, on the outskirts of the village of Doddington. Each home is registered with CQC as a separate location. There are some shared facilities such as a café and function room where some activities take place.

This inspection included two site visits to the home on 26 June 2018 and 10 July 2018. This was the first inspection of this care home since it was registered. Adults requiring long-term rehabilitation moved into the upper floor of Askham Grove at the end of January 2018.

The home has been rated Requires Improvement overall. This is the first time the home has been rated Requires Improvement.

The service was not well-led. Systems for identifying, capturing and managing organisational risks and issues were ineffective. Leadership was not visible or open and leaders were out of touch with some of what was going on in the service. People's views were not always sought or responded to. Leadership did not understand the importance of working within a person-centred equality, diversity and human-rights approach. Staff did not always understand, promote, uphold or work within the provider's stated values and ethos of community, empowerment, dignity, respect and quality. Oversight and governance had not identified four breaches in regulations.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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. The registered manager had not provided the leadership that people and staff needed in order to give people the best possible quality of life.

There were not enough staff deployed to make sure that people's needs, including social and emotional needs were fully met.

Some staff treated people well and showed empathy and understanding. However, not all staff treated people with kindness and compassion and people's emotional needs were not always recognised or met. People's need for privacy was not always upheld and confidentiality was not always maintained. Some staff were patronising and treated people as though they were children. People were not offered a choice of having their personal care provided by male or female staff. Staff did not always support people to maintain their independence.

Care plans were in place but did not always give staff guidance that was up to date enough for them to meet people's needs in a personalised way. Some information in care plans was contradictory. Not enough activities, based on people's individual interests and preferences were organised to ensure that people led fulfilling and meaningful lives.

Staff understood the ways in which the Mental Capacity Act affected their work. They gained people's consent to care and generally people were supported to have choice and control of their lives. However, people were not always supported in the least restrictive way possible.

A complaints procedure was in place and displayed so that people would know who to talk to if they had a complaint. However, not all complaints were dealt with in line with the provider's policy. Care records relating to end of life had not been completed or updated, which meant that people's preferences might not be known or fulfilled.

Arrangements for people to formally share their views about the home and put forward ideas for improvements were not yet fully in place. Quality assurance processes were in place but were not robust enough to ensure that a quality service was being provided. These processes had not recognised the issues we found during our visits.

Staff had received training in safeguarding people and allegations of abuse or avoidable harm were reported as required. Assessments of a number of potential risks to people had been carried out but some risks had not been assessed or managed so that people were kept safe and had maximum control over their lives.

Medicines were managed well and people had received their medicines safely and as they had been prescribed. Staff mostly followed infection prevention and control procedures so that the home was clean and hygienic. The process to recruit permanent staff was robust and reduced the risk of unsuitable staff being employed. Not all required information relating to agency staff had been acquired to make sure they were suitable to work in the home.

Assessments of people's support needs were carried out before the person was offered a place at the home. This was to ensure that the staff could provide the care and support that the person needed and in the way they preferred. Technology and equipment, such as call bells, pressure mats and hoists were used to enhance the support being provided.

Staff received induction, training and support to enable them to do their job. People were provided with a choice of nutritious and appetizing meals and special diets were catered for. A range of external health and social care professionals worked with the staff team to support people to maintain their health.

We saw some warm, friendly, caring interactions between staff and the people they were supporting. Staff made efforts to communicate with people in a way they could understand. Visitors were made to feel welcome.

Staff were given opportunities to express their views about the service. A staff recognition scheme was in place, rewarding long service.

The registered manager was aware of their responsibility to uphold legal requirements, including notifying the CQC of various matters. The management team worked in partnership with other professionals. There were some links with the local community including a café that was open to the general public.

We found four breaches of Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff deployed to fully meet people's needs at all times.

Some risks had not been assessed or managed in a way that ensured that people were in control of their lives and were kept safe.

Staff had received safeguarding training and allegations of abuse and avoidable harm were reported appropriately.

Medicines were given safely and staff followed infection prevention and control procedures to keep the home clean and hygienic.

Is the service effective?

Good

The service was effective.

People were supported to have choice and control of their lives.

People were offered a choice of nutritious meals and a range of healthcare professionals supported people to maintain their health.

Staff received training and support to enable them to carry out their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with kindness and compassion. People's need for privacy was not always met. Some staff were patronising and treated people like children.

Confidential information was not stored securely.

Staff made some efforts to communicate with people in a way they could understand. Visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not up to date so did not give staff appropriate guidance on how to meet each person's needs in the way that person preferred.

There were not enough activities delivered, based on individual interests and preferences, to keep people occupied and their minds stimulated.

There was a complaints process in place. Complaints were not always responded to in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership was not visible or open. The quality assurance system was not robust enough to recognise areas where improvements were needed.

Arrangements for people to formally air their views and put forward ideas for improvement were not in place. People's views were not always respected or responded to.

Staff did not always work within the provider's values and ethos.

A staff recognition scheme was in place and staff had opportunities to express their views about the service being delivered.

Askham Grove

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 home under the Care Act 2014.

This comprehensive inspection included an unannounced visit to the home on 26 June 2018 and an announced visit on 10 July 2018. The visits were carried out by two inspectors. An expert-by-experience worked with the inspectors at the first visit. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of using, and caring for someone who used a range of health and social care services.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

During our visits we observed how the staff interacted with people who lived at Askham Grove. We spoke with five people who lived there and two relatives of people who lived there. Another relative emailed their responses to our questions. We spoke with 10 members of staff: three care workers; one kitchen assistant; two nurses; the registered manager; the Quality Nurse; a member of the maintenance team; and a trainee Assistant Practitioner. We looked at five people's care records as well as other records relating to the management of the home. These included records relating to the management of medicines, fire safety checks and audits that had been carried out to check the quality of the service being provided.

Following the inspection visits we wrote to two external health and social care professionals who the registered manager told us had regular contact with the home. One external professional responded to our questions and their comments have been included in this report. We also contacted the local authority contract monitoring and safeguarding teams and the fire safety officer. We completed the inspection on 31 July 2018.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff deployed to meet people's individual needs. There were mixed views, from people using the service and staff, about whether or not there were enough staff deployed to fully meet people's individual needs. One person told us, "Sometimes they say they haven't got time to dry my hair….that annoys me when they try and leave me with wet hair." Two other people told us they did not always have the number of showers each week that they would have liked, because staff did not have time.

The provider used a tool to determine the minimum number of staff needed for each shift. This was based on the amount of care each person living in the home needed. On both days we visited there were fewer staff than this minimum number.

The provider had a contingency plan in place to ensure there were sufficient staffing numbers to meet people's needs. This contingency plan included taking on 19 bank staff through an agency. However, on both days, all these staff were already working in the provider's other homes. This meant the plan was not working and there were not enough staff to meet people's needs at all times.

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

Staff recruitment included thorough checks of potential staff that included a criminal records check and references from previous employers to ensure the new staff were suitable for the role. One member of staff told us, "As soon as [the criminal records check] was through, I could start." The provider employed a high number of bank staff through an agency. On the first day we visited we found that there was little or no evidence that checks had been carried out on 10 out of 19 of the agency staff. Although this had been rectified by our second visit, this meant that the provider's recruitment process was not robust enough to ensure that checks were in place to ensure that all staff were suitable to work at the home.

The provider had a risk management system in place to manage and minimise risks. We found that staff had not assessed all risks. We visited the home on two very warm days during a heatwave. Older, ill or vulnerable people are more at risk during temperatures above 25C. We would expect a contingency plan to be in place to reduce the risk to people from extreme heat. We would also expect risk assessment and risk management strategies for those at most risk to provide additional care, support and surveillance. Although the heatwave had been predicted and had been taking place for some time, senior staff confirmed that risk assessment and risk management strategies had not been put in place. We found no evidence to show that people had been protected from the risk of dehydration and heat exhaustion.

Staff had assessed some potential risks to each person and had put guidance in place so that staff would know how to reduce the risks. Potential risks included falls, pressure areas, malnutrition and people's lack of mobility. However, not all risks had been managed to give people maximum choice and control over their lives. For example, one person told us they had had a fall from the toilet. Rather than trying to find a way of managing the risk so that the person could maintain their independence, staff had told the person they now

had to call for staff assistance and not use the toilet independently.

The provider had systems in place to safeguard people from abuse and avoidable harm. A relative said, "I haven't seen anybody being badly treated." Staff had undertaken training in safeguarding people and most staff showed us that they understood what they should report and to whom. Care staff and ancillary staff said they reported to the lead nurse or the registered manager. They also knew which external agencies to report to, such as the local authority and CQC, if the issue was not addressed by Askham staff. There was information on notice boards so that everyone, including people living at or visiting the home, and staff had access to the correct telephone numbers to ring if they had concerns about abuse.

The provider's systems included protecting people from discrimination. Staff had received training in Equality, Diversity and Human Rights (EDHR) and were aware that there was an expectation that discrimination would never happen. Not all staff put their training into practice. One member of staff told us about one person living at the home who had protected characteristics. They said, "We just treat [them] as [they] want to be treated, as an individual." However, another member of staff used very inappropriate language when speaking with us, even though they confirmed they had completed the EDHR training.

People said that generally the housekeeping staff kept the home clean. One person said, "The cleaners do a reasonable job." There were procedures in place to make sure the home was clean and hygienic and housekeeping staff were clear about their role in preventing the spread of infection. Staff used personal protective equipment such as disposable gloves and aprons appropriately. One person confirmed that staff always wore gloves when attending to personal care. On the first day we visited we found that staff were not keeping the sluice room door locked, which meant that anyone could have had access. The registered manager locked the door but it was clear from staff responses that they usually left the door unlocked. This created a risk of the spread of infection.

People told us they felt safe living at Askham Grove for a variety of reasons. These included: call- bells available; staff present; codes required to enter the building; and level flooring throughout the unit. One person told us that they felt safe, although they would have felt safer if the entry codes to all areas had not been the same. One person told us, "Staff check on me in my room so I know they're looking out for me." Relatives also told us that they were sure their family members were safe in Askham Grove. One told us, "I feel my [family member] is safe in the care of Askham – if I didn't he wouldn't be there."

The provider had procedures in place relating to fire safety. The maintenance team carried out tests of fire safety equipment such as the alarm system, emergency lighting and fire extinguishers at the required intervals. The maintenance team reported any faults and acted to rectify these. In 2017 the fire service had served an enforcement notice relating to a number of areas in which the provider had failed to take adequate precautions to keep people safe from fire. When the fire officer had returned, the provider had rectified all deficiencies to their satisfaction. Each person had a personal emergency evacuation plan (PEEP) in place so that emergency services as well as staff would know the support the person needed in an emergency. One person's PEEP had not been updated since they moved to Askham Grove from Askham Court.

The maintenance team had carried out tests of systems and equipment, such as testing of portable appliances, gas safety, and tests for legionella as required. Staff had received training in topics that enabled them to keep people and themselves safe, such as moving and handling and the use of equipment to assist people to move.

We checked how medicines were managed. People were happy that the staff looked after their medicines

for them. One person said, "[Staff] look after my medication for me and make sure I take it on time." Staff had signed medicine administration record charts correctly to show that they had given each person each of their medicines, or staff had used a code to explain why a medicine had not been given. Numbers of tablets remaining in the packets we checked tallied with the records, indicating that people had been given their medicines as they had been prescribed. Protocols were in place so that staff knew when to give people medicines prescribed to be taken 'when required'. The protocols included other actions that staff could try before giving people medicine to calm them. We noted that for one person the record included words such as 'aggressive' and 'agitated' but there was no explanation as to what that meant for the individual. Medicines were stored in a locked store room.

Staff recorded accidents and incidents. Senior staff discussed issues at Board level as well as during team meetings and handovers. The registered manager told us that action plans were drawn up so that lessons could be learned and improvements achieved. For example, the process for reporting any safeguarding allegations had become the responsibility of the whole staff team, not just the managers.

Good

Is the service effective?

Our findings

The registered manager told us that senior staff assessed each person's needs before they were offered a place at the home. The information from the assessment formed the basis for the person's care plan.

Technology in the form of call bells was available throughout the home. Additional technology, such as hoists and pressure mats to alert staff if a person had entered or left a room, or got out of bed, was available for people whose needs indicated they would benefit from this type of assistance.

New staff underwent an induction when they first started work at Askham Grove. Induction included training in a range of topics in order that new staff should be equipped to do their job as well as possible. A relative told us, "There have been some new staff employed. They have been trained well and soon fully understood my [family member's] needs." Further training relevant to their role was offered to all staff, including refresher training in line with the provider's policy. Training was available as on-line training on the computer. The training was followed by a test, which had to be completed correctly to show that the individual had understood and learnt about the topic. Some face-to-face training had also been available. One member of staff told us they were undertaking the provider's 'Assistant Practitioner' course. However, we found that, relating to equality, diversity and human rights training, one member of staff was either not putting the training into practice, or the training had not been effective. We discussed this with the registered manager and quality nurse.

Daily menus offered people a choice of nutritious and appetizing meals. A kitchen assistant asked each person, each day what they would like for the next day's meal. If they did not like either of the two main choices, alternative meals were available. People were happy with the food the chefs gave them. People's comments included, "We can make a choice of what to eat"; "The food is very nice, I like it"; and "The food is very good." Special diets were available for those people who needed them. Staff offered drinks to people and drinks were available in their bedrooms. Staff assisted people to eat if they needed assistance. However, the level of support given to one person (lack of assistive equipment) meant that staff did not encourage that person to eat enough.

The staff worked closely with the local GP, who hosted a weekly multi-disciplinary team (MDT) meeting on site. Each of the care homes in the Askham Village Community was allotted a 20 to 30-minute slot to discuss clinical problems and sort out medication queries. This had resulted in nursing staff gaining in confidence, which had led to a reduction in the number of emergency calls made to the surgery. The GP said, "I personally always feel confident in Askham Grove and know the team put their residents first."

Through the MDT, staff made referrals to a range of healthcare professionals, such as community nurses, speech and language therapist and chiropodist to support people with their healthcare. One external professional told us they were very pleased with the improvements they had seen in staff referring clinical problems appropriately. One person told us that staff arranged for them to see the GP when they needed to and they had their feet attended to by the chiropodist regularly. Staff had referred another person, whose intake of food and drink was very low, to a dietician. However, staff were not always following advice from

healthcare professionals. One care plan showed that a speech and language therapist had advised that the person needed mouth care two to four hourly. Staff were only doing this twice a day.

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. Staff had received training and understood the ways in which this legislation related to their everyday work. They gave people choices in some aspects of their lives and asked people's consent to carry out care tasks. A relative told us they had seen staff using their family member's chosen methods of communication to ensure consent before performing daily tasks. Assessments of people's capacity had been carried out and recorded in their care records. Best interests decisions had also been recorded.

The registered manager told us that, for people who did not have capacity to make their own decisions, applications had been made to the local authority for authorisation to restrict people's liberty. These applications had not yet been authorised.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about the staff. One person said, "The staff are really pleasant and don't rush you… I can't fault them [staff], they will do anything for you." Another person described the staff as "very nice." A third person described one staff member as "brilliant" and said "[Name] really knows how to deal with me when I'm upset." One relative told us that staff were "kind, caring, helpful, considerate, understanding and patient." Another told us, "There are some really excellent staff. [Name's] getting excellent care." A third relative said, "Staff are very very helpful and very kind to [my family member]. They treat [them] with respect."

However, there were comments about staff which were not so positive and we saw that some staff did not treat people as well as they should have done. One person said, "Some staff can be a bit brusque" and two people felt the staff had not bothered to get to know them at all. A relative said that one member of staff had shouted at their family member and a couple of others "have been cross" with their family member. We saw staff ignoring one person when they were calling out. Staff dismissed this, using phrases such as "that's just [name], [they] always do that" and "that's what [name] does". At lunchtime we noted that staff were mostly chatting to each other about their own activities while they were assisting people to eat. They did not involve people in these conversations.

One relative told us that staff "talk to my [family member] appropriately and as an adult." However, two people told us that some staff treated them like children. They gave us some scenarios when this had happened, including being told to go back to their own room when they wanted to be elsewhere and being told they had used too much toilet paper. One person said, "I sometimes feel I am being spoken to and treated as if I'm a child. This is my home and I should be treated like an adult." Another person told us they did not like the way some of the staff spoke to them. They said, "They talk to me as if I'm a two-year old… they seem to forget that some people here come from an intellectual background." We saw staff behaving in a very patronising way when they were playing cards with people.

People were supported to make some decisions and choices about their everyday lives, such as what they wanted to eat. Staff told us people also chose what time they wanted to get up, go to bed and what they wanted to wear. However, there were some areas where they did not have the choices they should have done. For example, people could not choose whether they had male or female staff and people could not independently access the ground floor, which meant their choices about where they spent their time were limited.

Staff did not always respect people's privacy and dignity. They did not always knock on people's bedroom doors or they knocked and entered before being invited in. One person had requested to see the doctor. Staff asked them why they wanted to see the doctor and were reluctant to request a doctor's visit without knowing. Staff did not always respect people's confidentiality. Staff had left documents with personal information in the communal lounge where anyone could look at them, including other people living in the home or their visitors.

All of these shortfalls showed that staff did not always treat people with dignity and respect.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us, "The care has been improved beyond my imagination. I'm seriously happy with the care [my family member] is now getting." Another relative said, "The staff always do what they can to make [my family member] feel valued and included."

Staff chatted to people who were sitting in the lounge and we saw some warm, friendly interaction. Some staff bent down so that they were at the person's level when they spoke with them and staff mostly sat down when they were assisting a person to eat. We heard staff singing with people and everyone was having a laugh and a joke. A relative told us how pleased they were that staff knew how much their family member enjoyed watching certain programmes on the television so they always made sure the television was on the right channel.

One person, who did not communicate using words, used various means of communication, such as a yes/no board, thumbs-up or nod of the head. Their relative told us that staff knew that the person used some or all of these methods at different times. The relative had seen staff trying to ensure they gained the person's consent to a task by using these different techniques.

Staff were encouraged to support people to remain as independent as possible with their personal care. In one person's care plan relating to personal hygiene there were details of what the person could/could not do for themselves. The plan stated, 'The aim is to promote [name's] independence as far as possible by encouraging and actively involving [them] in the care.' However, we also saw, for example when a person was not provided with equipment that would have enabled them to be independent with their meal, that staff did not always support people to be independent.

Visitors were always made to feel welcome and were offered drinks and meals if they wanted them.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan. Care plans were intended to give staff guidance on how to meet the person's physical, mental, emotional and social needs in a responsive, personalised way. One person told us they were involved in discussing their care plan and knew they could see it if they wanted to. In one person's care plan photographs showed exactly how the person wanted to be positioned, for example when using a bath chair. There were good details for staff about how the person's medical condition might affect them and what the staff were to do. However, we found that care plans were not always up to date, staff did not always know the care and support a person needed and some care plans contained contradictory information.

One person was being supported with a view to moving on to more independent living. They told us that when they moved to Askham Grove staff had discussed their care and support needs with them. They said a care plan had been written but it had never been put into practice. The registered manager told us they did not count this person "as one of the residents" so there was no care plan in place and staff did not support them. However, staff told us they did support this person. Each member of staff we spoke with told us something different about the support they offered this person. The person's support plan had not been updated since the first week the person had moved in (December 2017). The support detailed at that time was totally different to the support they now required, including that staff from one of the other homes would be supporting this person. This meant that this person was not being offered consistent support, nor was their support based on any plan that would aid their move to independence.

One person's communication care plan was contradictory. In the 'identified need' section, the plan stated "[Name] cannot communicate properly…". It went on to state, "[Name] can communicate [their] likes/dislikes with non-verbal cues". The 'actions/interventions' section made it clear that this person communicated very well in a number of ways. Evaluations of the care plan had not identified this anomaly, even when the care plan had been updated. A relative of another person told us that their family member preferred to have assistance with their meals. Their medical condition worsened when they got stressed about spilling food over themselves. The relative knew this instruction was in the care plan but, "Not all staff seem aware of this."

We also found that staff did not always follow the guidance in people's care plans. For example, relating to mouth-care and assisting someone to eat. Staff did not always respond to one person who called out when they needed reassurance, as advised in the person's care plan.

Despite some positive opportunities for people to go out on trips or participate in pre-arranged or group activity this experience was not consistent for all people across the service. People were not provided with regular opportunity for meaningful activity or to pursue their interests, in order to keep their bodies and minds active and promote their wellbeing.

Two people told us they really enjoyed a recent outing to the seaside. Two other people told us they liked to go over to the café. The activity record for one of them showed they had participated in eight activities

within a 24-day period; a boat trip, the trip to the seaside, café and chat (four times), a game of dominoes in the café (once) and a chat in bedroom (once). Another person said, "I think they could do with more activities. It can get a bit boring just watching TV all the time."

The provider had an activities team that worked across all five care homes on the site. Activities and outings included boat trips, a trip to the seaside, a monthly church service and communion. A group of staff had formed a choir called The Sunshine Singers and they led sing-along sessions each month. A gentleman's club met bi-weekly in the 'pub' that had been set up in a room in one of the other homes. Although this appeared to be a fairly wide range of activities, they were spread across all the people living in the five homes on the site. This meant there was little time to engage regularly and meaningfully on an individual basis with people, particularly for those with more complex needs or those who preferred not to participate in group activities or leave the home.

Staff told us they were concerned that only one member of the activities team visited Askham Grove on a regular basis, usually in the afternoon, when most people were having a nap. They told us all they did was read children's books to people. Staff were also concerned that the activities team only ever asked the same people to go to any of the activities in the other homes, or on any of the trips out. This meant that people with more complex needs were left out. One member of care staff told us they had recently been appointed to do activities, but this had not yet started.

Shortfalls in meeting people's needs, related to care planning and the provision of activities, were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a minibus, which people told us they could book if they wanted to go out. However, they said that this was worryingly unreliable. Their bookings could be cancelled if the bus was needed for other things or if there was no driver. This worried people if they had a specific need to go out on a certain day, such as to a family celebration or to an appointment. Following the inspection, we were reassured by the Provider that in fact there were no recent instances of the bus having been cancelled and that in fact if that were to happen, alternative transport would be booked such as a taxi. No resident would not be able to attend a commitment.

The provider had a complaints process in place, which was displayed in the entrance foyer, but not on the notice board on the first floor. In their factual accuracy comments, the provider told us "There is a copy [of the complaints process] in every bedroom to ensure that residents have easy access to it."

People were not sure to whom they would complain although this was set out in the complaints policy. They told us they would talk to their family members if they had a concern. Relatives told us they knew how to complain: one relative said they had never had to. No person we spoke with said they would talk to the staff. One person told us there were some issues with their room, which were affecting their ability to maintain their independence. They had written to the registered manager but had not received a response. This meant that the provider's complaints policy was not always being adhered to.

The provider used technology in a number of ways to support care delivery. Each person had a call bell in their bedroom so that they could call staff if they needed to. Equipment such as hoists, hospital-style beds and pressure mats was in place to assist people, and staff, to stay safe. One person who required it had a seizure monitor to alert staff if they had an epileptic seizure.

We checked whether there were plans in place so that people could be supported in the way they wanted at the end of their life. We saw that Do Not Attempt Resuscitation forms, correctly signed, were in place for

people who had chosen not to be resuscitated. However, some addresses had not been updated following the move to Askham Grove. One person's DNAR still had their home address. We were concerned that these anomalies might make a difference, in an emergency, to what the person wanted. However, the provider has since assured us that this would not be the case. The GP told us that end-of-life care plans were completed so that people would be sure that any doctor attending them (such as out-of-hours doctors) would understand their choices, including their preferred place of care. The GP had a MSc in palliative medicine so was well equipped to guide staff. A 'Choices at end of life' document was included in people's care plans. However, staff had not kept these up to date. For one person staff had not updated this since 2013 and for another person the document had not been updated since June 2017. Senior staff said people were often reluctant to discuss this subject.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. Systems for identifying, capturing and managing organisational risks and issues were ineffective. Leadership was not visible or open and leaders were out of touch with some of what was going on in the service. People's views were not always sought or responded to. Leadership did not understand the importance of working within a person-centred equality, diversity and human-rights approach. Staff did not always understand, promote, uphold or work within the provider's stated values and ethos of community, empowerment, dignity, respect and quality. Oversight and governance had not identified the four breaches in regulations that we found during our inspection.

People told us they hardly ever saw the manager. One person said, "I used to see the [registered] manager quite a lot, but not so much now…I would speak to the [registered] manager but she is not over here enough to make a difference." Another person told us, "You don't see the [registered] manager very often" and a third person said, "You never get to see the [registered] manager."

The provider had a quality assurance system in place. Governance included the Board, comprised of directors and senior managers, that met weekly. Staff of Askham Grove carried out audits of some aspects of the service, such as medicine management, infection control and care plans. The provider employed a Quality Nurse who worked across all five homes. Their role was to carry out their own monitoring to ensure that all audits were completed effectively; that action plans were in place to address any shortfalls; and that actions were completed. In spite of this, issues that we found had not been identified or addressed. These included care plans not being up to date, not fully reflective of the person's needs and not always followed by staff; and not enough staff to fully meet people's needs. This meant that oversight and governance were not effective.

We had inspected another of the provider's homes on this site in April 2018 and found their quality assurance system had not been robust enough to identify and address issues. At the inspection of Askham Grove, the Quality Nurse told us that, following our previous inspection, they had recognised the shortfalls in their quality assurance tool, so a re-vamped tool was being piloted in one of the other homes. Our findings showed that they were still using a tool that was not working effectively. There was little evidence of learning, reflective practice or service improvement.

People living at the home and their relatives had been given few opportunities to comment on the service being provided. One person told us that when they lived in Askham Place they had had residents' meetings. There had not been any since they moved to Askham Grove. This person assumed there hadn't been any because only a few people communicated using words. The provider held a relatives' meeting every three months to which relatives of people living in all five homes were invited. One relative told us that this did not really give them the opportunity to raise issues specific to Askham Grove.

The provider also sent out an annual quality questionnaire but as Askham Grove had only been open with the current group of people since February, this had not yet happened. From our discussion with the registered manager, it was clear that the provider had not made any effort to contact people and their

relatives in a formal way to find out whether they had settled in at Askham Grove or if there were any issues. One person told us that the registered manager had not responded to an email raising issues about the accommodation. Issues about the coded door locks restricting people's independence had not been addressed. This meant that as well as not identifying issues through audits, the provider's quality assurance system did not take sufficient notice of people's views and overlooked their needs.

Ten of the people who had been living in Askham Place had moved into Askham Grove in February 2018. The registered manager confirmed that when they moved in people were not given a choice of bedroom and they had not had any choice in the way the room was decorated or furnished.

Although people liked the bigger bedrooms and wider corridors, the building did not meet people's diverse needs and did not promote people's independence. Some people felt that the design of the building had taken away their independence and choices. They had been used to being able to go outside independently, either via the front door of the home or via the door in their bedroom that opened onto the gardens. They now found themselves on the first floor and there were coded locks to get up and down in the lift and through the door into the foyer downstairs. People's comments included, "I'm in a wheelchair all the time and now I'm on the top floor of the building I can't get out on my own. There are codes for everything and by the time I've put [the code] in and tried to get myself in the lift, the doors have shut. I have to get someone to help me all the time now. I feel I've lost my independence"; "I can't get out so easily now. By the time I've pushed the door release and manoeuvred my wheelchair to get out, the door is shut again…I have to get a member of staff to help me"; and "I sometimes feel like I'm in prison." The registered manager said they had recognised the coded locks were an issue, when people moved in. However, six months later they had done nothing to address this. The design of the lounge area meant that people were no longer able to sit and watch visitors, staff and other people living in the Community coming and going, which they had very much enjoyed doing in the other home.

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

There was a registered manager who had been in post for about nine months. People, relatives and staff all told us they did not see the registered manager very often. The registered manager demonstrated that she did not know people who lived at the home very well, as she introduced us to one person using another person's name. The person, who struggled to communicate using words, had tried to correct this but the registered manager had not understood. One person said, "They need a manager over here all the time to keep an eye on things." Another person told us, "I think the staff have lost motivation. They don't seem interested. I don't know why but I think it comes from the top."

Staff were given opportunities to air their views about the home. In February 2018 the provider had sent a written questionnaire to 138 staff of all grades who worked in the five homes on the site and in the shared services that supported the homes, such as maintenance, kitchen, laundry and administration. Responses had been received from 30 staff. When they published the results of the staff survey, the provider wrote, "Overall, Askham is meeting the expectations of the majority. However, there is significant room for improvement."

Staff meetings were held regularly for Askham Grove staff and the provider held an annual 'whole service staff meeting'. A 'smiles and frowns' box was available for staff to make anonymous comments, both positive and where improvements could be made. The provider responded in writing to comments that were made. They explained how suggestions were going to be followed up, or, if that was not possible, the reasons why not.

Staff understood the provider's whistleblowing policy, through which they could report bad practice and be protected. One member of staff said that although they understood the whistleblowing policy was to protect the member of staff who had made a disclosure, they "would not care if they knew it was me who reported."

The provider had a staff recognition scheme in place, with two separate aspects of celebration. A long-service recognition scheme had been introduced in which staff were presented with a certificate of appreciation and a monetary reward if they had been employed at Askham Village Community for five years or more. Certificates presented to long-service staff now working at Askham Grove were displayed on the wall on the first floor, near the lift. There was also a 'star of the month' scheme available but the registered manager told us that staff had voted not to have this at Askham Grove.

The provider had introduced a promotion scheme for care staff. A 12-month 'Assistant Practitioner' course had started. This role would fall between care and nursing and one member of staff from Askham Grove had started the training.

Staff were happy to be working at Askham Grove. One member of staff said, "I like it here, I do enjoy it…it's sort of like one big family." Although another member of staff told us, "I am happy here, but there's something missing….I can't put my finger on what." Nurses and care staff felt supported by each other. Care staff received supervision from one of the nurses. One member of the care team told us they found supervisions "very useful". The registered manager or Quality Nurse supervised the nurses and carried out annual appraisals. Housekeeping/kitchen staff told us they also felt supported by their manager and received adequate training opportunities.

The registered manager was aware of their responsibility to work within relevant legislation, including sending notifications to the CQC. Notifications are events in the home that the provider is required by law to tell us about.

There were minimal links with the local community. People and their relatives from all five homes were encouraged to use the café where they could meet other people. The café was open to the general public. A board on the road invited passers-by in, but few people took up the invitation. Groups such as the Girl Guides used the function room for their regular meetings, although people living in the homes were not involved. Staff worked in partnership with other agencies such as the GP, the local authority and the CCG.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans that fully met people's needs and gave staff sufficient guidance were not always in place or up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's privacy was not always respected. People were not always supported to retain their independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had not been operated effectively to ensure that people's views were sought and acted on. Quality monitoring was not effective to ensure compliance with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to meet people's needs at all times.