Resicare Homes Limited

Ashton Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Ashton 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.

Ashton Lodge provides personal care and accommodation for older people. Many people living at the home were living with some form of dementia. Ashton Lodge is registered to provide care for up to 54 adults. At the time of this inspection 51 people were living at the home. Ashton Lodge comprises of a building offering accommodation over two floors.

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 service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had not been a registered manager since 25 July 2017.

The previous provider's nominated individual had taken over the management of the home following the last inspection. However, there were no provider level quality monitoring visits, to review the quality of the care being provided. The service had benefited from involvement from the local authority following the last inspection and rating of Inadequate. However, the service had no other plans in place to provide an independent review of the service. When this level of involvement provided by the local authority ends, it was unclear how the service will continue to develop. Especially without a registered manager in place.

Staff did not always treat people in a respectful way which promoted their dignity and wellbeing. Although improvements had been made in this area following our previous inspection staff were not consistently treating people in a respectful way.

Improvements had been made to promote people's social needs. Activities were being provided daily. People who spent all their time in their rooms received some support and time from staff, although we questioned if these people needed or would benefit from more support from staff.

Despite this we found that the service was not always trying to meet people's individual social needs. The

management of the home was not always identifying people's interests, past hobbies, and achievements. They were not using this knowledge in a meaningful way to actually promote people's social needs. Staff were not spending time chatting and engaging with people on a regular basis.

These issues constituted a breach in the legal requirements. There were breaches of Regulation 17, 10, and 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These are continued breaches from the last inspection. You can see what action we told the provider to take at the back of the full version of the report.

People now had risk assessments in place which identified their needs and the risks they faced. However, these assessments did at times lack details about how people's long term conditions were being managed and how they affected people on an individual basis. One person's risk assessment had not been updated following a change to their needs. There was no new plan of action for staff to follow to help reduce the risks which they faced on a daily basis.

Infection control practices had improved which reduced the risk of spreading infection and potentially causing people to become unwell.

People received their medicines in a safe way. However it was not clear if people received their prescribed creams as the GP intended. Records of the administration of these products were not completed in full to demonstrate this.

Potential safeguarding concerns had been responded to appropriately by the manager at the home. Staff knowledge about how to protect people from experiencing harm and discrimination was not fully complete.

Various safety checks were completed to ensure the equipment used at the home was safe to use. Fire safety checks were being completed but it was unclear following a visit from the fire service if the home was fully legally compliant. The fire service had last visited the home in 2015. We suggested the manager revisited this safety issue.

The service's emergency plan was not robust. It lacked some step by step practical information to guide the person in charge about what actions they should take in the event of certain emergencies.

Although staff practice had improved in key areas of their work, this was still an on-going process. Staff competency was now being reviewed and we saw staff practice being monitored when we visited the home. However, these competency checks were not well evidenced and did not demonstrate how the assessor had reached the conclusion that those individual members of staff were competent in areas of their work.

People were supported to have enough to eat and drink especially those who were at risk of being an unhealthy weight. These people's food and fluid intake was being closely monitored and professional involvement was obtained and advice followed when this was appropriate. People were being given choices about what they ate and drank and people's dining experience was being monitored. However, we still found that choice with food and drinks was not being fully promoted by the service. Improvements were also still required in people's 'meal experiences.'

People were being supported to make choices about the day to day care they received. Staff had a good knowledge about how to encourage people to make their own decisions. However, we found that 'best interest' processes when people potentially lacked capacity to make certain decisions, were not always

being followed. This process is to support people to make decisions which they would have made if they did not lack capacity to do so.

We saw many examples of staff being kind and caring towards the people they supported. The management of the home had made changes to improve the culture and awareness of staff in meeting vulnerable people's needs. However, work was still required in this area and we observed that some staff did not consistency treat people with respect or in a kind way.

Complaints were being processed in an open and transparent way. The management team sought people's feedback and views on elements of their care and responded positively to this. However, further work was needed to fully review and consider if people's individual needs were being met. Plans were being made to do this in the future.

The management team were monitoring how the care and support at the home was being provided. They were providing feedback to staff and reviewing their systems to try and ensure effective care was provided. They had identified the home's values and were implementing these. Notable improvements had been made since our last inspection. Further time was required to see if the service developed further and to evidence if these changes are fully embedded into the service.

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

We found that some action had been taken to improve safety but improvements were still needed.

People had risk assessments in place but these were not always complete.

Infection control practices had improved.

Potential safeguarding concerns had been responded to appropriately.

Fire safety at the home needed further action.

The service's emergency plan was not robust.

Is the service effective?

Requires Improvement

We found that some action had been taken to improve people receiving effective care but improvements were still required.

Staff practice had improved in key areas of their work.

Staff competency was being monitored but this was not always well evidenced.

People were supported to have enough to eat and drink especially those who were at risk of being an unhealthy weight.

People were not always supported to have choices with what they ate and drank.

Best practice when supporting people who lacked capacity to make certain decisions was not always being followed.

Is the service caring?

Requires Improvement

We found that the service was still not consistently caring towards the people at the home.

Staff did not always treat people with respect or dignity.

Staff were not always thoughtful and kind towards people.

People were not being fully involved in the planning of their care.

People's confidential information was protected.

Is the service responsive?

Requires Improvement

We found that some action had been taken to improve how the service responded to people's needs. However, people's needs were not being fully met in a person centred way.

People's assessments had improved but these were still not fully personal to the individual person.

Activities were taking place but these were not always meeting people's individual social needs.

Complaints were being processed appropriately.

Is the service well-led?

Inadequate

We found that some improvements had been made but the service was still not well led.

There was no Registered Manager in place.

The provider was not completing quality monitoring audits.

Existing quality audits were not always effective.

There was a lack of community involvement at the home.

Ashton Lodge

Detailed findings

Background to this inspection

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

We undertook an unannounced inspection of Ashton Lodge on 10 and 11 April 2018. This was to check if improvements had been made to meet legal requirements planned by the provider after our previous comprehensive inspection on the 31 August and 1 September 2017 when the service was rated as Inadequate. The inspection team inspected the service against all of the five questions we ask about services: is the service safe, effective, caring responsive and well led. This is because the service was not meeting some legal requirements.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of this type of care service. To support consistency, the inspectors for this inspection were the same inspectors who visited the service six months ago.

Over the last six months we have been in contact with a representative from the local authority contracts team. We spoke with Healthwatch who had been asked by the local authority to conduct a recent visit to the home. Healthwatch is a statutory organisation set up to understand the experiences of people living in health and social care settings. We asked these organisations for their views on the service to aid with our planning. We looked at the notifications that the manager had sent us in the last six months. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with 13 people who lived at the home, five people's relatives, four members of staff, and the chef, the deputy manager and the manager of the home. During the inspection we also spoke with three visiting health and social care professionals. We looked at the care records of five people, and medicines records of people at the home. We also looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the

home and the staff. We also reviewed the audits and safety records completed at the home.

Requires Improvement

Is the service safe?

Our findings

When we visited Ashton Lodge in September 2017 we found that people's safety was not always being promoted at the home. We found a breach of the Health and Social Care Act 2008 Regulation of Safe Care and Treatment in relation to limited or incomplete risk assessments. Infection control processes were not always being followed. Safe processes when administering people their medicines were not being adhered to. At this inspection in April 2018 we found that some improvements had been made in these areas.

We looked at a sample of five people's care records. These identified the key risks which people faced. These risks were also being reviewed on a regular basis. When we spoke with staff they were knowledgeable about these risks. However, out of this sample of the five records we looked at we found that one person's needs had changed recently, and their risk assessment did not reflect how this change could impact on the risks which they faced. This person's risk assessment also did not identify how this additional risk to their safety was being managed. We raised this with the management team during our visit.

During our visit we did not observe any unsafe infection control practices. The home was clean. We spoke with people's relatives who commented on this. One relative said, "It's (the home) always clean." Another relative said, "It's (the home) clean and tidy." However, we did find some used continence products which had not been fully disposed of in the correct way. Some used incontinence products had been placed in the correct container, but they had not been placed in a bag before being placed in the container.

We looked at people's medicines to see if they had been administered safely. We observed that staff administered people their medicines in a safe way. Staff who completed this task were not interrupted. The medicine trolley was secured and stored correctly. We completed a spot check on four people's medicines and found that the correct amount of medicines had been given.

Despite this, we found that people's prescribed cream (skin care) charts did not confirm that people had in fact received this product as prescribed. It stated that cream had been applied but it did not state where. The manager told us that staff did check people's Medication Administration Record (MARs) when applying people's creams. However, the records used did not demonstrate this. The manager said they would review the records to ensure full information was recorded in the future.

Some people's prescribed creams were being stored in their rooms. These products should not be stored above a certain temperature. We saw that the temperatures of these rooms were being checked two to three times a week. However, we noted that some people's rooms were very warm. Therefore there was a risk that these products could exceed the recommended temperature.

When we visited the home in September 2017 the management of the home did not have a contingency plan in place. When we visited in April 2018 we were shown the service's contingency plan. Although it was positive that a plan was in place, we found it was not complete and did not contain some essential information.

When we visited Ashton Lodge in September 2017 we found that a safeguarding incident had not been reported to the local authority safeguarding team and processed in the correct way. This resulted in a breach of the Health and Social Care Act 2008 Safeguarding service users from abuse and improper treatment. When we visited in April 2018 we found that potential incidents had been reported to the local authority and the management had a system of responding to potential safeguarding concerns.

We spoke with staff about their understanding about how to protect people from experiencing potential harm and abuse. We spoke with four members of staff about this. Two members of staff needed guidance about what abuse could look like. When we spoke with two other members of staff they were clear about what abuse is and how to identify the potential signs. We asked staff what they would do if they had concerns. All said they would speak with the manager. Two members of staff did not know of outside agencies they could also report their concerns to such as the local authority safeguarding team. Two members of staff did know of this team but they did not know how to make contact. These members of staff spoke of a telephone number, "Somewhere" in the office or in the hall ways. But they did not know where it was located.

During our visit we also asked staff about their understanding of discrimination. Staff did not have a clear and good understanding about this. Staff had heard of protected characteristics such as race, age, sexuality. However, staff did not have a clear understanding of how people living at the home could be vulnerable to experiencing discrimination or what this could look like. This was not a concept staff had considered.

The management of the home had ensured that the various equipment, which was used in the home had been tested, to ensure it is safe to use. People had emergency evacuation plans in place which contained information about how people should be supported to evacuate in the event of an emergency.

We looked at the fire safety checks the service completed. Routine monthly checks were completed in relation to various fire related equipment at the home. We saw records showing that fire drills had taken place regularly in different parts of the home. But there was no clear information to show that all staff, at some point, had been involved in a fire drill.

During our fire safety checks we found a letter from the Bedford Fire and Rescue Service, stating in 2014 the service was not compliant with the fire regulations. We spoke with the manager about this who contacted the fire service who later sent via e-mail a letter stating in 2015, "All measures in the enforcement notice have been satisfactory completed." However, the letter also goes on to say that the service needs to address the "Additional fire safety deficiencies notified in the schedule." The manager was unable to tell us if these 'deficiencies' had been resolved.

The service had a system of recording and responding to 'accidents and incidents' which stated the outcome for each person. Action plans to manage a change in need were put in place following an incident or accident. Some analysis on an individual basis was undertaken for example when people had experienced falls. However, there was no wider analysis which the management completed to look for trends or patterns with incidents and accidents. We spoke with the deputy manager about this. They told us the home had just started this as of April 2018.

At this inspection we found that there were sufficient numbers of staff who were also effectively deployed about the home. The people who lived at the home and their relatives confirmed this. One person said, "The staff are excellent, there seems plenty of them." A relative told us how staff came quickly when they pressed their relatives alarm in their room when their relative was unwell.

We observed that staff were present and available to support people's needs in the communal parts of the home. When some people became distressed staff were quick to respond. However, when we spoke with staff they told us what time they were finishing that day. Some members of staff had asked for additional hours and this meant that they had a long working day; some said they were working from 7 am to 9 pm with breaks. A relative commented that, "Five pm is the staff's worse time. They're tired and energy is low. Mistakes can be made." We did not observe any examples of this but this is an issue the management of the service needs to consider.

We looked at the services recruitment checks. We noted that staff had Disclosure and Barring Service (DBS) checks before they started working at the home. All three staff recruitment files we looked at had two references from their previous employers. However, we noted that, as found at our previous inspection, not all staff had full and completed employment histories with any gaps in their work history explained. We spoke with the manager and advised them that full employment histories were required. Staff personnel records had proof of their identities. These are all part of the important checks which need to take place to ensure people are safe around the staff at the home.

The people we spoke with said that they felt safe. One person said, "Yes, it's safe. I find it quite friendly. It's the staff that makes me feel safe." Another person said, "I feel safe here." A person's relative said, "It's always safe, we have no real concerns at all."

Requires Improvement

Is the service effective?

Our findings

When we visited Ashton Lodge in September 2017 we found that staff practice was not always effective. The management of the service was not monitoring staff practice. This resulted in a breach of the Health and Social Care Act 2008 Regulation in relation to Staffing. When we visited in April 2018 we found that improvements had been made in this area.

We observed staff assisting people to transfer from a seated position into a wheel chair and vice versa. We noted that people were supported to have safe transfers on all but one occasion. In this instance a person was walking backwards to sit in a wheelchair. As the person began to sit down the wheelchair moved backwards because the brakes had not been put on. Although the member of staff had put the brakes on immediately, the chair should have been secured before this to minimise the risk of an accident occurring. We also saw three occasions when some individuals declined to be transferred out of their armchair and a group of staff had gathered around the person. On one occasion, four members of staff and the manager had gathered around one person. This was not necessary or effective practice.

During this inspection we looked at food and fluid charts for people who were at risk of not eating enough. We also looked at repositioning charts for people who were recovering from a breakdown to their skin. These records were up to date and information was recorded in full. We could see from these records that people who had experienced a breakdown to their skin that their pressure ulcers were reducing in size. We concluded that this demonstrated that staff practice in relation to skin integrity was effective.

The management of the home were now monitoring staff practice. When we visited, a senior member of staff was observing staff. We looked at the staff competency checks completed after staff had started working at the home and on an on-going basis. There were regular checks completed to see if staff were competent in their work. However, these did not evidence how staff competency had indeed been checked. These records did not show how the assessor had reached their conclusion that staff were competent in their work.

Staff spoke positively about their inductions to their work. The manager told us that they had recruited new members of staff following the last inspection. New members of staff now had a two week induction period, or longer if necessary, where they completed training and shadowed senior staff. The manager said staff competency was checked before staff started working independently in the home. The manager also said that all staff induction training was completed before this point. However, this was not demonstrated on the staff training matrix. We spoke with the manager about this who said they would add this information to the service's training record.

When we looked at the staff training programme we could see that all staff had up to date training in key areas. This included training in first aid, fire awareness, safeguarding, mental capacity, dementia care, and moving and handling. However, the training programme did not state when this training was delivered but when it expired. This is important because it shows how current the training was. A long period of time after

the training was completed and when it needs to be refreshed, may indicate that training needs to be revisited earlier than stated.

The people we spoke with felt the staff were well trained. One person said, "The staff are well trained." Another person said, "The staff are wonderful, they seem well trained."

When we visited in September 2017 we found that there were issues with how people were supported with their food and drinks. When we visited in April 2018 we noted that some improvements had been made in this area. However, further progress was still required.

The people we spoke with spoke positively about the food. One person said, "The food is great, like home cooking." Another person said, "The food is excellent, I'm getting fat. The choices are excellent; there are alternatives if you don't like the menu."

We observed lunch and we saw that people who needed assistance were being supported to eat at their own pace. Most people could eat independently with minimal support but staff were available and did offer support in most cases when it was needed. However, we did observe that one person was struggling to eat both their meal and pudding. Staff did not offer this person support, and at times, this person struggled to put food on their fork or spoon. However, we did observe that this person did eat all their food independently in a reasonable time frame. This person may have benefitted from some assurance or offer of support. Staff were seen asking other people if they were ok, but they did not always ask people individually, instead they said it to the room as a whole. Sometimes staff also did not wait for an answer.

Most staff were seen to be sensitive to what people wanted to eat and how they wanted to eat it. People were asked if they wanted gravy and where they wanted it on their food. However, one member of staff did not ask a person where they wanted their salad cream and drizzled it all over their meal, without checking if this was ok with this person.

During lunch we observed people had a choice of three different meals. Staff told us that people had chosen what they were having for lunch in the morning. One person had asked for something else and this was accommodated. Some people were shown pictorial cards to check they still wanted what they had chosen. However, most people were not asked if what they had chosen earlier was still what they wanted. Most people were living with some form of short term memory loss. Other ways to prompt people's memory or support them to make a choice was not being considered at the home.

We spoke with the chef who told us that they spoke with people on a daily basis about the food and checked that people were happy with what they were eating. The chef was aware of those people who were on specialist diets and they showed us the products they brought for these people. Some people were at risk of choking and had a soft or pureed diet. The chef showed us the special plates that these people used to separate the food. They also told us how they made this food look appetising.

During our visit we spoke with one person who had been at the home since 2014. They told us that they enjoyed the food which the chef prepares for them but they particularly enjoyed certain foods which were to their origin of birth and family culture. They told us that the chef had spoken with them about producing this food. However, no action had been taken and no real plans had been made about this. The chef also told us that they had suggested this person taught them how to cook the dishes they liked. However, again no actual plan had been made. The manager told us that they had suggested the home would arrange for a take away occasionally for this person. However, they had not explored with this person which take away location they would use. We found out that this person had not engaged with this idea. The management of

the home had not investigated why this person had responded in this way to this idea or if they were actually eating food on a daily and regular basis that they wanted to eat.

Some people were at risk of dehydration and malnutrition who lived at the home. There had been substantiated concerns in the past that these people's needs were not being met. At this inspection we found that clear improvements had been made in this area. Staff were monitoring people's fluid intake during the day. Lounges had discreet charts totalling these people's fluid intakes. We saw that when some people's weight dropped below recommended healthy levels, action was taken to respond to this issue.

People were being offered drinks throughout the day and snacks in between meals. Although we did note that often people were offered one type of snack or another rather than both. For example people were being offered biscuits or fruit. Staff had not considered if people wanted both. Apart from one person, people were not offered additional helpings or seconds when they had lunch. People were offered a hot drink at set times. We noted that one member of staff asked one person if they would like a cup of tea. The person said, "Oh yes." At this point other people in the room asked for a cup of tea as well. It appeared to us that people would like the option of having more hot drinks during the day.

The management team were completing audits of the dining experience on a regular basis. We saw that, on two occasions, the deputy manager had suggested that the TV was turned down during at mealtimes and music was put on. When we observed lunch, we found that the TV was on at a high volume. In one dining room both the TV and the CD player was on at a high volume. People were not asked if they were happy with this. In one dining room the CD of one artist played on a loop three times. On one occasion a member of staff increased the volume of the CD player. But they did not ask people sitting near the CD player if they were happy about this. We noted that people struggled to hear staff when they offered people a choice of condiments in this dining room.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

When we looked at people's care records and assessments we found some examples of when people potentially lacked the capacity to make particular decisions about the care and support they received. However, in these situations, the service was not following a best interest process. Often they were assuming the person understood the situation in question rather than assessing this person's capacity and then taking appropriate action. Alternatively we could also see that the management of the home were consulting with people's allocated professionals and relatives, but this information was not being used as part of a best interest process.

The manager was in the process of identifying when people did not have capacity, if there was a legal appointee. People who did have capacity had signed consent forms to receive care and support at Ashton Lodge.

The staff we spoke with told us how they promoted choice with people's day to day care needs. One member of staff told us how they helped a person who was visually impaired choose what they were going to wear that day. People were asked and offered choices during the day in relation to food and drinks.

Some people had been placed under a DoLS by the local authority to restrict their freedoms in order to provide them with safe care. We could see that the manager had made applications for standard authorisations in a timely way. When we asked staff about their understanding of DoLS two members out of the four we spoke with did not know what a deprivation of liberty was. Staff should have had a good understanding of what this was and how they needed to support these people who had a DoLS in place.

We concluded that further work was required for the service to be compliant with MCA and DoLS.

People had access to healthcare services when they needed professional involvement in relation to their health. We saw referrals to dieticians when people had difficulties maintaining a healthy weight. The care records we looked at also confirmed that the GP was contacted and visited when this support was needed. We spoke with a visiting health professional told us the staff reacted quickly when there was a change to a person's health needs. They also said, "They [staff] always follow our advice." Some of the people we spoke with talked about getting new glasses and staff arranging optician appointments. A relative told us, "The doctor has been called out recently; I was called and kept up to date." We spoke with other people's relatives who echoed this.

There had been a redecoration and refurbishment programme underway at Ashton Lodge for some time. The manager told us they had redecorated and altered parts of the home to enhance the experience of people living at Ashton Lodge. In particular they told us how they had moved the staff's smoking area out of the garden to enable people at the home to see this as their space. The manager and deputy manager had created new signage to help people orientate themselves around the home. This process was still underway.

Requires Improvement

Is the service caring?

Our findings

At our last Inspection we found that people were not always treated in a kind and respectful way. This was a breach of the Health and Social Care Act 2008 Regulation 10, Dignity and Respect. At this inspection we found that the ways staff interacted with people had partially improved. However, staff practice in this area was not consistently good.

During our visit we observed three interactions which were not respectful. In relation to one member of staff, it was how they spoke to a person on two separate occasions, and how they gave another person their dessert. These interactions were blunt and unkind. People's responses to these situations were not positive. We spoke with the manager about this member of staff because we felt they required further support and training in how to interact with people at the home.

Later in the day we observed an activity. A person was distressed that their relatives were visiting and would not be able to find them in the home. They expressed this to a member of staff. This member of staff started to use exaggerated mimes in front of people, staring into a room then round a corner with their hand shading their eyes. This member of staff then said loudly, "Is she here? No. Is she here? No. Is she here? No. Well, I'll go then." This member of staff then said to the resident, "You don't really think that would happen." At this point this member of staff turned away from this person. This person was then quiet and appeared withdrawn.

The above concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also received positive comments about the staff. One person said, "Staff are always kind and nice." Another person said, "The staff are wonderful." A relative told us that, "I've never seen any unkindness, ever."

During our inspection we observed some thoughtful and kind interactions from staff towards the people living at the home. We saw one member of staff supporting one person with their drink. They spoke gently to this person and helped them sip their drink; they left this person when they had indicated they had had enough and returned to this person to assist them further after this point. We saw staff asking people throughout the day if they were ok. One person was distressed and wanted to see their relative. A member of staff spoke with them at their level and tried to reassure them that their relatives do visit often. They spoke in a calm, age appropriate way to this person. They then made plans to contact their relative. We noted that two people who were living with dementia often called out in a potentially distressed way. We saw staff going to them when this happened. These members of staff were kind and sincere with these people. Often holding their hands and asking how they are. One person often walked about the home. Staff were seen walking with this person about the home at their pace talking with them.

At this inspection we also asked people if they felt staff treated them with respect. One person said, "Staff

always knock on the door and introduce themselves." Another person said, "I am treated with dignity and respect." A further person said, "Privacy is not invaded in anyway."

When we looked at people care records we could see that this had included quotes from the individual concerned. This told us that people had been involved in the planning of their care. The manager spoke with us about how they wanted to promote the use of advocates at the home to support people to be more involved in the planning of their care. However, no plan or action had been taken or made at present. People had been assigned key workers but this was not always displayed in people's rooms or in their records. The people we spoke with did not know if they had a key worker. One person's relative told us that they were aware their relative had a key worker. It was unclear how this role was being used to promote people's rights and interests.

We found that people's private information was stored securely about the home. People's electronic records were stored on a password protected computer system. People's paper records were stored in the manager's office which was locked. Some people's records were stored in their rooms; these were placed in discreet areas in these rooms.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Ashton Lodge in September 2017 we found that the service was inadequate in how they responded to people's needs. This was a breach of the Health and Social Care Act 2008 Regulation 9, Person centred care. At this inspection in April 2018 we found that some improvements had been made. However, sufficient improvements had not been made and there is a continued breach of Regulation 9 Person centred care.

We looked at a sample of five care records. These records contained information about people's routines and their interests and backgrounds. Some people who were living with dementia who could express behaviour which some people found challenging had 'behavioural' assessments in place. We could see that the relevant health professionals were involved and their advice was added to these plans. These people had regular reviews and action plans were put in place and followed up in order to meet these people's needs.

Despite this, some people's care records did not fully capture their backgrounds, interests, and past achievements. One person's record stated they liked music from the 1960's and 1970's but it did not say what bands or types of music they actually liked from these eras. We spoke with this person who told us what they found interesting and what inspired them. This information was not in this person's assessment. This person also preferred support from one member of staff, but this person's name was not in their record. This person's needs had also changed in February 2018 but their care plan and their risk assessment had not been updated when we visited in April 2018. We looked at another person's record which talked about staff talking to this person about their social history, but there was no information to say what this was. There was also generic information about people's long term conditions but this had not been tailored to the individual. Generic information was given about Parkinson's disease and Multiple Sclerosis but this can affect people in different ways and this was not explored.

People were having regular reviews about the support they received. However, these were not person centred. They were not used as an opportunity to look at all elements of the support the person received and their needs. One person's review stated that they were to be made aware of the activities which were taking place in the home to encourage them to be more involved in the home. But they had not tried to tailor the activities to their interests as a meaningful way of opening up this person's social opportunities. With this person's care there had been discussions about various options to improve their quality of life, but no action had been taken. In this person's assessment it also referred to this person as, "Demanding" without any real explanation for this. We believed it was unlikely that this element of their assessment had been shared with them.

Another person spent all their time in their room and was living with advanced dementia. When we visited in September 2017 we found them sitting in bed with the TV on. But the TV was positioned in such a way they could not see it. When we visited this person on the first day we visited the home, this person had a tactile object to touch in their hands but the TV was still in a position they could not see. We spoke again with the

management of the home about this. We visited this person on our second day. Their bed had been moved, but still they could not really see the TV. Also the TV was playing day time TV programmes. The service had not considered what this person's interests were, their favourite films or music, as a way of helping this person engage in some of their past interests.

We spoke with the manager about this who said they were aware of the issues with reviews. They had recently decided that they and the deputy manager would take this role on and complete holistic reviews of people's needs and their care.

At this inspection we found that the service was making efforts to provide activities that people found interesting. There was an activity programme in the reception area. We observed a book club meeting taking place and a quiz. A trip was being planned which would involve most of the people at the home. Some people occasionally went out with staff to the local area for a coffee. However, there was no planned outside entertainment visiting the home on a regular basis. There were times that people sat in silence with the TV on with no interaction and sometimes the sound of the TV was turned off.

People who spent all their time in their rooms had one to one time with staff. We saw on one person's one to one record that a member of staff had read to them and that this person, who was living with advanced dementia, had responded positively to this. We could see that the management of the home was responding to the potential isolation that some people experience who spend all their time in their room. However, one person only had one to one time once a week. Staff said they "Popped" into to see this person but we believed that this is not a sufficient amount of time for this person considering they spent all their time in their room and they were unable to fully express their views.

During our visit we saw that staff did have quick conversations with people and they responded to people when they were distressed or entering into a potential argument with one another. However, we did not see staff spending time and having a 'proper chat' with people. The staff we spoke with said they try and make time to do this. However, they said that it was difficult to fit this into their daily work. Often staff saw this as in addition to their work rather than a part of it.

We visited people's rooms and found the degree to which these rooms were personalised varied. Some people told us that their relatives helped them set their rooms up. Some people were unable to communicate with us in ways we could understand. It was unclear if the sparseness of people's rooms were a result of people's wishes or if the service needed to work with some people or their representatives, so they had the kind of rooms that they wanted to have or would have had before they became unwell. We did note that all people's rooms which we visited were clean and warm. We also noted that people had a lot of incontinence products stored in their bedrooms in cardboard boxes. We found examples of three large boxes of these products often placed in an obvious part of their room. One person had eight large cardboard boxes of these products pilled together in their room in front of their armchairs. This was not a personalised or dignified way of storing these products.

The above concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had some form of end of life plans in place. However, the sample of five end of life plans which we looked these were not detailed. Whether people had requested not to be resuscitated was not always mentioned. These plans lacked detail about how people wanted to spend this part of their lives. Where and how they wanted to be cared for if they become unwell was not identified. Most people had relatives involved in their lives, but the service needed to be making these plans with people. If people did not want

to share their wishes or talk about the end of their lives, the service should be recording this and be returning to this subject in the future. We spoke with the manager about this who agreed a review of the service's approach to these plans was required.

There was a complaints policy in place which was included in the 'service user guide' for people and a copy was displayed in the reception area of the home. Two complaints had been logged in 2017 and both had been responded to appropriately. We also noted many compliments had been received by people whose relatives had lived at the home. One person's relative said, "They [staff] are doing all the right things that will make [name of relative] live well with dementia."

Inadequate

Is the service well-led?

Our findings

When we visited Ashton Lodge in September 2017 we found that the leadership of the service was Inadequate. As a result of this there was a breach of the Health and Social Care Act 2008 Regulation 17. At this inspection in April 2018 we found that improvements had been made. However in terms of the leadership of Ashton Lodge there were still areas which required improvements to be made and the service remained in breach of this regulation. Therefore the rating in this area is Inadequate.

Ashton Lodge did not have a registered manager. The last registered manager deregistered on 25 July 2017. We formally wrote to the provider early 2018 and raised this issue with them. Some applications had been made by an applicant but these were rejected by our registration team due to errors in these applications. The provider had not taken timely action to resolve this issue. Despite this length of time no registered manager was in place when we returned to the service.

The Nominated Individual (person who is legally accountable for meeting the conditions and regulations of the Health and Social Care Act 2008) had taken over the management of the home, following the last inspection. Since the inspection of September 2017 this nominated individual changed. After this change the provider had not completed any quality monitoring audits. There was no plan in place for the provider to do so in the future. There were also no systems in place to enable the provider to do this. The purpose of these provider audits are to give a second review of the service in order to identify areas of improvements and make plans with the management of the service to make these improvements. We found during the inspection the management team were seeking our advice on particular areas relevant to the service. At present due to the service being in 'Special Measures' the local authority have been closely involved in supporting the service. This level of support from the local authority was being provided in the short term, but there was no established provider input to support the development of the service. Therefore, there was a risk that improvements made to the service since the last inspection might not be sustained or built upon.

Audits taking place were not always effective. We looked at the internal audits which the management team were completing. These included the meal time experience, medication and the general manager's quality checks. These were detailed; however, we also identified the same issues found in the meal time audit. This demonstrated that this audit was not effective as it had not resolved the issues it had identified. We identified some shortfalls in staff practice, which the general manager's quality checks had not found. We also found some issues with how people were being supported to have their skin creams administered and how these items were being stored, which the medication audit had not identified. Staff competency checks were in place but they did not evidence how staff were in fact competent.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had outlined their values of the service and these were displayed in the reception area at Ashton Lodge. The staff we spoke with and the management team presented as open and transparent during the

inspection visit. We saw from looking at staff records of meetings, complaints, audits of the food, and from speaking with relatives that the management team responded well to feedback about the service. The management told us about their plans to involve relatives more in the future.

Despite this the service had not fully embedded their vision of person centred care. Not all staff were always implementing this in their day to day practice. Audits of staff competency had not identified this issue. The management team had not implemented person centred reviews at present, but there were plans to do this.

The leadership of the home was available and present in the day to day running of the service. Staff and relatives told us that the management team were available and always responded to their requests and views.

The management team had notified us about all the important events which the service must notify us about by law.

When we visited the home in April 2018 we found improvements had been made. This was as the result of the current management of the Ashton Lodge.

We found that the service was working closely with health and social care professionals in order to meet people's needs. We spoke with visiting professionals who told us that they had a good relationship with the management of the home. However, the wider community was not being involved in the day to day life at the home. The service had not made efforts to strengthen or build relationships beyond key professional organisations.

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 Regulation 9 HSCA 2008 (RA) Regulations 2014: Person Centred Care The service had failed to ensure that people's emotional and social needs were always met by staff. Regulations 9 (1) (c) (b) and 3 (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and respect. The service had failed to ensure that people were always treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the quality of the service provided. Regulation 17 (1) and (2) (a) (e)